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### COVID-19 PANDEMIC IN THE REGION OF THE AMERICAS

#### **Introduction**

1. As of 15 July 2020, the Region of the Americas is the epicenter of the COVID-19 pandemic. The Region includes six (Argentina, Brazil, Colombia, Mexico, Peru, United States of America) of the 10 countries reporting the highest number of cases and deaths globally, with two of those (Brazil and United States of America) ranking in the top three. All 54 countries and territories in the Region have reported COVID-19 cases. Their measures to control the pandemic have shown varying levels of implementation and success.
  2. Although not yet quantifiable, the negative social and economic impact of the COVID-19 pandemic in the short, medium, and long term, at local, national, and global levels, is believed to be unprecedented. This nonetheless presents an opportunity for national authorities to strengthen, restart, and rebuild institutions, capitalizing on successes and lessons learned through innovation, whole-of-government, and whole-of-society engagement in responding to the pandemic. Particularly in countries and territories that have succeeded in responding without exceeding the capacity of their health services, there is increasing pressure to resolve the tension between public health and economic priorities in a manner that does not compromise the gains achieved thus far.
  3. This document provides an update on the COVID-19 pandemic in the Region of the Americas and on the response of the Pan American Sanitary Bureau (PASB). It provides information for Member States of the Pan American Health Organization (PAHO) on how to strengthen and support responsive and adaptive health systems in the face of risks from this pandemic so that the health and well-being of societies, as well as social and economic development in the Region, can be sustained. It assumes that the Region will experience recurring epidemic waves and outbreaks interspersed with periods of low-level transmission over the next 24 months, pending development of a safe, efficacious, and equitably accessible COVID-19 vaccine and achievement of appropriate population coverage
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## Background

4. Since its creation in 1902, the PASB has supported Member States, working in a spirit of solidarity, to respond to a broad range of emergencies and disasters caused by various hazards nationally, regionally, and globally. The most recent major events include pandemic influenza A(H1N1) in 2009; cholera outbreak in Haiti in 2010; Chikungunya virus outbreak in 2014; preparedness for Ebola virus disease during the outbreak occurring in West Africa in 2014-2015; Zika virus outbreak in 2015; Hurricanes Irma and Maria in 2017; and the resurgence of measles and yellow fever in the Region since 2016.

5. Since 1976, PAHO Member States, through numerous resolutions, have requested the Director to support Member States as they prepare for and respond to emergencies and disasters. Over the past 15 years, in particular, Member States have expressed their commitment to enhance their multisectoral preparedness and response capacity vis-à-vis multiple hazards by strengthening the capacity of their health systems and by sharing information in a timely, responsible, and transparent manner. This commitment is expressed through various high-level frameworks and resolutions of PAHO<sup>1</sup> and the World Health Organization (WHO).<sup>2</sup> These include, among others, the International Health Regulations (IHR) (1); the PAHO Strategy for Universal Access to Health and Universal Health Coverage (2); the PAHO Plan of Action for the Coordination of Humanitarian Assistance (3); the Sendai Framework for Disaster Risk Reduction 2015-2030 (4); and the PAHO Plan of Action for Disaster Risk Reduction 2016-2021 (5).

6. Pursuant to the provisions of the IHR, on 31 December 2019, the WHO Secretariat recorded information about a cluster of pneumonia cases of unknown etiology occurring in Wuhan City, Hubei Province, China. On 1 January 2020, the WHO Secretariat requested further information on the event from national authorities in China. The following day, WHO Headquarters sent an email to all WHO IHR Contact Points hosted by the WHO Regional Offices, including PAHO, listing the above-mentioned event among several daily signals/events. On 5 and 12 January 2020, the WHO Secretariat shared related information with all WHO Member States through the secure Event Information Site (EIS). It also published the information in the public domain on its Disease Outbreak News web page on those days.<sup>3,4</sup>

7. On 17 January 2020, PASB activated an Organization-wide Incident Management Structure (IMS). This enabled the release of funds from the PAHO Epidemic Emergency Fund and triggered a series of mechanisms to allow reinforcement of the PASB response

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<sup>1</sup> PAHO Governing Bodies web page. Available at:

[https://www.paho.org/hq/index.php?option=com\\_content&view=article&id=42:governing-bodies&Itemid=419&lang=en](https://www.paho.org/hq/index.php?option=com_content&view=article&id=42:governing-bodies&Itemid=419&lang=en)

<sup>2</sup> WHO Governing Bodies web page. Available at: <https://apps.who.int/gb/gov/>

<sup>3</sup> WHO Disease Outbreak News, 5 January 2020. Available at: <https://www.who.int/csr/don/05-january-2020-pneumonia-of-unkown-cause-china/en/>

<sup>4</sup> WHO Disease Outbreak News, 12 January 2020. Available at: <https://www.who.int/csr/don/12-january-2020-novel-coronavirus-china/en/>

to the introduction in the Region of SARS-CoV-2 virus, the novel coronavirus that causes COVID-19. Also on 17 January, PASB published Epidemiological Alert: Novel Coronavirus (nCoV).<sup>5</sup> On 24 January, the PASB Director sent a letter to ministers of health and other senior officials in the Region of the Americas on the emergence of SARS-CoV-2, including technical considerations and advice.

8. On 22 and 23 January 2020, the Director-General (DG) of WHO convened the first meeting of the IHR Emergency Committee for Pneumonia due to the Novel Coronavirus 2019-nCoV.<sup>6</sup> On that occasion, the DG, based on the inconclusive advice of that committee, determined that the event did not constitute a Public Health Emergency of International Concern (PHEIC).<sup>7,8</sup> On 30 January 2020, the DG convened the second meeting of the IHR Emergency Committee; following the meeting, he determined that the spread of the SARS-CoV-2 virus constituted a PHEIC and issued related Temporary Recommendations.<sup>9</sup> On 11 March 2020, the DG declared COVID-19, the disease caused by the SARS-CoV-2 virus, to be a pandemic.<sup>10</sup> And on 1 May 2020, following the third meeting of the IHR Emergency Committee, the DG issued updated Temporary Recommendations related to the PHEIC.<sup>11</sup> The fourth meeting of the IHR Emergency Committee took place virtually on 31 July 2020.

9. The United Nations General Assembly subsequently adopted COVID-19 pandemic-related resolutions on 2 and 20 April 2020 (6, 7). These were followed by Resolution WHA73.1, adopted by the 73rd World Health Assembly on 19 May 2020 (8). These resolutions highlight the fact that responding to, controlling, and coexisting with the

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<sup>5</sup> PAHO Epidemiological Alert: Novel Coronavirus (nCoV), 16 January 2020. Available at:

<https://www.paho.org/en/documents/epidemiological-alert-novel-coronavirus-ncov-16-january-2020>

<sup>6</sup> WHO IHR Emergency Committee for Pneumonia due to the Novel Coronavirus 2019-nCoV web page. Available at: <https://www.who.int/ihr/procedures/novel-coronavirus-2019/en/>

<sup>7</sup> WHO Director-General's statement on IHR Emergency Committee on Novel Coronavirus, 22 January 2020. Available at: <https://www.who.int/dg/speeches/detail/who-director-general-s-statement-on-ihr-emergency-committee-on-novel-coronavirus>

<sup>8</sup> WHO statement on the meeting of the International Health Regulations (2005) Emergency Committee regarding the outbreak of novel coronavirus (2019-nCoV), 23 January 2020. Available at: [https://www.who.int/news-room/detail/23-01-2020-statement-on-the-meeting-of-the-international-health-regulations-\(2005\)-emergency-committee-regarding-the-outbreak-of-novel-coronavirus-\(2019-ncov\)](https://www.who.int/news-room/detail/23-01-2020-statement-on-the-meeting-of-the-international-health-regulations-(2005)-emergency-committee-regarding-the-outbreak-of-novel-coronavirus-(2019-ncov))

<sup>9</sup> WHO statement on the second meeting of the International Health Regulations (2005) Emergency Committee regarding the outbreak of novel coronavirus (2019-nCoV), 30 January 2020. Available at: [https://www.who.int/news-room/detail/30-01-2020-statement-on-the-second-meeting-of-the-international-health-regulations-\(2005\)-emergency-committee-regarding-the-outbreak-of-novel-coronavirus-\(2019-ncov\)](https://www.who.int/news-room/detail/30-01-2020-statement-on-the-second-meeting-of-the-international-health-regulations-(2005)-emergency-committee-regarding-the-outbreak-of-novel-coronavirus-(2019-ncov))

<sup>10</sup> WHO Director-General's opening remarks at the media briefing on COVID-19, 11 March 2020. Available at: <https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020>.

<sup>11</sup> WHO statement on the third meeting of the International Health Regulations (2005) Emergency Committee regarding the outbreak of coronavirus disease (COVID-19), 1 May 2020. Available at: [https://www.who.int/news-room/detail/01-05-2020-statement-on-the-third-meeting-of-the-international-health-regulations-\(2005\)-emergency-committee-regarding-the-outbreak-of-coronavirus-disease-\(covid-19\)](https://www.who.int/news-room/detail/01-05-2020-statement-on-the-third-meeting-of-the-international-health-regulations-(2005)-emergency-committee-regarding-the-outbreak-of-coronavirus-disease-(covid-19))

COVID-19 pandemic in the coming months will depend on international solidarity and cooperation.

10. This document is aligned with the WHO COVID-19 Strategic Preparedness and Response Plan as updated in April 2020 (9); with the PAHO Strategic Plan 2020-2025 (10); and with the Sustainable Health Agenda for the Americas 2018-2030 (11). It is also aligned with the overall objectives of the Sustainable Development Goals (SDGs) (12), in particular (but not limited to) SDG 3, “Ensure healthy lives and promote well-being for all at all ages.” SDG 3 targets and indicators call for interventions to address global health challenges, strengthen health systems, and improve management of and reduce global health risks.

### **Situation Analysis**

11. From 21 January to 15 July 2020,<sup>12</sup> a total of 7,016,851 laboratory-confirmed cases of SARS-CoV-2 virus infection, including 294,301 deaths, have been reported by all 54 countries and territories in the Region of the Americas. Twenty-six of these countries and territories with available data by age and sex reported 4,076,628 cases, including 168,613 deaths. Sixty percent (60%) of these cases occurred in persons 20 to 59 years of age, and 80% of the reported deaths were in persons 60 years or older. While there are no differences in the proportion of cases by sex, higher death rates are observed in men, who represent 60% of the total deaths.

12. As of 15 July 2020, an overall increasing trend in the incidence of confirmed cases is observed in the Region of the Americas. The regional pooled crude case-fatality rate estimate (number of reported deaths divided by number of reported confirmed cases) is 4.2%. The median country-specific estimate is 2.8%, with an interquartile range from 0.8% to 5.7%.

13. As an estimation of active transmission in the population, the 7-day moving average of the observed COVID-19 incidence rate is used (hereafter referred to as the incidence rate). In the North American subregion, during the week of 9-15 July 2020, the incidence rate showed a significant decrease in Canada (6 cases per 100,000 population) but an acceleration in the United States of America and Mexico, both of which on that date, recorded their highest incidence rate to date – 33 cases per 100,000 population in Mexico and 131 cases per 100,000 population in the United States of America. Consistent with Region-wide trends, in the North American subregion there are no differences in the proportion of cases by sex, and the 20 to 59 year age group accounts for the highest proportion of cases (66%). In this subregion, 61% of the deaths occurred in persons aged 70 years or older, with 60% of deaths occurring in men.

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<sup>12</sup> PAHO COVID-19 Information System for the Region of the Americas. Available at: <https://paho-covid19-response-who.hub.arcgis.com/>

14. The incidence rate is continuing to increase in all countries in the Central America subregion. A small but consistent decrease has been observed in Honduras since 4 July 2020, but the trends should be interpreted with caution as it could be related to a reported decrease in testing during those weeks. The highest rates are reported in Panama, where the incidence rate has continued to increase since the end of May 2020, with the highest level to date—182 cases per 100,000 population—observed on 14 July 2020. Costa Rica, which saw a first peak in early April 2020, has seen a sharp increase since the end of May 2020, with the highest incidence rate at 59 cases per 100,000 population reported as of 15 July 2020. Since the last update, Costa Rica declared community transmission due to the rapid increase in cases and more precisely, the rise in community cases without an epidemiological link. El Salvador and Guatemala both observed a sharp increase in their 7-day COVID-19 incidence rates in the first two weeks of July and are both at or near their highest rates reported to date – 32 cases per 100,000 population in El Salvador as of 15 July 2020 and 37 cases per 100,000 population in Guatemala as of 8 July. The most affected age group in the Central American subregion is persons 20 to 59 years old (78% of cases), with a higher proportion of cases reported in men (59%). With respect to deaths, the most affected group is persons 70 years of age or older (44%), with men in the majority (68%).

15. The incidence rate is continuing to increase in most countries of the South American subregion, and as of 15 July 2020 it has reached, or is nearing, its highest levels since the beginning of the pandemic in each of those countries. Chile has been experiencing a declining trend in its incidence rate since the end of June, but the country continues to report the second highest incidence rate in this subregion with 95 cases per 100,000 population reported as of 15 July. Brazil continues to report increasing numbers of cases and deaths, reporting an incidence rate of 122 cases per 100,000 population as of 15 July 2020. Peru has been experiencing a decline in its incidence rate since 2 June 2020 with 74 cases per 100,000 population reported as of 15 July 2020. In Ecuador, after holding steady during the month of June, the 7-day incidence rate had increased again in the first two weeks of July and reached a rate of 40 cases per 100,000 population reported as of 15 July 2020. The last time Ecuador reported an incidence rate of more than 40 cases per 100,000 population was 5 May 2020. It is important to note both Ecuador and Peru rely on serological rapid diagnostic tests in addition to polymerase chain reaction (PCR) tests to confirm cases. A majority (77%) of the cases in this subregion have occurred in the 20 to 59 year age group, with no significant difference in the proportion of men and women. However, of the 77% of the deaths that occurred in persons over 60 years of age, 61% were men.

16. While an overall decreasing trend in incidence rates has been observed in most countries and territories of the Caribbean subregion, notable increasing trends are being observed in the Dominican Republic, French Guiana, Guyana, Haiti, Puerto Rico, and Suriname. Puerto Rico's incidence rate reached 57 cases per 100,000 population on 15 July 2020, up from 36 cases per 100,000 on 12 June. French Guiana currently has the highest incidence rate in the Region with 281 cases per 100,000 population reported as of 15 July 2020. The drastic increase in cases is driven by cases reported from the coastal regions which include areas on the border with Brazil. Similarly, in Suriname, the incidence rate

began accelerating at the end of June when an incidence rate of 28 cases per 100,000 population was reported between 22-28 June. Since then, the incidence rate in Suriname has remained elevated with a high of 34 cases per 100,000 population reported on 1 July 2020. As of 15 July 2020, the Dominican Republic reached its highest incidence rate since the start of the pandemic – 75 cases per 100,000 population. The incidence rate in Haiti has been decreasing steadily since its peak on 6 June 2020 (12 cases per 100,000 population) and reached a low of 3.5 cases per 100,000 population as of 15 July 2020. However, the percent positivity (positive cases/total cases tested) in Haiti remains high with 45% of the cases testing positive as of 14 July 2020. In the Caribbean subregion as a whole, the majority (74%) of cases were reported in the 20 to 59 year age group. However, most deaths (69%) were registered in persons over 60 years of age. Across all age groups, there were no significant differences in number of cases reported by sex, but 69% of deaths occurred in men.

17. Thirty-four countries and territories have each implemented molecular diagnostic methods for the detection of SARS-CoV-2 virus in at least one National Public Health and Reference Laboratory with support from PASB. While at least 18 countries and territories have in-country sequencing capacity, all have access to sequencing from selected laboratories outside the country. However, the procurement of supplies for in vitro diagnostics has been hindered by the shortage of products available on the market. In that context, as of 30 June 2020, PASB has provided primers, probes, controls, and/or PCR kits to support approximately 4,900,000 reactions/tests. Countries and territories were also supported in the procurement of over 10 million PCR tests through the PAHO Regional Revolving Fund for Strategic Public Health Supplies (hereafter referred to as Strategic Fund).

18. To mount a comprehensive response, all 35 Member States activated intersectoral coordination mechanisms in response to the COVID-19 pandemic. These involve the highest political leadership, including officials in key sectors, and the active engagement of local governments and authorities, as well as the activation of crisis management plans and emergency response mechanisms.<sup>13</sup> Twenty-three Member States declared a State of Emergency,<sup>14</sup> and at the time of this writing, 12 of them have extended that initial declaration.<sup>15</sup> Across the Region, countries and territories mobilized domestic resources and more than US \$500 million in loans (new or redirected) from international financial institutions (World Bank, Inter-American Development Bank) and grants from other development partners (e.g., the Global Fund and Gavi, the Vaccine Alliance).

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<sup>13</sup> World Health Organization. Tracking Public Health and Social Measures dataset. Available at: <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/phsm>

<sup>14</sup> Antigua and Barbuda, Argentina, Barbados, Belize, Bolivia, Canada, Chile, Colombia, Costa Rica, Dominica, Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Haiti, Mexico, Paraguay, Peru, Suriname, United States of America, Uruguay, and Venezuela.

<sup>15</sup> Antigua and Barbuda, Argentina, Barbados, Colombia, Dominica, Dominican Republic, Ecuador, El Salvador, Guatemala, Haiti, Peru, and Venezuela.

19. Twenty-seven Member States have activated or established health sector emergency administrative structures and measures to strengthen country health systems.<sup>16</sup> Chronic health systems' challenges include fragmentation, inequitable access to comprehensive health services, weaknesses related to human resources for health, inequitable access to health technologies, limited capacities for essential public health functions (EPHF), underfunded infection prevention and control (IPC) programs, and limited compliance with IPC practices.<sup>17</sup> These have become a priority for immediate action to rapidly scale up and expand public health and individual health care services to respond to the COVID-19 pandemic, while maintaining other essential services (2, 13).

20. Between 30 January and 12 June 2020, all but two of the 35 Member States (Mexico and Nicaragua) implemented measures to drastically limit the flow of incoming international travelers and conveyances or to completely prohibit incoming and outgoing flows. Of these 33 countries, 16 adopted international traffic-related measures before the first case of SARS-CoV-2 virus infection in their territory was confirmed. Generally speaking, international travelers and conveyances on missions with humanitarian purposes (e.g., repatriation, medical evacuation, transport of supplies for the response) are exempt from the above-mentioned measures and subject to *ad hoc* procedures, as are those traveling for purposes related to food security, maintenance of essential services,<sup>18</sup> and national security.

21. From 2 March 2020 onward, all but one (Nicaragua) of the 35 Member States adopted community-wide measures to drastically restrict the movement of the population. These measures range from the cancellation of routine and major mass gatherings, closure of businesses, and closure of schools to generalized lockdowns. Of the 34 Member States that adopted such measures, nine did so before confirmation of the first case of SARS-CoV-2 virus infection in their territory.

22. In the absence of a specific treatment or vaccine for COVID-19, the pattern and magnitude of SARS-CoV-2 virus spread observed in most of the Region up to the beginning of May 2020 is attributable to the adoption of nationwide non-pharmaceutical interventions. These initially appeared successful in slowing transmission of the SARS-CoV-2 virus. In early May 2020, approximately six to eight weeks into the implementation of international traffic-related and social distancing measures, questions about the economic and social sustainability of these measures became increasingly salient. There were also emerging political tensions between political parties and/or between the

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<sup>16</sup> Antigua and Barbuda, Bahamas, Barbados, Belize, Bolivia, Brazil, Canada, Cuba, Dominica, Dominican Republic, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Mexico, Panama, Paraguay, Peru, Saint Kitts and Nevis, Saint Lucia, Suriname, Trinidad and Tobago, United States of America, Uruguay, and Venezuela.

<sup>17</sup> PAHO Desk Review, information not published.

<sup>18</sup> Joint call to world governments on need for 'key worker' designations for essential air and sea personnel; ICAO, ILO, and IMO, 26 May 2020. Available at: <https://www.icao.int/Newsroom/Pages/ICAO-ILO-and-IMO-issue-joint-call-to-world-governments-on-need-for-key-worker-designations-for-essential-air-and-sea.aspx>

central and subnational levels, including issues related to the electoral cycle, in certain countries. Amid these concerns—combined with, possibly, a false sense of having brought the pandemic under control—countries experienced heightened needs and pressures to relax the measures adopted.

23. A COVID-19 readiness self-assessment was conducted between January and April 2020 by more than 500 hospitals (public and private) in 18 countries and territories.<sup>19</sup> Results indicated moderate levels of preparedness in some key areas such as laboratory capacity for diagnosis of SARS-CoV-2, isolation, and case management. Scores were lowest for areas related to the care of patients requiring critical care and the availability of equipment for medical care, including personal protective equipment (PPE) and ventilators. Expanding and reorganizing the health network has required important short-term actions and investments to address identified priority gaps. All countries and territories have implemented measures to expand hospital capacity to respond to the COVID-19 pandemic, including executive decisions at national level to integrate national capacities to the extent possible, especially for critical care; centralized management of beds; repurposing, retrofitting, and upgrading beds; and strengthening clinical management within the network for continuity of care and efficient use of hospital resources, among others.

24. All countries and territories have implemented measures to reinforce IPC. As of 30 June 2020, 33 countries and territories<sup>20</sup> reported having a national IPC program and water, sanitation, and hygiene (WASH) standards in health care facilities. Reinforcing compliance with hand hygiene practices, use of PPE, and cleaning and disinfection of medical devices has been a priority for countries, territories, and PASB from the onset of the pandemic.

25. Emergency Medical Teams (EMTs) and Alternative Medical Care Sites (AMCS) played a key role during the medical surge to expand capacity in order to meet the needs created by the exponential increase in patients. EMTs were primarily national, given the unavailability of international EMTs as a result of travel restrictions and countries' needs to support their own national health systems. As of 7 July 2020, fifteen countries reported 176 national EMTs deployed and nine on standby, as well as 96 AMCS made operational, providing a total of 8,330 inpatient beds and 458 critical care beds. In addition, regional EMTs have been supporting clinical care in border and remote areas, providing access to migrants and indigenous population, particularly of the Amazonia region. Some stadiums and mobile hospitals, used as AMCS, prioritized an increase in the numbers of beds rather than the capacity for effective patient care.

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<sup>19</sup> Argentina, Bolivia, Chile, Colombia, Costa Rica, Cuba, Dominican Republic, Ecuador, Guatemala, Haiti, Mexico, Nicaragua, Panama, Paraguay, Peru, Suriname, Trinidad and Tobago, and Venezuela.

<sup>20</sup> Antigua and Barbuda, Argentina, Bahamas, Barbados, Belize, Bolivia, Brazil, Canada, Chile, Colombia, Costa Rica, Cuba, Dominica, Dominican Republic, Ecuador, El Salvador, Grenada, Guyana, Haiti, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago, United States of America, Uruguay, and Venezuela.



26. In May 2020, through the PAHO/WHO Country Offices, a survey on the first level of care in the context of the COVID-19 pandemic was conducted. The feedback received covered 24 countries<sup>21</sup>. Twenty of them (83%) indicated the incorporation of the first level of care into the health response to the COVID-19 pandemic. Actions taken to tackle the pandemic included education and communication (67%), case investigation and contact tracing (63%), triage (63%), testing (42%), referral (54%), and follow-up of cases and contacts in the community (54%). Main actions undertaken for the continuity of essential services relate to the care of pregnant women (58%) and newborns (54%), immunizations (63%), dispensing of medications (42%), and monitoring of patients with chronic conditions by teleconsultation or home care (71%). According to a recent assessment, outpatient services for noncommunicable diseases (NCDs) continue to be maintained, with limited access in 18 countries (64%) and full access in seven countries (25%) (14). Since April 2020, through the PAHO/WHO Country Offices, PASB has conducted four surveys on routine immunization services. The feedback received on 11 June covered 39<sup>22</sup> countries. Routine immunization services were maintained in 31<sup>23</sup> (79%). However, eight<sup>24</sup> countries (21%) experienced partial suspension of services. Comparison of DPT3 administered doses during the first quarter of 2019 and the same period of 2020 shows a decline of 12.3%. HIV treatments have continued uninterrupted despite shortages, thanks to mitigation measures implemented by countries and territories, including support from PASB through the Strategic Fund.

27. The continuity of essential services provided at the first level of care has been especially affected in peri-urban and rural areas and among indigenous populations. This relates to the already existing deficit of health workers along with social distancing measures, infected health workers, and the closure of various primary care facilities in these areas.

28. The main limitations faced by the first level of care include the human resources gap as well as the lack of incentives; difficulties in connectivity; shortages of medicines, supplies, medical devices, and PPE; and the logistics for conducting case investigation and contact tracing, testing, triage, home care, management of call centers, and teleconsultations. The main reasons for disruption of NCD services include cancellation of

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<sup>21</sup> Argentina, Bahamas, Belize, Bolivia, Brazil, Chile, Colombia, Costa Rica, Cuba, Dominican Republic, Ecuador, El Salvador, Guatemala, Guyana, Honduras, Jamaica, Mexico, Panama, Paraguay, Peru, Suriname, Trinidad and Tobago, Uruguay, and Venezuela.

<sup>22</sup> Anguilla, Antigua and Barbuda, Argentina, Aruba, Bahamas, Barbados, Belize, Bermuda, Bolivia, Brazil, British Virgin Islands, Cayman Islands, Chile, Colombia, Cuba, Curacao, Dominica, Ecuador, Grenada, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Montserrat, Nicaragua, Panama, Paraguay, Peru, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Sint Maarten, Suriname, Trinidad and Tobago, Turks and Caicos, Uruguay, and Venezuela.

<sup>23</sup> Anguilla, Antigua and Barbuda, Aruba, Bahamas, Barbados, Belize, Bermuda, British Virgin Islands, Chile, Colombia, Cuba, Dominica, Grenada, Guatemala, Guyana, Honduras, Jamaica, Mexico, Montserrat, Nicaragua, Panama, Paraguay, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Sint Maarten, Suriname, Trinidad and Tobago, Turks and Caicos, Uruguay, and Venezuela.

<sup>24</sup> Argentina, Bolivia, Brazil, Cayman Islands, Curacao, Ecuador, Haiti, and Peru.

elective care services (14 of 24 countries, or 58%), reallocation of clinical staff to the COVID-19 response (12/24, 50%), and patients not presenting (12/24, 50%) (14).

29. Member States have accelerated actions to strengthen information systems for health and to adopt digital solutions for access to timely (close to real-time) and disaggregated data to support decision-making for responding to the COVID-19 pandemic. Control interventions are being strengthened through the introduction of digital platforms and tools for the management of cases and contacts, as well as for the monitoring of population mobility. Additionally, digital platforms and tools allow for the rapid and extensive dissemination of information on preventive measures. Platforms and applications for teleconsultations, telemedicine visits, remote monitoring of patients, and remote communication are being implemented to enable health workers, in particular at the first level of care, to manage medical care and facilitate home monitoring of people with COVID-19.

30. Health workers are on the frontlines of the COVID-19 response, in occupational categories classified as having very high potential exposure to SARS-CoV-2 virus. As a result, WHO has provided guidance on the rights and responsibilities of health workers, including measures needed to protect occupational safety and health. The occupational risks include late recognition or suspicion of COVID-19 in some patients; work in high-risk departments with long shifts and long exposure to large numbers of COVID-19 patients; suboptimal IPC practices, including insufficient hand hygiene and lack of or improper use of PPE; and insufficient training. As of 2 June 2020, health care workers represented 4.7% of total cases reported through the global COVID-19 surveillance scheme<sup>25</sup> (10, 11).

31. Many countries have promulgated legal and normative tools for the management of human resources for health (HRH), with some declaring COVID-19 an occupational disease. Approaches to expanding HRH capacities have included using health sciences students to support contact tracing, issuing temporary contracts and increasing the number of permanent contracts, entering bilateral arrangements with other countries,<sup>26</sup> authorizing temporary licenses on an exceptional basis for health professionals who received their degree in another country, and reaching agreements to accelerate the graduation of residents and students in the final years of their training.<sup>27</sup> Some countries have also provided economic and non-economic incentives for personnel responding to the pandemic.<sup>28</sup>

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<sup>25</sup> WHO Situation Report, 11 April 2020. Available at: [https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200411-sitrep-82-covid-19.pdf?sfvrsn=74a5d15\\_2](https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200411-sitrep-82-covid-19.pdf?sfvrsn=74a5d15_2).

<sup>26</sup> Many countries in the Caribbean rely on Cuban health workers on a regular basis, and others have received new Cuban brigades to respond to COVID-19 (Antigua and Barbuda, Barbados, Belize, Dominica, Grenada, Jamaica, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, and Trinidad and Tobago).

<sup>27</sup> Argentina, Bolivia, Brazil, Chile, Colombia, Cuba, El Salvador, Dominican Republic, Haiti, Honduras, Mexico, Panama, Paraguay, Peru, Trinidad and Tobago, and Venezuela.

<sup>28</sup> Argentina, Dominican Republic, El Salvador, Honduras, Paraguay, and Peru.

32. Since the beginning of the COVID-19 pandemic, countries and territories in the Region have experienced challenges in accessing essential health technologies for the response, such as in vitro diagnostics, ventilators, and PPE. Some manufacturing countries have imposed export restrictions on PPE, ventilators, and diagnostics, and manufacturers are prioritizing certain markets above others. Border closures and limited flights have further hindered access and increased the costs of essential supplies. The involvement of multiple intermediaries is also affecting the transparency and timeliness of the acquisition process, as well as the ability to monitor the quality of products. These restrictions have further aggravated disruptions to the supply chain for essential health supplies triggered by the pandemic's impact on manufacturing. The challenges experienced in accessing medical supplies due to increased demand during the current pandemic may predict a similar struggle to access COVID-19 therapeutics and vaccines once these become available.

33. The need to accelerate the development and availability of essential health technologies has spurred several global collaborative initiatives. These include the Access to COVID-19 Tools (ACT) Accelerator, a global collaboration to accelerate the development, production, and equitable access to new COVID-19 diagnostics, therapeutics, and vaccines.<sup>29</sup> Another example is the Solidarity Call to Action, an initiative spearheaded by Costa Rica that promotes equitable global access to COVID-19 health technologies through pooling of knowledge, intellectual property, and data.<sup>30</sup> The facilitation of access to international suppliers in the Region, the mobilization of donor resources, and the reorientation of cooperation funds has allowed the expansion of PASB support to countries and territories in need.

34. The scientific community has focused on developing and/or repurposing medicines that can target SARS-CoV-2 virus and infection. Member States are funding and promoting research in a variety of disciplines to address the COVID-19 pandemic,<sup>31</sup> including studies that are not clinical trials and thus are not registered in the WHO International Clinical Trials Registry Platform. Member States have established procedures for rapid ethics review, a practice that was almost entirely absent in the Region in early 2020. Although at the time of this writing, no pharmaceutical therapeutic or prophylactic intervention has proven effective in targeting SARS-COV-2 virus, clinical management guidelines issued by some Member States recommend interventions based on expert consensus, very low quality of evidence, and contradictory research. It is, however, noteworthy that in a recent

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<sup>29</sup> World Health Organization. Access to COVID-19 Tools (ACT) Accelerator. Available at: [https://www.who.int/publications/m/item/access-to-covid-19-tools-\(act\)-accelerator](https://www.who.int/publications/m/item/access-to-covid-19-tools-(act)-accelerator)

<sup>30</sup> World Health Organization. Solidarity Call to Action. Available at: <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/global-research-on-novel-coronavirus-2019-ncov/covid-19-technology-access-pool/solidarity-call-to-action>

<sup>31</sup> The following countries have registered clinical trials or observational studies in the WHO International Clinical Trials Registry Platform: Argentina (13), Bahamas, Barbados, Belize, Bolivia (2), Brazil (41), Canada (64), Chile (8), Colombia (13), Costa Rica (2), Cuba (13), Curacao, Dominica, Dominican Republic, Ecuador (5), El Salvador, Grenada, Guatemala, Haiti, Honduras (3), Jamaica, Mexico (25), Montserrat, Paraguay, Peru (9), Saint Kitts and Nevis, Saint Lucia, Trinidad and Tobago, United States of America (395), Uruguay, and Venezuela.

study, low doses of steroids (dexamethasone) reduced mortality in ventilated patients and in patients receiving oxygen only.<sup>32</sup> The use of pharmaceutical interventions of unproven efficacy—which may not be beneficial and may even harm patients—outside of research settings raises ethical concerns. The pandemic has also brought bioethics to the forefront due to the challenges in prioritizing scarce resources in the delivery of critical care (e.g., ventilators). Advancing equity among countries and territories in the distribution of therapeutics and vaccines that are now in the pipelines is an upcoming challenge, which includes defining what the application of equity entails in such an unprecedented scenario (15-29).

35. Various humanitarian actors have had to reorient their capacities due to the difficulty of mobility and the uneven availability of resources. The Regional Group on Risks, Emergencies and Disasters for Latin America and the Caribbean (REDLAC), an interagency coordination space, has kept the humanitarian community in the Americas informed and has harmonized technical messages and promoted coordination under its structure so that agencies and organizations can provide support in the countries. Weekly information has been made available, and meetings of the health sector cluster in a collaborative fashion with other entities have fostered the creation of thematic groups on topics such as mental health and psycho-social care.

36. The rapidly-evolving nature of the COVID-19 pandemic has required PASB to implement an agile and adaptive mechanism, within an adjusted work context influenced by travel restrictions and social distancing, to respond to the pandemic affecting all countries and territories within the Region. To complement local PAHO resources, where available, personnel and/or supplies have been mobilized to 51 countries and territories in the Region. These have served to, among other things, train national health authorities; support development and activation of national emergency plans and assessment of the reorganization of services; disseminate technical specifications for PPE and biomedical equipment; and support the analysis of needs to cover the requirements of PPE, supplies, and reagents with their usual suppliers, and support Member States to advance purchasing processes to generate a strategic national reserve. From February to mid-March 2020, laboratory trainings were organized in Brazil for nine South American countries, and in Mexico for seven Central American and Caribbean countries; laboratory experts were deployed to nine countries.<sup>33</sup> Experts in clinical management, IPC, and reorganization of health services were deployed to nine countries.<sup>34</sup> Experts on implementation of the Go.data Contact Tracing digital platform were deployed to Argentina, Brazil, Colombia, and Mexico. Additionally, over 90 virtual training sessions have been completed with over 20,000 participants from 33 countries, and more than 90 technical documents and tools have been developed, adapted, and/or translated for use in the Americas. PASB is supporting the strengthening or installation of SARS-CoV-2 virus laboratory diagnostic

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<sup>32</sup> The RECOVERY Collaborative Group. Dexamethasone in hospitalized patients with Covid-19 — preliminary report. *N Engl J Med*. DOI: 10.1056/NEJMoa2021436.

<sup>33</sup> Bahamas, Barbados, Dominica, Colombia, Guyana, Haiti, Jamaica, Suriname, and Venezuela.

<sup>34</sup> Antigua and Barbuda, Bolivia, Dominica, Ecuador, Grenada, Honduras, Nicaragua, Paraguay, and Venezuela.

capacity in 38 countries and territories and has already purchased and distributed laboratory reagents, PPE, and medical supplies and equipment to 37 countries and territories. PASB recently updated its resource requirements to support COVID-19 preparedness and response efforts in the Americas to US \$200 million for the 11-month period from February to December 2020. PASB is engaging WHO, key donors, and partners to bridge the 53% funding gap that remains (as of 15 July 2020).

37. A more detailed update on PASB support to countries and territories in the Americas in their preparation for and response to the COVID-19 pandemic has been published as Pan American Health Organization Response to COVID-19 in the Americas, 17 January to 31 May 2020.<sup>35</sup>

### **Actions Necessary to Improve the Situation**

38. In the absence of a specific treatment and vaccine for COVID-19, this document assumes that the most likely scenario in the evolution of the pandemic is one of recurring waves and outbreaks occurring in different locations within the same country, simultaneously or at different points in time, as the economy progressively reopens.

39. The policy is based on four complementary and mutually reinforcing lines of action:

- a) Strengthening leadership, stewardship, and governance
- b) Strengthening epidemic intelligence
- c) Strengthening health systems and service delivery networks
- d) Strengthening emergency operations response and supply chain

### ***Strengthening Leadership, Stewardship, and Governance***

40. Experiences and lessons learned at national level while responding to the COVID-19 pandemic 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. In particular, evidence has accumulated about the effectiveness of non-pharmaceutical interventions in slowing the transmission of SARS-CoV-2 virus.<sup>36</sup> Advances have been made in strengthening national health systems since the virus emerged, through the application of technology in an innovative manner that facilitates for social distancing, among other measures. The implementation of these non-mutually exclusive measures for controlling COVID-19 is necessarily intersectoral, extending

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<sup>35</sup> Pan American Health Organization. Pan American Health Organization Response to COVID-19 in the Americas. Available at:

<https://www.paho.org/en/documents/pan-american-health-organization-response-covid-19-americas>

(Updated report will be available late September).

<sup>36</sup> Non-pharmaceutical interventions include personal protective measures, environmental measures, social distancing measures, and international traffic-related measures.

beyond the mandate and reach of the health sector. Although not yet precisely quantifiable, their negative social and economic impact in the immediate and long term, at local, national, and global levels, is likely to be unprecedented, thus undermining, among other things, the attainment of the SDGs. Toward this end, national authorities and the PAHO and WHO Secretariats should consider taking the following actions:

- a) Strengthen or maintain a whole-of-government and whole-of-society approach to ease tensions and strike a balance between public health and socioeconomic priorities and interests. This will require continuously and progressively adjusting measures in either direction—either tightening or relaxing them—depending on the transmission scenario experienced. The provision of social, financial, and fiscal protection, especially in communities heavily dependent on informal economies, is critical to prevent and/or mitigate the unintended consequences of those measures.
- b) Strengthen or maintain a consistent risk communication approach regarding measures introduced, adjusted, or discontinued, while maintaining a high degree of individual risk awareness.
- c) Refine strategies for the isolation of COVID-19 cases and the quarantine of their contacts in order to further adapt these strategies to local contexts and increase their efficiency (e.g., through the use of proximity technology).
- d) Anchor the decision-making process related to the adjustment of measures in an iterative analysis of increasingly granular health, economic, and sociological data, aiming at a more geographically targeted implementation of those measures. Efforts and investments are required to expand sources of information and to refine the granularity of the analytical approach so that the decision-making process is based on a robust set of indicators.
- e) Make relevant operational and administrative arrangements, especially in countries highly dependent on tourism, for resuming non-essential international travel by air and sea. This will involve measures by operators of conveyances, at points of entry, and in the hospitality industry. Arrangements must be based on scientific evidence; on global, regional, and national epidemiological situations; and, most importantly, on the capacity of the national health system. Given that the risk of further introductions of SARS-CoV-2 virus cannot be eliminated, resuming non-essential international travel in a progressive, orderly, and fluid manner requires utmost harmonization of policies and practices among countries worldwide, as well as timely and clear communication of those policies and practices in the public domain. At present, the resumption of international non-essential travel should be based on an iterative risk assessment process and not on the requirement for SARS-CoV-2 virus-related laboratory tests results, obtained through either molecular or serological methods.
- f) Ensure timeliness, relevance, and consistency in the formulation of Temporary Recommendations and related technical guidance (e.g., travel advice) by the WHO Secretariat.

41. Strengthen governance of the health systems with management, coordination, and special arrangements for overcoming fragmentation of service delivery in order to leverage capacities in all sub-systems and sectors (public and private). To facilitate critical decision-making processes, develop integrated information systems to provide real-time information on key health services indicators and conduct action reviews.

42. Position public health at the center of health systems transformations and increase investments to develop capacities to implement EPHF, including those required for the application of and compliance with the IHR. Based on multisectoral and country-driven assessments of the EPHF, incorporate actions in national health policies and plans, with the respective budget allocation, giving priority to increasing the workforce for public health and the capacities of health services networks to prepare for and respond to public health events, with due attention to the first level of care and actions at the territorial level.

43. Initiate preparatory activities for immunization in anticipation of a COVID-19 vaccine in the next 24 months. These include expert consultations (in particular, meetings of the regional Technical Advisory Group on Vaccine-Preventable Diseases and of the National Immunization Technical Advisory Committees) to recommend immunization strategies and best practices. Actions should be taken to train national stakeholders (in particular in countries with little or no experience with established seasonal influenza immunization programs); evaluate and strengthen cold chain capacities; develop or update national vaccine deployment plans; strengthen information systems for immunization registries and vaccination coverage; and develop social and risk communication capacities and initiatives. Additionally, participation in regional networks for vaccine safety surveillance should be ensured.

44. Incorporate health sector emergency and disaster risk management into national policies, plans, and budgets, and promote the integration of health into national plans and strategies for response to crisis and pandemics. Strengthen Incident Management Systems at national, subnational and local levels, including leadership roles, and health emergency operations centers (30).

45. Strategically invest resources in research and development, not only for the COVID-19 response, but also for regular health systems and services delivery, to increase their resilience to crises. Establish and implement clear guidance on acceptable ethical approaches to the use of unproven and unresearched interventions for the benefit of patients. Promote the institutionalization of ethical sample collection mechanisms; rapid response collaborative mechanisms, informed by evidence, to support future COVID-19 research; and mechanisms to rapidly translate scientific evidence into policy and practice.

46. Establish and implement policies and programs that mitigate the negative consequences faced by populations in vulnerable situations whose pre-existing adverse conditions have worsened as a consequence of the public health measures. They include, among others, workers without social protection or health insurance, people living in crowded spaces, people in institutions, migrants, the homeless, and indigenous and

Afro-descendant communities living in precarious conditions. For many populations in the Region, the implementation of and adherence to public health measures has been challenging. Among them are workers in the informal economy, dependent on a daily income, who must comply with stay-at-home orders; families living in overcrowded housing with increased risk of interfamily violence and little space for social distancing; and persons without access to running water and soap to practice frequent hand washing.

47. Develop rigorous guidance to advance justice and equity in the global allocation of COVID-19 therapeutics and vaccines.

### ***Strengthening Epidemic Intelligence***

48. Make early detection of suspect cases, followed by their laboratory testing, isolation, contact tracing, and quarantine of contacts, the cornerstone of a targeted and sustainable strategy to control COVID-19 in the medium term. In most countries and territories, this will require a significant scaling up of human resources, greater financial investment, and innovative tools, as well as the maintenance of mechanisms to ensure surveillance of COVID-19 and other communicable diseases.

49. Implement novel approaches and tools for contact tracing and quarantine, adapted to the legal, social, and epidemiological context of each country or territory. Monitor and evaluate the timeliness and completeness of contact tracing and adherence to quarantine. Experiences and lessons learned should be shared with countries within and outside the Region in a spirit of solidarity and to provide mutual assurances on the quality of the response.

50. Implement a combination of strategies for COVID-19 surveillance, such as universal and nominal surveillance based on a suspect case definition; sentinel surveillance of severe acute respiratory infections (SARI) and influenza-like illness (ILI); and event-based surveillance (i.e., systematic collection and assessment of media reports and rumors). Active case finding and SARI/ILI sentinel surveillance (under way in the Americas for over a decade to monitor influenza and other viruses) are critical to enhanced detection and monitoring of COVID-19 transmission in the community. Continued surveillance of influenza viruses should be ensured, given their epidemic and pandemic potential.

51. Strengthen the collection of samples from cases of pneumonia or unusual SARI infections, ensuring adequate collection and timely delivery of samples to the national influenza centers or national laboratories in charge of surveillance and detection of respiratory viruses.

52. Enhance understanding of SARS-CoV-2 virus transmission patterns and epidemiology. PASB considers information on viral genomics to be critical for understanding the origin and global spread of the virus, providing insight into pathogenicity and hence allowing for the development of treatment and vaccine. This has already helped the scientific community sequence as many genomes of SARS-CoV-2 virus as possible.



53. Strengthen event-based surveillance to address the challenges of early detection in populations in vulnerable situations, including indigenous and Afro-descendant populations, whose lack of access to health, communication, and transportation services increases their vulnerability to SARS-CoV-2 virus.

***Strengthening Health Systems and Service Delivery Networks***

54. Strengthen governance of health systems and management of health services networks to increase their adaptive response capacity. Within the most likely scenario for the evolution of COVID-19, health services must adjust rapidly, sustaining and expanding public health and critical care capacities developed for the response to COVID-19. Adjustments must also be made for the continued provision of routine health services, ensuring that essential services are not compromised.

55. Establish defined plans for preparing for, responding to, and mitigating new outbreaks or catastrophes during the pandemic. Disseminate and apply documents and tools for updating response and recovery plans and procedures in a cross-disciplinary and multisectoral way, to improve efficiency, reduce duplication of effort, and enable coordinated collective actions.

56. Implement medical surge strategies according to Emergency Medical Team guidelines to ensure sustainable and self-sufficient responses by medical teams. Consider gaps identified during the response in processes for planning, needs estimates, and expansion of health services network's capacity.

57. Invest in and increase the resolution capacity of the first level of care, which will be critical for identification of cases, containment of expansion, timely management of ambulatory COVID-19 cases in the community, and continuity of essential health services. This includes scaling up human resources capacity (with specific attention to transfer or repurposing of personnel), as well as telecommunications and transportation capacity; ensuring availability of medicines, supplies, medical devices, equipment, and PPE; adapting physical structures as relevant; and instituting measures for home care. The latter includes monitoring of active and recovered cases and the provision of essential health services, requiring equipment for teleconsultations, mobilization logistics, and supplies for medical and nursing care.

58. Identify access barriers and implement strategies to provide coverage to populations in conditions of vulnerability or with specific vulnerabilities during the pandemic, with due attention to specific and differentiated needs. Implementation of mechanisms for community engagement and intersectoral action is critical to respond to the health needs of the population during COVID-19.

59. Implement actions aligned with the strategy and plan of action on human resources for health. This includes establishing unified, reliable, and up-to-date HRH information systems to allow rapid mobilization and task sharing according to the needs for response.

There should be a review of agreements, norms, and regulations for mobility and migration of the health workforce, which has been particularly important for the Caribbean and South America during the pandemic, as well as a review of employment conditions for health workers to ensure that workers with COVID-19 are covered by workers' compensation schemes. Also critical is the strengthening of occupational health programs for health workers.

60. Strengthen IPC programs, considering governance, leadership, and resource allocation, to contain endemic or epidemic pathogens. Utilize a multimodal strategies approach to implement IPC programmatic activities at national level. Integrate IPC activities with other related programs, such as those on HIV, tuberculosis, and viral hepatitis, and with immunization.

61. Continue to accelerate the strengthening of information systems for health and the adoption of digital solutions to enhance access to health services. This will facilitate the assessment, diagnosis, and management of suspected and positive cases in a safe and effective manner, minimizing the risk of transmission while fostering greater equity in access to timely medical care. To strengthen the first level of care during the pandemic, the following, at a minimum, should be adopted: *a)* digital disease registries, *b)* apps for ethical data collection, *c)* apps for secure interaction with patients, *d)* electronic health records and patient portals, *e)* electronic prescription systems, *f)* telehealth tools, and *g)* second medical opinion tools.

62. Leverage advances and innovations from the response to COVID-19 to progress toward universal access to health and universal health coverage, with health systems based on primary health care.

### ***Strengthening Emergency Operations Response and Supply Chain***

63. Ensure that financial and political commitments are in place to provide timely access to diagnostics, medical devices, new vaccine, and therapeutics for all Member States. This will require engaging in global discussions and initiatives such as the Access to COVID-19 Tools (ACT) Accelerator, the United Nations COVID-19 Supply Task Force, and others.

64. Contribute to the adoption of transparent criteria for equitable access and allocation of essential health technologies. Use of the pooled procurement and technical cooperation capacities available through the Revolving Fund for Access to Vaccines and the Strategic Fund could help improve the affordability, availability, and appropriate use of these technologies in Member States.

65. Prepare the national mechanisms required for swift and effective introduction, use, and oversight of new medical products that can mitigate the pandemic. Ensuring quality, safety, and effectiveness of new products needs to be a priority in the context of emergency authorizations for use of these products. It is also important to reinforce the supply chain

capacities to efficiently deploy the incoming technologies while ensuring appropriate access to all other essential health technologies.

66. Strengthen sectoral and intersectoral health coordination and decision-making capacities at national, subnational, and municipal levels, guided by scientific evidence.<sup>37</sup> Apply lessons learned from hard-hit major cities to smaller cities that have not yet been through the outbreak peak, and that can benefit from knowledge transfer on best practices, protocols, and implementation of public measures.

67. Strengthen and integrate national supply chains, warehousing, and logistics capacities and resources, particularly in the context of the uncertainties pertaining to global supply chains.

68. Develop capacity in the Region for the fabrication and manufacturing of essential supplies and technology.

### **Monitoring and Evaluation**

69. This policy will contribute to implementation of Outcomes 1, 2, 4, 5, 9, 15, 16, 17, 18, 20, 21, 23, 24, and 25 of the PAHO Strategic Plan 2020-2025, as well as to the goals of the Sustainable Health Agenda for the Americas 2018-2030.

70. The monitoring and evaluation of this plan will be aligned with the Organization's results-based management framework and with its performance, monitoring, and evaluation processes. A progress report will be issued in 2023, by which time it is assumed that COVID-19 vaccine and/or therapeutics might become available.

### **Financial Implications**

71. The total estimated cost of PASB technical cooperation to support Member States as they implement actions linked to this policy, from 2020 to 2022, including personnel and activity costs, is US \$30 million. Financing of country initiatives will be assumed by the Member States.

### **Action by the Directing Council**

72. The Directing Council is invited to review this document, provide the recommendations it deems pertinent, and consider approving the proposed resolution presented in Annex A.

### **Annexes**

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## 58th DIRECTING COUNCIL

### 72nd SESSION OF THE REGIONAL COMMITTEE OF WHO FOR THE AMERICAS

*Virtual Session, 28-29 September 2020*

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CD58/6\*  
Annex A  
Original: English

### ***PROPOSED RESOLUTION***

#### **COVID-19 PANDEMIC IN THE REGION OF THE AMERICAS**

##### ***THE 58th DIRECTING COUNCIL,***

(PP1) Having reviewed the document *COVID-19 Pandemic in the Region of the Americas* (Document CD58/6);

(PP2) Recalling resolutions COVID-19 response (Resolution WHA73.1 [2020]), International cooperation to ensure global access to medicines, vaccines and medical equipment to face COVID-19 (Resolution A/RES/74/274 [2020]), Global solidarity to fight the coronavirus disease 2019 (COVID-19) (Resolution A/RES/74/270 [2020]), Plan of Action for Disaster Risk Reduction 2016-2021 (Resolution CD55.R10 [2016]), Transforming our world: the 2030 Agenda for Sustainable Development (Resolution A/RES/70/1 [2015]), Sendai Framework for Disaster Risk Reduction 2015–2030 (Resolution A/RES/69/283 [2015]), Strategy for Universal Access to Health and Universal Health Coverage (Resolution CD53.R14 [2014]), Plan of Action for the Coordination of Humanitarian Assistance (Resolution CD53.R9 [2014]), and Revision of the International Health Regulations (Resolution WHA58.3 [2005]);

(PP3) Recognizing that, in each and every single country and territory, the COVID-19 pandemic is, and will be, requiring national leadership and responsibility as well as the whole-of-government and the whole-of-society commitment to sustain consistent and robust response, mitigation, and recovery efforts in the medium and long terms;

(PP4) Considering warranted that the commitment and requests expressed in the World Health Assembly's resolution WHA73.1 on COVID-19 response for responding to,

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\* The proposed resolution version contains editorial adjustments in paragraphs (OP)1e and (OP)2g to ensure alignment with Document CD58/6.

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mitigating the impact of, and recovering from the COVID-19 pandemic are reemphasized and renewed in the Region of the Americas,

***RESOLVES:***

(OP)1. To urge all Member States, considering their contexts, needs, vulnerabilities, and priorities, to:

- a) maintain, enhance, expand, and plan for sustained and sustainable, whole-of-government and whole-of-society policies, strategies, and actions to continue responding to the COVID-19 pandemic;
- b) continue investing, and leveraging advantages and innovation resulting from the response to the COVID-19 pandemic in population- and individual based services throughout the health system, with emphasis on the essential public health functions;
- c) initiate preparatory activities for immunization in anticipation of the availability of a safe, efficacious, and accessible COVID-19 vaccine;
- d) comply with the provisions of the International Health Regulations (IHR), in particular with those related to the timely sharing of information: *(i)* allowing for the comprehensive monitoring of the evolution of the COVID-19 pandemic; *(ii)* enabling States Parties to undertake risk management activities accordingly; *(iii)* allowing the Pan American Sanitary Bureau (the Bureau) to deploy support in the field;
- e) conduct and document—with the support of the Bureau as necessary—reviews of the national response to the COVID-19 pandemic;
- f) take into account the movement of people (e.g., humanitarian and health workers, essential workers, aircraft, and vessel crew members), equipment, and supplies needed for COVID-19 pandemic response operations; as well as of essential goods;
- g) provide sustainable funding to the Pan American Health Organization so that it can fulfill its mandates while responding to, mitigating the impact of, and recovering from the COVID-19 pandemic.

(OP)2. To request the Director to:

- a) continue providing evidence-based technical cooperation to Member States, promote innovation and sharing of experiences, to resume and maintain uninterrupted operations and interventions of the health system in all relevant aspects necessary for responding to the COVID-19 pandemic;
- b) exert transparency, independence, and impartiality, when calling upon States Parties to timely and responsible sharing of truthful information—pursuant to the provisions of the IHR—about the evolution of the COVID-19 pandemic in their territory;

- c) maintain the regional network for the surveillance of influenza and other respiratory viruses, and expand them through the creation of a Regional Genomic Surveillance Network;
- d) support Member States through the Bureau's technical areas, the Revolving Fund for Access to Vaccines (Revolving Fund), and the Regional Revolving Fund for Strategic Public Health Supplies (Strategic Fund) to improve equitable access to, and appropriate use of, affordable, safe, efficacious and quality vaccines, therapeutics, diagnostics, biomedical equipment, and personal protective equipment that can improve health outcomes and reduce the impact of the pandemic;
- e) support Member States in engaging with global initiatives, such as the Access to COVID-19 Tools Accelerator, for vaccines, diagnostics and therapeutics, the Solidarity Call to Action and all other relevant initiatives for the development and access to essential health technologies for COVID-19;
- f) inform Member States on a regular basis on advances in the research and development of COVID-19 vaccines, therapeutics and diagnostics, as well as recommendations for use, principles for access and allocation, regulatory requirements, and actions that the Revolving Fund and the Strategic Fund have initiated to ensure access to vaccines and products for COVID-19;
- g) promote, facilitate and consolidate reviews of the response to the COVID-19 pandemic conducted by Member States, as well as carry out and document an equivalent exercise focusing on the response by the Bureau in alignment with Resolution WHA73.1;
- h) maintain and continue to strengthen the capacity of the Bureau at all organizational levels to respond to the COVID-19 pandemic and other emergencies and disasters;
- i) report regularly to the Governing Bodies of the Pan American Health Organization on the progress made and challenges faced in the implementation of this Resolution.

## **Report on the Financial and Administrative Implications of the Proposed Resolution for PASB**

**1. Agenda item: 4.2 – COVID-19 Pandemic in the Region of the Americas**

**2. Linkage to [Program Budget of the Pan American Health Organization 2020-2021](#):**

*Outcome 1:* Increased response capacity of integrated health services networks (IHSNs), with emphasis on the first level of care, to improve access to comprehensive, quality health services that are equitable, gender- and culturally sensitive, rights-based, and people-, family-, and community-centered, toward universal health

*Outcome 2:* Healthier lives promoted through universal access to comprehensive, quality health services for all women, men, children, and adolescents in the Americas, focusing on groups in conditions of vulnerability

*Outcome 4:* Increased response capacity of integrated health services networks (IHSNs) for prevention, surveillance, early detection and treatment, and care of communicable diseases, including vaccine-preventable diseases

*Outcome 5:* Expanded equitable access to comprehensive, quality health services for the prevention, surveillance, early detection, treatment, rehabilitation, and palliative care of noncommunicable diseases (NCDs) and mental health conditions

*Outcome 9:* Strengthened stewardship and governance by national health authorities, enabling them to lead health systems transformation and implement the essential public health functions for universal health

*Outcome 15:* Improved intersectoral action to contribute to the reduction of violence and injuries

*Outcome 16:* Increased promotion of mental health, reduction of substance use disorders, prevention of mental health conditions and suicide, and diminished stigmatization, through intersectoral action

*Outcome 17:* Health systems strengthened to achieve or maintain the elimination of transmission of targeted diseases

*Outcome 18:* Increased capacity of health actors to address social and environmental determinants of health with an intersectoral focus, prioritizing groups in conditions of vulnerability

*Outcome 20:* Integrated information systems for health developed and implemented with strengthened capacities in Member States and the Pan American Sanitary Bureau

*Outcome 21:* Increased capacity of Member States and the Pan American Sanitary Bureau to generate, analyze, and disseminate health evidence and translate knowledge for decision making at national and subnational levels

*Outcome 23:* Strengthened country capacity for all-hazards health emergency and disaster risk management for a disaster-resilient health sector

*Outcome 24:* Countries’ capacities strengthened to prevent and control epidemics and pandemics caused by high-impact and/or high-consequence pathogens

*Outcome 25:* Rapid detection, assessment, and response to health emergencies

**3. Financial implications:**

- a) **Total estimated cost for implementation over the lifecycle of the resolution (including staff and activities):** \$30 M

Areas	Estimated cost (in US\$)
Human resources	3,800,000
Training	10,000,000
Consultants/service contracts	4,000,000
Travel and meetings	1,800,000
Publications	900,000
Supplies and other expenses (PPEs, diagnostics, etc)	9,500,000
<b>Total</b>	<b>30,000,000</b>

- b) **Estimated cost for the 2020-2021 biennium (including staff and activities):** \$18,000,000, primarily related to regional level actions, including some stock piling.
- c) **Of the estimated cost noted in b), what can be subsumed under existing programmed activities?** \$12,000,000

**4. Administrative implications:**

- a) **Indicate the levels of the Organization at which the work will be undertaken:**  
Regional, sub regional, and national levels, with emphasis on the national level
- b) **Additional staffing requirements (indicate additional required staff full-time equivalents, noting necessary skills profile):**  
No new personnel are foreseen. However, it is critical that the Organization’s current capacity is at least maintained at all organizational levels to prepare and get ready for other potential pandemic- and epidemic-prone pathogens, and to respond to the COVID-19 pandemic and other emergencies and disasters.
- c) **Time frames (indicate broad time frames for the implementation and evaluation):**  
The guidance provided in this policy document should be reviewed, assessed, and revised within two years (2022).

## Analytical Form to Link Agenda Item with Organizational Mandates

1. **Agenda item:** 4.2 – COVID-19 Pandemic in the Region of the Americas

2. **Responsible unit:** Health Emergencies (PHE)

3. **Preparing officer:** Dr. Ciro Ugarte, Director, PAHO Health Emergencies (PHE)

4. **Link between Agenda item and the [Sustainable Health Agenda for the Americas 2018-2030](#):**

This proposed policy document is in alignment with the following goals of the of the Sustainable Health Agenda for the Americas 2018-2030:

Goal 1: Expand equitable access to comprehensive, integrated, quality, people-, family-, and community-centered health services, with an emphasis on health promotion and illness prevention.

Goal 5: Ensure access to essential medicines and vaccines, and to other priority health technologies, according to available scientific evidence and the national context.

Goal 6: Strengthen information systems for health to support the development of evidence-based policies and decision making.

Goal 8: Strengthen national and regional capacities to prepare for, prevent, detect, monitor and respond to disease outbreaks and emergencies and disasters that affect the health of the population.

Goal 9: Reduce morbidity, disabilities, and mortality from noncommunicable diseases, injuries, violence, and mental health disorders.

Goal 10: Reduce the burden of communicable diseases and eliminate neglected diseases.

Goal 11: Reduce inequality and inequity in health through intersectoral, multisectoral, regional, and sub regional approaches to the social and environmental determinants of health.

5. **Link between Agenda item and the [Strategic Plan of the Pan American Health Organization 2020-2025](#):**

As stated in Annex B, this Plan of Action will contribute to achieving the outcomes 1, 2, 4, 5, 9, 15, 16, 17, 18, 20, 21, 23, 24, 25 of the PAHO Strategic Plan 2020-2025.

6. **List of collaborating centers and national institutions linked to this Agenda item:**

- WHO CC on **Laboratory Biosafety** (Departamento de Control de Muestras y Servicios, Instituto de Diagnóstico y Referencia Epidemiológicos (InDRE), Secretaria de Salud)
- WHO CC on **Laboratory Quality Management** (Dirección de Servicios y Apoyo Técnico DSAT, Instituto de Diagnóstico y Referencia Epidemiológicos (InDRE), Secretaria de Salud)
- WHO CC for **Biosafety and Biosecurity** (Centre for Biosecurity, Health Security Infrastructure Branch, Public Health Agency of Canada (PHAC))

- WHO CC for **Biosafety and Biosecurity** (Office of the Associate Director for Laboratory Science, Center for Global Health, Centers for Disease Control and Prevention (CDC))
- WHO CC for **Implementation of IHR Core Capacities** (Programs and Partners Team, Global Health Security Branch, Division of Global Health Protection, Center for Global Health, Centers for Disease Control and Prevention (CDC))
- WHO Collaborating Centre for the **International Health Regulations (IHR)** (Center for Epidemiology and Health Policy, Faculty of Medicine, Universidad del Desarrollo)
- WHO CC for Surveillance, Epidemiology and Control of **Influenza** (Influenza Division, National Center for Immunization and Other Respiratory Diseases, Centers for Disease Control and Prevention (CDC))
- WHO CC for Research and Policy Guidance in **Humanitarian Health Assistance** (Center for Humanitarian Health, Department of International Health, Bloomberg School of Public Health, Johns Hopkins University)
- WHO CC for **Emerging Infectious Disease Response Research and Preparedness** (Office of the Director, National Institute of Allergy and Infectious Diseases (NIAID), National Institutes of Health (NIH))

#### **7. Best practices in this area and examples from countries within the Region of the Americas:**

States Parties in the Region of the Americas have historically embraced the principles of shared responsibility towards global public health underpinning the International Health Regulations (IHR). To that effect, for mutually accountability purposes, they have been systematically submitting their State Party Annual Report of the implementation of the IHR to the World Health Assembly and, most importantly, embracing the quality improvement approach, they have been promoting after action reviews of acute public health events as a tool to further their degree of preparedness. Additionally, as reported to the PAHO Governing Bodies, pursuant to IHR provisions, the volume and timeliness of information sharing regarding events which might entail international public health implications can generally be commended. In response to the COVID-19 pandemic, with few exceptions, States Parties have demonstrated an extraordinary ability to step up their adaptive response capacity, with a whole-of-government engagement.

Other examples of building health system resilience have been observed in programs such as Remediar in Argentina, where counter-cyclical investments in health systems, in particular provision of essential medicines through primary care programs, were made during a period of economic crisis, augmenting the capacity of the country's public health primary care network to provide health care services to the population.

Several countries in the Region are in the process of developing strategies to meet the health needs of migrants. For example, migrants in Brazil have unrestricted access to health care and medicines, and the government of Colombia has enacted a resolution to provide emergency care to migrants.

In addition, the development of NIPPs by countries during the last 10 years following the Influenza H1N1 has proven to be a base for developing COVID-19 response plans including the expansion of the Influenza surveillance systems with a molecular testing capacities for respiratory viruses existing in most of the countries of the Americas.

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