GPHIN Daily Report for 2020-09-10

Special section on Coronavirus

Canada
Areas in Canada with cases of COVID-19 as of 09 September 2020 at 19:00 EDT
Source: Government of Canada

Province, territory or other	Number of confirmed cases	Number of active cases	Number of deaths
Canada	134,294	6,868	9,155
Newfoundland and Labrador	270	1	3
Prince Edward Island	55	11	0
Nova Scotia	1,086	3	65
New Brunswick	192	2	2
Quebec	64,056	1,885	5,771
Ontario	43,685	1,540	2,813
Manitoba	1,365	404	16
Saskatchewan	1,670	59	24
Alberta	15,191	1,692	248
British Columbia	6,691	1,378	213
Yukon	15	0	0
Northwest Territories	5	0	0
Nunavut	0	0	0
Repatriated travellers	13	0	0

A detailed epidemiologic summary is available.
https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection.html#a1

Canada – Coronavirus disease (COVID -19) Outbreaks and Outcomes (Official and Media)

[APG]

Canada

Statement from the Chief Public Health Officer of Canada on September 9, 2020

Source: Public Health Agency of Canada

September 9, 2020

In lieu of an in-person update to the media, Dr. Theresa Tam, Canada's Chief Public Health Officer, issued the following statement today:

“There have been 133,748 cases of COVID-19 reported in Canada, including 9,153 deaths. 88% of people have now recovered. Over the past week, 47,806 people were tested daily, with 1.1% of people testing positive. An average of 618 new cases have been reported daily during the most recent seven days.

As Canadians continue to experience the joy of welcoming new additions to their families, there are important public health measures to consider to keep their infants safe.

Newborns are particularly vulnerable to a variety of infectious diseases, and it is especially important to protect them from COVID-19.

If you are pregnant, or thinking of becoming pregnant, you may consider taking additional precautions to protect yourself beyond the public health measures of physical distancing, frequent hand hygiene, and wearing a mask when distancing is not possible.

Ask visitors to postpone their visit if they’ve experienced any symptoms of COVID-19 in the last 14 days, or if they’ve had contact with a confirmed case. Limit in-person visits to only those inside your close contacts bubble, with the exception of medical visits. Ensure those in your close contacts bubble practise good hand hygiene and wear a mask while visiting.

If you have or suspect you have COVID-19, your best source of health information is your primary health care provider. The Government of Canada also has an online self-assessment tool.

Breastfeeding provides many nutritional and health benefits to newborns and can provide some protection against certain infections. For these reasons, breastfeeding is still recommended when possible during the pandemic. At present, the evidence suggests that COVID-19 cannot be transmitted through breastmilk.

Childbirth and parenting during the COVID-19 pandemic can be stressful, and new parents and caregivers may experience increased feelings of sadness, fear or confusion during this time. Parents are encouraged to stay connected with family, friends, and community supports, even if that connection is virtual.

Some Canadians have reported increased alcohol consumption during the COVID-19 pandemic. September is fetal alcohol spectrum disorder (FASD) awareness month, which serves as a reminder that there is no known safe amount of alcohol to drink during pregnancy. Alcohol consumption can lead to the development of fetal alcohol spectrum disorder (FASD) in infants exposed to alcohol before birth. If you’re struggling with alcohol use and are pregnant, or thinking of becoming pregnant, reach out to your healthcare provider.

Mental health support services and resources are available online, such as the Wellness Together Canada portal for mental wellness and substance use issues. The Public Health Agency of Canada also has resources for new parents.
https://www.canada.ca/en/public-health/news/2020/09/statement-from-the-chief-public-health-officer-of-canada-on-september-9-2020.html

Canada

B.C.'s fall pandemic response plan includes more testing, tracing and flu shots

Source: The Canadian Press - Broadcast wire
ID: 1007807485

[APG]

VICTORIA — British Columbia's fall and winter pandemic battle plan involves ramping up COVID-19 testing, contact tracing and a campaign to administer almost two million flu shots.
Health Ministry officials say they have prepared the province for COVID-19 scenarios ranging from low to exceptional outbreaks and they are confident the health system can meet the challenges.
The officials say some of the preparations include being able to conduct up to 20,000 daily COVID-19 tests, hiring more than 600 additional contact tracers and purchasing more than 1.9 million doses of flu vaccine.
The officials say the plan will also focus on protecting older people, who are particularly vulnerable to COVID-19, with staff increases at long-term care homes and administering 45,000 high-dose flu shots for seniors.
Health officials say the plan represents responses to what the province has learned about preventing the spread of COVID-19 since March.
Premier John Horgan says the province is spending $1.6 billion on its pandemic plan, which will result in hiring an additional 7,000 people to work in the health-care system.
This report by The Canadian Press was first published Sept. 9, 2020.
https://nationalpost.com/pmn/news-pmn/canada-news-pmn/b-c-s-fall-pandemic-response-plan-includes-more-testing-tracing-and-flu-shots

Canada
Hillel Lodge declares COVID-19 outbreak; 17 new cases reported in Ottawa
Source: OttawaMatters.com

Published: 2020-09-10 12:09 UTC
Received: 2020-09-10 12:09 UTC (0 minutes)
Unique ID: 1007811280

Ottawa Public Health has added Hillel Lodge long-term care home to its list of local institutional COVID-19 outbreaks after a staff member tested positive for the virus.
OPH says the staff member tested positive on Tuesday, September 8.
There are 17 institutions dealing with COVID-19 in Ottawa.
OPH has counted 17 more new lab-confirmed positive cases of the virus across the city, bringing the community to 3,151 since the beginning of the pandemic. There have been 2,659 resolved cases (84.4 per cent) since March.
Active cases are down to 225 in Ottawa, according to OPH. The public health agency reported 249 on Tuesday.
There are 11 people hospitalized with COVID-19 in the capital -- one of whom is in intensive care.
The last COVID-19-related death in Ottawa was reported by OPH on August 31. The local pandemic death toll remains at 267.
https://www.ottawamatters.com/local-news/hillel-lodge-declares-covid-19-outbreak-17-new-cases-reported-in-ottawa-2699081

Canada
Spike in Ontario teachers seeking medical exemptions from work amid COVID-19 pandemic
ID: 1007807245
Source: CBC News

Family physicians 'increasingly' facing requests, including from teachers, says college
Posted: Sep 09, 2020 5:00 AM ET | Last Updated: 12 hours ago

Organizations representing family physicians and teaching staff say there's an uptick in the number of Ontario teachers requesting medical exemptions from work amid growing concerns over potential COVID-19 transmission in schools.

Those inquiries have prompted the Ontario College of Family Physicians (OCFP) — which represents more than 12,500 family doctors across the province — to provide new guidance to its members on how to handle work accommodation requests from people coping with chronic illnesses.

Family physicians are "increasingly" getting the requests, including many from teachers, said Dr. Jennifer Young, president of the OCFP.

"The guidance is if you have a chronic disease that is severe, a chronic disease that's not well controlled, a chronic disease that requires immuno-suppressants ... the severity of the disease requires more than average accommodation," Young said.

That could mean requests for an in-class work exemption or other accommodations for someone with severe asthma or chronic obstructive pulmonary disease, for instance, or patients taking drugs that suppress their immune system for a variety of conditions ranging from cancer to inflammatory bowel disease.

"We have educators who were able to work in a classroom pre-pandemic, but have underlying conditions that now make being in that face-to-face situation too great a risk," said Harvey Bischof, president of the Ontario Secondary School Teachers Federation (OSSTF).
Bischof said the union's members are making a rising number of requests, while a spokesperson for the Ontario Public School Boards' Association (OPSBA) also confirmed its members are hearing of an increase "anecdotally."

- **Ontario puts 'pause' on further loosening of public health measures as COVID-19 numbers rise**
- **Have a kid signed up for school bus service? You might need to make other arrangements**

While the organizations CBC News contacted don't have hard data on the spike, numbers from the Toronto District School Board (TDSB) show roughly one in five returning permanent staff members may have some kind of accommodation request for the new school year.

Out of more than 24,000 permanent staff members who completed a survey from the board, roughly 95 per cent said they are returning to work, with 20 per cent of those requiring some form of accommodation, according to figures provided by the TDSB.

Meanwhile, in the Peel District School Board, more than 440 teachers have so far asked for personal medical accommodations for the start of the school year.

Of those, 366 teachers have been offered online assignments as a medical accommodation, said spokesperson Kayla Tishcoff.

Boards 'directed' to prioritize medical exemptions

According to the Elementary Teachers Federation of Ontario (ETFO), there are typically no "cookie cutter" accommodations, which can also be either temporary or permanent.

A member with a vascular condition might be excused from yard duty in extreme weather, or someone with diabetes might require coverage when carrying out necessary blood testing or going for snacks, examples ETFO offers from before the onset of the pre-pandemic.
"When an accommodation is being sought, the employer is entitled to request documentation from a medical professional, and will usually do so," the union explains on its website.

As for who actually grants those accommodations — it's not family doctors.
"Family physicians are expected to use their clinical judgment and knowledge of their patients as it relates to any potential requirements for that individual to be exempt from working in person, or to work remotely," said David Jensen, a spokesperson for the Ministry of Health, in a statement.
"It is not up to the family physician to determine the necessary accommodation."

Instead, it's "up to the employer based on the Human Rights Code to make the accommodation for their employee," notes the guidance for family physicians from their college.
In this case, that means school boards. And so far, teachers' requests are typically being granted across the province.

[APG]

"School boards have been directed to prioritize those with medical exemptions when granting COVID-19 workplace accommodations," noted T.J. Goertz, a spokesperson for the Ontario Public School Boards' Association, in a statement.

- **Worried about getting your kids ready for school during the pandemic? We asked the experts for help**

"We are not aware of any boards having trouble managing the current volume of workplace accommodation requests."
Speaking for the Peel board, Tishcoff said a medical accommodation to work out-of-school has not been offered in the past for teaching staff, but that's changed this year.
"Given the significant number of students who will be moving to fully-online learning, the board will be able to offer online assignments in the PDSB Online School to teaching staff who requested the accommodation within the specified time period and that demonstrate a need to be accommodated by working remotely," she explained.
Bischof said when it comes to teacher requests across the province, things are "going pretty well."

- **200 staff, students at 5 French Catholic schools told to isolate**

The safety issue at hand, he added, isn't boards accommodating teachers, but provincial officials implementing proper policies to protect staff and students who will be in class this year.
While the government maintains safety is at the forefront of back-to-school plans, Bischof maintains the province has "failed" to ensure there is safe ventilation or physical distancing in many Ontario schools.
https://www.cbc.ca/news/canada/toronto/spike-in-ontario-teachers-seeking-medical-exemptions-from-work-amid-covid-19-pandemic-1.5716126

Canada
Alberta orders hundreds of students to stay home after potential exposure to COVID-19
Source: The Globe and Mail
GPHIN ID: 1007803990

Alberta has ordered hundreds of students to stay home from school after they were potentially exposed to the coronavirus at their respective institutions across the province, just days after pupils returned to their classrooms.
The isolation restrictions will last two weeks, even if a person who was potentially exposed to the infection tests negative for COVID-19, according to Deena Hinshaw, the province's Chief Medical Officer of Health.
Alberta counted 1,692 active cases of COVID-19 as of Sept. 7, the highest since May 9, when the pandemic first gripped the province.
Alberta is loathe to impose restrictions that would temper its economy, but Dr. Hinshaw said if community transmission continues to rise, the province's education plans may have to change in areas where the infection is spreading quickly. But even without official restrictions, the virus has already shuttered at least one school in the province.
Alberta Health Services, since Sept. 1, has identified 11 different cases where someone who was infectious attended a school, affecting 11 schools, Dr. Hinshaw told reporters Tuesday. The number of schools affected by the virus is likely larger than 11 because the AHS count includes only those who attended the institution while they were considered infectious, she noted when pressed by reporters. All those who are considered close contacts of such a case – including every classmate – must isolate for 14 days. AHS does not believe the identified cases were infected at their respective school.
"I know that it can be frustrating after just a few days in school that they already may need to stay home for two weeks if they are a close contact," Dr. Hinshaw said. "A single negative test does not assure safety."
Alberta did not identify which 11 schools were affected by the 11 cases. Scores of schools, however, have sent parents letters or posted notices online about COVID-19 at their institutions. The Calgary Board of Education on Tuesday confirmed four schools in its network had identified a COVID-19 case; Edmonton Public Schools counted one case. Fort Vermilion Public School Division on Monday discovered a staff member tested positive for COVID-19, shuttering classrooms for some students until Sept. 21.
"The decision to transition to online learning was made due to reduced in-person staffing levels available at the schools," Michael McMann, the division's superintendent, said on Facebook.

Angela Vernon has three kids in school, including her son Oliver, who attends Bowness High School in Calgary. It is among the CBE schools with a positive case. Ms. Vernon is a single mom and nurse and worried about the possibility of her children being sent home, making it difficult for her to work. The schools, she said, are doing the best they can, but she believes the government has not provided enough support. Information, she said, is sparse.
“It is like jumping off a bridge and not knowing how deep the water is,” Ms. Vernon said about sending her children to school.
Alberta encouraged students and school staff members to get a voluntary COVID-19 test before classes resumed, noted Lynora Saxinger, an infectious disease specialist at the University of Alberta.
“Because we’ve been doing a ton of testing in kids, we’re going to find some positives,” Dr. Saxinger said. She understands why parents might be anxious, but believes it is possible for kids to safely return to schools. It is rare, she noted, for children to suffer from severe outcomes from COVID-19.
Only 3 per cent of COVID-19 patients in hospital in the country are younger than 18 years old, according to Public Health Agency of Canada’s most recent report on the coronavirus. People under the age of 20 accounted for 17 per cent of Canada’s new COVID-19 cases between Aug. 23 and Aug. 29, but just 9 per cent of the country’s total infections over the course of the pandemic, PHAC said in its report published Sept. 4.
We have a weekly Western Canada newsletter written by our B.C. and Alberta bureau chiefs, providing a comprehensive package of the news you need to know about the region and its place in the issues facing Canada.
https://www.theglobeandmail.com/amp/canada/alberta/article-alberta-orders-hundreds-of-students-to-stay-home-after-potential/

Canada
BR-COVID-Tests-Immigrants
Source: The Canadian Press
GPHIN ID: 1007801299

TORONTO — A new report finds immigrants, refugees and other newcomers accounted for nearly 44 per cent of Ontario's COVID-19 cases in the first half of the year.

That's despite the fact overall testing rates were lower for those groups, and that they comprised just one quarter of the population.

The non-profit research institute ICES examined health administrative data collected between January 15th and June 13th, 2020.

Immigrants and refugees who worked in health-care, especially women, accounted for a disproportionate number of cases.

The report's lead author, Dr. Astrid Guttmann, notes many immigrants and refugees face systemic inequities including lower pay and precarious employment that may not offer sick leave.

She adds many also face language barriers and are more likely to live in crowded and multigenerational households, making it more difficult to isolate when cases occur.

The study excludes long-term care residents and those not eligible for provincial health coverage, such as asylum seekers awaiting refugee hearings.
https://gphin.canada.ca/cepr/showarticle.jsp?docId=1007801299

Canada
6 crew members on cargo ship docked in Metro Vancouver test positive for COVID-19
Source: CBC News
GPHIN ID: 1007804754

Unions are raising concerns over the health of seafarers and Metro Vancouver dock workers after cases of COVID-19 were reported on a bulk carrier that arrived in B.C. from South Korea.
The Japanese-owned vessel ended up stuck at a container terminal in Delta, B.C., for several days after its captain and at least one crew member tested positive for the disease, according to union officials.
The 192-metre-long Vega Rose, which is now anchored in Vancouver's English Bay, was berthed at Deltaport for five days with a sealed gangway to prevent people from boarding or disembarking due to the fear of spreading the coronavirus.
It's the second ship sailing Vancouver-area waters to report a potential COVID-19 outbreak among the crew since late August.
The captain of the Panama-registered Vega Rose began experiencing a sore throat and stomach pains shortly after arriving in B.C. waters on Sept. 2, according to a release from the International Transport Workers Federation (ITWF).
He tested positive for COVID-19 the next day, the release said.
At least one other crew member has already tested positive, according to ITWF co-ordinator Peter Lahay.
Lahay said he is trying to confirm reports that a total of seven of the 21 crew members on board have tested positive for COVID-19.
The federation said it was notified about the potential infections after the Vega Rose docked in Delta on Sept. 3.
A release by Rick Hurtubise, president of International Longshore & Warehouse Union Local 502, says two foremen had some limited contact with the vessel, but they wore full protective gear.
Westshore Terminals worked with Transport Canada and the Public Health Agency of Canada to move the vessel out of the terminal to English Bay.
Last Thursday, Transport Canada confirmed that a crew member had been taken off the Vega Rose and placed in quarantine. Transport Canada has deferred any further comment to health officials.
Public Health has yet to respond to CBC.
'It could go through our ranks rampant'
Dock workers' representatives say they are watching how the government handles the situation, which makes many port staff feel at risk given the transient nature of dock work and the close quarters for crew on board ships.
"If the infection hits the waterfront, it could go through our ranks rampant," said Rob Ashton, president of International Longshore & Warehouse Union.
Ashton also fears that any crew member who sets sail infected with COVID-19 may risk death or disability, due to the limited medical facilities on board such vessels.
"That's one of the biggest problems with this whole situation, is when vessels come in and they have sick crew members on them and we don't keep the vessel here until the crew members are safe — the health and welfare of these seafarers who are the life blood of the trade industry are at risk," he said.
"If we let ships set sail with sick crew members, what happens to those crew members? ... I don't want to see this vessel leave Canadian waters until everybody is healthy."
In other parts of the world, Ashton said, ships are held in quarantine for 14 days or until the crew are healthy, but there is a reluctance to start doing that due to the impact on commerce.
In late August, a German-registered container ship called the Sofia Express reported two crew members with symptoms of COVID-19 while docked in Vancouver.
A Westshore Terminals dock worker who was last on shift in Delta on Sept. 1 also tested positive for COVID-19, though sanitization precautions meant there was low risk of further infection, the longshoremen's union said.
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https://www.cbc.ca/news/canada/british-columbia/vega-rose-bulk-carrier-panama-ship-westshore-captain-crew-virus-covid-19-vancouver-1.5715846

Canada
Several schools on Montreal's South Shore reporting multiple COVID-19 cases
Source: CBC News
GPHIN ID: 1007804140

Adrien-Gamache Elementary School in Longueuil is reporting five cases

The Marie-Victorin school service centre (CSSMV) on Montreal's South Shore is reporting 15 cases of COVID-19 at eight of its schools and centres, with three of them reporting multiple cases.

Five cases have been reported at Adrien-Gamache Elementary School in Longueuil.

On Monday, a mobile testing clinic was set up by Quebec public health for students and staff at the school. The CSSMV says 250 people were tested.

Students in five classes were sent home, and the school set up distance learning for them until the situation improves.
In a statement, the CSSMV says the number of cases in school coincides with an increase in cases in the community.
"Our priority remains to provide a safe return to school for all, and to ensure the continuation of our students' learning, while being extra careful about the current situation," the service centre said in a statement.
The other schools where positive cases were detected are:
Charlotte-Tassé Vocational Training Centre — 1 case
Pierre-Dupuy Vocational Training Centre — 3 cases
Lucille-Teasdale International School — 1 case
André-Laurendeau High School — 1 case
Gérard-Filion High School — 2 cases
Monseigneur-A.-M.-Parent High School — 1 case
Vieux-Longueuil International School — 1 case

The CSSMV says its schools have been following a strict protocol of disinfecting common surfaces and enforcing masks and physical distancing in common areas (outside the classroom).

The service centre is also monitoring the situation at Laurent-Benoît Elementary School, where Longueuil Mayor Sylvie Parent attended a news conference last Thursday. Parent tested positive for COVID-19 on Sunday.

The CSSMV says all sanitary measures recommended by public health were followed, and the news conference attendees did not have close contact with students or the teaching staff.

"So far, no cases of COVID-19 among students or school staff at Laurent-Benoît have been declared," the CSSMV said.

According to figures released earlier Tuesday by the government, there have been 120 confirmed cases of COVID-19 among students and staff since schools reopened two weeks ago.
https://www.cbc.ca/amp/1.5716876

Canada
B.C. closes nightclubs, banquet halls after confirming 429 new COVID-19 cases over long weekend
Source: CBC News
GPHIN ID: 1007804004

B.C. is ordering nightclubs and stand-alone banquet halls closed, ending the sale of liquor at restaurants past 10 p.m. and telling venues to reduce the volume from music or other sources to conversational levels, as cases of COVID-19 continue to spike in the province.
Bars and restaurants must close by 11 p.m., unless they are serving food.
The amendments to public health orders come as the province reported 429 new cases of COVID-19 over a four-day period, bringing the total to 6,591. Two more people, both in long-term care, have died of the virus.
The new numbers represent four reporting periods over the long weekend. Provincial health officer Dr. Bonnie Henry said 123 of the cases were recorded between Friday and Saturday, 116 were reported between Saturday and Sunday, 107 between Sunday and Monday, and 83 new cases were confirmed between Monday and Tuesday.

'A difficult day': Nightclub and banquet hall operators in B.C. react to forced closures
There are three new health-care associated outbreaks, at Burnaby Hospital, Rideau Retirement Centre and Holy Family Hospital. There are no new community outbreaks, though there have been several exposure events in the Lower Mainland. Hospitalizations in B.C. remain relatively stable, with 32 people in hospital and 12 in intensive care.
Watch | Dr. Bonnie Henry lays out amendments to the province's public health orders:
Show more
Henry said the amended orders were issued as "a last resort."

"We recognize that these venues have tried. We've made adjustments but there are still exposures happening," she said.
"Going to a nightclub, going to a bar, going to somebody's home — close spaces with face-to-face encounters with people we don't know … that's a risk."
Reduce personal contacts
Henry also reiterated that B.C. residents should be easing up on social interactions as the fall approaches, reining in bubbles to five or six people.
She said the province's philosophical approach to the pandemic has been to issue minimal mandatory restrictions — but that exposures in venues like nightclubs had become a "major source" of transmission, putting strain on public health resources.
"We want to do the least amount we can by order, and make sure we can support people to do the right things they need to do for their own individual situation," she said.

Asked whether she fears that shuttering nightclubs will drive people to private parties, she said the province would continue issuing fines, especially to repeat offenders. But despite the spike in cases linked to private events and venues, Henry said B.C. is "lucky" that community transmission remains relatively low, and that the province is not considering delaying the return to school.
"If we do not put our priority as a community back on [schools], we will have long-term generational downsides," she said.
Henry said she felt restaurants remain safe — adding she "couldn't survive without them" — especially as the industry has worked hard to implement individualized safety plans.
'Second ripple'
Earlier Tuesday, Henry said B.C. was experiencing a "second ripple" of cases of COVID-19 and that she was looking at bringing in new measures to help curb the spread of the virus.
At the beginning of the pandemic, health officials and epidemiologists predicted a second wave, possibly connected to colder weather. Now, modelling predicts a pattern of cases more like ripples or "moguls," as Henry has previously called them, that will spike upwards when enough people in a population become complacent around physical distancing measures.
"I think we're probably in our second ripple," said Henry, speaking to CBC's The Early Edition on Tuesday morning.

"Partly, it's because our testing has gone up and we've had contact with larger numbers in younger people. And I think people needed a bit of a release during the summer. It was very extreme measures that we took in March and April, and it was very concerning for people."
On Tuesday, potential exposure was confirmed among staff and students at a private school in West Vancouver. In a letter to parents, the head of Mulgrave School, John Wray, wrote that the exposure occurred while Grade 9 students were away from campus for an off-site day camp experience.
Vancouver Coastal Health is now conducting contact tracing and those students and staff are self-isolating for two weeks. The students were all part of the same learning group, and the camp activities took place outdoors, with physical distancing measures in place.
"We have had such a successful start to the year. This event may feel like a setback, but such exposures are expected and we have faith in the system that Vancouver Coastal Health has put in place," wrote Wray in the letter.

B.C.'s restrictions began to ease in mid-May, as public health orders were gradually lifted. B.C. entered Phase 3 of its pandemic response plan in late June, allowing for travel within the province.

By mid-July, cases had begun to climb steadily upwards, and B.C. recorded its highest single-day jump in new cases on Aug. 28.
"We had a bit of a grace period in the summer, and allowed people to have that time," said Henry. "We know we need to put our focus and attention on priority things like getting children back into school."

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With files from The Early Edition
https://www.cbc.ca/amp/1.5716065

Canada
B.C. First Nation declares state of emergency due to COVID-19 outbreak.
Source: CBC News
GPHIN ID: 1007806389

The Tla'amin First Nation on B.C.'s Sunshine Coast has declared a state of emergency and issued a shelter-in-place order for 72 hours due to four lab-confirmed cases of COVID-19 in the community.
The order went into effect Tuesday at 5 p.m. PT and requires residents to stay home — or wherever they were at the time the order was issued — until Friday.
Tla'amin Nation leaders posted several statements online notifying residents of emergency measures that have been put in place as they work with provincial health authorities and the First Nations Health Authority to deal with the outbreak.
In addition to the four confirmed cases, several other people in the community are exhibiting symptoms, according to the Tla'amin Nation's notice.
The Tla'amin Nation, located north of Powell River, says it has 1,100 members, with more than 60 per cent of them under the age of 40.
Hegus Clint Williams, a Tla'amin leader, said a "community lockdown" is necessary to help prevent the aggressive spread of the virus.
"We ask our community members to abide by and be respectful of this lockdown and we also ask our friends and neighbours to respect this as well, by not having any unnecessary visits within our community."
Parents are asked to keep their children home for the remainder of the week.
The First Nation is taking other precautions, such as limiting access to the community to a single entry point.
Vancouver Coastal Health issued a warning letter Tuesday to people who attended a wake on Sept. 3 and a funeral on Sept. 4 to notify them of possible exposure to COVID-19.
The First Nation plans to issue a daily update at 4 p.m. on its website and Facebook page during the state of emergency to provide members with advice and guidance.
https://www.cbc.ca/news/canada/british-columbia/b-c-first-nation-covid-outbreak-state-emergency-1.5716803

Canada
School bus routes cancelled across Ontario as COVID-19 worsens driver shortage
Source: CP24 (@CP24)
ID: 1007808266

Published Wednesday, September 9, 2020 3:07PM EDT

School bus cancellations are piling up in Ontario, with transportation providers saying fears related to the COVID-19 pandemic are compounding an existing bus driver shortage across the industry.
Twelve bus routes were cancelled in both the Grey-Bruce and Thunder Bay regions as of Wednesday.
In Sudbury, Ont., the student services consortium announced Monday that 23 routes will not run for at least the first week of school because not enough drivers returned to work.

Providers cited the pandemic and related health concerns as reasons for keeping drivers off the job.

"The school bus industry has been struggling with a driver shortage for more than five years and the global COVID-19 pandemic has only worsened the problem for this school year," Student Transportation Services of Thunder Bay said in a Tuesday statement.

The statement said the average age of a bus driver in the area is 57, with some in their 70s, and many drivers have decided to remain off the job due to age-related health risks from COVID-19.
"We respect their right to make this decision regarding their safety. Unfortunately, we are now faced with the unfortunate situation of having to suspend some bus routes at the start of the school year."

Debbie Montgomery, president of Unifor Local 4268, which represents bus drivers, said the full picture of driver retention and recruitment is still shaking out and may not be clear for a few weeks.

But she said that lack of clarity around safety protocols and access to personal protective equipment has contributed to the situation unfolding across the province this week.
"Now we're hearing that routes are just being cancelled. There's nothing else they can do," Montgomery said by phone Wednesday.

"They can't attract new people and they can't keep those they had. The vehicle might be there but the operator is not."
She said around 60 per cent of bus drivers are over the age of 60 and many are feeling pressure from their families who argue a job paying between $16 and $20 per hour is not worth the health risk.
"When you can't feel confident in your protection, that's huge," Montgomery said. "Every day, there's at least another person saying, 'I can't risk this.'"

The cancellations come weeks after concerns were raised the union, asking for better health and safety guidance for the industry.

Montgomery said the union's requests, including calls for greater compensation for new duties like taking attendance and making sure kids stay in their assigned seats, have not changed.

Parents in Thunder Bay and Grey-Bruce are being advised to check online in the evenings and mornings for any new cancellations.

Brandi Gowan, a mother in the Bruce County area, said the uncertainty around transportation is making a difficult back-to-school year even more stressful for families.
"Families are already feeling stress ... from the pandemic, stress around job security and stress from sending their child back to school, and now we have to worry about busing and whether we have anyone to look after or drive our children into school," Gowan said in an email.

Busing has posed challenges as classes resume across the country, with concerns raised about physical distancing on packed routes and drivers on strike in Winnipeg this week.
Even for families with operational bus routes, sending kids off on a bus and into the classroom has been an emotional transition.

Jennifer McLean, a mother based in Oro-Medonte north of Barrie, Ont., said her Grade 10 daughter texted from the bus Wednesday morning reporting that little had changed on her route, where she was seated a few inches away from another rider.
With health issues preventing her from driving her kid to school, McLean said the initial reports are scary as their small family bubble grows "exponentially" with the return to school.
"I hugged her goodbye this morning and she knows that she can't hug me when she comes home," she said in a telephone interview. "We don't know how to deal with this."
This report by The Canadian Press was first published Sept. 9, 2020.
https://www.cp24.com/news/school-bus-routes-cancelled-across-ontario-as-covid-19-worsens-driver-shortage-1.5098151

[APG]

Canada

N.S. investigating whether latest COVID-19 case involving home-care nurse is a reinfection | CTV News

Source: atlantic.ctvnews.ca
GPHIN ID: 1007806534

HALIFAX -- Nova Scotia's latest case of COVID-19 is a home-care nurse who already tested positive several months ago and was considered recovered.

The case, located in the Nova Scotia Health Authority's central zone, was first reported Monday. The provincial government said the case was under investigation by public health.

Chief Medical Officer of Health Dr. Robert Strang provided more details during a news conference in Halifax Wednesday afternoon.

"The individual's test results have been inconclusive and we are working with our local lab and the national lab to determine whether this is a true case of reinfection or not," said Strang.

"That's why this test required much more investigation from public health in collaboration with our laboratory colleagues."

In the meantime, Strang said they are assuming the case is a new positive case of COVID-19.

"We can't wait to get the final question or answer from the lab, whether we ever get that or not," he said. "We have to make decisions … and we're always erring on the side of caution."

Strang said the person wore full personal protective equipment and followed the appropriate infection controls while working as a home-care nurse.

Public health has been following up with household and close social contacts and working with the home-care agency to determine each client's risk of exposure.

"Appropriate actions will be taken for each client based on these individual assessments," said Strang.

This is a developing story. A previous version is below.

Nova Scotia reported no new cases of COVID-19 on Wednesday. There are still three active cases in the province.

Nova Scotia has gone two days without reporting a new case of the novel coronavirus.

The Nova Scotia Health Authority labs completed 801 Nova Scotia tests on Tuesday.

To date, Nova Scotia has 81,092 negative test results.

There are 1,086 confirmed cases of COVID-19 in Nova Scotia, but 1,018 cases are considered resolved, and 65 people have died, leaving three active cases in the province.

No one is currently in hospital as a result of COVID-19.

The province's confirmed cases range in age from under 10 to over 90.

Sixty-one per cent of cases are female and 39 per cent are male.

There are cases confirmed across the province, but most have been identified in the central zone, which contains the Halifax Regional Municipality.

The provincial government says cumulative cases by zone may change as data is updated in Panorama, the province's electronic information system.

The numbers reflect where a person lives, and not where their sample was collected.

western zone: 55 cases
central zone: 910 cases
northern zone: 67 cases
eastern zone: 54 cases

UPDATED LIST OF SYMPTOMS

Last week, the province reduced the number of COVID-19 symptoms for which health officials are screening. The provincial government said the updated list of symptoms reflects the current epidemiology in Nova Scotia.

Anyone who experiences a new or worsening fever or cough, or two or more of the following new or worsening symptoms is encouraged to take an online test to determine if they should call 811 for further assessment:

sore throat
headache
shortness of breath
runny nose

SELF-ISOLATION

Anyone who tests positive for COVID-19 is required to self-isolate at home, away from the public, for 14 days.
Anyone who travels to Nova Scotia from outside the Atlantic region is also required to self-isolate for 14 days and must fill out a self-declaration form before coming to the province.
Residents of New Brunswick, Prince Edward Island and Newfoundland and Labrador are not required to self-isolate when travelling to Nova Scotia, but they must be prepared to provide proof of their place of residency at provincial borders.
Visitors from outside the Atlantic region who have already self-isolated in another Atlantic province for 14 days may travel to Nova Scotia without having to self-isolate again.
The provincial state of emergency, which was first declared on March 22, has been extended to Sept. 20.
https://atlantic.ctvnews.ca/n-s-investigating-whether-latest-covid-19-case-involving-home-care-nurse-is-a-reinfection-1.5097670

Canada

Canada Is Starting to Reverse COVID-19 Reopening Plans as Cases Rise
Source: VICE US
GPHIN ID: 1007806430
British Columbia's top doctor has ordered nightclubs and banquet halls to close and has imposed new restrictions on restaurants and bars following a spike in COVID-19 cases in the province.

It's just one example of reopening plans across Canada now at risk as the country grapples with a "concerning" rise of the daily rate of new COVID-19 cases, which increased by 25 percent last week.

In B.C., the sale of alcohol must end at 10 p.m., and all restaurants must close at 11 p.m., unless they are serving food, Dr. Bonnie Henry said.

B.C. establishments must also keep TV and music volume down to prevent people from shouting, which increases the likelihood of spreading germs, she said.

Henry announced the public health order changes as the province recorded 429 new cases of the coronavirus and two deaths over the long weekend. The new total confirmed cases of the virus in B.C. is 6,591.
"We recognize that these venues have tried. We've made adjustments but there are still exposures happening," Henry said, noting that the new changes to her public health orders are a "last resort."

Ontario hasn't scaled back any health order yet, but has opted to pause further reopening of the economy. The province recorded 190 new cases of the virus on Monday, 185 on Tuesday, and 149 on Wednesday—a significant increase considering the daily rate of new cases hovered in the double digits at the end of August. Ontario has recorded a total of 43,536 cases, with 1,527 active right now.

The pause in Ontario's reopening plan, which will last for at least a month, means social gatherings and sports event attendance won't increase for now, Ontario Health Minister Christine Elliott said.

"Taking a pause in further re-opening will help avoid broad-scale closures and shutdowns," Elliott said on Twitter.
Elliott added that the slowdown in reopening will help protect children who are currently going back to school. "On the first day of school for many students, we need to do everything we can to limit the spread of COVID-19," Elliott said. "The best way to keep our schools safe is to keep our communities safe."

In Ontario, Premier Doug Ford's back-to-school plan has been heavily criticized, in particular, for not mandating smaller class sizes. Four major teachers' unions have filed complaints with the province's labour board against the Ford government, alleging that the current school reopening plan fails to uphold workplace safety laws, CBC News reported.

Schools across the country are already reporting cases of COVID-19. Alberta is sending hundreds of students home to self-isolate after potential exposure to the virus, the Globe and Mail reported. Ottawa's

Catholic school board is sending about 200 students and staff home after possible exposure on school buses, and 46 Quebec schools already have reported COVID-19 cases.

Dr. Deena Hinshaw, Alberta's chief medical officer, said it's too early to tell whether the province's back-to-school plan is effective. In Alberta, physical distancing is not mandatory in schools. Students also don't need to wear face masks while at their desks if they're not facing others.

The province currently has the second highest number of active virus cases in Canada with 1,692. Canada has confirmed a total of 133,748 COVID-19 cases and 9,153 deaths. Almost 88 percent of infected Canadians have recovered.
https://www.vice.com/en_us/article/y3zjam/canada-is-starting-to-reverse-covid-19-reopening-plans-as-cases-rise

United States - Coronavirus Disease 2019 (COVID-19) - Communication Resources (Official and Media)

United States
Trump Administration Takes Action to Expand Access to COVID-19 Vaccines
Source: U.S. Department of Health & Human Services
ID: 1007807823

FOR IMMEDIATE RELEASE: September 9, 2020
Today, under the leadership of President Trump, the U.S. Department of Health and Human Services (HHS), through the Assistant Secretary for Health, issued guidance under the Public Readiness and Emergency Preparedness Act (PREP Act) to expand access to safe and effective COVID-19 vaccines when they are made available. This guidance authorizes state-licensed pharmacists to order and administer, and state-licensed or registered pharmacy interns acting under the supervision of the qualified pharmacist to administer, COVID-19 vaccinations to persons ages 3 or older, subject to certain requirements.

"This action builds upon our Administration's progress toward delivering a safe, effective, and widely available vaccine by 2021," said Assistant Secretary for Health ADM Brett P. Giroir, M.D. "Allowing pharmacists to order and administer COVID-19 vaccines will greatly expand convenient access for the American people."

To qualify as "covered persons" under 42 U.S.C. § 247d-6d((i)(8)(B) when administering COVID-19 vaccines authorized or licensed by the U.S. Food and Drug Administration (FDA) to persons ages 3 or older, state-licensed pharmacists and pharmacy interns licensed or registered by their state board of pharmacy must satisfy the following requirements:
•The vaccine must be FDA-authorized or FDA-licensed.
•The vaccination must be ordered and administered according to the Advisory Committee on Immunization Practices' (ACIP) COVID-19 vaccine recommendation.
•The licensed pharmacist must complete a practical training program of at least 20 hours that is approved by the Accreditation Council for Pharmacy Education (ACPE). This training program must include hands-on injection technique, clinical evaluation of indications and contraindications of vaccines, and the recognition and treatment of emergency reactions to vaccines.
•The licensed or registered pharmacy intern must complete a practical training program that is approved by the ACPE.
•The licensed pharmacist and licensed or registered pharmacy intern must have a current certificate in basic CPR.
•The licensed pharmacist must complete a minimum of two hours of ACPE-approved, immunization-related continuing pharmacy education during each state licensing period.
•The licensed pharmacist must comply with recordkeeping and reporting requirements of the jurisdiction in which he or she administers vaccines, including reviewing the vaccine registry or other vaccination records prior to administering a vaccine.

•The licensed pharmacist must, if the patient is 18 years of age or younger, inform the patient and the adult caregiver accompanying the patient of the importance of a well-child visit with a pediatrician or other licensed primary-care provider and refer patients as appropriate.
•The licensed pharmacist and the licensed or registered pharmacy intern must comply with any applicable requirements (or conditions of use) as set forth in the Centers for Disease Control and Prevention COVID-19 vaccination provider agreement and any other federal requirements that apply to the administration of COVID-19 vaccine(s).

The authorization preempts any state and local laws that prohibit or effectively prohibits those who satisfy these requirements from ordering or administering COVID-19 vaccines as set forth above. The authorization does not preempt state and local laws that permit additional individuals to administer COVID-19 vaccines to additional persons.

Access a copy of the guidance - PDF*

Information on Operation Warp Speed

Clinical resources on vaccines, including continuing education training on best practices

* Persons using assistive technology may not be able to fully access information in this file. For assistance, please contact the Office of the Assistant Secretary for Health at ashmedia@hhs.gov.
https://www.hhs.gov/about/news/2020/09/09/trump-administration-takes-action-to-expand-access-to-covid-19-vaccines.html

United States - New Resource: Discharge Planning During the COVID-19 Pandemic (Official)
On 9 September 2020, HHS' Assistant Secretary for Preparedness and Response recently published Discharge Planning and Care Coordination during the COVID-19 Pandemic, a resource developed in partnership with ACL and the Centers for Medicare & Medicaid Services.
This tool is designed to support nurses, social workers, case managers, and others conducting discharge planning for adults with disabilities after COVID-19 treatment.
https://acl.gov/news-and-events/announcements/new-resource-discharge-planning-during-covid-19-pandemic

United States
New Resource: Discharge Planning During the COVID-19 Pandemic
Source: U.S. Department of Health & Human Services, Administration for Community Living

September 9, 2020
HHS' Assistant Secretary for Preparedness and Response recently published Discharge Planning and Care Coordination during the COVID-19 Pandemic, a resource developed in partnership with ACL and the Centers for Medicare & Medicaid Services.

This tool is designed to support nurses, social workers, case managers, and others conducting discharge planning for adults with disabilities after COVID-19 treatment.

The resource:
•Describes legal protections for people with disabilities including the Olmstead decision;
•Explains the CMIST (Communication, Maintaining Health, Independence, Services and Support, Transportation) framework and person-centered planning;
•Provides considerations for three potential discharge scenarios to facilitate person-centered discharge planning and care coordination to the most integrated setting; and
•Highlights state and federal resources, including the aging and disability networks, to assist care coordinators and discharge planners.

Last modified on 09/09/2020

https://acl.gov/news-and-events/announcements/new-resource-discharge-planning-during-covid-19-pandemic

United States - CDC
COVID-19 Forecasts: Hospitalizations

Updated Sept. 9, 2020

Interpretation of Forecasts of New Hospitalizations

- This week, three national forecasts predict a likely increase in the number of new hospitalizations per day over the next four weeks, three forecasts predict a likely decline, and one forecast is uncertain about the trend. For October 5, the forecasts estimate 1,600 to 6,000 new COVID-19 hospitalizations per day.
- State-level forecasts also show a high degree of variability, which results from multiple factors. Hospitalization forecasts use different sources of data for COVID-19 cases or deaths, with different limitations, and make different assumptions about social distancing.

National Forecasts

- The seven national forecasts show the predicted number of new COVID-19 hospitalizations per day for the next four weeks in the United States.
- The forecasts make different assumptions about hospitalization rates and levels of social distancing and other interventions and use different methods to estimate the number of new hospitalizations.

State Forecasts

Eight state-level models predicting the number of new hospitalizations were submitted this week. These forecasts show the predicted number of new COVID-19 hospitalizations per day for the next four weeks in each state. Each state forecast uses a different scale, due to differences in the number of new COVID-19 cases occurring per day in each state.

Download state forecasts pdf icon[7 pages][1]
Download forecast data excel icon[2 MB]

Additional forecast data and information on forecast submission are available at the COVID-19 Forecasting Hubexternal icon.

Forecast Assumptions

These forecasts make different assumptions about social distancing measures and use different methods and data sets to estimate the number of new hospitalizations. Information about individual models is available here: https://github.com/cdcepi/COVID-19-Forecasts/blob/master/COVID-19_Forecast_Model_Descriptions.mdexternal icon.

Social distancing is incorporated into the forecasts in two different ways:

- These modeling groups make assumptions about how levels of social distancing will change in the future:
  - Columbia Universityexternal icon (Model: Columbia)
  - Institute of Health Metrics and Evaluationexternal icon (Model: IHME)
  - Johns Hopkins University, Infectious Disease Dynamics Labexternal icon (Model: JHU-IDD)
- These modeling groups assume that existing social distancing measures in each jurisdiction will continue through the projected four-week time period:
  - Georgia Institute of Technology, College of Computing,external icon (Model: GT-DeepCOVID)
  - Karlen Working Groupexternal icon (Model: Karlen)
  - Los Alamos National Laboratoryexternal icon (Model: LANL)
  - US Army Engineer Research and Development Centerexternal icon (Model: ERDC)
  - University of California, Los Angelesexternal icon (Model: UCLA)

The rate of new hospitalizations is estimated using one of four approaches:

- These modeling groups assume that a certain fraction of infected people will be hospitalized:
  - Columbia Universityexternal icon
  - Johns Hopkins University, Infectious Disease Dynamics Labexternal icon
  - Los Alamos National Laboratoryexternal icon
  - US Army Engineer Research and Development Centerexternal icon
  - University of California, Los Angelesexternal icon
- The Institute of Health Metrics and Evaluationexternal icon estimates numbers of new hospitalizations based on numbers of forecasted deaths.

- The Georgia Institute of Technology, College of Computing,external icon uses COVID-19 hospitalization data reported by some jurisdictions to forecast future hospitalizations.
- The Karlen Working Groupexternal icon uses the rate of reported infections to estimate the number of new hospitalizations in a given jurisdiction, unless the rates of reported infections and hospitalizations differ. In that case, the rate of reported hospitalizations is used to forecast new hospitalizations.

[1] The full range of the prediction intervals is not visible for all state plots. Please see the forecast data for the full range of state-specific prediction intervals.

Additional Resources

- Previous COVID-19 Forecasts: Hospitalizations
- FAQ: COVID-19 Data and Surveillance
- CDC COVID Data Tracker
- COVID-19 Mathematical Modeling

https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/hospitalizations-forecasts.html

Markets: Operational considerations for COVID-19 mitigation measures in global low-resource setting

Updated Sept. 9, 2020

Document purpose: Markets are a critical place of commerce and a source of many essential goods, but they can pose potential risks for COVID-19. This document provides suggestions for mitigating COVID-19 transmission in markets in global low-resource settings and describes considerations associated with each mitigation measure. The proposals are presented in table format and are organized by mitigation practice (**physical distancing, hand hygiene, cleaning and disinfection, and respiratory hygiene**).

Document audience: This document is intended for use by any person, institution, or organization preparing for or responding to cases of COVID-19 in the community, and for those assisting those organizations (federal and local governments, CDC country offices, and others).

What this document adds to previously published guidance: This document provides suggestions that can be considered by personnel in low-resource settings outside the U.S. and can be adapted to follow national or local guidelines, and to account for local context. Local populations can be engagedpdf iconexternal icon in the planning and decision-making process by identifying trusted stakeholders and community leaders to provide feedback on proposed mitigation measures before their implementation.

Layered approach: Mitigation measures in markets can be organized into three categories: personal controls, administrative controls, and engineering controls. These should be layered on top of each other to reduce overall risk of COVID-19 for customers and vendors in markets.

- **Personal controls:** Individual behaviors to protect themselves and those around them
- **Administrative controls:** Processes and policies that keep people safe
- **Engineering controls:** Physical structures put in place to distance people from hazards

Physical Distancing

Personal controls: General recommendations for physical distancing in markets

Maintain at least a **2-meter distance from others** and practice no-contact greetings.

Customers can also try to stay home as much as possible by combining trips to the market.

Administrative and engineering controls: Possibilities for markets[1]

- Space stalls a few (2+) meters apart, use every other stall, and/or extend the market area when possible so that customers and vendors stay as far apart from each other as possible.
- Consider limiting to one vendor per stall.
- Food vendors make items take-away only (not for eating on-site).
- Make aisles and entrances/exits go in one direction only (see diagrams below).
- Set up markers for where customers should stand at stalls and check-out stations (2+ meters from the vendor/cashier and from other customers) and where to stand in queues (see diagrams below).
- Extend operating times to help space out crowding.
- Consider separate days or times (such as when the market opens, before others arrive) for people who are elderly or who have serious underlying medical conditions.

- Encourage households to send a designated family member, rather than multiple family members, to buy food and supplies. The designated family member would ideally not be elderly or have serious underlying medical conditions.
- Encourage use of digital payment tools when feasible, such as mobile money. If digital payment tools are not feasible, consider advising vendors and customers to place cash and change on a counter or other surface rather than exchanging money hand to hand. Advise vendors to clean and disinfect the surface on a routine basis.
- Control the flow of people in and out of the market by closing off some entry and exit points.
- Consider decreasing the number of customers allowed in the market at the same time. This can be done by assigning people with certain last names to certain days or times of day or setting a limit on the number of people allowed inside at once.
- Consider advising only vendors to handle food and other goods, not customers.
- For grocery stores/supermarkets, consider installing partitions or other physical barriers between customers and cashiers at check-out stations, if feasible.

Materials, activities, and personnel needed for implementation

- Communication campaigns (via radio, newspaper, social media, WhatsApp, or other platforms) so that customers understand new procedures.
- Signs and/or audio messages in formats and languages suitable for local audiences within the market explaining procedures and rationale to customers and vendors.
- Paint, chalk, or other tools for marking where to stand and walk.
- Market staff to explain and remind customers of physical distancing rules and to help control the number of people in the market.
- Support from local authorities.

Considerations and challenges for implementation

Because these engineering and administrative controls require oversight in order to be implemented effectively, markets without clear management structures may have difficulty implementing them.

There will be a cost associated with the development of communication materials, markings for where to walk and stand, and possibly paying additional staff to monitor physical distancing.

Limiting the number of people allowed in the market could be difficult to implement and could have negative impacts on households' access to food.

Top of Page

Hand Hygiene

Personal controls: General recommendations for hand hygiene in markets

Clean hands frequently. Hand hygiene is a critical way that people can reduce the risk of COVID-19. In markets, customers and vendors should clean hands upon entry and exit, before and after each transaction, and after blowing their nose, sneezing, or coughing, in addition to other key times.image iconexternal icon

Types of hand hygiene:

Handwashing with soap and water. Soap and water are available in most contexts and are effective against coronaviruses. The cleanest water available (ideally from an improved sourceexternal icon[a]) should be used for handwashing, and all types of soap (bar soap, liquid soap, soapy water,[b] and powder soap) are effective at removing germs from hands, including the virus that causes COVID-19. Hands should be scrubbed with soap and water for at least 20 seconds and dried using single-use hand drying materials when available, or air dried.

Cleaning with alcohol-based hand rub. If hands are not visibly dirty, hand rub with at least 60% alcohol content can be used against coronaviruses as an alternative to cleaning hands when soap and water are not available. To use, rub hands together until they feel dry, or for approximately 20 seconds.

If soap and water or alcohol-based hand rub are unavailable or infeasible, **handwashing with 0.05% chlorine solution** can be considered as a temporary option. New chlorine solution should be made each day using the below instructions. Unused chlorine solution should be safely discarded at the end of each day in a latrine or toilet/drain connected to a septic system or sewer. Users should exercise caution to avoid getting the chlorine solution in their eyes or mouth.

To mix a chlorine handwashing solution using liquid bleach, use the percentage found on the bleach bottle (for example, 5%) and **follow these instructions:**

[% chlorine in liquid bleach / % chlorine desired] − 1 = Total parts of water for each part bleach

Example of making 0.05% chlorine solution with 5% liquid bleach:

[5% chlorine in liquid bleach / 0.05% chlorine desired] – 1 = [5 / 0.05] – 1
= 99 parts of water for each 1 part liquid bleach
If you are using a 20 L container to mix the solution, you need 200 mL of liquid bleach and should fill the rest of the container with water.
20 L / 100 parts = 0.2 L, or 200 mL per part
Further instructions are available herepdf icon.
[a]An improved drinking water sourceexternal icon is a source that, by nature of its construction, adequately protects the source from outside contamination and may include piped household water connections, public standpipes, boreholes, protected dug wells, protected springs, and rainwater.
[b]"Soapy water" is a mix of water and either powdered soap (such as laundry powder or detergent) or liquid soap. To prepare, mix enough soap with water so that you can create a lather when rubbing hands together. You can use soapy water like liquid soap, being sure that there is plain water for rinsing. As detailed above, the cleanest water available should be used for soapy water and rinse water. Instructions for making soapy water can be found in this documentexternal icon.

Administrative and engineering controls: Possibilities for markets

- Ensure widespread access to hand hygiene facilities by placing hand hygiene stations (handwashing stations or alcohol-based hand rub dispensers) at entrances, exits, and throughout the market, including within 5 meters of toilets if any are present at the market. Hand hygiene can be made obligatory upon entry and exit of the market. Hand hygiene stations should be obviously placed so that they are hard to avoid. Vendors and customers should have easy access to handwashing facilities (ideally one per vendor or group of vendors, depending on the layout).
- In particular, handwashing stations should: 1) Allow users to scrub their hands under a stream of running water; 2) Secure provided soap (either a cage, rope, or other device); 3) Have a place to catch used water; 4) Provide single-use hand drying materials whenever possible; 5) Provide a waste bin to collect single-use hand drying materials (when applicable). More information on different handwashing station designs is available hereexternal icon.
- The installation, supervision, and regular refilling should be the responsibility of local public health authorities but can be delegated to building / market managers.[2]
- If using 0.05% chlorine solution, provide those doing the mixing with personal protective equipment (rubber gloves, thick aprons, and closed shoes, as well as masks and eye protection, if available).

Materials, activities, and personnel needed for implementation

- Handwashing stations or alcohol-based hand rub dispensers.
- Daily access to water (or alcohol-based hand rub) to refill hand hygiene stations and a consistent supply of soap.
- Market staff to check on hand hygiene stations regularly and refill when necessary.
- Market staff to enforce hand hygiene practice upon entry and exit to the market.
- Signs and/or audio messages in formats and languages suitable for local audiences within the market prompting customers to practice hand hygiene. Messaging should include information about when to practice hand hygiene as well as how.
- Personal protective equipment (rubber gloves, thick aprons, and closed shoes) if using 0.05% chlorine solution.
- Locked location for storing handwashing stations or alcohol-based hand rub dispensers overnight.

Considerations and challenges for implementation

Continuous oversight will be required to ensure that hand hygiene stations are refilled regularly, which may be difficult without clear management structures.
If water supply is not available on site, it will be more challenging and costly to regularly refill handwashing stations.
There will be costs associated with purchasing the handwashing stations or alcohol-based hand rub dispensers, refilling water and soap (or rub), personal protective equipment (if needed), developing and printing communications materials, and possibly paying staff to refill and reinforce use of hand hygiene stations upon entry and exit.
There could be supply chain constraints on soap and alcohol-based hand rub if demand increases as COVID-19 spreads. Single-use hand drying materials (such as paper towels) are often unavailable.

If using 0.05% chlorine solution, those mixing the solution should be adequately protected by wearing rubber gloves, thick aprons, and closed shoes during the mixing process because of potential skin, eye, and inhalation hazards. They should also be trained on how to mix chlorine solution.
If no rubber gloves are available, other non-permeable gloves can be substituted. Those mixing should remove gloves and wash hands immediately after mixing. If no aprons are available, cleaning personnel can wear protective clothing (such as long pants and long-sleeved shirts) and launder after use.
Top of Page
Cleaning and Disinfection
Personal controls: General recommendations for cleaning and disinfection in markets
Clean and disinfect frequently touched surfaces at least once a day.[3] In many market settings, the only surfaces that customers touch include the items that they are purchasing, cash, and any shared utensils, cups, or plates for food and beverages sold in markets. It is also possible that surfaces that are porous and therefore difficult to disinfect, such as wood tables, are touched frequently, but this will be different in every market and will need to be left up to the market administrator to assess. Railings, door handles, shopping carts, and sanitation (restroom/toilet/latrine) surfaces are other examples of frequently touched surfaces.
Cleaning refers to the removal of germs, dirt, and impurities from surfaces. It does not kill germs, but by removing them, it lowers their numbers and the risk of spreading infection. Removing dirt and impurities also helps disinfectant be more effective.
Disinfecting refers to using chemicals, for example, sodium hypochlorite (bleach), to kill germs on surfaces. This process does not necessarily clean dirty surfaces or remove germs, but by killing germs on a surface after cleaning, it can further lower the risk of spreading infection.
In market settings, use a **0.1% chlorine solution** made from bleach, Calcium Hypochlorite (HTH), or bleaching powder and water (using non-turbid water source) for disinfection. Instructions for using HTH powder or bleaching powder can be found here.
To mix a chlorine solution using liquid bleach, use the percentage found on the bleach bottle (for example, 5%) and **follow these instructions:**[4]
[% chlorine in liquid bleach / % chlorine desired] − 1 = Total parts of water for each part bleach
Example of making 0.1% chlorine solution with 5% liquid bleach:
[5% chlorine in liquid bleach / 0.1% chlorine desired] – 1 = [5 / 0.1] – 1
= 49 parts of water for each 1 part liquid bleach (50 parts total)
If you are using a 20 L jerry can to mix the solution, you need 400 mL of liquid bleach and should fill the rest of the jerry can with water.
20 L / 50 parts = 0.4 L or 400 mL per part
Further instructions are available herepdf icon.
Cleaning and disinfection procedures:[4]

1. Put on personal protective equipment (rubber gloves, thick aprons, and closed shoes, as well as masks and eye protection if available).
2. Mix 0.1% chlorine solution using the procedures described above in well-ventilated area.
3. Clean with detergent or soap and water to remove organic matter.
4. Apply the 0.1% chlorine solution to the surface with a cloth and allow for a contact time (the amount of time that the disinfectant should remain wet and undisturbed on the surface) of at least 1 minute. Additional disinfectant may need to be applied to ensure it remains wet for 1 minute. After 1 minute has passed, rinse residue with clean water (this will also protect the surface or item from damage).
5. After cleaning and disinfection, carefully remove personal protective equipment (PPE) and wash hands immediately. Re-usable PPE (e.g. aprons) should be laundered immediately.
   Cleaning and disinfecting should not take place near children or people with asthma.
   Procedures for various surfaces (hard surfaces, soft surfaces, electronics, and laundry) can be found here.

Administrative and engineering controls: Possibilities for markets

- Market administrators should designate set ‘cleaning personnel’ (chosen vendors, cleaning staff, or other staff) to carry out cleaning and disinfection of high-touch surfaces once a day, or more frequently if possible. This can take place either before the market opens or after it closes, whichever makes the most sense based on the context.
- Market administrators and designated cleaning personnel should walk through the market together and decide which surfaces are touched frequently by customers and vendors and therefore should be the target of cleaning and disinfection efforts.

- Provide the market's designated cleaning personnel with cleaning supplies (soap/detergent, bleach, buckets) and personal protective equipment (PPE) to wear when mixing, cleaning, and disinfecting (rubber gloves, thick aprons, and closed shoes). PPE used for cleaning and disinfecting the market should be stored at the market in a secure, designated area. Cleaning personnel should not bring the PPE home.
- Provide those who typically clean (vendors, cleaning personnel, or other staff) with information (e.g. written or pictorial instructions) about when and how to clean and disinfect and how to safely prepare disinfectant solutions, as described in the leftmost column.

Materials, activities, and personnel needed for implementation

- Stocks of soap, bleach, buckets, and other cleaning supplies (e.g. mops, rags).
- Personal protective equipment for designated cleaning personnel (rubber gloves, thick aprons, safety glasses/face shields if available, and closed shoes).
- Sufficient access to non-turbid water to meet all cleaning and disinfection needs.
- Communications materials describing the cleaning and disinfection process, including proper mixing of solutions, for use by designated cleaning personnel.

Considerations and challenges for implementation

There will be costs associated with purchasing the bleach, soap, cleaning supplies, and personal protective equipment; printing communications materials; and possibly having to pay additional staff to clean.

If no rubber gloves are available for cleaning personnel, other non-permeable gloves can be used. If no aprons are available, cleaning personnel can wear protective clothing (such as long pants and long-sleeved shirts) and launder after use.

There could be further supply chain constraints on soap and chlorine products and PPE as demand increases as COVID-19 spreads.

If water supply is not available on site, it will be more challenging and costly to clean and disinfect daily.

There is potential for harm to users when using disinfection products, so it is important for cleaning personnel to be adequately protected in the mixing and disinfection process and trained on how to mix and disinfect.

Note: Large-scale spraying of disinfectant in public places, including markets, is **not** recommended. There is limited evidence that it is effective. To be effective, disinfectants need to have sufficient contact time and coverage, which is difficult to get when doing large-scale spraying. There is also limited ability to control spray-related inhalation hazards by nearby people. Additionally, organic matter such as dirt or trash would need to be picked up/removed before disinfectants would work.[4]

Top of Page

Respiratory Hygiene

Personal controls: General recommendations for respiratory hygiene in markets

Individuals should **cover coughs and sneezes**pdf icon with their elbow or a disposable tissue and clean hands immediately.

In areas where there is any level of known community transmission, all individuals, including those who lack symptoms, should **wear masks** when in public settings where other physical distancing measures are difficult to maintain. Individuals should wear masks correctly and make sure they are made from appropriate materialsexternal icon. Masks should not be worn by some individuals with physical, mental, emotional or behavioral issues, children under 2 years, or anyone who has trouble breathing or is unconscious or incapacitated.

Administrative and engineering controls: Possibilities for markets

- Market administrators can make it compulsory for vendors and customers to wear masks while at the market, aside from those individuals who should not wear masks.
- Use of masks can be enforced by the market staff member who is making sure customers practice hand hygiene and informing them about physical distancing measures.
- In closed markets, open doors and windows as much as possible to increase air flow. If available, fans can help increase air flow. However, steps should be taken to minimize fans blowing from one person directly to another person to reduce the potential spread of respiratory droplets or aerosols.

Materials, activities, and personnel needed for implementation

- Signs and/or audio messages in formats and languages suitable for local audiences within the market to remind people to wear masks, explain why they are wearing masks (to protect others), and remind them to cover their coughs and sneezes.

- Communication campaigns (via radio, newspaper, social media, WhatsApp, or other platforms) so that customers and vendors are aware of the new procedures and know to bring masks with them when they go to the market.

Considerations and challenges for implementation

This is a relatively low-cost measure and should be straightforward to implement, especially if masks are encouraged for use in other public settings, but there will still be costs associated with developing and printing communications materials.

Top of Page

Examples of how COVID-19 mitigation measures could be implemented in different types of markets

https://www.cdc.gov/coronavirus/2019-ncov/global-covid-19/markets.html

Make a Handwashing Solution For Use in Global, Low-Resource Settings

Updated Sept. 9, 2020

Download PDF in Englishpdf icon | Arabic | Spanish | French | Portuguese

Make a Handwashing Solution

Remember, only use chlorine-based hand washing solutions when soap and water or alcohol-based hand rub are not available.

Making handwashing solution from 5% liquid bleach

Use the **MILD** chlorine water to wash hands. Make new **mild** chlorine water every day.

1. Mix 14 tablespoons of 5% bleach into 20 liters of clear water every day. Stir well. Label plastic bucket for handwashing only / **MILD** 0.05%. Do not drink or use for cooking.
2. Make sure the bucket is covered. Use the **MILD** chlorine water to wash hands.

Making handwashing solution from HTH chlorine powder

Use the **MILD** chlorine water to wash hands. Make new **mild** chlorine water every day.

1. Mix 1 tablespoon of HTH chlorine powder into 20 liters of water every day. Stir well. Label plastic bucket for handwashing only / **MILD** 0.05%. Do not drink or use for cooking.
2. Stir well and wait 30 minutes.
3. Use the **MILD** chlorine water to wash hands.

Call out box:

- Do NOT drink chlorine water.
- Do NOT put chlorine water in mouth or eyes.

https://www.cdc.gov/coronavirus/2019-nCoV/index.html

Federal Government Adjusts COVID-19 Entry Strategy for International Air Passengers

Media Statement

For Immediate Release: Wednesday, September 9, 2020

Contact: Media Relations

(404) 639-3286

As the COVID-19 pandemic continues, the United States Government (USG) is innovating and taking a new approach to help keep international air passengers healthy. The new, more effective strategy focuses on the continuum of travel and the individual passenger, including pre-departure and post-arrival education, efforts to develop a potential testing framework with international partners, and illness response. This strategy is consistent with the current phase of the pandemic and more effectively protects the health of the American public.

Beginning September 14, 2020, the USG will remove requirements for directing all flights carrying airline passengers arriving from, or recently had a presence in, certain countries to land at one of 15 designated airports and halt enhanced entry health screening for these passengers. Currently, enhanced entry health screening is conducted for those arriving from, or with recent presence in, China (excluding the Special Administrative Regions of Hong Kong and Macau), Iran, the Schengen region of Europe, the United Kingdom (excluding overseas territories outside of Europe), Ireland, and Brazil.

We now have a better understanding of COVID-19 transmission that indicates symptom-based screening has limited effectiveness because people with COVID-19 may have no symptoms or fever at the time of screening, or only mild symptoms. Transmission of the virus may occur from passengers who have no

symptoms or who have not yet developed symptoms of infection. Therefore, CDC is shifting its strategy and prioritizing other public health measures to reduce the risk of travel-related disease transmission.
USG resources will instead be dedicated to more effective mitigation efforts that focus on the individual passenger, including: pre-departure, in-flight, and post-arrival health education for passengers; robust illness response at airports; voluntary collection of contact information from passengers using electronic means as proposed by some airlines to avoid long lines, crowding and delays associated with manual data collection; potential testing to reduce the risk of travel-related transmission of the virus that causes COVID-19 and movement of the virus from one location to another; country-specific risk assessments to assist passengers in making informed decisions about travel-related risk; enhancing training and education of partners in the transportation sector and at United States ports of entry to ensure recognition of illness and immediate notification to CDC; and post-arrival passenger recommendations for self-monitoring and precautions to protect others, with enhanced precautions, including staying home to the extent possible for 14 days for people arriving from high-risk destinations.
By refocusing our mitigation efforts on individual passenger risk throughout the air travel journey, the USG can most effectively protect the health of the American public.
###
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICESexternal icon
CDC works 24/7 protecting America's health, safety and security. Whether disease start at home or abroad, are curable or preventable, chronic or acute, or from human activity or deliberate attack, CDC responds to America's most pressing health threats. CDC is headquartered in Atlanta and has experts located throughout the United States and the world.
Page last reviewed: September 9, 2020
Content source: Centers for Disease Control and Prevention
https://www.cdc.gov/media/releases/2020/s-0909-covid-19-entry-strategy-air-passengers.html

If You Have Pets
Updated Sept. 9, 2020
What you need to know

- A small number of pets worldwide, including cats and dogs, have been reportedexternal icon to be infected with the virus that causes COVID-19, mostly after close contact with people with COVID-19.
- Based on the limited information available to date, the risk of animals spreading COVID-19 to people is considered to be low.
- It appears that the virus that causes COVID-19 can spread from people to animals in some situations.
- Treat pets as you would other human family members – do not let pets interact with people outside the household.
- If a person inside the household becomes sick, isolate that person from everyone else, including pets.
- This is a rapidly evolving situation and information will be updated as it becomes available.

info circle light icon
For more information on COVID and Animals
See COVID-19 and Animals and COVID-19 and Animals Frequently Asked Questions.
Coronaviruses are a large family of viruses. Some coronaviruses cause cold-like illnesses in people, while others cause illness in certain types of animals, such as cattle, camels, and bats. Some coronaviruses, such as canine and feline coronaviruses, infect only animals and do not infect humans.
Risk of people spreading the virus that causes COVID-19 to pets
We are still learning about the virus that causes COVID-19, but it appears that it can spread from people to animals in some situations. A small number of pets worldwide, including cats and dogs, have been reportedexternal icon to be infected with the virus that causes COVID-19, mostly after close contact with people with COVID-19.
Infected pets might get sick or they might not have any symptoms. Of the pets that have gotten sick, most only had mild illness and fully recovered.
What to do if you own pets

Until we learn more about how this virus affects animals, treat pets as you would other human family members to protect them from a possible infection.
Because there is a risk that people with COVID-19 could spread the virus to animals, CDC recommends that pet owners limit their pet's interaction with people outside their household.

- Keep cats indoors when possible and do not let them roam freely outside.
- Walk dogs on a leash at least 6 feet (2 meters) away from others.
- Avoid public places where a large number of people gather.
- Do not put a mask on pets. Masks could harm your pet.

There is no evidence that the virus can spread to people from the skin, fur, or hair of pets. Do not wipe or bathe your pet with chemical disinfectants, alcohol, hydrogen peroxide, or other products, such as hand sanitizer, counter-cleaning wipes, or other industrial or surface cleaners. Talk to your veterinarian if you have questions about appropriate products for bathing or cleaning your pet.
Talk to your veterinarian if your pet gets sick or if you have any concerns about your pet's health.external iconexternal iconexternal icon
question icon
Questions about keeping your pet safe?
See Frequently Asked Questions about Animals and COVID-19.
Protect pets if you are sick
If you are sick with COVID-19 (either suspected or confirmed by a test), you should restrict contact with your pets and other animals, just like you would with people. Until we know more about this virus, people sick with COVID-19 should avoid contact with pets and other animals.

- When possible, have another member of your household care for your pets while you are sick.
- Avoid contact with your pet including petting, snuggling, being kissed or licked, sharing food, and sleeping in the same bed.
- If you must care for your pet or be around animals while you are sick, wear a mask and wash your hands before and after you interact with them.

If you are sick with COVID-19 and your pet becomes sick, do not take your pet to the veterinary clinic yourself. Call your veterinarian and let them know you have been sick with COVID-19. Some veterinarians may offer telemedicine consultations or other plans for seeing sick pets. Your veterinarian can evaluate your pet and determine the next steps for your pet's treatment and care.
For more information visit: What to Do if You are Sick.
Stay healthy around animals
In the United States, there is no evidence that animals are playing a significant role in the spread of COVID-19. Based on the limited information available to date, the risk of animals spreading COVID-19 to people is considered to be low. However, because all animals can carry germs that can make people sick, it's always a good idea to practice healthy habits around pets and other animals.

- Wash your hands after handling animals, their food, waste, or supplies.
- Practice good pet hygiene and clean up after pets properly.
- Talk to your veterinarian if you have questions about your pet's health.
- Be aware that children 5 years of age and younger, people with weakened immune systems, and older adults are more likely to get sick from germs some animals can carry.

For more information, visit CDC's COVID-19 and Animals webpage and Healthy Pets, Healthy People website.
Guidance and recommendations

- What to Do if Your Pet Tests Positive for the Virus that Causes COVID-19
- Interim Guidance for Public Health Professionals Managing People with COVID-19 in Home Care and Isolation Who Have Pets or Other Animals
- Interim recommendations for intake of companion animals from households where humans with COVID-19 are presentexternal icon
- Interim Infection Prevention and Control Guidance for Veterinary Clinics
- Evaluation for SARS-CoV-2 Testing in Animals
- Guidance for Handlers of Service and Therapy Animals

https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/pets.html

United States

Half a million U.S. children have been diagnosed with COVID-19

Source: CTV News

GPHIN ID: 1007801153

Half a million U.S. children have been diagnosed with COVID-19, according to the American Academy of Pediatrics and the Children's Hospital Association.

The groups said 70,630 new child cases were reported from Aug. 20 through Sept. 3. This is a 16 per cent increase in child cases over two weeks, bringing up the total to at least 513,415 cases, the groups said in their weekly report on pediatric coronavirus cases.

"These numbers are a chilling reminder of why we need to take this virus seriously," American Academy of Pediatrics President Dr. Sally Goza said in a news release. "While much remains unknown about COVID-19, we do know that the spread among children reflects what is happening in the broader communities," she added.

"A disproportionate number of cases are reported in Black and Hispanic children and in places where there is high poverty. We must work harder to address societal inequities that contribute to these disparities."

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Children represent nearly 10 per cent of all reported cases in the U.S., according to the report. The child cases are likely underreported because the tally relies on state data that is inconsistently collected.

"This rapid rise in positive cases occurred over the summer, and as the weather cools, we know people will spend more time indoors," Dr. Sean O'Leary, the vice chair of the AAP Committee on Infectious Diseases, said in a news release.

"Now we are heading into flu season. We must take this seriously and implement the public health measures we know can help," O'Leary added.

"That includes wearing masks, avoiding large crowds, and maintaining social distance. In addition, it will be really important for everyone to get an influenza vaccine this year. These measures will help protect everyone, including children."

The AAP recommends that any child six months or older get a flu shot -- in line with recommendations from the U.S. Centers for Disease Control and Prevention.

Pediatricians say it's more important than ever to make sure kids get either the flu shot or the protective nasal spray before the end of October.

That's because having two respiratory disease circulating at the same time -- flu and coronavirus -- will be confusing to doctors, parents and caregivers. Plus, hospitals and clinics could become overwhelmed with the double burden.

The two viruses cause similar symptoms but a study published Tuesday in JAMA Network Open found that children hospitalized with COVID-19 were more likely to have fever, aches, diarrhea and vomiting than were children with influenza.

Children with COVID-19 also tended to be older and have at least one underlying health condition.

COVID-19 and seasonal flu in children lead to similar rates of hospitalization, intensive care admission, and need for a ventilator to help breathing, the study found. The CDC says 188 children died from flu over the 2019-2020 season.

https://www.ctvnews.ca/health/coronavirus/half-a-million-u-s-children-have-been-diagnosed-with-covid-19-1.5096725

WHO

COVID-19 could reverse decades of progress toward eliminating preventable child deaths, agencies warn

Source: WHO
9 September 2020
News release

New York/Geneva

With the number of under-five deaths at an all-time recorded low of 5.2 million in 2019, disruptions in child and maternal health services due to the COVID-19 pandemic are putting millions of additional lives at stake

The number of global under-five deaths dropped to its lowest point on record in 2019 – down to 5.2 million from 12.5 million in 1990, according to new mortality estimates released by UNICEF, the World Health Organization (WHO), the Population Division of the United Nations Department of Economic and Social Affairs and the World Bank Group.
Since then, however, surveys by UNICEF and WHO reveal that the COVID-19 pandemic has resulted in major disruptions to health services that threaten to undo decades of hard-won progress.
“The global community has come too far towards eliminating preventable child deaths to allow the COVID-19 pandemic to stop us in our tracks,” said Henrietta Fore, UNICEF Executive Director. “When children are denied access to health services because the system is overrun, and when women are afraid to give birth at the hospital for fear of infection, they, too, may become casualties of COVID-19. Without urgent investments to re-start disrupted health systems and services, millions of children under five, especially newborns, could die.”
Over the past 30 years, health services to prevent or treat causes of child death such as preterm, low birthweight, complications during birth, neonatal sepsis, pneumonia, diarrhea and malaria, as well as vaccination, have played a large role in saving millions of lives.
Now countries worldwide are experiencing disruptions in child and maternal health services, such as health checkups, vaccinations and prenatal and post-natal care, due to resource constraints and a general uneasiness with using health services due to a fear of getting COVID-19.
A UNICEF survey conducted over the summer across 77 countries found that almost 68 per cent of countries reported at least some disruption in health checks for children and immunization services. In addition, 63 per cent of countries reported disruptions in antenatal checkups and 59 per cent in post-natal care.
A recent WHO survey based on responses from 105 countries revealed that 52 per cent of countries reported disruptions in health services for sick children and 51 per cent in services for management of malnutrition.
Health interventions such as these are critical for stopping preventable newborn and child deaths. For example, women who receive care by professional midwives trained according to internationals standards are 16 per cent less likely to lose their baby and 24 per cent less likely to experience pre-term birth, according to WHO.
"The fact that today more children live to see their first birthday than any time in history is a true mark of what can be achieved when the world puts health and well-being at the centre of our response,” said Dr. Tedros Adhanom Ghebreyesus, WHO Director-General. “Now, we must not let the COVID-19 pandemic turn back remarkable progress for our children and future generations. Rather, it’s time to use what we know works to save lives, and keep investing in stronger, resilient health systems.”
Based on the responses from countries that participated in the UNICEF and WHO surveys, the most commonly cited reasons for health service disruptions included parents avoiding health centers for fear of infection; transport restrictions; suspension or closure of services and facilities; fewer healthcare workers due to diversions or fear of infection due to shortages in personal protective equipment such as masks and gloves; and greater financial difficulties. Afghanistan, Bolivia, Cameroon, the Central African Republic, Libya, Madagascar, Pakistan, Sudan and Yemen are among the hardest hit countries.
Seven of the nine countries had high child mortality rates of more than 50 deaths per 1000 live births among children under five in 2019. In Afghanistan, where 1 in 17 children died before reaching age 5 in 2019, the Ministry of Health reported a significant reduction in visits to health facilities. Out of fear of contracting the COVID-19 virus, families are de-prioritizing pre- and post-natal care, adding to the risk faced by pregnant women and newborn babies.

Even before COVID-19, newborns were at highest risk of death. In 2019, a newborn baby died every 13 seconds. Moreover, 47 per cent of all under-five deaths occurred in the neonatal period, up from 40 per cent in 1990. With severe disruptions in essential health services, newborn babies could be at much higher risk of dying. For example, in Cameroon, where 1 out of every 38 newborns died in 2019, the UNICEF survey reported an estimated 75 per cent disruptions in services for essential newborn care, antenatal check-ups, obstetric care and post-natal care.
In May, initial modelling by Johns Hopkins University showed that almost 6,000 additional children could die per day due to disruptions due to COVID-19.

[APG]

These reports and surveys highlight the need for urgent action to restore and improve childbirth services and antenatal and postnatal care for mothers and babies, including having skilled health workers to care for them at birth. Working with parents to assuage their fears and reassure them is also important.
“The COVID-19 pandemic has put years of global progress to end preventable child deaths in serious jeopardy,” said Muhammad Ali Pate, Global Director for Health, Nutrition and Population at the World Bank. “It is essential to protect life-saving services which have been key to reducing child mortality. We will continue to work with governments and partners to reinforce healthcare systems to ensure mothers and children get the services they need.”
"The new report demonstrates the ongoing progress worldwide in reducing child mortality,” said John Wilmoth, Director of the Population Division of the United Nations Department of Economic and Social Affairs. “While the report highlights the negative effects of the COVID-19 pandemic on interventions that are critical for children’s health, it also draws attention to the need to redress the vast inequities in a child's prospects for survival and good health.”
https://www.who.int/news-room/detail/09-09-2020-covid-19-could-reverse-decades-of-progress-toward-eliminating-preventable-child-deaths-agencies-warn

International - Coronavirus disease (COVID-19) Outbreak and Outcomes (Media)

What's happening around the world
ID: 1007807249
Source: CBC News
Excerpt
09 September 2020
Thailand said on Wednesday it had tested nearly 600 people potentially exposed to the country's first domestic coronavirus case in over three months, but has so far found no new infections.
The man, 37, had worked as a nightclub DJ at three different venues in the capital Bangkok in the two weeks before he tested positive on arrival in prison, following his recent conviction for a drugs-related offence.
Individuals deemed at risk across 12 venues including the court where he appeared, nightclubs and supermarkets were tracked down and 569 tests were administered, the Public Health Ministry said.
The **Czech Republic** reported on Wednesday a record one-day spike in COVID-19 infections, with 1,164 new cases, as it battles a surging spread of the coronavirus.
Daily case figures have regularly come in above 500 so far in September, already well above a previous daily peak of 377 in March during the first wave of infections.
However, the death toll in the Czech Republic has remained lower than in many other European countries, with 441 fatalities reported as of Wednesday out of a total of 29,877 cases since the start of the pandemic.
New limits on social gatherings in **England** to six people are set to stay in place for the "foreseeable future," potentially until or even through Christmas, British Health Secretary Matt Hancock said Wednesday.
Hancock said the new limit for both indoor and outdoor gatherings, which will come into force and be enforceable by law from Monday, will provide "more clarity" to people and should help keep a lid on a recent sharp spike in new coronavirus cases.
One of the reasons for the pick-up in cases is that many people have been confused over the past few months as lockdown restrictions have been eased, notably over how they relate to gatherings both in and out of the home. Scientists say a clear message is crucial in containing pandemics.
Russia said on Wednesday 142 people had died from the coronavirus in the last 24 hours, raising the official death toll to 18,135.
Russia's coronavirus taskforce reported 5,218 new cases, bringing its nationwide tally to 1,041,007, the fourth largest caseload in the world.
The number of new coronavirus cases registered in the **Netherlands** surged to 1,140 in the past 24 hours, the health minister said on Wednesday, the highest daily total since April.
Hugo de Jonge announced the figures recorded by the National Institute for Health (RIVM) during a live video stream. "It's not going the right way," De Jonge said. A day earlier, the country recorded 964 cases, with cases rising quickly among young adults.
The RIVM said the increase was not tied to the reopening of primary schools across the country over the past three weeks.

Security officials in Germany say thousands of far-right extremists took part in a demonstration against the country's coronavirus restrictions last month that culminated in attempts by some protesters to storm parliament.
The head of Berlin state's intelligence service, Michael Fischer, told lawmakers Wednesday that a preliminary review of images from the Aug. 29 protest indicated that "at least 2,500 to 3,000 right-wing extremists and Reich Citizens took part in the protests." The Reich Citizens movement disputes the legitimacy of the post-Second World War German constitution, and the movement overlaps with far-right groups.
Fischer said those counted so far were identified as far-right extremists based on the clothing, flags, symbols and slogans they were carrying.
Portugal reported 646 new coronavirus cases on Wednesday, the highest daily toll since April 20, with transmission primarily occurring in family households, Health Secretary of State Jamila Madeira told a news conference.
New cases fell to around 100 a day at the beginning of August but have crept back up since then, worrying the tourism industry as it waits to hear whether it will be taken back out of the U.K.'s air bridge list allowing restriction-free travel between countries with low infection rates.
Stricter measures to curb the coronavirus outbreak will be introduced across Portugal from mid-September as students return to schools and many workers go back to the office, although details have yet to be announced.
https://www.cbc.ca/news/world/coronavirus-covid19-world-sept-9-1.5716866

Czech Republic

University develops new test of coronavirus, flu presence
ID: 1007807872
Source: 1007807872

Prague, Sept 9 (CTK) - The Prague-seated Charles University (UK) today presented its newly-developed test to detect the presence of COVID-19 and the flu of A and B types, which is to become available in October, speeding up the testing procedure.
Michal Pobudka, from the UK's daughter company GeneSpector, said the use of the new test kits may raise the current capacity of laboratories. The price of the kits should not exceed 1,200 crowns apiece, compared with the maximum price of 1,674 crowns per coronavirus test plus 82 crowns for the sample taking, set by the Health Ministry.
The authors of the test said the whole testing procedure, from the sample's arrival in the laboratory until the result of the testing of a 94-sample series will take less than 90 minutes, compared with two hours usual with the current PCR tests.
When it comes to the sample taking-kits, the researchers drew attention to the special solution that inactivates the virus and also enables the sample's safe preservation in the room temperature. It took several years to develop this solution, its author Stanislav Kmoch, from the UK's 1st Medical Faculty, said today, adding that in the spring it turned out that the solution may also be used in COVID-19 testing.
The sample-taking kit is complemented with the isolation and detection kit, which shortens the virus RNA isolation process, the most demanding phase of the testing, to less than ten minutes. These parts have been supplied by firms cooperating with the UK.
Kmoch's team cooperated on the test development with the companies Generi Biotech, Spadia Lab and ZKV Career, which in August established the daughter company UK GeneSpector, the future supplier of the new tests.

Greece

Greece's Supplier for COVID-19 Vaccine Suspends Trial Over Illness
Source: The National Herald
GPHIN ID: 1007804944

Greece's hopes to get an initial batch of 600,000 COVID-19 vaccines from the British pharmaceutical company AstraZeneca were dashed when it paused global trial of its experimental version after a participant became ill.

The company expected to have a first batch of 30 million doses of the vaccine in November for the European Union if it's proved safe and effective during the ongoing trials in a rush to find an answer to COVID-19.

EU officials said another 100 million shots could be available in a second development with the Greek government saying a crucial issue is the terms of indemnification for vaccine manufacturers for the cost of compensating patients if there are unexpected side effects.

Charalambos Gogos, an infectious disease specialist and member of Greece's COVID-19 Committee of Experts, said the second wave hitting the country can be held down with early diagnosis and treatment and effective tracking.

The suspension was reported by the Reuters news agency which said the vaccine, being developed in conjunction with the University of Oxford, the trial seen as the first best hope to deal with the lingering pandemic.
The British drugmaker said it voluntarily paused trials to allow an independent committee to review safety data, and it was working to expedite the review to minimize any potential impact on the trial timeline, the report said.

"This is a routine action which has to happen whenever there is a potentially unexplained illness in one of the trials," the company said in an emailed statement but it would not reveal the illness or whether the participant had contracted the disease itself during the experiment.

The participant is expected to recover, according to Stat News, which first reported the suspension due to a "suspected serious adverse reaction," the company refusing to disclose it.

The US Food and Drug Administration defines an adverse event as one in which evidence suggests a possible relationship to the drug being tested - essentially meaning the vaccine transmitted the virus it's designed to stop.

A New York Times report which cited a person familiar with the situation said the participant in the UK was found to have transverse myelitis, an inflammatory syndrome that affects the spinal cord and is often sparked by viral infections.

Whether the illness was directly linked to AstraZeneca's vaccine remains unclear, the report said. AstraZeneca declined to comment on the report despite the whole world wanting to know what happened.

Staying mum didn't help the company's financial picture as its shares plummeted more than 8 percent in after-hours US trading, while shares in rival vaccine developer Moderna rose more than 4%.

Called AZD1222, the vaccine is in late-stage clinical trials in the United States, Britain, Brazil and South Africa and additional trials are planned in Japan and Russia. The trials aim to enroll up to some 50,000 participants globally.

The US National Institutes of Health, which is providing funding for AstraZeneca's trial, declined to comment as President Donald Trump said he wants a vaccine to boost his reelection bid before the Nov. 3 polls.

Moderna said in an emailed statement it was "not aware of any impact" to its ongoing COVID-19 vaccine study at this time and nine leading US and European vaccine developers pledged to uphold scientific safety and efficacy standards for their experimental vaccines despite the urgency to contain COVID-19.
https://gphin.canada.ca/cepr/showarticle.jsp?docId=1007804944

Netherlands
Three more mink farms infected with coronavirus
Source: NL Times

GPHIN ID: 1007805006

Three more Dutch mink farms have been infected with the novel coronavirus SARS-CoV-2. The three fur farms in Venhorst, Deurne, and Wilbertoord together have around 9 thousand dam animals. These minks and their litters are in the process of being culled. That brings the total number of affected farms to 50.
The SARS-CoV-2 infection at the farm in Venhorst, in the municipality of Boekel, was confirmed on Friday after the farm reported that its minks were showing symptoms earlier in the week. The Ministries of Agriculture and Public Health confirmed the other two infections on Monday. In the latter two cases, the infections were identified through early monitoring systems in which mink carcasses are tested on a weekly basis.
Due to the still increasing coronavirus outbreaks on mink farms, despite various hygiene measures taken, the government decided to accelerate the ban on mink farming in the Netherlands. These fur farms will have to close their doors after the current fur season in March 2021, three years earlier than the original plan.
The government allocated 182 million euros to compensate mink farmers for the three years of lost business due to this accelerated plan.
Critics believe that amount too high for the around 110 still active mink farms in the country. Nearly 15 thousand people signed a petition against this compensation scheme. And D66 parliamentarian Tjeerd de Groot even suggested that it is now more profitable for mink farmers be culled out of business than to sell their furs.
"The compensation that those companies receive is higher than the market price," De Groot said to the Volkskrant last week. "It is more attractive to be culled than to sell. The mink farmers say they adhere to all hygiene and other corona rules, and yet the infections are getting worse. Then either the rules are not right or they don't follow the rules."
https://nltimes.nl/2020/09/07/three-mink-farms-infected-coronavirus

Japan
Olympics: IOC set to hold "important" talks on coronavirus measures
Source: Kyodo News
GPHIN ID: 1007806311

The International Olympic Committee is set to hold "important discussions" on coronavirus countermeasures in the coming weeks, but it is still too early to say what steps will be taken at the postponed Tokyo Games, IOC President Thomas Bach said Wednesday.

In a teleconference following an online meeting of the IOC executive board, Bach said the Tokyo Olympics organizers had to "prepare for different scenarios" without knowing the exact situation surrounding the games next summer.

"We will continue to follow the principle that has driven all our decisions so far, which is to organize the Olympic Games Tokyo 2020 in a safe environment for all people involved next summer," Bach said.

"In the next coming weeks, you will see important and intensive discussions taking place with regard to the different scenarios regarding the COVID-19 countermeasures."

John Coates, chairman of the IOC's coordination commission for the Tokyo Olympics, gave a report on the progress of the games during the online board meeting.

Coates earlier this week told AFP the games would open as planned on July 23 next year "with or without" the coronavirus.

His comments were echoed by Japan's Olympic minister Seiko Hashimoto, who said the games should be held next year "at any cost" in consideration of the preparations being made by athletes and organizers.

But Bach said Coates' comments should be seen "in context," and that the chairman was fully committed to "ensure safety for all participants" in line with the IOC's position.

The board also discussed virus countermeasures for the 2022 Beijing Winter Olympics, with safety plans under way for Tokyo also applying to the games in China, according to Bach.
https://english.kyodonews.net/news/2020/09/ece0475d23aa-olympics-ioc-set-to-hold-important-talks-on-coronavirus-measures.html

Studies Related to Coronavirus disease (COVID -19) Outbreak (Media)

Canada
Saliva test could fill COVID-19 assessment gaps: Ottawa study
Source: Ottawa Citizen
GPHIN ID: 1007804329

At the beginning of the pandemic, Ottawa surgeon Dr. Stephanie Johnson-Obaseki had a brainwave resulting in research that could lead to saliva testing becoming another tool in the toolbox of COVID-19 assessment.
Johnson-Obaseki, who is a head and neck cancer surgeon at The Ottawa Hospital and normally researches human papillomavirus in head and neck tumours, had previously worked on HPV testing using kits designed by Ottawa company DNA Genotek. When the pandemic hit and other research slowed down, she began thinking of those kits.
“When everything fell apart in the middle of March, I wondered if those kits might work for COVID-19,” she said.
It turns out they did work and were subsequently used by Johnson-Obaseki and other researchers to study the feasibility of saliva testing.

She is senior author of a paper that suggests saliva testing, while slightly less sensitive than nasal swabs, could play a role in rapidly expanding COVID-19 testing, especially in remote communities and in other challenging populations, such as with long-term care residents and students.

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Article content continued
The study, published in the Annals of Internal Medicine, was based on data from just fewer than 2,000 people who presented for testing at The Ottawa Hospital’s COVID-19 assessment centre at Brewer arena earlier this year. Participants agreed to a self-administered saliva test after having undergone the standard nasal test.

Seventy of those tested were found to be positive for COVID-19, 34 of them were positive on both tests, 22 were positive only on the swab test and 14 were positive on the saliva test alone.

The results convinced researchers that there may be a place for such tests.

“In our study, the swab test detected more cases than the spit test,” said Johnson-Obaseki. “However, we feel that because the spit test is so much easier, it may still have a place in COVID-19 testing in certain situations. Further research is crucial in this rapidly changing field.”

Saliva testing has been the subject of debate in Canada. It is used around the world, largely because it is easy to produce and can be self-administered. It also avoids the need for a nasal swab, which can be uncomfortable, even upsetting, for some, especially those who are subject to repeated tests.

Some have pushed to have saliva testing used in schools or at home. But it is only available in Canada for experimental use. In June, Health Canada said it would not be reviewing applications from domestic and international manufacturers of in-home test kits. Last week, Health Canada indicated it is now considering

such test kits for screening, not diagnostic, purposes.

Article content continued
Johnson-Obaseki, who is also an assistant professor at the University of Ottawa and departmental research chair in quality improvement, said the ease of the spit test, compared with nasal swab testing, gives it a place in COVID-19 testing.

“Saliva testing brings another tool into the tool box to add to the testing options,” she said. It is important that such tests be thoroughly studied first, she added.

DNA Genotek provided the DNA collection system it developed free of charge for the purposes of the study. It did not have a role in designing the study or interpreting the results. The spit samples were shipped to the National Microbiology Laboratory in Winnipeg to detect COVID-19 genetic material. Its kit is now among those being used in the U.S.

Johnson-Obaseki is among researchers who have shifted their focus to COVID-19 during the pandemic. “I am a cancer researcher who happened to know about a spit test. My other areas of interest have slowed down while everybody’s focus is on this. I find it very interesting to be part of potentially some of the knowledge that helps in this pandemic. I think that is super rewarding.”

A number of Canadian and international companies are also producing kits for saliva testing. In August, the U.S. government gave emergency authorization to a saliva COVID-19 test developed at Yale University in conjunction with the NBA and its players union. Researchers said the Yale test might miss patients with low levels of the virus but regular testing could offset that weakness. Other test kits, including the one developed by DNA Genotek, have also been given emergency authorization in the U.S.
https://ottawacitizen.com/news/local-news/saliva-test-could-fill-covid-19-assessment-gaps-ottawa-study

United States
U.S. biker rally may have led to 260,000 new COVID-19 cases: study | CTV News
Source: CTV News
GPHIN ID: 1007804081

WASHINGTON -- A massive motorcycle rally held in South Dakota last month may have been responsible for 260,000 new coronavirus cases, according to an analysis published Tuesday.
This figure, which came from a paper that hasn't yet been peer-reviewed, would represent the biggest COVID-19 spreading event documented in the U.S. to date.
The study was published by the Institute of Labor Economics and conducted by economists at the University of San Diego who studied the Sturgis Motorcycle Rally, which drew an estimated 460,000 people from August 7 and August 16.
The analysis is a statistical approximation based on anonymized cell phone data that documented the influx in the town from non-residents and showed where they came from.
The data also showed a rise in foot traffic at restaurants and bars, retail establishments, entertainment venues, hotels and campgrounds.
The bikers generally did not wear masks or practice social distancing, the study said, citing media reports.
Using data from the Centers for Disease Control and Prevention (CDC), the researchers then showed that a month following the rally, cases in the county where Sturgis is located rose by six or seven per 1,000.
U.S. counties that contributed the highest numbers of attendees experienced a rise of 7 to 12.5 percent in the number of cases compared to those that did not contribute inflows.
Researchers said their calculations indicated "a total of 263,708 additional cases in these locations due to the Sturgis Motorcycle Rally".
A limitation of the study is that it was based on statistical methods, rather than tracking and surveying rally participants.
https://www.ctvnews.ca/health/coronavirus/u-s-biker-rally-may-have-led-to-260-000-new-covid-19-cases-study-1.5096667

United States

US cases could be three to 20 times higher than publicly confirmed

Source: AlJazeera.com

Published: 2020-09-10 10:58 UTC
Received: 2020-09-10 11:07 UTC (+9 minutes)
Unique ID: 1007811055

US cases could be three to 20 times higher than publicly confirmed

A study published in Nature says the US has a "substantial underestimation" of coronavirus cases because of its restrictions on testing, and the actual figure could be three to 20 times higher.

The US mainly tests people with moderate to severe symptoms so those with mild or no symptoms are rarely tested, noted the researchers, led by Sean Wu of the Division of Epidemiology and Biostatistics at the University of California, Berkeley.

The team analysed testing rates in each state between February and April and corrected for incomplete and inaccurate tests. They found discrepancies between states, with higher rates of testing in the northwest and northeast, and lower levels in the south and Midwest.

Original study:

Substantial underestimation of SARS-CoV-2 infection in the United States

Abstract

Accurate estimates of the burden of SARS-CoV-2 infection are critical to informing pandemic response. Confirmed COVID-19 case counts in the U.S. do not capture the total burden of the pandemic because testing has been primarily restricted to individuals with moderate to severe symptoms due to limited test availability. Here, we use a semi-Bayesian probabilistic bias analysis to account for incomplete testing and imperfect diagnostic accuracy. We estimate 6,454,951 cumulative infections compared to 721,245 confirmed cases (1.9% vs. 0.2% of the population) in the United States as of April 18, 2020. Accounting for uncertainty, the number of infections during this period was 3 to 20 times higher than the number of confirmed cases. 86% (simulation interval: 64–99%) of this difference is due to incomplete testing, while 14% (0.3–36%) is due to imperfect test accuracy. The approach can readily be applied in future studies in other locations or at finer spatial scale to correct for biased testing and imperfect diagnostic accuracy to provide a more realistic assessment of COVID-19 burden.

https://www.aljazeera.com/news/2020/09/coronavirus-emergency-puts-jakarta-lockdown-live-news-200910003222088.html
https://www.nature.com/articles/s41467-020-18272-4

Hong Kong

Study shows lower case-fatality rate in COVID-19 second wave

ID: 1007807952

Source: CIDRAP

A new study in *Transboundary and Emerging Disease* calculated the case-fatality rate (CFR) of COVID-19 infections in 53 countries or regions that experienced a second wave—or resurgence—of coronavirus activity, and found a significantly lower death rate among all confirmed cases than in the first wave.

This is the first study to compare the CFR in the first and second waves of the pandemic.

Researchers from Hong Kong based the study on daily confirmed COVID-19 cases and deaths for 216 countries or regions, during February of 2020 through August 2020, and weekly influenza confirmations during 2015 to the current week of 2020, from the World Health Organization (WHO). They defined the first

wave as cases before Jun 1, and deaths before Jun 10, and second wave as any case after Jun 1 or any death after Jun 10.
Forty-three of the 53 regions studied showed lower CFRs during the second wave than the first. The 10 countries or regions with higher CFRs in the second wave were mostly in the Southern hemisphere (eg, Peru, Chile) and had reported mild first waves of the pandemic.
The authors offer possible explanations for the higher CFR in the first wave, including a harvest effect, where the elderly and infirm were first infected. They also said countries improved testing and surveillance, which helped them record more mild cases. Finally, they said younger people were more likely to be infected in subsequent waves and were less likely to die from infections.
Flu data from the WHO also showed steep declines in flu transmission during both waves, a sign that physical distancing measures reduced influenza spread.
"Although the lower CFR in the second phase is a positive sign to suggest the decrease[d] severity of COVID-19 infections, the shift to younger age groups could bring more difficulty in containing the pandemic," the authors concluded. "We also need to stay vigilant for the potential rebound of influenza outbreaks as many countries or regions are planning to lift social distancing control measures."
https://www.cidrap.umn.edu/news-perspective/2020/09/news-scan-sep-09-2020
https://onlinelibrary.wiley.com/doi/abs/10.1111/tbed.13819

United Kingdom
AstraZeneca may resume COVID-19 vaccine trials next week - FT
Source: Financial post
ID: 1007807666

Sep 09, 2020

British drugmaker AstraZeneca Plc could resume trials for its experimental coronavirus vaccine next week, the Financial Times reported on Wednesday, citing people associated with the trials.

The London-listed firm had to pause global trials of its potential vaccine for COVID-19 after an unexplained illness in a participant, which sent its shares lower as the move was seen as dimming prospects for an early rollout.

The director of the US National Institutes of Health Francis Collins told a Senate committee on Wednesday that the vaccine trial had stopped due to a "spinal cord problem."

Appearing before the Senate Committee on Health, Education, Labor and Pensions, Collins said the serious adverse event in question was transverse myelitis, a neurological disorder that causes inflammation of the spinal cord. If the review of AstraZeneca finds that the adverse event is related to the vaccine, all doses already manufactured will be discarded, Collins said.

"This should be reassuring for everyone who listens when we say we're going to focus first on security and we're not going to make concessions, this is Test A," Collins told the Senate committee on Wednesday.

"This is based on a single serious adverse event that may or may not have anything to do with the vaccine, but it's the best kind of cautious approach to stop quickly and see if there's any other evidence to worry about," he added.

Meanwhile, AstraZeneca CEO Pascal Soriot told investors on Wednesday morning that the company's vaccine studies stopped worldwide after a woman in the UK began showing symptoms of a rare and devastating neurological condition.

AstraZeneca did not immediately respond to a Reuters request for comment.
https://financialpost.com/pmn/business-pmn/astrazeneca-may-resume-covid-19-vaccine-trials-next-week-ft

Domestic Events of Interest

Canada

Government of Canada and Bingwi Neyaashi Anishinaabek celebrate Grand Opening of new Health Centre

Source: Canada.ca
GPHIN ID: 1007805012

News release
September 8, 2020 — Thunder Bay, Fort William First Nation Territory, Ontario — Indigenous Services Canada
Health centers and infrastructure that meet and are tailored to Indigenous Peoples' needs are fundamental for the well-being of individuals and communities. The COVID-19 pandemic has made the necessity of having this type of infrastructure even more critical, and Indigenous-led projects are part of the solution.

Today, on behalf of the Honourable Marc Miller, Minister of Indigenous Services, the Honourable Patty Hajdu, Minister of Health and Member of Parliament for Thunder Bay-Superior North and Chief Joe Ladouceur from Bingwi Neyaashi Anishinaabek (BNA) celebrate and announce the grand opening of the community's new Health Centre. Minister Hajdu attended an outdoor event in the community today to cut the ribbon marking this milestone.

This facility will offer patient assessment and referral when needed, health promotion consultations and other health-related services to all members, as well as members of other nearby First Nations. Indigenous Services Canada provided $334,333 to BNA for the design and construction of the new Health Centre. This facility will offer patient assessment and referral, health promotion, consultation and other health-related services to members currently living on reserve, those living off reserve, and members of other nearby First Nations. This will enhance the communities control over the delivery of health services according to their priorities and needs.

Quotes
"Bingwi Neyaashi Anishinaabek is proud to announce the opening of our new Health Centre. Since I have become Chief, we have worked tirelessly to prepare for the return of BNA members to their home community, and we now have 4 of our housing units rented to members living on the land year-round, with more housing being constructed. I believe that ensuring the safety and well-being of our members is of the utmost importance, and this new Health Centre will provide these important services to our membership, and to the surrounding region. We thank ISC for their support for this important milestone for our First Nation".
Chief Joe Ladouceur
Bingwi Neyaashi Anishinaabek

"Congratulations to Chief Ladouceur and Bingwi Neyaashi Anishinaabek First Nation on the grand opening of your new Health Centre. We are happy to continue to support and work collaboratively with the community as it makes progress on building infrastructure that will benefit the well-being of the whole community. We look forward to celebrating many more milestones and successes in the future."
The Honourable Marc Miller

Minister of Indigenous Services

"Congratulations to Chief Ladouceur and Bingwi Neyaashi Anishinaabek on the grand opening of the community's new Health Centre. This partnership is reconciliation in action. When people have equal access to health care, all of Canada benefits. The Health Centre will support a healthier region for generations to come.

The Honourable Patty Hajdu

Minister of Health and Member of Parliament for Thunder Bay-Superior North

Quick facts

Bingwi Neyaashi Anishinaabek is located 180 kilometres northeast of Thunder Bay, Ontario on the southeast shore of Lake Nipigon and has year-round road access.

The Health Centre includes a vestibule, reception area, one assessment area, one exam room, one patient washroom, a living space with a kitchen and washroom, and a mechanical room.

Indigenous Services Canada continues to work with BNA on a number of other infrastructure projects, including housing, access road improvements, and the design of a three-phase power line so that their membership can occupy their reserve land.
https://www.canada.ca/en/indigenous-services-canada/news/2020/09/government-of-canada-and-bingwi-neyaashi-anishinaabek-celebrate-grand-opening-of-new-health-centre.html

International Events of Interest

WHO

More than 3 billion people protected from harmful trans fat in their food

But, 11 out of 15 countries with the most coronary heart disease deaths due to trans fats have yet to take actions to eliminate the substances
9 September 2020 News release Geneva

Two years into the World Health Organization's (WHO) ambitious effort to eliminate industrially produced trans fats from the global food supply, the Organization reports that 58 countries so far have introduced laws that will protect 3.2 billion people from the harmful substance by the end of 2021. But more than 100 countries still need to take actions to remove these harmful substances from their food supplies.

Consumption of industrially produced trans fats are estimated to cause around 500,000 deaths per year due to coronary heart disease.

"In a time when the whole world is fighting the COVID-19 pandemic, we must make every effort to protect people's health. That must include taking all steps possible to prevent noncommunicable diseases that can make them more susceptible to the coronavirus, and cause premature death," said WHO Director-General Dr Tedros Adhanom Ghebreyesus. "Our goal of eliminating trans fats by 2023 must not be delayed."

Fifteen countries account for approximately two thirds of the worldwide deaths linked to trans fat intake. Of these, four (Canada, Latvia, Slovenia, United States of America) have implemented WHO-recommended best-practice policies since 2017, either by setting mandatory limits for industrially produced trans fats to 2% of oils and fats in all foods or banning partially hydrogenated oils (PHO).

But the remaining 11 countries (Azerbaijan, Bangladesh, Bhutan, Ecuador, Egypt, India, Iran, Mexico, Nepal, Pakistan, Republic of Korea) still need to take urgent action.

The report highlights two encouraging trends. First, when countries do act, they overwhelmingly adopt best-practice policies rather than less restrictive ones. New policy measures passed and/or introduced in the past year in Brazil, Turkey and Nigeria all meet WHO's criteria for best-practice policies. Countries, such as India, that have previously implemented less restrictive measures, are now updating policies to align with best practice.

Second, regional regulations that set standards for multiple countries are becoming increasingly popular, emerging as a promising strategy for accelerating progress towards global elimination by 2023. In 2019,

the European Union passed a best-practice policy, and all 35 countries that are part of the WHO American Region/Pan American Health Organization unanimously approved a regional plan of action to eliminate industrially produced trans fats by 2025. Together, these two regional initiatives have the potential to protect an additional 1 billion people in more than 50 countries who were not previously protected by trans fat regulations.

“With the global economic downturn, more than ever, countries are looking for best buys in public health,” said Dr Tom Frieden, President and CEO of Resolve to Save Lives. “Making food trans fat-free, saves lives and saves money, and, by preventing heart attacks, reduces the burden on health care facilities.”

Despite the encouraging progress, important disparities persist in policy coverage by region and country income level. Most policy actions to date, including those passed in 2019 and 2020, have been in higher-income countries and in the WHO Regions of the Americas and Europe. Best-practice policies have been adopted by seven upper-middle-income countries and 33 high-income countries; no low-income or lower-middle-income countries have yet done so.

Note to editors:

Industrially produced trans fats are contained in hardened vegetable fats, such as margarine and ghee, and are often present in snack food, baked foods, and fried foods. Manufacturers often use them as they have a longer shelf life and are cheaper than other fats. But healthier alternatives can be used that do not affect taste or cost of food.

WHO recommends that trans fat intake be limited to less than 1% of total energy intake, which translates to less than 2.2 g/day with a 2,000-calorie diet. To achieve a world free of industrially produced trans fats by 2023, WHO recommends that countries:

- develop and implement best-practice policies to set mandatory limits for industrially produced trans fats to 2% of oils and fats in all foods or to ban partially hydrogenated oils (PHO);
- invest in monitoring mechanisms, e.g. lab capacity to measure and monitor trans fats in foods; and
- advocate for regional or sub-regional regulations to expand the benefits of trans fat policies.

This report launches during 2020 Global Week for Action on Noncommunicable Diseases (NCDs) from 7 to 13 September. This year's theme is accountability to ensure that commitments made by governments, policy makers, industries, academia, and civil society become a reality.
https://www.who.int/news-room/detail/09-09-2020-more-than-3-billion-people-protected-from-harmful-trans-fat-in-their-food

FAO/OIE/WHO
Tripartite Statement on the Pandemic Risk of Swine Influenza
Source: United Nations Food and Agriculture Organization (FAO), the World Organization for Animal Health (OIE), and the World Health Organization (WHO)
9 September 2020

A recent report1 on the circulation of A(H1N1) subtype influenza viruses in the swine population in China with evidence of zoonotic potential has alerted the world to the pandemic risk associated with swine influenza viruses. This particular genetic clade (1C.2.3) of swine influenza A (H1N1) viruses had previously been reported by the Harbin Veterinary Research Institute, China in 2016, and from 2016-2018 remained the most commonly detected genotype of influenza viruses in surveillance undertaken in swine populations in China.

“Although there is limited data assessing human infections and circulation of these viruses in pigs, awareness and vigilance is strongly advised for a number of reasons” says Keith Sumption, Chief Veterinary Officer of the FAO. “The viruses analysed in the recent report from China show characteristics associated with increased ability for zoonotic transmission – the potential ability to infect humans. The viruses have

some genetic markers to suggest human infection is possible; they can replicate in human airway cells, and viruses can be spread via respiratory droplets passed between ferrets."

It is important that new and updated swine influenza surveillance data collected by countries are rapidly analysed and risk-assessed on a global scale to enable tracking how endemic and novel viruses are spreading. With the aim to facilitate and support this, OFFLU (OIE-FAO Network of Expertise on Animal Influenza) advocates timely sharing of swine surveillance data from all regions to ensure that a One Health approach is applied to emerging influenza A viruses and that diagnostic tools are regularly updated to detect a wide range of influenza viruses, including emergent strains.

It is recommended that laboratories continue to conduct tests for swine influenza according to OIE International Standards. Further testing information, protocols, and guidance for surveillance in animals and in humans are given on the OIE, FAO and WHO websites

A number of countries have reported sporadic human infections with novel influenza viruses including strains of swine-origin, under the WHO International Health Regulations in the past decades. Cases of human infections with swine influenza A viruses from the 1C genetic clade have been reported from Eurasia2 3 in recent years.

"The timely release of genetic sequence data and sharing of virus isolates of emerging influenza viruses with GISRS (Global Influenza Surveillance and Response System has allowed both public and animal health specialists to rapidly assess associated risks" informs Ann Moen, Chief Influenza Preparedness and Response Unit, WHO. "Such timely action is critical to inform effective mitigation measures and prepare for a potential pandemic."

Over the past four decades instances of sporadic transmission of influenza viruses between animals and humans have occurred. These sporadic zoonotic infections remind us that the threat of an influenza pandemic is persistent. While avian influenza has been the focus of surveillance and pandemic preparedness, swine influenza should not be neglected. The 2009 H1N1 pandemic was caused by a strain of swine influenza A virus which was introduced into humans and spread worldwide. Since then humans have re-introduced these viruses back into pigs, where they continue to evolve. It is important to identify emerging influenza viruses in swine populations and investigate their potential to infect humans.

The Tripartite contributes to this through supporting the understanding of the complexity and diversity of human-animal interfaces in different regions and significant differences in capacities of animal and human health national surveillance between countries and across geographic regions.

"Influenza in swine is not an OIE listed disease and thus does not require reporting to the OIE by the veterinary authorities. However, due to the pandemic risk associated with animal influenza viruses, there is a need for continued surveillance and risk assessment of emerging strains in swine populations" says Dr Matthew Stone, Deputy Director General (International Standards and Science), OIE.

"Through the international partnership between OIE, FAO, WHO and contributing laboratories, emerging influenza variants, that may be of public or animal health concern, can be identified and flagged for further attention. We continuously monitor changes in circulating influenza virus strains in animal populations worldwide."

The development of zoonotic influenza A candidate vaccine viruses, coordinated by WHO, remains an essential component of the global strategy for pandemic preparedness. Such readiness is dependent on continued monitoring through surveillance in animals including swine populations and timely reporting of human infections under International Health Regulations. The WHO Collaborating Center at China CDC has previously reported human infections by other 1C A(H1N1) variant viruses, including two recent viruses with a similar 1C.2.3 genotype. A candidate vaccine virus from a similar 1C.2.3. (Eurasian avianlike) A(H1N1) virus has been developed by the WHO Collaborating Center at China CDC, available for development of human vaccines for pandemic preparedness purposes.

[APG]

Knowledge gained from international One Health cooperation, highlighted in the Tripartite's Commitment (2017) and WHO Global Influenza Strategy, allows animal and human health experts to conduct timely risk assessment, update diagnostic tests and diagnostic reagents, anticipate vaccine component requirements, and develop response plans for current or future events.
https://www.oie.int/fileadmin/Home/eng/Animal_Health_in_the_World/docs/pdf/Swine_influenza/2020-09_TripartiteStatement_RiskSwineFlu.pdf

Researches, Policies and Guidelines

United States

E-cigarette Use Among Middle and High School Students — United States, 2020
Source: Morbidity and Mortality Weekly Report (MMWR)
GPHIN ID: 1007804081

The use of any tobacco product by youths is unsafe, including electronic cigarettes (e-cigarettes) *(1)*. Most e-cigarettes contain nicotine, which is highly addictive, can harm the developing adolescent brain, and can increase risk for future addiction to other drugs (*1*). E-cigarette use has increased considerably among U.S. youths since 2011 (*1*,*2*). Multiple factors have contributed to this increase, including youth-appealing flavors and product innovations (*1*–*3*). Amid the widespread use of e-cigarettes and popularity of certain products among youths, on February 6, 2020, the Food and Drug Administration (FDA) implemented a policy prioritizing enforcement against the manufacture, distribution, and sale of certain unauthorized flavored prefilled pod or cartridge-based e-cigarettes (excluding tobacco or menthol).*
CDC and FDA analyzed nationally representative data from the 2020 National Youth Tobacco Survey (NYTS),† a cross-sectional, school-based, self-administered survey of U.S. middle school (grades 6–8) and high school (grades 9–12) students conducted during January 16–March 16, 2020.§ The NYTS study protocol was approved by the CDC institutional review board. Current (past 30-day) e-cigarette use was assessed, overall and by device¶ and flavor** type. Weighted prevalence estimates and population totals†† were calculated. Analyses were conducted using SAS-callable SUDAAN (version 11.0.3; RTI International).
In 2020, 19.6% of high school students (3.02 million) and 4.7% of middle school students (550,000) reported current e-cigarette use. Among current e-cigarette users, 38.9% of high school students and 20.0% of middle school students reported using e-cigarettes on 20 or more of the past 30 days; 22.5% of high school users and 9.4% of middle school users reported daily use. Among all current e-cigarette users, 82.9% used flavored e-cigarettes, including 84.7% of high school users (2.53 million) and 73.9% of middle school users (400,000).
Among high school current e-cigarette users, the most commonly used device type was prefilled pods or cartridges (48.5%; 1.45 million), followed by disposables (26.5%; 790,000), and tanks (14.8%; 440,000). Among middle school current e-cigarette users, the most commonly used device type was prefilled pods or cartridges (41.3%; 220,000), followed by tanks (21.5%; 110,000), and disposables (15.2%; 80,000).
Among high school students who currently used any type of flavored e-cigarettes, the most commonly used flavor types were fruit (73.1%; 1.83 million); mint (55.8%; 1.39 million); menthol (37.0%; 920,000); and candy, desserts, or other sweets (36.4%; 910,000). Among middle school students who currently used any type of flavored e-cigarettes, the most commonly used flavor types were fruit (75.6%; 290,000); candy, desserts, or other sweets (47.2%; 180,000); mint (46.5%; 180,000); and menthol (23.5%; 90,000).
Among current users of flavored prefilled pods or cartridges, the most commonly used flavor types were fruit (66.0%; 920,000); mint (57.5%; 800,000); menthol (44.5%; 620,000); and candy, desserts, or other sweets (35.6%; 490,000) (Figure). Among current users of flavored disposable e-cigarettes, the most commonly used flavor types were fruit (82.7%; 650,000), mint (51.9%; 410,000); candy, desserts, or other sweets (41.7%; 330,000); and menthol (23.3%; 180,000).
In 2020, approximately one in five high school students and one in 20 middle school students currently used e-cigarettes. By comparison, in 2019, 27.5% of high school students (4.11 million) and 10.5% of middle school students (1.24 million) reported current e-cigarette use (*2*). Although these data reflect a decline in current e-cigarette use since 2019, 3.6 million U.S. youths still currently used e-cigarettes in 2020, and among current users, more than eight in 10 reported using flavored e-cigarettes.
Consistent with 2019, prefilled pods or cartridges were the most commonly used device type in 2020; however, during 2019–2020, disposable e-cigarette use increased approximately 1,000% (from 2.4% to

26.5%) among high school current e-cigarette users and approximately 400% (from 3.0% to 15.2%) among middle school current e-cigarette users. Although use of fruit flavored e-cigarettes was common among users in 2020, findings also suggest prominent menthol e-cigarette use, including among nearly one half of flavored prefilled pod or cartridge users and one quarter of flavored disposable product users.
Comprehensive implementation of evidence-based strategies at the national, state, and local levels, in coordination with FDA regulation, can prevent and reduce youth tobacco product use (*1*,*4*,*5*). Strategies to address factors driving youth e-cigarette use are particularly critical. In addition to FDA's enforcement policy that prohibits the sale of prefilled pod or cartridge-based e-cigarettes in any flavor other than tobacco or menthol, several states and communities have restricted all flavored e-cigarette sales, including menthol.§§
https://www.cdc.gov/mmwr/volumes/69/wr/mm6937e1.htm?s_cid=mm6937e1_e&deliveryName=DM37503

United States

E-cigarette Unit Sales, by Product and Flavor Type — United States, 2014–2020
Source: Morbidity and Mortality Weekly Report (MMWR)

Summary

What is already known about this topic?

Since electronic cigarettes (e-cigarettes) entered the U.S. marketplace in 2007, the landscape has evolved to include disposable e-cigarettes and rechargeable e-cigarettes with prefilled cartridges and flavored e-liquids (e.g., fruit, candy, and mint).

What is added by this report?

During September 2014–May 2020, e-cigarette sales increased by 122.2%. Sales of prefilled cartridges increased during September 2014–August 2019; since then, sales of disposable products have increased. Prefilled mint cartridge e-cigarette sales increased from September 2014 to August 2019, then decreased, as menthol sales increased during August 2019–May 2020.

What are the implications for public health practice?

Continued monitoring of e-cigarette sales and use is critical to inform strategies to minimize risks. As part of a comprehensive approach, such strategies could include those that address youth-appealing product innovations and flavors.

Since electronic cigarettes (e-cigarettes) entered the U.S. marketplace in 2007, the landscape has evolved to include different product types (e.g., prefilled cartridge–based and disposable products) and flavored e-liquids (e.g., fruit, candy, mint, menthol, and tobacco flavors), which have contributed to increases in youth use (*1*,*2*). E-cigarettes have been the most commonly used tobacco product among U.S. youths since 2014; in 2019, 27.5% of high school students reported current e-cigarette use (*3*). To assess trends in unit sales of e-cigarettes in the United States by product and flavor type, CDC, CDC Foundation, and Truth Initiative analyzed retail scanner data during September 14, 2014–May 17, 2020, from Information Resources, Inc. (IRI). During this period, total e-cigarette sales increased by 122.2%, from 7.7 million to 17.1 million units per 4-week interval. By product type, the proportion of total sales that was prefilled cartridge products increased during September 2014–August 2019 (47.5% to 89.4%). During August 2019–May 2020, the proportion of total sales that was disposable products increased from 10.3% to 19.8%, while the proportion that was prefilled cartridge products decreased (89.4% to 80.2%). Among prefilled cartridge sales, the proportion of mint sales increased during September 2014–August 2019 (<0.1% to 47.6%); during August 2019–May 2020, mint sales decreased (47.6% to 0.3%), as menthol sales increased (10.7% to 61.8%). Among disposable e-cigarette sales during September 2014–May 2020, the proportion of mint sales increased (<0.1% to 10.5%), although tobacco-flavored (52.2% to 17.2%) and menthol-flavored (30.3% to 10.2%) sales decreased; during the same period, sales of all other flavors combined increased (17.2% to 62.1%). E-cigarette sales increased during 2014–2020, but fluctuations occurred overall and by product and flavor type, which could be attributed to consumer preferences and accessibility. Continued monitoring of e-cigarette sales and use is critical to inform strategies at the national, state, and community levels to minimize the risks of e-cigarettes on individual- and population-level health. As part of a comprehensive approach to prevent and reduce youth e-cigarettes use, such strategies could include those that address youth-appealing product innovations and flavors.
Retail sales data were licensed from IRI, Inc., which included Universal Product Code sales from convenience stores, gas stations, grocery stores, drugstores/pharmacies, mass merchandiser outlets, club stores, dollar stores, and military sales. Sales from the Internet and tobacco-specialty stores, including

"vape shops," were not included. E-cigarette products were categorized as one of the following product types: prefilled cartridge devices, disposable devices, and e-liquids.* E-cigarette accessories and devices sold without e-liquids, which accounted for 9.4% of sales, were excluded. Products with explicit flavor names were categorized as tobacco, menthol, mint, or all other flavors (e.g., fruit, clove/spice, candy/desserts/other sweets, chocolate, alcoholic and nonalcoholic drinks). Ambiguous or concept flavors (e.g., "fusion") (5.6%) were searched for online and back-coded into one of the four flavor categories. E-cigarette unit sales were standardized and aggregated in 4-week intervals from September 14, 2014, through May 17, 2020† (*4*). Analyses were performed for total unit sales and the proportion of total unit sales by product type and flavor using Stata (version16; StataCorp). Trends during 2014–2020 were analyzed using Joinpoint (version 4.8.0.1; National Cancer Institute), and average 4-week interval percentage change (AIPC) with corresponding 95% confidence intervals (CIs) were calculated. Statistical significance was defined as $p<0.05$. This study did not involve human subjects, and thus, was not submitted for Institutional Review Board review.

During September 2014–May 2020, total unit sales increased by 122.2% ($p<0.05$), from 7.7 million to 17.1 million units per 4-week interval. (AIPC = 1.1; 95% CI = 0.6 to 1.6); however, within the context of this general increase, sales fluctuated (Figure 1). During November 2016–August 2019, sales increased by 294.3%, from 5.6 million to 22.0 million units per period (AIPC = 4.1; 95% CI = 3.2 to 5.1) ($p<0.05$). During August 2019–February 2020, sales decreased 32.7%, from 22.0 million to 14.8 million units per period (AIPC = −5.1; 95% CI = −7.2 to −2.8) ($p<0.05$). No significant change in total sales occurred during February–May 2020.

Among total e-cigarette unit sales during September 2014–August 2019, the proportion that were prefilled cartridges increased from 47.5% to 89.4% (AIPC = 1.0) ($p<0.05$) (Table). The proportion of total sales that were prefilled cartridges decreased thereafter ($p<0.05$), accounting for 80.2% of total sales in May 2020 (AIPC = −1.3). As the proportion of sales accounted for by prefilled cartridges decreased beginning August 2019, the proportion of sales that were disposable products increased from 10.3% of total sales in August 2019 to 19.8% in May 2020 (AIPC = 7.5) ($p<0.05$).

Among total e-cigarette unit sales during September 2014–August 2019, the proportion accounted for by mint products increased from 0.01% to 43.4% (AIPC = 10.5) ($p<0.05$) (Figure 1). During August 2019–May 2020, although mint sales declined from 43.4% to 2.3% of total e-cigarette sales (AIPC = −28.3), the proportion of menthol sales increased from 11.4% to 51.6% of total sales (AIPC = 18.9), and tobacco-flavored sales increased from 23.0% to 33.1% of total sales (AIPC = 4.6). During September 2014–October 2018, sales of all other flavored e-cigarettes increased from 17.6% to 52.4% of total sales (AIPC = 2.0) ($p<0.05$); however, sales of all other flavored e-cigarettes declined thereafter, from 52.4% to 12.8% of total sales by May 2020 (AIPC = −5.9) ($p<0.05$).

Among prefilled cartridge sales during September 2014–August 2019, the percentage that were mint increased from <0.1% to 47.6% (AIPC = 14.1) ($p<0.05$) (Figure 2). During August 2019–May 2020, although the mint sales declined from 47.6% to 0.3% of all prefilled cartridge sales (AIPC = −42.3), the proportion of menthol sales increased from 10.7% to 61.8% (AIPC = 22.3), and the percentage of tobacco-flavored sales increased from 22.8% to 37.1% (AIPC = 6.1). During September 2014–October 2018, sales of all other flavors increased from 12.9% to 54.4% of prefilled cartridge sales (AIPC = 3.3) ($p<0.05$); however, sales of these products declined thereafter to 0.8% of all prefilled cartridge sales by May 2020 (AIPC = −18.1) ($p<0.05$).

Among disposable e-cigarette sales during September 2014–May 2020, the percentage of sales of tobacco-flavored and menthol-flavored products decreased; sales of tobacco-flavored e-cigarettes accounted for 17.2% and menthol-flavored accounted for 10.2% of all disposable e-cigarette sales in May 2020, ($p<0.05$). (Figure 3). During the same period, mint-flavored sales increased from <0.1% to 10.5% of all disposable e-cigarette sales (AIPC = 7.4), and the proportion of all other flavors increased from 17.2% to 62.1% (AIPC = 1.6).

Top

Discussion

During November 2016–August 2019, total e-cigarette unit sales in the U.S. increased nearly 300%. Although prefilled cartridges remained the leading product type sold, disposable sales increased beginning in August 2019, reaching 19.8% of total sales by May 2020. Among prefilled cartridge sales, the proportion of mint-flavored products declined beginning in August 2019; by May 2020, menthol (61.8%) and tobacco (37.1%) flavors dominated the market. Among disposable e-cigarette sales, tobacco-flavored and menthol-flavored sales decreased during September 2014–May 2020; during the same period, the proportion of

sales that were mint and all other flavors increased, with mint reaching 10.5% and all other flavors reaching 62.1% of total sales by May 2020. Continued monitoring of e-cigarette sales could inform strategies to reduce use among U.S. youths, including strategies that address youth-appealing product innovations and flavors (*1,2*).

The increase in total e-cigarette sales that occurred during November 2016–August 2019 was driven by sales of prefilled cartridges, which made up nearly 90% of the market by August 2019. Previous research indicates this increase in total sales was primarily driven by JUUL (*5*), a prefilled cartridge-based e-cigarette that accounted for approximately 75% of total U.S. e-cigarette sales by December 2018.§ The rise in JUUL sales occurred during the same period as when youth e-cigarette use increased considerably; during 2017–2018, current e-cigarette use increased 78% among U.S. high school students and 48% among middle school students (*6*). The decline in total e-cigarettes sales during August 2019–February 2020 might be attributable, in part, to shifts in consumer behaviors following the national outbreak of e-cigarette, or vaping, product use-associated lung injury (EVALI) (*7*).

Among prefilled cartridge e-cigarettes, sales of mint and other flavors declined beginning in August 2019, after which menthol and tobacco-flavored sales increased considerably. During the same period, overall disposable e-cigarette sales increased, particularly mint and other flavored (excluding menthol or tobacco) products. Flavored e-cigarette sales patterns by product type are likely influenced by multiple factors. For example, JUUL voluntarily removed mango, creme, fruit, and cucumber flavored cartridges from retail stores (November 2018) and online (October 2019)¶ and removed mint-flavored cartridges entirely from the market in November 2019.** Moreover, on January 2, 2020, the Food and Drug Administration (FDA) finalized an enforcement policy that prohibits the sale of prefilled cartridge e-cigarettes in any flavor other than tobacco or menthol.††

The findings in this report are subject to at least three limitations. First, sales data did not include purchases from the Internet or "vape shops," which accounted for approximately one half of U.S. e-cigarette sales in 2019;§§ a data source for Internet and "vape shop" sales does not currently exist. Second, the study could not assess purchaser age. These sales could reflect products purchased by adults or those obtained directly or indirectly by youths; however, three quarters of youths who use JUUL, the mostly commonly sold e-cigarette brand in the United States, reported obtaining it from a physical retail location. Finally, ambiguous or concept flavors were back-coded using online searches and might be subject to misclassification; however, this only applied to 5.6% of total sales.

Youth use of tobacco products in any form, including e-cigarettes, is unsafe (*1,2*). In the U.S., e-cigarette use is markedly higher among youths than adults; in 2018, current use of e-cigarettes was 20.8% (past 30-day use) among high school students, 7.6% (everyday/someday use) among adults aged 18–24 years, and 3.2% (everyday/someday use) among adults aged ≥18 years (*6,8*). In addition to regulation of the manufacturing, marketing, and sale of e-cigarettes by FDA,*** strategies to reduce e-cigarette use among youths include increasing price, implementing comprehensive smoke-free policies that include e-cigarettes, restricting youths' access to e-cigarettes in retail settings, licensing retailers, developing educational initiatives targeting youths, curbing youth-appealing advertising and marketing, and implementing strategies to reduce youth access to flavored tobacco products (*1*,*2*,*9*).

https://www.cdc.gov/mmwr/volumes/69/wr/mm6937e2.htm?s_cid=mm6937e2_e&deliveryName=DM37503