GPHIN Daily Report for 2020-09-17

Special section on Coronavirus

Canada

Areas in Canada with cases of COVID-19 as of 16 September 2020 at 07:00 pm EDT
Source: Government of Canada

Province, territory or other	Number of confirmed cases	Number of active cases	Number of deaths
Canada	139,747	8,105	9,193
Newfoundland and Labrador	271	1	3
Prince Edward Island	57	1	0
Nova Scotia	1,086	1	65
New Brunswick	194	3	2
Quebec	65,857	2,265	5,788
Ontario	45,383	2,316	2,822
Manitoba	1,489	283	16
Saskatchewan	1,751	107	24
Alberta	16,128	1,495	254
British Columbia	7,498	1,633	219
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)

Canada

Prime Minister announces next steps for Safe Restart Agreement

September 16, 2020
Ottawa, Ontario

As we move into the fall and the world continues to deal with the impacts of COVID-19, the Government of Canada remains focused on keeping Canadians safe and healthy, while continuing to ensure they have the supports needed during this global health and economic crisis.

The Prime Minister, Justin Trudeau, today shared the details of the investments that will be made through the Safe Restart Agreement. This will provide continued support to Canadians, as we safely restart our economy and build a more resilient Canada.

Through the Agreement, reached earlier this summer, the Government of Canada announced over $19 billion in federal funding to help provinces and territories safely restart the economy. Provinces and territories were asked to outline in a letter how these funds would best be allocated within their jurisdictions, based on their priorities. The premiers have now submitted the letters and the federal funding will be transferred to the provinces and territories.

The Safe Restart Agreement supports measures to increase testing and contact tracing to protect Canadians from future waves of the virus. It will help support the capacity of our health care systems, including through services for people facing mental health challenges. It will also provide municipalities with funding so they can quickly deliver essential services, like public transit, that Canadians rely on every day, and secure a reliable source of personal protective equipment for essential workers.

The Agreement will also provide direct support to Canadian workers, including safe child care to help parents returning to work. It will also provide income support for people without paid sick leave, and takes steps to protect the most vulnerable, like Canada's seniors.

As we continue to deal with the health and economic challenges of the pandemic, the government will continue to invest in Canadians. Together, working with the provinces and territories, we will build a more resilient Canada – one that is healthier and safer, cleaner and more competitive, and fairer and more inclusive for everyone.

https://pm.gc.ca/en/news/news-releases/2020/09/16/prime-minister-announces-next-steps-safe-restart-agreement

Canada
Statement from the Chief Public Health Officer of Canada on September 16, 2020
From: Public Health Agency of Canada

Statement
On September 16, 2020, Dr. Theresa Tam, Canada's Chief Public Health Officer, issued the following statement on COVID-19.

September 16 2020 - Ottawa, ON - Public Health Agency of Canada

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 138,803 cases of COVID-19 in Canada, including 9,188 deaths. 88% of people have now recovered. Labs across Canada tested an average of 47,111 people daily over the past week with 1.4% testing positive. An average of 722 new cases have been reported daily during the most recent seven days.

Today, I would like to call attention to the over *six million* Canadians who have been tested for COVID-19 over the past months, including the over 300,000 people currently being tested each week across Canada. I would like to thank *all* Canadians who made the decision to get tested.

In the more than six months since the pandemic began, public health officials like myself have talked a lot about what each one of us can do to protect ourselves, our families and our communities. A lot of this advice has focused on proven effective prevention measures, such as, staying home and away from others if experiencing any symptoms, even if mild; keeping a physical distance of at least two metres from others when out in public; wearing a non-medical mask or face covering when physical distancing is difficult; and maintaining good hand hygiene.

But one of the most important public health measures we can take if we have symptoms, or think we have been exposed to someone with COVID-19, is to get tested. For assistance in deciding whether and how to be tested for COVID-19, you can access COVID-19 self-assessment tools online.

Testing enables local public health agencies to interrupt chains of transmission and prevent further spread of the virus through case detection and contact tracing, and isolation and quarantine, respectively. I recognize that there may be line-ups at some local testing facilities, and awaiting test results may be stressful and disruptive to your family and work life, but I thank you for your patience. Your actions are vital to keeping COVID-19 activity at manageable levels.

Being tested for COVID-19 is an act of kindness, and frankly, bravery -- it means you are choosing not only to protect yourself, but also to protect those around you. If the test is positive, that starts the process of local public health authorities notifying others who may have been exposed so they can take steps to self-isolate and get tested if they develop symptoms.

If someone you know is being tested for COVID-19 or awaiting results, you can help by letting them know you're available to support them, whether by offering to run an urgent errand, leaving supplies at their door or connecting with them virtually so they know they are not alone while they are self-isolating and awaiting their test results. And if we test positive we will need the same support during the period of self-isolation.

Another way you can help break the cycle of infection is to download the Government of Canada's free COVID Alert app on your phone. While protecting your privacy, the app can alert you of a possible exposure before any symptoms appear. If you have downloaded the app and you test positive for COVID-19, you will get a one-time key from your provincial or territorial health care authority that you can enter into the app. The app will then notify other app users you may have come into close contact with while you were infectious. The app works without collecting personally identifiable or location data.

We are all adjusting to new ways of resuming school, work, business… in our adapted way of life. As we do so, let's continue to support each other and protect each other with, compassion and understanding. You can find additional information on COVID-19 risk factors and precautions here."

ERRATUM

In Tuesday's media availability, we reported that an average of 838 new cases had been reported daily during the preceding seven days. The calculation of this average erroneously included some cases that had been identified during Labour Day holiday weekend but were not reported until Tuesday September 8th. With these cases removed, the correct average daily case count for the period September 8th to September 14th is 696 cases. In addition, the correct average for the daily case count for the period September 7th to 13th is 681, not 618 as reported in our statement on Monday. We apologize for these errors. We remain concerned about the steady increase in national daily case counts reported during recent weeks.

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https://www.canada.ca/en/public-health/news/2020/09/statement-from-the-chief-public-health-officer-of-canada-on-september-16-2020.html

Canada
Top medical expert says Ontario needs smaller classes as COVID-19 cases accelerate
Source: National Post
ID: 1007853235

TORONTO — Classes in Canada's high risk schools should ideally have 20 or fewer students so children can maintain safe distance from each other, a top doctor who advised the government of Ontario on school reopening said, as sometimes crowded classes resumed in the midst of a spike in COVID-19 cases. Dr Ronald Cohn, president of Toronto's Hospital for Sick Children, is one author of two reports that Canada's most populous province cited repeatedly in drafting back to school plans.
Cohn said much depends on the size of classrooms – some can accommodate only 15, while others may be large enough to teach 18 or 20 children, but likely not many more than that.
"It's critical that we create a classroom environment where we reduce class sizes so that physical distancing can be happening," Cohn told Reuters late Monday, adding that this is particularly important in areas with higher community transmission, often home to the most vulnerable children and families.
Preliminary results of a new study released by the hospital on Monday showed it was not possible to maintain two meters (6.5 ft) of social distancing in standard classrooms with more than 12 to 15 students. (https://safeschoolcovid19.ca/updates/)

https://nationalpost.com/pmn/health-pmn/top-medical-expert-says-ontario-needs-smaller-classes-as-covid-19-cases-accelerate

Canada
Alberta outlines plans to spend $1.3B under Safe Restart Agreement
Source: CBC | Edmonton News
ID: 1007853135

Alberta plans to spend $1.3 billion allocated by the federal government to increase COVID-19 testing, enhance health-care capacity, funnel money to municipal transit systems and buy more personal protective equipment.
Plans for the spending under the Safe Restart Agreement were outlined in a letter sent to the prime minister by Alberta Premier Jason Kenney.
Under the agreement reached earlier this summer, the federal government announced it will provide more than $19 billion to help provinces and territories safely restart the economy.
In his letter to Prime Minister Justin Trudeau, Kenney lists key six priorities and outlines how much money will be spent on each.
The province will spend $349.9 million to increase testing, contact tracing, and data management.
Plans for that money include:

- Increase testing capacity from current levels of 12,000 per day to a peak of 22,000 tests per day, though actual numbers will depend on demand;
- Expansion of MyHealth Records to include all test results;
- Reimburse some COVID-related spending undertaken by Alberta Precision Labs during the first eight months of this year.

- The province plans to spend $139 million to ramp up health-care capacity, Kenney said. Plans for that money include:
- Funding additional infection prevention and control in health-care settings.
- Reducing the backlog of non-COVID procedures.
- Paying to backfill or hire new health-care staff.
- Increasing online, phone and in-person mental health and addiction recovery support.
- The province will spend $303.2 million on municipalities and transit.

Alberta's plans for that money, which will mainly be allocated on a per-capita basis, include:
Funding for the 15 municipal transit systems in Alberta to pay for operating costs incurred due to COVID-19, including the purchase of personal protective equipment, costs of additional cleaning, and replacement of revenues lost due to declines in ridership.
Providing money to municipalities to cover operating losses incurred as a result of COVID-19 and to replace lost revenues such as parking fees, recreation facility entrance fees and building permit fees.
A portion of the funding will be set aside for the tourism centres of Banff, Jasper, and Canmore.
The province will spend $71.8 million on child care.
That money will go to:
Paying for child-care spaces and increasing availability of spaces for families of children with disabilities or at risk.
Providing a time-limited grant to cover some fixed costs for preschool, day care, family day homes, and out-of-school programs.
Providing a one-time grant to early childhood educators.
Alberta will spend $86.3 million to help vulnerable populations.
Plans for that money include:
Providing support for continuing care and lodge operators, including enhanced staffing, extra cleaning supplies, lost accommodation revenue.
Providing support to people who use shelters or temporary housing, including women's shelters.
Providing support to address and prevent family violence and sexual violence.
Funding to charities and civil societies.
The province will also spend almost $350 million on personal protective equipment.

https://www.cbc.ca/news/canada/edmonton/alberta-covid-19-coronavirus-coronavirus-safe-restart-agreement-funding-1.5726475?cmp=rss

Canada
BC Centre for Disease Control to post all school-related COVID-19 cases
ID: 1007853610
Source: globalnews.ca

The BC Centre for Disease Control will now notify the public about every case of COVID-19 detected in the school system, with details, following public outcry and comparisons to policies in other provinces. Previously, school districts in B.C. notified staff and students that someone in their individual school community had tested positive for the disease caused by the coronavirus.

But parents and other members of the public clamoured for more specifics, such as the date and type of exposure, similar to what happens in other jurisdictions like Ontario.

As of Wednesday, the centre will include links to regional health authorities' school notification pages, including additional details such as date and type of exposure, on its overall list of exposures.
The Fraser Health notification page was already immediately available following the announcement.

Officials have yet to identify any outbreaks in schools, but there are single confirmed cases at five schools in Surrey and one in Delta.
Surrey School District superintendent Jordan Tinney said he supports the further notification.
“I think transparency is really important … to build trust. But not to the point where it infringes on privacy,” Tinney said.
“We need to protect privacy yet at the same time have the right amount of alert to the public.”
https://globalnews.ca/news/7339757/bc-centre-for-disease-control-to-post-all-school-related-covid-19-cases/

Canada
Bar and restaurant staff contribute 20% of COVID cases: City’s top doc
Toronto Sun
ID: 1007853783

Indoor activities such as dining at restaurants and hanging out in bars are contributing to about 20% of COVID-19 community transmission cases, says Toronto’s medical officer of health.
Dr. Eileen de Villa said Wednesday said instances of staff infecting one another at bars and restaurants are on the rise. However, the same cannot be said for infections being passed from restaurant and bar staff to their customers.

De Villa added one venue generated six cases — four in staff and two in patrons. Another generated nine cases with seven staff members and two patrons. At a restaurant, there were four staff members and one customer who contracted COVID, she said.

“Our data tells us that people are getting COVID-19 in part by socializing indoors without wearing masks, while standing too close to each other and for too long,” she said.
“It’s happening particularly when your guard is down … Our investigators have also noticed that people are coming to work in symptoms and working during the time when they’re infectious. I cannot stress enough that if you know you’re sick, or you might be, the first thing to do is deal with your symptoms and keep apart from others as much as possible.”
Article content continued

De Villa implored employers to allow for sick time for workers who display symptoms and reminded people to wash their hands frequently and to social distance.

She said her team is also tracking four different weddings that have generated 22 infections.
“You cannot tell if someone has COVID-19 just by looking at them,” she said. “Just because they’re family or friends or people you know well from work doesn’t mean they can’t infect you.”

De Villa said the city has lists of individuals who can pinpoint the contact of infection, relevant exposure periods.
“Those who are at any kind of public health risk are informed accordingly,” she said. “One of the steps in case management is isolation, so that effectively removes the risk to the public.”

Toronto reported 86 new COVID-19 cases Wednesday for a total of 17,028 total cases. De Villa said 15,089 people have recovered and 20 people remain in hospital from the virus — seven of them are in intensive care.

https://torontosun.com/news/local-news/bars-and-restaurant-staff-contribute-to-20-of-covid-transmission-city

Canada

Ontario Launches New COVID-19 Screening Tool to Help Protect Students and Staff

Source: Government of Ontario
Unique ID: 1007851127

TORONTO — The Ontario government launched a new voluntary interactive screening tool to assist parents, students and staff with the daily assessment of COVID-19 symptoms and risk factors that is required before attending school. The results will let parents, students, and education staff know whether they should attend school each day or guide at-risk individuals to proper resources. This tool is another layer of prevention that the province is using to protect the health and safety of students, staff, and the communities where they live and work.

Details were provided today by Premier Doug Ford, Christine Elliott, Deputy Premier and Minister of Health, Stephen Lecce, Minister of Education, and Peter Bethlenfalvy, President of the Treasury Board.

"We are doing everything we can to keep students and staff safe, and that includes this new screening tool which will help people protect themselves and others from COVID-19," said Premier Ford. "It's everyone's responsibility to screen themselves or their child for symptoms before going to school. If you're sick or someone in your household is sick, even with mild symptoms, please stay home."

The new easy-to-use tool is voluntary and available for all parents, students and staff to use to help screen for symptoms of illness every day. Users will simply respond to clinician-informed symptom and risk questions, and the tool will then immediately inform users whether it is safe to attend school that day. The tool protects privacy and does not collect any personal health information. The tool was also developed in house by the Ontario Digital Service at no additional cost to taxpayers.

"Our government is taking every preventive action to safely reopen our schools, including the introduction of Ontario's new COVID-19 screening tool for students and staff," said Minister Lecce. "We have made tremendous progress as a province, which is why we must continue to heighten our vigilance by stepping up screening of each student and staff member before they enter our schools."

Earlier this summer, Ontario unveiled the nation's most comprehensive plan for the safe reopening of schools in September. The plan is supported by $1.3 billion in critical supports to hire more teachers and increase physical distancing, purchase personal protective equipment (PPE), enhance cleaning of schools and school buses, improve ventilation, hire more custodians, and add more school leadership positions and administrative support for virtual schools. The province has also established a mandatory masking policy for grades 4-12, and a robust surveillance and testing strategy to ensure a successful return to classrooms.

In addition, local public health units have filled over 530 nursing positions, or 85 per cent, of the additional 625 nursing positions created to help keep students and staff safe. The nurses will be providing rapid-response support to schools and school boards in facilitating public health and preventative measures, including screening, testing, tracing and mitigation strategies. In order to ensure that schools are supported from the start of the school year, several public health units have temporarily redeployed existing nurses while recruitment activities continue.

As part of Ontario's commitment for transparency, and in partnership with the Ministry of Heath and the Ontario Digital Service, the Ministry of Education has also launched a webpage to report COVID-19 cases in schools and child care centres. This page will be updated every weekday with the most up-to-date COVID-19 information available, including a summary of cases in schools and licensed child care centres and agencies. This important resource will help parents and guardians know whether a COVID-19 case has been confirmed at their children's school, and where the numbers come from.

"As students across the province return to school, it's more important than ever that we provide families with the tools and information they need to stay safe and healthy," said Minister Bethlenfalvy. "Throughout the pandemic, our government has worked swiftly to leverage technology and innovation that puts vital programs and services at your fingertips. This tool is another example of how we're building a government that works for you."

The government also released the Operational Guidance: COVID-19 Management in Schools document. This guide was developed in consultation with public health experts, including Ontario's Chief Medical Officer of Health, and aims to help schools identify and isolate COVID-19 cases, reduce the spread of COVID-19 in schools, and prevent and minimize outbreaks.

Quick Facts
•Ontario has committed to making $1.3 billion in COVID-19 resources available to school boards in support of the COVID-19 outbreak, which includes $381 million in federal funding to support provincial back-to-school plans and $50 million in provincial funding for air quality and ventilation in schools.
•For September, the government has delivered over 37 million pieces of PPE to Ontario's 72 school boards and 10 education authorities, including more than 19.5 million masks, 16 million gloves, 317,000 face shields, 320,000 bottles of hand sanitizer, and 218,000 containers of disinfectant, among other critical supplies.
•The Ontario government has named Dr. Dirk Huyer as Coordinator, Provincial Outbreak Response. In this role, he will lead the province's efforts to prevent and minimize COVID-19 outbreaks in a number of sectors, including the education, child care, agriculture, and health care sectors.
•The voluntary screening tool is one of several tools Ontarians should use to stop the spread of COVID-19. Other tools include Ontario's self-assessment tool, which helps people check whether they have symptoms of COVID-19, and the COVID Alert app, which lets people know if they've been exposed to COVID-19—and alert others if they test positive.
https://news.ontario.ca/en/release/58385/ontario-launches-new-covid-19-screening-tool-to-help-protect-students-and-staff

Canada
COVID-19 Update: 124 new cases - Six Calgary schools with two or more cases; St. Wilfrid under 'watch'
Unique ID: 1007850024

The province reported Tuesday 124 new cases of COVID-19 and no additional deaths. There are 1,491 active cases in Alberta.
Drop-in COVID-19 testing is moving from Alberta Health Services' Richmond Road Diagnostic and Treatment Centre to its location at the former Greyhound Bus Station, AHS announced Tuesday. The Richmond Road location will still offer testing by appointment.
Six Calgary schools have now met the threshold for a declared outbreak. Notre Dame High School and Crescent Heights High School are the latest schools to make the list.
The province listed St. Wilfrid Elementary School under "watch" status on Tuesday, meaning there have been five or more cases in the school with possible in-school transmission.
City council voted Monday to extend Calgary's mask bylaw until at least December. City councillors heard during the meeting that the bylaw might be in place until there is a vaccine.
Prime Minister Justin Trudeau warned Canadians against relaxing their guard against COVID-19 as he and his cabinet kicked off two days of closed-door meetings to discuss the pandemic and how to lead the country through a second wave.
In a reversal from previous restrictions, the province will allow limited band practices, indoor singing and concerts involving wind instruments, Alberta's top doctor announced Friday.
https://calgaryherald.com/news/local-news/covid-19-update-124-new-cases-six-calgary-schools-with-two-or-more-cases-st-wilfrid-under-watch

Canada
Hundreds of Quebec's nurses quit their jobs in first 6 months of the pandemic

Source: CBC News
www.cbc.ca

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Categories: Infectious disease - human, Other disease, Product
Locations: Canada, Quebec
Unique ID: 1007850020

As Quebec braces for a second wave of COVID-19 cases, the province's health-care system has lost hundreds of nurses who have quit the profession in the past six months.

A Radio-Canada analysis has found that more than 1,700 nurses working for 13 of the province's regional health boards left their jobs between mid-March and August. That's compared to around 1,300 during the same period in 2019.

At least 11 of those establishments saw more nurses leave their jobs compared to the same period last year.

The CISSS Laval saw a 52-per-cent increase in nurses who left their jobs. For the CIUSSS Ouest-de-l'Île-de-Montréal, that number is 17 per cent. At the CIUSSS Mauricie-et-Centre-du-Québec, 247 nurses left their jobs, an increase of 72 per cent.

Quebec Premier François Legault says he is aware there's a problem.

"It takes three years to train nurses," Legault said. He says the recruitment issues that existed before the pandemic are a persistent problem.

He pointed out that in the coming weeks, thousands of new patient attendants who were recruited and trained over the summer to work in long-term care homes will start their jobs.

A toll on mental health

Monika Grzes left her job as a nurse in May after she started working in a long-term care facility — CHSLD Herron, where more than 50 patients died of COVID-19.

Until March, she had spent her career working in schools. Grzes said she was not prepared for what she saw.

"When I got home my children asked me, 'What are you doing, why do you cry, mom?' I told them, 'Well, I had a difficult day,'" Grzes said.

"In those two months I saw 25 people, maybe 35 people, die."

After 20 years as a nurse, Grzes quit the profession.

She says she still loves nursing, but after her experience this spring, there's no guarantee she'll ever go back.

Work-family balance and improving nurse-patient ratios are among the topics being discussed in the government's collective bargaining with health-care unions.

Efforts to hire nurses continue

While the number of nurses leaving the profession has grown, the province's regional health boards say they are working to make up for the departing staff.

At the CIUSSS du Nord-de-l'Île-de-Montréal, where there has been an increase in departures, hiring has also gone up.

"We are working to upgrade part-time positions to full-time positions," said spokesperson Émilie Jacob. "We are convinced that this will have very positive repercussions on the stability of the workforce, making it possible to strengthen our health-care teams and reduce travel between our various facilities."

At the CIUSSS du Centre-Ouest-de-l'Île-de-Montréal, spokesperson Carl Thériault said the higher number of departures in 2020 is due to nurses who temporarily came in to lend a hand last spring. The CIUSSS also hired 470 auxiliary nurses, for a net gain of 280 employees.

https://www.cbc.ca/news/canada/montreal/nurses-quitting-covid-19-1.5725870?cmp=rss

Canada

Outbreak at John Pritchard School as five students test positive for COVID-19

Source: Global News
Unique ID: 1007849633

Parents whose students attend John Pritchard School on Henderson Highway were told late Tuesday night that there were four newly confirmed cases of COVID-19 at the school, bringing the total to five after a previously asymptomatic child tested positive. The school sent a letter telling parents that Grades 6, 7 and 8, the split class of 4/5, and the before and after school program will begin remote learning immediately. A total of five students at a Winnipeg school have now tested positive for the novel coronavirus.
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Parents whose students attend John Pritchard School on Henderson Highway were told late Tuesday night that there were four newly confirmed cases of COVID-19 at the school, bringing the total to five after a previously asymptomatic child tested positive.
The school sent a letter telling parents that Grades 6, 7 and 8, the split class of 4/5, and the before and after school program will begin remote learning immediately.
“At the present time, public health anticipates that remote learning will continue for these cohorts/grades for 14 days but this may be lengthened or shortened as the investigation continues,” the letter reads.
The school said while they’re not allowed to release any identifying information about the case to the community, anyone identified as a close contact will be contacted by Manitoba Public Health.
Global News has reached out to River East Transcona School Division for more information.
https://globalnews.ca/news/7338133/outbreak-at-john-pritchard-school-as-five-students-test-positive-for-covid-19/

Canada
Ontario premier will push to lower social gathering limits in COVID-19 hotspots
Source: CTV
Unique ID: 1007851036

TORONTO -- Ontario Premier Doug Ford is now pushing to rollback social gathering limits in Toronto, Peel and Ottawa, which have been driving the province’s COVID-19 case numbers, CTV News Toronto has learned.
The province increased the social gathering limit in mid-July allowing up to 50 people to gather indoors and 100 people outdoors.
People quickly capitalized on the new rules, throwing end-of-summer parties, which public health official say contributed to spread of COVID-19 in densely populated cities.
Ontario's chief medical officer of health acknowledged that residents might have been confused about the new rules, and stressed that masking and physical distancing still applied during those gatherings – except for those included in a social bubble.
While Premier Ford originally said last week that regional medical officers of health could impose localized restrictions, none took the premier up on the offer.
Instead, mayors of the affected areas held direct talks with Ford to raise concerns about the social gathering rules, strip clubs, and alcohol serving hours – pressing the premier to impose restrictions from a provincial level, but on a regional basis.
Today, Ford and his cabinet will consider a number of options on social gathering limits . Government sources say, however, the limits may not apply to businesses, which have expressed concerns about the impact of further restrictions on the viability of their operations.
https://toronto.ctvnews.ca/ontario-premier-will-push-to-lower-social-gathering-limits-in-covid-19-hotspots-1.5107057

Canada
Two more schools in Surrey, B.C., report cases of COVID-19
Source: Global news
Unique ID: 1007851027

Two more schools in Surrey, B.C., are reporting cases of COVID-19.
One individual attended Sullivan Heights Secondary and the other attended William Watson Elementary, district superintendent Jordan Tinney said Tuesday night.
Both people were at the schools last Thursday, on Sept. 10, he added. The cases are considered low-risk.

Only individuals who are believed to have had a possible exposure to COVID-19 are being notified to self-isolate or watch for symptoms.
Parents who haven't been notified by phone or letter are to send their child to school as normal.
On Tuesday, Health Minister Adrian Dix said he would review notification guidelines on cases in schools, after the disease was reported at three Metro Vancouver high schools.
A staff member at Panorama Ridge Secondary and a person at Johnston Heights Secondary — both in Surrey — tested positive for COVID-19 before in-person classes were back in session.
The Delta School District would not say whether its confirmed case is a student or staff member, but added the person is self-isolating at home. That exposure occurred after the new school year began.
https://globalnews.ca/news/7338564/surrey-schools-covid-19-cases/

Canada
Canada shifts focus in upcoming throne speech to deal with potential second wave of COVID-19
Source: NEWS 1130
Unique ID: 1007850866

OTTAWA – The priorities for the Trudeau government have shifted as a result of rising COVID-19 cases across the country.
This comes as the federal cabinet retreat wraps up on Wednesday. The ambitious plan for economic recovery has been put on the back burner at this retreat as ministers try to figure out the best way to deal with a potential second wave of COVID-19.
The aim is to prevent a major surge and another shutdown of the economy, likely indicating a change in focus for next week's throne speech.
However, Minister of Innovation, Science and Industry Navdeep Bains says that doesn't mean the government is ignoring the economy, and that ministers will be putting forward ideas to try and spark more job creation.
"We need unique, tailored solutions to help the workers and these communities and that's exactly what we'll be doing in the near future," he said on Wednesday.
Other ministers point out you can't have an economic recovery unless you keep Canadians safe through the fall.
The president of the treasury board says the government will be there to support Canadians and keep them safe but would not say if the government has a ceiling for its already-record deficit.
"The objective is never to hit that ceiling. It's to make sure that we don't have to get there, and we will not get there if, as I said, we protect the integrity of our nation — both from the social and economic perspective," Minister Jean-Yves Duclos explained.
Meanwhile, Minister for Economic Development Melanie Joly says both the economy and keeping Canadians safe go hand in hand.
"There's a strong link between the health of our economy and the health of Canadians. And what Canadians expect of us right now is definitely that we're in charge of dealing with a pandemic with provinces and territories," she said.
The prime minister is expected to speak later today.
https://www.citynews1130.com/2020/09/16/canadas-economic-recovery-second-wave-covid-19/

Canada
TDSB no longer needs extra school spaces after more parents opt for online class
Source: National Post
Unique ID: 1007850850

TORONTO — Canada's largest school board says it no longer needs additional classroom spaces for elementary schools because so many parents have opted out of in-person learning.
The Toronto District School Board says there were initial concerns about the lack of space at five of its schools, but more students have since switched over to online learning.
Spokesman Ryan Bird says thousands of parents have made the switch in recent weeks as the spread of COVID-19 increases in Ontario.
He says that means those schools where there were concerns will now be able to make do by using gyms and libraries for teaching.

The board says it will continue to look for additional classroom spaces in case the need arises.
Earlier in the summer, the TDSB identified multiple Toronto neighbourhoods that were hardest-hit by the coronavirus and set out to lease learning spaces outside of schools.
However, Bird said in an email Wednesday that in the five schools initially identified, existing spaces will be able to accommodate all students.
“At this point in time, no schools will require additional space outside of their building for the start of the school year,” said Bird.
“We are developing plans should additional space be required.”
https://nationalpost.com/pmn/news-pmn/canada-news-pmn/tdsb-no-longer-needs-extra-school-spaces-after-more-parents-opt-for-online-class

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

United States

Ten Clinical Tips on COVID-19 for Healthcare Providers Involved in Patient Care
Source: US CDC
ID: 1007853284

Ten Clinical Tips on COVID-19 for Healthcare Providers Involved in Patient Care

Updated Sept. 16, 2020

Treatment and Prophylaxis
1.The National Institutes of Health has developed guidance on treatmentexternal icon, which will be regularly updated as new evidence on the safety and efficacy of drugs and therapeutics emerges from clinical trials and research publications.
2.There is currently no FDA-approved post-exposure prophylaxis for people who may have been exposed to SARS-CoV-2.

Symptoms and Diagnosis
3.Non-respiratory symptoms of COVID-19 – such as gastrointestinal symptoms (e.g., nausea, vomiting, diarrhea), or neurologic symptoms (e.g., anosmia, ageusia, headache), or fatigue or body and muscle aches – may appear before fever and lower respiratory tract symptoms (e.g., cough and shortness of breath).
4.Children with COVID-19 may have fewer symptoms than adults. Although most children with COVID-19 have not had severe illness, clinicians should maintain a high index of suspicion for SARS-CoV-2 infection in children, particularly infants and children with underlying medical conditions. CDC is investigating multisystem inflammatory syndrome in children, a rare but serious complication associated with COVID-19. CDC recommends monitoring children for worsening of COVID-19 illness.
5. CT scansexternal icon should not be used to screen for COVID-19 or as a first-line test to diagnose COVID-19. CT scans should be used sparingly and reserved for hospitalized, symptomatic patients with specific clinical indications for CT scans.

Co-Infections
6.Patients infected with SARS-CoV-2 (the virus that causes COVID-19) can have another viral (such as influenza), bacterial, or fungal infection at the same time. During widespread cocirculation of SARS-CoV-2 and influenza, clinicians should consider testing patients with compatible symptoms for both viruses.
7.Several patients with COVID-19 have been reported presenting with concurrent community-acquired bacterial pneumoniaexternal icon. Decisions to administer antibiotics to COVID-19 patients should be based on the likelihood of bacterial infection (community-associated or healthcare-associated), illness severity, and current clinical practice guidelinesexternal icon.

Severe Illness
8.Clinicians should be aware of the potential for some patients to rapidly deteriorate 1 week after illness onset.
9.The median time to acute respiratory distress syndrome (ARDS) ranges from 8 to 12 days.
10.Lymphopenia, neutrophilia, elevated serum alanine aminotransferase and aspartate aminotransferase levels, elevated lactate dehydrogenase, high CRP, and high ferritin levels may be associated with greater illness severity.

Last Updated Sept. 16, 2020
Content source: National Center for Immunization and Respiratory Diseases (NCIRD), Division of Viral Diseases

https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-tips-for-healthcare-providers.html

United States

COVID-19 Parental Resources Kit
Source: CDC

Ensuring Children and Young People's Social, Emotional, and Mental Well-being
Updated Sept. 16, 2020
Languages
Resources, by Age Group

- Overview
- Early Childhood (0-5y)
- Childhood (6-12y)
- Adolescence (13-17y)
- Young Adulthood (18-24y)

Children and Young People's Social, Emotional, and Mental Health
Coronavirus disease (COVID-19) can affect children and young people directly and indirectly. Beyond getting sick, many young people's social, emotional, and mental well-being has been impacted by the pandemic. Trauma faced at this developmental stage can continue to affect them across their lifespan. Some of the challenges children and young people face during the COVID-19 pandemic relate to:

- **Changes in their routines** (e.g., having to physically distance from family, friends, worship community)
- **Breaks in continuity of learning** (e.g., virtual learning environments, technology access and connectivity issues)
- **Breaks in continuity of health care** (e.g., missed well-child and immunization visits, limited access to mental, speech, and occupational health services)
- **Missed significant life events** (e.g., grief of missing celebrations, vacation plans, and/or milestone life events)
- **Lost security and safety** (e.g., housing and food insecurity, increased exposure to violence and online harms, threat of physical illness and uncertainty for the future)

CDC developed this **COVID-19 Parental Resource Kit: Ensuring Children and Young People's Social, Emotional, and Mental Well-being** to help support parents, caregivers, and other adults serving children and young people in recognizing children and young people's social, emotional, and mental health challenges and helping to ensure their well-being.
Resources, by Age Group
Learn about the social, emotional, and mental health challenges faced by each age group, find out what you can do to help, and access age-group specific resources to get you started.
Early Childhood (0-5y) | Childhood (6-12y) | Adolescence (13-17y) | Young Adults (18-24y)
Resources

Explore different types of resources available to help you support young people's social, emotional, and mental well-being across the lifespan.
https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/parental-resource-kit/index.html

United States

Crew Disembarkations through Commercial Travel

Updated Sept. 16, 2020

Source: CDC

CDC is committed to helping cruise lines provide for the safety and well-being of their crew members while onboard cruise ships and as they disembark. CDC is allowing crew members to disembark from all cruise ships in U.S. waters with certain precautions. Cruise lines with complete and accurate response plans will be able to use commercial travel to disembark crew members from certain ships if the ships meet certain criteria set by CDC including that there have been no confirmed cases of COVID-19 or COVID-like illnesses on board the ship within the last 28 days. These ships are also able to lessen certain social distancing restrictions onboard. Cruise lines with complete and accurate response plans under the No Sail Order but not meeting the above criteria will still be able to disembark their crew members using non-commercial travel. Cruise lines must have measures in place to ensure those involved in transport are not exposed to the virus that causes COVID-19 and follow all CDC requirements to prevent interaction of disembarking crew with the public.

Criteria for Commercial Transport of Crew

Learn more about Cruise Ship Crew Member Disembarkations during the COVID-19 pandemic.

Ships that are requesting the use of commercial travel for disembarking crew members will need to meet the following criteria:

- **A response plan under the No Sail Order** that is complete and accurate
  - This does not mean ships are allowed to resume passenger travel, but rather that they have met CDC's requirements to provide a safe environment for crew members to work and to disembark crew safely by non-commercial travel.
  - Cruise company officials must sign an acknowledgment of the completeness and accuracy of their response plan.
- **No confirmed cases of COVID-19[1] or COVID-like illness[2] for 28 days, as determined by a qualified medical professional.**
- **If the ship has received ship-to-ship transfers, the crew must have come from a ship that had no confirmed cases of COVID-19 or COVID-like illness within the 28 days before the transfer occurred.**
- **If land-based crew embarked, they were immediately quarantined for 14 days upon embarking the ship.**
- **Submission of a signed attestation for commercial travel.**

Meeting these criteria does not mean cruise ships can resume passenger operations. We don't have enough information at this time to say when it will be safe to resume sailing with passengers. Cruise lines may need to establish additional safety measures before sailing with passengers is permitted to resume. CDC will continue to evaluate and update its recommendations as the situation evolves.

All cruise ships operating in U.S. waters, or seeking to operate in U.S. waters, must comply with all of the requirements under the No Sail Order and Interim Guidance During the Period of the No Sail Order for the entire period of the No Sail Order even when outside U.S. waters.

As ships become eligible to transport crew members commercially, this page will provide a list of cruise ships meeting those criteria.

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1. Confirmed COVID-19 means laboratory confirmation for SARS-CoV-2, the virus that causes COVID-19, by polymerase chain reaction (PCR) testing
2. COVID-like illness means acute respiratory illness (ARI), influenza-like illness (ILI), or diagnosis of pneumonia.

Status of No Sail Order Response Plans and Commercial Transport of Crew

As a prerequisite for requesting commercial travel, cruise lines must have a complete and accurate response plan that provides a safe environment for crew members to work and disembark during the period of the No Sail Order. CDC has provided feedback regarding all the response plans that have been submitted and is working with the cruise lines to ensure they are implementing the safeguards outlined in their plans.

The following table lists cruise lines that have ships operating or planning to operate in U.S. waters during the period of the No Sail Order extension.

Determination for color-coding status (Green, Red, or Yellow) can only be made for ships if the following are true:

1. CDC has finished the review of the cruise line's plan, and
2. Cruise line has returned an acknowledgement attesting that their No Sail Order response plan is complete and accurate.

Ships of cruise lines that have not met the above two criteria will be listed as Provisionally Green* or Provisionally Red^.

This table is updated once a week every Tuesday. Last updated September 15, 2020.
Table is not included. Please refer to the link

1. Review and revision of the cruise line's No Sail Order response plan, or
2. Cruise line's signed acknowledgement of a complete and accurate plan, or
3. Ship's submission of a signed attestation to CDC for crew to travel commercially.

ᵛProvisionally Yellow: Ship meets the surveillance criteria for "Yellow" status, but the following have not been completed:

1. Review and revision of the cruise line's No Sail Order response plan, or
2. Cruise line's signed acknowledgement of a complete and accurate plan, or
3. Ship's submission of a signed attestation to CDC for crew to travel commercially.

^Provisionally Red: Ship meets the surveillance criteria for "Red" status, but the following have not been completed:

1. Review and revision of the cruise line's No Sail Order response plan, or
2. Cruise line's signed acknowledgement of a complete and accurate plan.

¥Commercial Travel Allowed: Allowed for ships that are "Green" and have submitted a signed attestation to CDC for crew to travel commercially.

Note: The above list includes cruise ships operating in U.S. waters or seeking to operate in U.S. waters during the period of the No Sail Order extension.

Frequently Asked Questions

What does it mean for a cruise ship operator to have a plan that is complete and accurate?

A complete and accurate plan adequately addresses every element of the No Sail Order. A cruise ship operator must be in compliance with the No Sail Order, the operator's No Sail Order response plan, and CDC's *Interim Guidance for Mitigation of COVID-19 Among Cruise Ship Crew During the Period of the No Sail Order*. CDC assesses compliance through implementation checks on a sample of ships covered under a cruise ship operator's plan. There must be no evidence of noncompliance.

What steps is CDC taking to make sure ships stay in compliance with the criteria for commercial transport of crew?

CDC will review weekly surveillance data provided by ships, and only those ships that continue to report no cases of COVID-19 or COVID-like illness will maintain this status.

What other changes can cruise ships make if they meet these criteria?

CDC is committed to helping cruise lines provide for the safety and well-being of their crew members onboard. As cruise ships are able to show they have no cases of confirmed COVID-19 or COVID-like illnesses on board, crew members will be able to resume some of their daily interactions with fellow crew members.

Some examples of decreased restrictions on cruise ships if they meet these criteria include resuming in-person meetings, events, and social gatherings; reopening bars, gyms, or other group settings onboard for crew member use; and removing requirements to wear face coverings.

What is the difference between the two attestations CDC requires under the No Sail Order?
Under the No Sail Order, cruise lines are required to develop and implement comprehensive plans to prevent, detect, respond to, and contain COVID-19 among crew members onboard. While these response plans have been under review, CDC has allowed cruise lines to disembark crew members if they submit a signed attestation stating they have complied with the requirements to safely disembark crew members. This attestation included a requirement that crew members only use noncommercial travel to disembark and reach their final destinations and do not interact with the public during travel. Cruise lines that have a complete and accurate No Sail Order response plan may disembark crew members without a signed attestation if they use noncommercial travel and follow CDC requirements. Cruise company officials must sign an acknowledgment of the completeness and accuracy of their response plan. Cruise ships that want to use commercial travel for crew members must meet additional requirements, which include demonstrating there are no confirmed cases of COVID-19 or COVID-like illness on board and submitting a signed attestation for commercial travel.
What does it mean if a *cruise line* is not listed on the table above?
If a cruise line is not listed, it means the cruise line is not operating and does not plan to operate any of its ships in U.S. waters during the period of the No Sail Order.
What does it mean if a *cruise ship* is not listed on the table above?
If a cruise ship is not listed, it means the ship is not operating in U.S. waters and does not plan to operate in U.S. waters during the period of the No Sail Order.
https://www.cdc.gov/coronavirus/2019-ncov/travelers/crew-disembarkations-commercial-travel.html

United States

U.S. releases plan to provide free coronavirus vaccine
Source: Global News
Unique ID: 1007850018

The United States outlined a sweeping plan Wednesday to make vaccines for COVID-19 available for free to all Americans, even as polls show a strong undercurrent of skepticism rippling across the land.
In a report to Congress and an accompanying “playbook” for states and localities, federal health agencies and the Defence Department sketched out complex plans for a vaccination campaign to begin gradually in January or possibly later this year, eventually ramping up to reach any American who wants a shot.
The Pentagon is involved with the distribution of vaccines, but civilian health workers will be the ones giving shots.
The campaign is “much larger in scope and complexity than seasonal influenza or other previous outbreak-related vaccination responses,” said the playbook for states from the Centers for Disease Control and Prevention.
Among the highlights:
For most vaccines, people will need two doses, 21 to 28 days apart. Double-dose vaccines will have to come from the same drugmaker. There could be several vaccines from different manufacturers approved and available.
Vaccination of the U.S. population won’t be a sprint but a marathon. Initially, there may be a limited supply of vaccines available, and the focus will be on protecting health workers, other essential employees, and people in vulnerable groups. The National Academy of Medicine is working on priorities for the first phase. A second and third phase would expand vaccination to the entire country.
The vaccine itself will be free of charge, and patients won’t be charged out of pocket for the administration of shots, thanks to billions of dollars in taxpayer funding approved by Congress and allocated by the Trump administration.
States and local communities will need to devise precise plans for receiving and locally distributing vaccines, some of which will require special handling such as refrigeration or freezing. States and cities have a month to submit plans.
Some of the broad components of the federal plan have already been discussed, but Wednesday’s reports attempt to put the key details into a comprehensive framework. Distribution is happening under the umbrella of Operation Warp Speed, a White House-backed initiative to have millions of doses ready to ship once a vaccine is given what’s expected to be an emergency use approval by the Food and Drug Administration. Several formulations are undergoing final trials.

But the whole enterprise is facing public skepticism. Only about half of Americans said they'd get vaccinated in an Associated Press poll taken in May. Of those who wouldn't get vaccinated, the overwhelming majority said they were worried about safety. To effectively protect the nation from the coronavirus, experts say upwards of 70% of Americans must either be vaccinated or have their own immunity from fighting off COVID-19.
Since the poll, questions have only mounted about whether the government is trying to rush COVID-19 treatments and vaccines to help President Donald Trump's reelection chances.
Before the Republican National Convention in August, the FDA granted authorization for treatment of COVID-19 patients with plasma from people who have recovered, even though some government scientists were not convinced the clinical evidence was sufficiently strong. And last week it was reported that Michael Caputo, a Health and Human Services Department political appointee, tried to gain editorial control over a weekly scientific publication from the Centers for Disease Control and Prevention.
As public confidence in core health agencies has taken a beating, Trump administration officials have been forced to play defence.
"We are working closely with our state and local public health partners … to ensure that Americans can receive the vaccine as soon as possible and vaccinate with confidence," HHS Secretary Alex Azar said in a statement Wednesday. "Americans should know that the vaccine development process is being driven completely by science and the data."
That could be a tough sell. In the AP poll, 1 in 5 Americans said they would not get a coronavirus vaccine, and 31% said they were unsure.
https://globalnews.ca/news/7338230/u-s-free-coronavirus-vaccine-rollout/

United States

NIH funds community engagement research efforts in areas hardest hit by COVID-19
Source: National Institute of Health
Unique ID: 1007851014

The National Institutes of Health today announced a $12 million award for outreach and engagement efforts in ethnic and racial minority communities disproportionately affected by the COVID-19 pandemic. The award to RTI International, a non-profit research institution, will support teams in 11 states established as part of the NIH Community Engagement Alliance (CEAL) Against COVID-19 Disparities. These teams have received initial funding to immediately create CEAL programs, and RTI will serve as the Technical and Administrative Support and Coordination (TASC) center.

The CEAL research teams will focus on COVID-19 awareness and education research, especially among African Americans, Hispanics/Latinos, and American Indians — populations that account for over half of all reported cases in the United States. They also will promote and facilitate the inclusion and participation of these groups in vaccine and therapeutic clinical trials to prevent and treat the disease.
The communities of special focus include counties in Alabama, Arizona, California, Florida, Georgia, Louisiana, Michigan, Mississippi, North Carolina, Tennessee and Texas.
"Addressing health disparities affecting racial and ethnic minority populations has long been a priority for NIH," said NIH Director Francis S. Collins, M.D., Ph.D. "The burden of the COVID-19 pandemic borne by diverse communities, especially those that include Blacks and Latinos, makes clear the urgent need for treatments and vaccines that are effective for all Americans. Inclusive research that reflects the entire population is essential to this goal."

CEAL is an NIH-wide effort led by the National Institute on Minority Health and Health Disparities (NIMHD) and the National Heart, Lung, and Blood Institute (NHLBI). It expands existing community outreach efforts already underway by NIH COVID-19 trial networks.
The CEAL research teams will leverage established relationships between NIH-funded researchers and local community-engaged leaders to help reach underserved communities that might not be located near COVID-19 clinical research recruitment sites. "Building on the strength of local organizations, as well as our long-standing community-engaged research efforts, will help us communicate effectively to address disparities and support the proven resilience within communities," said NIMHD Director Eliseo J. Pérez-Stable, M.D. "This work will help ensure people get accurate and trustworthy information about the virus, how to reduce its spread, and how to protect themselves and their families."

CEAL research teams include NIH and other federally funded entities that have community engagement expertise, non-academic community-based organizations, Federally Qualified Health Centers (FQHCs(link is external)pdf), state and/or local health departments, and others. Their goal is to quickly launch outreach efforts that can help reduce the impact of COVID-19 on the most vulnerable populations and to evaluate these efforts through community-engaged research. “Since communities of color have been particularly affected, and also historically underrepresented in clinical research, it is essential that we encourage people to join COVID-19 research studies,” said NHLBI Director Gary Gibbons, M.D. “That’s why NIH is partnering with messengers who live, work, and worship in the same communities where the disease has caused the highest rates of sickness and death. In the middle of a pandemic, people need to hear familiar, trusted voices they know are advocating for their health and safety.”

For more information about CEAL, visit the NIH COVID-19 communities page.
About the National Heart, Lung, and Blood Institute (NHLBI): NHLBI is the global leader in conducting and supporting research in heart, lung, and blood diseases and sleep disorders that advances scientific knowledge, improves public health, and saves lives. For more information, visit https://www.nhlbi.nih.gov.

About the National Institutes on Minority Health and Health Disparities (NIMHD): NIMHD leads scientific research to improve minority health and eliminate health disparities by conducting and supporting research; planning, reviewing, coordinating, and evaluating all minority health and health disparities research at NIH; promoting and supporting the training of a diverse research workforce; translating and disseminating research information; and fostering collaborations and partnerships. For more information about NIMHD, visit https://www.nimhd.nih.gov.
About the National Institutes of Health (NIH): NIH, the nation's medical research agency, includes 27 Institutes and Centers and is a component of the U.S. Department of Health and Human Services. NIH is the primary federal agency conducting and supporting basic, clinical, and translational medical research, and is investigating the causes, treatments, and cures for both common and rare diseases. For more information about NIH and its programs, visit www.nih.gov.
https://www.nih.gov/news-events/news-releases/nih-funds-community-engagement-research-efforts-areas-hardest-hit-covid-19

United States
More than 1 in 3 U.S. pediatricians dismiss vaccine-refusing families.
Source: Infosur Hoy
Unique ID: 1007850827

The evidence for vaccines is so strong that doctors may feel they just can’t work with parents who stray so far from the standards of medical care,” said lead author Dr. Sean O’Leary. Thirty-seven percent of pediatricians themselves said they often dismissed families for refusing vaccines, and 6% said they would dismiss a family for choosing to spread out crucial early vaccines. But little is known about how pediatricians deal with parents who refuse vaccines, or who ask to spread them out, potentially leaving their child vulnerable to infections, such as measles.
Just over half (51%) of pediatric offices in the United States have a policy to dismiss families that refuse childhood vaccines, a nationwide survey found. Thirty-seven percent of pediatricians themselves said they often dismissed families for refusing vaccines, and 6% said they would dismiss a family for choosing to spread out crucial early vaccines.
“Arguments for dismissing families include that vaccination is the standard of care and the benefits far outweigh the risks. The evidence for vaccines is so strong that doctors may feel they just can’t work with parents who stray so far from the standards of medical care,” said lead author Dr. Sean O’Leary. He’s a professor of pediatrics at the University of Colorado Anschutz Medical Campus and Children’s Hospital Colorado in Aurora.
“Another argument for dismissing families is that doing so may increase vaccine rates when parents see that pediatric practices feel so strongly about vaccines. Some of the downsides are that kids might end up without a medical home, or parents will find pediatricians who don’t have policies about vaccines,” O’Leary said.
Last year, the World Health Organization called vaccine hesitancy one of the top 10 threats to global

health. But little is known about how pediatricians deal with parents who refuse vaccines, or who ask to spread them out, potentially leaving their child vulnerable to infections, such as measles.
To get a better idea of how doctors cope with these challenges, researchers surveyed about 300 U.S. pediatricians between April and July 2019.
The survey asked about pediatricians' current practices and office policies if families refused vaccines or significantly tried to alter the schedule, spreading the vaccines out.
"I was surprised the rate was as high as it was—more than half had a practice who would not take a family that refused vaccines. I think the Disney measles outbreak [in California's Disneyland from 2014-2015]may have had an impact. Parents started saying, 'If you're going to accept people who aren't vaccinated, I'm going to another practice so my children aren't at risk,'" O'Leary said.
When doctors dismiss families for refusing vaccines, parents are sometimes swayed, the survey revealed. In fact, 18% often or always change their minds, while another 48% sometimes do. Twenty-nine percent rarely change their minds, and 5% never do, according to the surveys.
The report found that private practices were more likely than community, hospital-based or health maintenance organizations to have a dismissal policy. Practices in the Midwest were less likely to have dismissal policies than practices in other regions.
Dr. Paul Offit, director of the Vaccine Education Center at Children's Hospital of Philadelphia, said the goal of dismissal policies is to make sure children get vaccinated. He was not part of the study.
"By drawing a line and saying, 'I can't see you if you choose to delay or refuse vaccines, because you're asking me to practice substandard care,'" Offit said. "'Were this child to be hurt, I—at some level—would be tacitly responsible, because at some level, I would be saying it's OK, if I continued to see your family.'"
Pediatricians also have a responsibility to all of the children in the waiting room. "Sometimes, kids in the waiting room can't be vaccinated—they may be too young, taking certain medications or be immunocompromised," Offit said.
The big concern, though, is that doctors don't know where a child might end up if they dismiss them.
"I do not think there is any good choice in this situation for pediatricians. It's very hard," Offit said.
O'Leary said he hopes parents understand that "many pediatricians feel so strongly that the benefits of vaccines far outweigh the risk that they are willing to take the extreme measure of not taking families who refuse to vaccinate. And, remember, these are people who have devoted their careers to taking care of children."
He said many questions remain and this topic needs further study. For example, do dismissal policies help with vaccination rates? What message do these policies actually send to the parents?
The findings were published Sept. 15 as a research letter in Journal of the American Medical Association.
https://infosurhoy.com/news-summary/more-than-1-in-3-u-s-pediatricians-dismiss-vaccine-refusing-families/

United States

Trump Administration Releases COVID-19 Vaccine Distribution Strategy
Source: HHS
Unique ID: 1007850596

The U.S. Department of Health and Human Services (HHS) and Department of Defense (DoD) today released two documents outlining the Trump Administration's detailed strategy to deliver safe and effective COVID-19 vaccine doses to the American people as quickly and reliably as possible.
The documents, developed by HHS in coordination with DoD and the Centers for Disease Control and Prevention (CDC), provide a strategic distribution overview along with an interim playbook for state, tribal, territorial, and local public health programs and their partners on how to plan and operationalize a vaccination response to COVID-19 within their respective jurisdictions.
"As part of Operation Warp Speed, we have been laying the groundwork for months to distribute and administer a safe and effective COVID-19 vaccine as soon as it meets FDA's gold standard," said HHS Secretary Alex Azar. "This in-depth, round-the-clock planning work with our state and local partners and trusted community organizations, especially through CDC, will ensure that Americans can receive a safe and effective vaccine in record time."
The strategic overview lays out four tasks necessary for the COVID-19 vaccine program:
Engage with state, tribal, territorial, and local partners, other stakeholders, and the public to communicate public health information around the vaccine and promote vaccine confidence and uptake.

Distribute vaccines immediately upon granting of Emergency Use Authorization/ Biologics License Application, using a transparently developed, phased allocation methodology and CDC has made vaccine recommendations.
Ensure safe administration of the vaccine and availability of administration supplies.
Monitor necessary data from the vaccination program through an information technology (IT) system capable of supporting and tracking distribution, administration, and other necessary data.
On August 14, CDC executed an existing contract option with McKesson Corporation to support vaccine distribution. The company also distributed the H1N1 vaccine during the H1N1 pandemic in 2009-2010. The current contract with McKesson, awarded as part of a competitive bidding process in 2016, includes an option for the distribution of vaccines in the event of a pandemic.
"CDC is drawing on its years of planning and cooperation with state and local public health partners to ensure a safe, effective, and life-saving COVID-19 vaccine is ready to be distributed following FDA approval," said CDC Director Robert Redfield. "Through the Advisory Committee on Immunization Practices, CDC will play a vital role in deciding, based on input from experts and stakeholders, how initial, limited vaccine doses will be allocated and distributed while reliably producing more than 100 million doses by January 2021."
Detailed planning is ongoing to ensure rapid distribution as soon as the FDA authorizes or approves a COVID-19 vaccine and CDC makes recommendations for who should receive initial doses. Once these decisions are made, McKesson will work under CDC's guidance, with logistical support from DoD, to ship COVID-19 vaccines to administration sites.
"The Department of Defense is using its world-class logistical expertise to plan for distributing a safe and effective vaccine at warp speed," said General Gustave Perna. "Americans can trust that our country's best public health and logistics experts are working together to get them vaccines safely as soon as possible."
About Operation Warp Speed:
OWS is a partnership among components of the Department of Health and Human Services and the Department of Defense, engaging with private firms and other federal agencies, and coordinating among existing HHS-wide efforts to accelerate the development, manufacturing, and distribution of COVID-19 vaccines, therapeutics, and diagnostics.
About HHS & CDC:
HHS works to enhance and protect the health and well-being of all Americans, providing for effective health and human services and fostering advances in medicine, public health, and social services. To learn more about federal support for the nationwide COVID-19 response, visit coronavirus.gov.
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.
About DoD: The Department of Defense's enduring mission is to provide combat-credible military forces needed to deter war and protect the security of our nation. The Department provides a lethal and effective Joint Force that, combined with our network of allies and partners, sustains American influence and advances shared security and prosperity.
People using assistive technology may not be able to fully access information in this file. For assistance, please contact digital@hhs.gov.
https://www.hhs.gov/about/news/2020/09/16/trump-administration-releases-covid-19-vaccine-distribution-strategy.html

United States

Becton Dickinson probes false-positive COVID-19 test results in U.S. nursing homes
Source: Leader Post
Unique ID: 1007850244

Tests conducted on the company's Veritor Plus system for detecting the virus are reporting multiple false positive results in some cases, Becton said.
The inaccurate results were first reported https://www.wsj.com/articles/covid-19-test-maker-examines-false-positive-results-in-nursing-homes-11600121878?mod=searchresults&page=1&pos=6 by the Wall Street Journal.

So far, the number of false-positive reports is small and the company has contacted the sites and is actively investigating the situation to obtain additional details, a spokesperson for Becton told Reuters in an email.
The company, under its agreement with the U.S. Department of Health & Human Services, provides more than 11,000 nursing homes in the country with COVID-19 tests for its residents and staff.
In July, the U.S. government agreed to buy 2,000 of the company's BD Veritor Plus Systems and 750,000 of its SARS-CoV-2 antigen test, as the country ramps up testing for the virus that has been spreading at an alarming rate.
Becton Dickinson plans to produce 10 million tests through September and then ramp up to producing 2 million tests per week thereafter.
(Reporting by Mrinalika Roy in Bengaluru; Editing by Amy Caren Daniel)
https://leaderpost.com/pmn/business-pmn/becton-dickinson-probes-false-positive-covid-19-test-results-in-u-s-nursing-homes/wcm/a2b56b79-a40d-45c0-a4ad-359ca686bb09/

UN/WHO

More research needed into COVID-19 effects on children, says WHO head
Source: news.un.org
Unique ID: 1007850035

UNICEF/Seyha Lychheang
Students at a primary school in Phnom Penh, Cambodia, on the second day after their school reopened. The students, teachers and school administrators wear masks while at the school and maintain physical distancing.
16 September 2020
Health
More research is needed into factors that increase the risk of severe COVID-19 disease among children and adolescents, the head of the UN World Health Organization (WHO) has said, adding that while children may have largely been spared many of the most severe effects, they have suffered in other ways.
Joining the heads of the UN Children's Fund (UNICEF) and the UN Educational, Scientific and Cultural Organization (UNESCO), at a press conference on Tuesday, WHO Director-General Tedros Adhanom Ghebreyesus outlined that since the start of the COVID pandemic, understanding its effects on children has been a priority.
"Nine months into the pandemic, many questions remain, but we are starting to have a clearer picture. We know that children and adolescents can be infected and can infect others", he said.
"We know that this virus can kill children, but that children tend to have a milder infection and there are very few severe cases and deaths from COVID-19 among children and adolescents."
Coronavirus Portal & News Updates
Given different situations among countries: some, where schools have opened and others, where they have not, UNESCO, UNICEF and WHO, issued updated guidance on school-related public health measures in the context of COVID-19.
Based on latest scientific evidence, the guidance provides practical advice for schools in areas with no cases, sporadic cases, clusters of cases or community transmission. They were developed with input from the Technical Advisory Group of Experts on Educational Institutions and COVID-19, established by the three UN agencies in June.
Schools provide critical, diverse services
Audrey Azoulay, UNESCO Director-General, also highlighted the importance of school, not only for teaching, but also for providing health, protection and – at times – nutrition services.
"The longer schools remain closed, the more damaging the consequences, especially for children from more disadvantaged backgrounds … therefore, supporting safe reopening of schools must be a priority for us all", she said.
In addition to safely reopening schools, attention must focus on ensuring that no one is left behind, Ms. Azoulay added, cautioning that in some countries, children are missing from classes, amid fears that many – especially girls – may not ever return to schools.
Alongside, ensuring flow of information and adequate communication between teachers, school administrators and families; and defining new rules and protocols, including on roles of and trainings for

teachers, managing school schedules, revising learning content, and providing remedial support for learning losses are equally important, she said.
“When we deal with education, the decisions we make today will impact tomorrow’s world,” said the UNESCO Director-General.
A global education emergency
However, with half the global student population still unable to return to schools, and almost a third of the world’s pupils unable to access remote learning, the situation is “nothing short of a global education emergency”, said Henrietta Fore, UNICEF Executive Director.
“We know that closing schools for prolonged periods of time can have devastating consequences for children,” she added, outlining their increased exposure risk of physical, sexual, or emotional violence.
The situation is even more concerning given the results from a recent UNICEF survey, which found that almost a fourth of the 158 countries questioned, on their school reopening plans, had not set a date to allow schoolchildren back to the classrooms.
“For the most marginalized, missing out on school – even if only for a few weeks – can lead to negative outcomes that last a lifetime,” warned Ms. Fore.
She called on governments to prioritize reopening schools, when restrictions are lifted, and to focus on all the things that children need – learning, protection, and physical and mental health – and ensure the best interest of every child is put first.
In addition, when governments decide to keep schools closed, they must scale up remote learning opportunities for all children, especially the most marginalized.
“Find innovative ways – including online, TV and radio – to keep children learning, no matter what”, stressed Ms. Fore.
https://news.un.org/en/story/2020/09/1072472

WHO

Keep health workers safe to keep patients safe: WHO
Source: WHO official

17 September 2020
News release
Geneva
The World Health Organization (WHO) is calling on governments and health care leaders to address persistent threats to the health and safety of health workers and patients.
“The COVID-19 pandemic has reminded all of us of the vital role health workers play to relieve suffering and save lives,” said Dr Tedros Adhanom Ghebreyesus, WHO Director-General. “No country, hospital or clinic can keep its patients safe unless it keeps its health workers safe. WHO’s Health Worker Safety Charter is a step towards ensuring that health workers have the safe working conditions, the training, the pay and the respect they deserve.”
The pandemic has also highlighted the extent to which protecting health workers is key to ensuring a functioning health system and a functioning society.
The Charter, released today for World Patient Safety Day, calls on governments and those running health services at local levels to take five actions to better protect health workers. These include steps to protect health workers from violence; to improve their mental health; to protect them from physical and biological hazards; to advance national programmes for health worker safety, and to connect health worker safety policies to existing patient safety policies.
Mounting reports of infections, illness and attacks among health workers fighting COVID-19
COVID-19 has exposed health workers and their families to unprecedented levels of risk. Although not representative, data from many countries across WHO regions indicate that COVID-19 infections among health workers are far greater than those in the general population.
While health workers represent less than 3% of the population in the large majority of countries and less than 2% in almost all low- and middle-income countries, around 14% of COVID-19 cases reported to WHO are among health workers. In some countries, the proportion can be as high as 35%. However, data availability and quality are limited, and it is not possible to establish whether health workers were infected in the work place or in community settings. Thousands of health workers infected with COVID-19 have lost their lives worldwide.

In addition to physical risks, the pandemic has placed extraordinary levels of psychological stress on health workers exposed to high-demand settings for long hours, living in constant fear of disease exposure while separated from family and facing social stigmatization. Before COVID-19 hit, medical professionals were already at higher risk of suicide in all parts of the world. A recent review of health care professionals found one in four reported depression and anxiety, and one in three suffered insomnia during COVID-19[1]. WHO recently highlighted an alarming rise in reports of verbal harassment, discrimination and physical violence among health workers in the wake of COVID-19.

5 steps to improve health worker safety and patient safety

On World Patient Safety Day, WHO reminds governments that they have a legal and moral responsibility to ensure the health, safety and wellbeing of health workers. The Organization's health worker charter calls on all Member States and relevant stakeholders to take steps to:

Establish synergies between health worker safety and patient safety policies and strategies:

Develop linkages between occupational health and safety, patient safety, quality improvement, and infection prevention and control programmes.

Include health and safety skills in personal and patient safety into education and training programmes for health workers at all levels.

Incorporate requirements for health worker and patient safety in health care licensing and accreditation standards.

Integrate staff safety and patient safety incident reporting and learning systems.

Develop integrated metrics of patient safety, health worker safety and quality of care indicators, and integrate with health information system.

Develop and implement national programmes for occupational health and safety of health workers:

Develop and implement national programmes for occupational health for health workers in line with national occupational health and safety policies.

Review and upgrade, where necessary, national regulations and laws for occupational health and safety to ensure that all health workers have regulatory protection of their health and safety at work.

Appoint responsible officers with authority for occupational health and safety for health workers at both the national and facility levels.

Develop standards, guidelines, and codes of practice on occupational health and safety.

Strengthen intersectoral collaboration on health worker and patient safety, with appropriate worker and management representation, including gender, diversity and all occupational groups.

Protect health workers from violence in the workplace

Adopt and implement in accordance with national law, relevant policies and mechanisms to prevent and eliminate violence in the health sector.

Promote a culture of zero tolerance to violence against health workers

Review labour laws and other legislation, and where appropriate the introduction of specific legislation, to prevent violence against health workers.

Ensure that policies and regulations are implemented effectively to prevent violence and protect health workers.

Establish relevant implementation mechanisms, such ombudspersons and helplines to enable free and confidential reporting and support for any health worker facing violence.

Improve mental health and psychological well-being

Establish policies to ensure appropriate and fair duration of deployments, working hours, rest break and minimizing the administrative burden on health workers.

Define and maintain appropriate safe staffing levels within health care facilities.

Provide insurance coverage for work-related risk, especially those working in high-risk areas.

Establish a 'blame-free' and just working culture through open communication and including legal and administrative protection from punitive action on reporting adverse safety events.

Provide access to mental well-being and social support services for health workers, including advice on work-life balance and risk assessment and mitigation.

Protect health workers from physical and biological hazards

Ensure the implementation of minimum patient safety, infection prevention and control, and occupational safety standards in all health care facilities across the health system.

Ensure availability of personal protective equipment (PPE) at all times, as relevant to the roles and tasks performed, in adequate quantity and appropriate fit and of acceptable quality. Ensure an adequate, locally

held, buffer stock of PPE. Ensure adequate training on the appropriate use of PPE and safety precautions.
Ensure adequate environmental services such as water, sanitation and hygiene, disinfection and adequate ventilation at all health care facilities.
Ensure vaccination of all health workers at risk against all vaccine-preventable infections, including Hepatitis B and seasonal influenza, in accordance with the national immunization policy, and in the context of emergency response, priority access for health workers to newly licenced and available vaccines.
Provide adequate resources to prevent health workers from injuries, and harmful exposure to chemicals and radiations; provide functioning and ergonomically designed equipment and work stations to minimize musculoskeletal injuries and falls.
In addition to the Health Worker Safety Charter, WHO has also outlined specific World Patient Safety Day 2020 Goals for health care leaders to invest in, measure, and improve health worker safety over the next year. The goals are intended for health care facilities to address five areas: preventing sharps injuries; reducing work-related stress and burnout; improving the use of personal protective equipment; promoting zero tolerance to violence against health workers, and reporting and analyzing serious safety related incidents.
For more information on World Patient Safety Day Campaign
[1] Pappa, S., Ntella, V., Giannakas, T., Giannakoulis, V. G., Papoutsi, E., & Katsaounou, P. (2020). Prevalence of depression, anxiety, and insomnia among healthcare workers during the COVID-19 pandemic: A systematic review and meta-analysis. *Brain, behavior, and immunity*, S0889-1591(20)30845-X. Advance online publication. https://doi.org/10.1016/j.bbi.2020.05.026
https://www.who.int/news-room/detail/17-09-2020-keep-health-workers-safe-to-keep-patients-safe-who

ECDC

COVID-19: Cases increasing across Europe
Source: ECDC
Unique ID: 1007851140

According to the latest COVID-19 data, the 14-day case notification rate for the EU/EEA and the UK has been increasing for more than 50 days, with over half of all EU countries currently experiencing an increase in cases.
While increased testing contributes to better awareness of all ongoing transmission, it is not the only reason for the increase of COVID-19 cases, which is also linked to the relaxation of physical distancing and other preventive measures.
As schools reopen and more indoor activities are held, the increase of cases comes as a reminder that the pandemic is not over.
Everybody has a role to play in preventing the further spread of the disease by observing simple preventive measures, including:
Increased hand hygiene;
Proper cough and respiratory etiquette;
Appropriate use of face masks;
Staying home when even mildly ill;
Physical distancing.
Recent evidence confirms the importance of physical distancing for the prevention of person-to-person transmission. Physical distancing of one metre or more has been proven to ensure a five-fold reduction in the transmission risk, and every extra metre of distance gives twice the protective effect.
ECDC recommends that testing efforts are maximised, with the aim of offering timely testing to all symptomatic cases, including mild ones. Along with rapid contact tracing, large-scale testing is the key to controlling transmission within a population, followed by the isolation and treatment of identified cases and the quarantining of contacts.
Furthermore, with the influenza season approaching, the preparedness of healthcare systems across Europe is vital. This includes essential services, primary care facilities and hospitals ensuring appropriate surge capacity plans in case of a high demand for the care of patients with respiratory distress.

ECDC continues to monitor the pandemic closely and provide guidance to the Member States on how to cope with the current challenges.
https://www.ecdc.europa.eu/en/news-events/covid-19-cases-increasing-across-europe

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

WHO
WHO doesn't recommend coronavirus passports because immunity remains questionable
ID: 1007853120
Source: CNBC

A World Health Organization official said Wednesday that the international agency does not recommend countries issue so-called immunity passports for the coronavirus, because scientists are still unsure whether Covid-19 antibodies reduce the risk of reinfection.
Earlier in the pandemic, some countries said they would issue passports or certificates that indicate whether someone has had Covid-19, allowing them to travel or return to work, assuming that they are protected.
That idea has since been abandoned because scientists still don't know how long immunity really lasts, Dr. Jarbas Barbosa, assistant director of the WHO's Pan American Health Organization, said at a press briefing on Wednesday.
"We do not have that information. Therefore, that person may receive that passport and believe that they're duly protected and later on have a new infection because the immunity may only last a couple of months," Barbosa said. "We do not know. For that reason, we do not recommend that."
Antibodies are generally produced in response to foreign particles or antigens that invade the body and help the body's immune system fight off infections. Health officials have said there is not enough data yet to indicate that coronavirus antibodies ensure immunity against the virus.
A small study published in Nature Medicine in June showed that coronavirus antibodies could last only two to three months after a person becomes infected with the virus. Researchers in the Wanzhou District of China compared the antibody response of 37 asymptomatic people with that of 37 symptomatic people. They found that people without symptoms had a weaker antibody response than those with symptoms. But scientists say it's unclear if no antibodies or low levels of antibodies mean that a person is actually at risk of reinfection if reexposed to the virus.
In June, Dr. Anthony Fauci, the nation's leading infectious disease expert, said if Covid-19 acts like other coronaviruses, "it likely isn't going to be a long duration of immunity."
"When you look at the history of coronaviruses, the common coronaviruses that cause the common cold, the reports in the literature are that the durability of immunity that's protective ranges from three to six months to almost always less than a year," he told JAMA Editor Howard Bauchner. "That's not a lot of durability and protection."
Duration of immunity has important implications for vaccine development. Even if a person loses immunity after a period of time, if scientists discover how long immunity lasts, they may be able to recommend when a person may need another vaccine dose.

https://www.cnbc.com/2020/09/16/who-doesnt-recommend-coronavirus-passports-because-immunity-remains-questionable.html

Germany
US general meets with German officials over resort outbreak
ID: 1007853117
Source: stcatharinesstandard.ca

Wed., Sept. 16, 2020

BERLIN - The general commanding American troops in Bavaria met Wednesday with local officials in the Alpine town of Garmisch-Partenkirchen to reassure them of the U.S. military's commitment to preventing the spread of COVID-19, after an outbreak at a troop hotel sickened dozens.

A total of 59 people in the town, including 25 staff at the U.S. military-run Edelweiss Lodge and Resort, tested positive for the new coronavirus after a 26-year-old American woman working at the hotel allegedly flouted quarantine rules by visiting several bars last week.

On Wednesday, German authorities said that further testing had found no additional cases, though they encouraged anybody who had frequented the affected bars and not yet been tested to come forward.

"While there is still much work ahead, we are encouraged by the results returned from yesterday and today's testing," Brig. Gen. Christopher Norrie said in a statement after his visit.

Norrie noted that after learning of the outbreak on Friday, the U.S. military had deployed four helicopters to Garmisch-Partenkirchen carrying additional medical personnel and testing kits.

Employees who had close contact with positive staff members were placed in quarantine and the hotel was closed for two weeks, he added.

"We are extremely grateful for Bavaria's proactive response to keep our communities as safe as possible from this virus," Norrie said. "We are part of this effort alongside our Bavarian hosts and friends, to act responsibly to limit the potential spread of COVID-19."

Norrie said his command — which includes about 51,000 soldiers, civilian employees and family members at seven locations in Bavaria — would ensure that community members who don't adhere to orders, including local ordinances, would be held to account.

U.S. Army personnel, including civilians and family members, are banned from visiting establishments that function exclusively as bars and nightclubs, he said.

"We know that environments that are close, crowded and confined are conducive to the spread of the virus," Norrie said.

He added that while it may not be possible to find out how the virus entered the community, "we all bear individual and collective responsibility in limiting the spread of COVID-19, and I'm confident our community overall will continue to be a positive contributor to this fight."

https://www.stcatharinesstandard.ca/ts/news/world/europe/2020/09/16/us-general-meets-with-german-officials-over-resort-outbreak.html

South Africa

Twelve million South Africans 'probably' had coronavirus but low death rate suggests immunity
ID: 1007853115
Source: scmp.com

About 12 million people in South Africa have "probably" been infected with the coronavirus, but that startlingly high number has not caused a similarly high death rate and might indicate a widespread "level of immunity," the country's minister of health says.

More than 20 per cent of South Africa's population of 58 million have had the virus at some point, Dr Zweli Mkhize estimated earlier this week. He cited studies that found the presence of coronavirus antibodies in blood samples taken from parts of the population. The findings have prompted the

government to start a more complete national study, Dr Mkhize said.

“South Africa has seen the surge receding, and thus raises the question of the level of immunity that may already be existing in society,” he said.

Other studies have indicated that up to 40 per cent of the population might be immune to the virus, the health minister said. Some South African experts suggest that Africa’s most developed economy may be approaching herd immunity, but scientists believe at least 70-80 per cent of a population needs to be immune before there’s any effect. And with COVID-19 it’s unclear how long that immunity might last.

Amid significantly decreasing confirmed virus cases, South African President Cyril Ramaphosa is addressing the nation on September 16 and is expected to announce a further easing of lockdown restrictions, which might include a limited opening of international borders to travellers from some countries.

South Africa’s number of confirmed virus cases have dropped dramatically in recent weeks after a peak in late July that saw the country recording up to 15,000 cases daily, and raised fears that health services in some major cities might collapse. Official figures showed just 772 new cases on Tuesday.

South Africa is also seeing declines in hospital admissions, people in intensive care units and deaths attributed to COVID-19, Mkhize said.
“Consistency across these indicators reassures us that, indeed, we are in the midst of a trough in the pandemic,” he said.

South Africa has just over 650,000 confirmed cases of COVID-19, according to the government’s latest official count, the eighth-highest caseload in the world. At its peak, South Africa was the fifth most affected country, behind the United States, India, Brazil and Russia, which all have much larger populations.

Experts have tried for months to figure out why South Africa’s official death rate from the virus is low. There were fears at the start of the pandemic that poverty, crowded living conditions, restricted access to clean water and the high prevalence of tuberculosis and HIV would put South Africa, and Africa at large, in danger of millions of deaths.

So far, that has not happened. South Africa is by far the worst affected country in Africa with nearly half of the continent’s 1.3 million confirmed cases. There have been 33,000 deaths from COVID-19 in the 54 countries in Africa, which has a population of 1.3 billion people. That death count is less than the number of people who have died in either the UK or Italy, and far less than the United States’ 195,000 confirmed deaths.

But Africa’s figures, tallied by the Africa Centres for Disease Control and Prevention, rely on figures from the individual countries and many have extremely limited testing.

The number of South Africa’s actual deaths from COVID-19 is expected to be considerably higher. From early May until mid-September, the country has recorded 44,000 more deaths than the historic average.

Many of those deaths are believed to be from COVID-19, but the people were not tested. Other deaths could be people with other diseases who avoided care because of COVID-19 infection fears or could not access it because resources were diverted to the pandemic, experts have said.
“We think roughly 30,000 rather than 15,000 people have died from COVID-19,” Shabir Madhi, professor of vaccinology at Johannesburg’s University of the Witswatersrand, said in a webinar this week. “We must appreciate that there had been many deaths outside of hospitals.”

Even with that higher level of deaths, South Africa’s mortality rate from COVID-19 appears relatively low.

Some health experts think that millions in South Africa’s poor, densely populated townships – which many thought would be terribly affected by the virus – may have generated an immunity to the virus because of the previous and frequent spread of other coronaviruses, including those for the common cold and flu.

“They have been exposed, they developed this key cell immunity which helps them to fight the severe effects of COVID-19,” said Madhi, the lead researcher on a clinical trial in South Africa of the coronavirus vaccine that Oxford University is developing with pharmaceutical company AstraZeneca. “They may have achieved an underpinning immunity.”

https://www.scmp.com/news/world/africa/article/3101852/twelve-million-south-africans-probably-had-coronavirus-low-death

China

Scientists to examine possibility Covid leaked from lab as part of investigation into virus origins
Source: The Telegraph Online
Unique ID: 1007845400

Lead investigator says no stone will be left unturned, although existing evidence points to a natural zoonotic spillover event
An international team of scientists will examine the possibility Sars-Cov-2 leaked from a laboratory as part of a comprehensive investigation into the origins of the virus.
The team is being set up as part of the Lancet COVID-19 Commission, a body established in July to “offer practical solutions” to the pandemic and make recommendations on how the next one can be avoided or better defended against.
The team looking at the origins of the virus will be led by Dr Peter Daszak, a British zoologist and leading authority on zoonotic spillover events.
Dr Daszak said yesterday he and his team would “systematically examine every theory” about the origin of the virus, carefully marshalling the scientific evidence for each.
He accepted conspiracy theorists would not welcome his appointment but said, as a scientist, he would “not be bound by preconceived ideas” and would investigate all avenues forensically and “with an open mind”.
He warned, however, it was not possible to “prove a negative” and said it was unlikely it would ever be possible to say with “absolute certainty” how the virus emerged.
“But what we can do is look at every possible theory on the origins of COVID-19 and say, ‘what is the evidence for that?’ And then we put all of those theories together and say, ‘where is the preponderance of evidence?’
“Is it for the virus coming from nature and spilling over into people and emerging that way? Or is it for some form of human involvement that involves a lab or biotechnology? Let's see where the evidence lies”.
Since the coronavirus first emerged in Wuhan, China in late December, a deluge of conspiracy theories have circulated about its origins.
The Lancet Commission notes in its mission statement that “the evidence to date supports the view that Sars-Cov-2 is a naturally occurring virus rather than the result of laboratory creation and release”.
But it adds that investigators should examine the ‘possibility of laboratory involvement” in “a scientific and

objective way that is unhindered by geopolitical agendas and misinformation".
It is hoped a full investigation will, if nothing else, will rule out "baseless and uninformed allegations and conspiracy theories that are unbacked by evidence".
The wider Lancet Covid-19 Commission is being chaired by Professor Jeffery Sachs, an eminent American economist and adviser to the UN.
He will oversee the investigation, not just into the origins of virus, but the world's reaction to it in order to make recommendations for strengthening pandemic preparedness globally.
"What we have learned, I think, about the public health response [to date] is that even though this is a devilish virus it is controllable", he told the Telegraph.
"Around two billion people live in countries that have substantially suppressed the virus. They've been able to do that, primarily because of public health means, and especially these non-pharmaceutical interventions [social distancing]".
"But if we look at the UK, the US, and western Europe, we failed to put such policies in place basically until now. In the US we still don't have an effective control system.
"We have a lot of emphasis on hospitals, but far far less on public health".
Prof Sachs said he hoped and expected the Lancet Commission would be conducted on an objective basis and would be free of political bias.
"There has been a lot of rumour-mongering and statements that are way out of line, that are part of a political agenda by some people, senators in the US and others that have really gone far beyond what we know," he said.
"The origins of the virus must be understood, both to help end the current pandemic and to prevent the next one."
Dr Daszak, like most zoologists, virologists and geneticists, says the strongest evidence available to date points to Sars-Cov-2 emerging naturally.
It is likely the virus has a natural reservoir in bats in which closely related coronaviruses viruses have been found.
From there it may have jumped directly to humans via a so-called spillover event, or perhaps indirectly via farmed mustelids such as ferrets, mink, martens, civets and weasels.
A recent study of mink farms in Holland demonstrated that closely packed mustelids catch and spread the Sars-Cov-2 efficiently. The researchers were also able to track the virus jumping back and forth between farmer workers and their animals, mutating as it moved.
The intensive farming of mustelids and other small animals is common in China where the animals are used for their fur and meat, and in traditional medicine.
Dr Daszak says the key to understanding zoonotic spillover is to think of it, not as a rare occurrence but as something happening all the time-a numbers game.
Most animal viruses quickly die out if they pass from human to human at all, but given the right virus and the right set of environmental circumstances, they can explode.
"It is not that every 10 years or so a person gets infected by a bat virus and it sparks a pandemic. What's really happening is, every day people are getting infected," he said.
"The chances of it spreading depends on things like is the virus replicating quickly? Does it cause illness? Does the infected person have a high level of contact with other people? Do they travel to busy cities or markets?"
As the world has become more developed, mobile and connected the risk of spillover events escalating has risen, causing scientists to speculate that we may be facing a "pandemic century" in which major outbreaks become much more common. "We may be much more vulnerable to these pandemics than we think," said Dr Daszak. "We may be creating a perfect storm. And if that's true, we need to know it. We need to get some data around it.
"It isn't a blame game or about politics. It's much more important. This is about how do we as a species deal with what is potentially an existential threat to our existence".
Protect yourself and your family by learning more about Global Health Security
https://gphin.canada.ca/cepr/showarticle.jsp?docId=1007845400

India

City hospital treats 10-year-old with paediatric co-infection of dengue and Covid-19

Source: hindustantimes
Unique ID: 1007843233

Her course of treatment was planned in a way that both her medical conditions of dengue and Covid-19 could be treated

A city hospital treated a paediatric co-infection, where a 10-year-old was treated of dengue and Covid-19 infection. The child was brought to Aditya Birla Hospital's flu clinic with complaints of high grade fever (more than 102F every 8-12 hours) along with sore throat, malaise and nausea since the past five days with positive Covid-19 RT-PCR report. There were no complaints of cough and breathlessness, as per the hospital authorities.

Her course of treatment was planned in a way that both her medical conditions of dengue and Covid-19 could be treated. Dr Vrushali Bichkar, a consultant at the hospital, said, "She was examined on an immediate basis. Her initial physical examination revealed a temperature of 103 F with tachycardia, a condition that makes one's heart beat more than 100 times per minute. There was no respiratory distress with her oxygen saturation (spO2) levels being 98% on room air, but she had comorbid condition of overweight (BMI – 25.6). Her outside reports suggested leucopoenia, a condition where the number of white cells reduce in the blood and her chest X-ray report showed bilateral infiltrates."

She was immediately admitted to the isolation ward. Her laboratory tests were conducted and initial screening reported worsening of leucopoenia, with normal platelets, deranged liver enzyme and raised inflammatory markers, according to hospital authorities. On the second day of her admission, the child developed erythematous maculopapular rash (abnormal redness and rash of both flat and raised lesion) on trunk (torso) and extremities. Her lab tests revealed that the WBC count had further reduced along with her platelets count.

"We conducted tests for NS1 and anti-IgM dengue, the results of which came positive. The patient was admitted on August 12 and we followed her up till two weeks to make sure that it was a primary dengue infection in a Covid-19 patient," added Bichkar.

"It is important for paediatricians and physicians to be increasingly aware of the phenomena of co-infection," added Dr Rahul Kallianpur, associate director, department of Neonatology and Paediatrics.

Repeat Covid RT-PCR test results turned out to be negative. The WBC and platelet count had normalised. Patient was discharged on oral vitamins in healthy condition.

However, Dr Pradeep Suryavashi, working with Bharati hospital, paediatric ward, said, "This is not a rare case because we have reported two such infections in children too. The viral antigens of both Covid-19 and dengue are similar and so they may test positive."

https://www.hindustantimes.com/pune-news/city-hospital-treats-10-year-old-with-paediatric-co-infection-of-dengue-and-covid-19/story-YSbfNqbmiKVPxysXgWVaBM.html

Taiwan

Local researchers develop COVID-19 antibody potency detection kit

Source: Focus Taiwan

Unique ID: 1007850021

Taipei, Sept. 16 (CNA) Researchers at Taiwan's Chang Gung University announced Wednesday that they have developed a kit that can detect the potency of COVID-19 antibodies, which they say will aid in the process of developing a vaccine for the disease.

According to the university's Research Center for Emerging Viral Infections, identifying the potency of a person's antibodies after they have been administered a vaccine is key to determining the efficacy of the vaccine.

The detection of neutralizing antibodies is particularly important, as they reflect how well a person is protected from the disease, Shih Shin-ru (施信如), director of the research center, said in a statement.

The current method of testing for neutralizing antibodies involves placing blood serum with a virus-infected cell to see if the virus is suppressed, the statement said.

The entire process takes five to seven days, and as it involves the cultivation of viruses, has to be done inside a biosafety level 3 lab, the statement said.

However, the test kit developed by Shih and her team, which uses a specialized protein to detect the neutralizing antibodies of the virus that causes COVID-19, can be used in any laboratory, according to the researchers.

Results are available in two to three hours, though the statement did not detail their accuracy.

Shih's research team signed a technology agreement with Formosa Biomedical Inc. on Wednesday, in the hope of making the kit more widely available, the statement said.
https://focustaiwan.tw/sci-tech/202009160025

International

Lilly's Covid-19 antibody helps some patients rid their systems of virus sooner in early analysis
Source: STAT
Unique ID: 1007850787

A drug being developed by Eli Lilly helped sick patients rid their systems of the virus that causes Covid-19 sooner and may have prevented them from landing in the hospital, according to newly released data. The drug is what is known as a monoclonal antibody, which experts view as being among the most likely technologies to help treat Covid-19. It's a manufactured version of the antibodies that the body uses as part of its response to a virus.
https://gphin.canada.ca/cepr/showarticle.jsp?docId=1007850787

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

United States

Viable SARS-CoV-2 in the air of a hospital room with COVID-19 patients
ID: 1007852949
Source: International Journal of Infectious Diseases/ CIDRAP

Abstract
Objectives
Because detection of SARS-CoV-2 RNA in aerosols but failure to isolate viable (infectious) virus are commonly reported, there is substantial controversy whether SARS-CoV-2 can be transmitted through aerosols. This conundrum occurs because common air samplers can inactivate virions through their harsh collection processes. We sought to resolve the question whether viable SARS-CoV-2 can occur in aerosols using VIVAS air samplers that operate on a gentle water-vapor condensation principle.
Methods

Air samples collected in the hospital room of two COVID-19 patients, one ready for discharge, the other newly admitted, were subjected to RT-qPCR and virus culture. The genomes of the SARS-CoV-2 collected from the air and isolated in cell culture were sequenced.

Results

Viable SARS-CoV-2 was isolated from air samples collected 2 to 4.8 m away from the patients. The genome sequence of the SARS-CoV-2 strain isolated from the material collected by the air samplers was identical to that isolated from the newly admitted patient. Estimates of viable viral concentrations ranged from 6 to 74 $TCID_{50}$ units/L of air.

Conclusions

Patients with respiratory manifestations of COVID-19 produce aerosols in the absence of aerosol-generating procedures that contain viable SARS-CoV-2, and these aerosols may serve as a source of transmission of the virus.

https://www.cidrap.umn.edu/news-perspective/2020/09/news-scan-sep-16-2020
https://www.ijidonline.com/article/S1201-9712(20)30739-6/fulltext#%20

United States

Characteristics of COVID-19 in Homeless Shelters
Source: Annals of Internal Medicine/CIDRAP
ID: 1007852949

A Community-Based Surveillance Study

Abstract

Background:
Homeless shelters are a high-risk setting for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) transmission because of crowding and shared hygiene facilities.

Objective:
To investigate SARS-CoV-2 case counts across several adult and family homeless shelters in a major metropolitan area.

Design:
Cross-sectional, community-based surveillance study. (ClinicalTrials.gov: NCT04141917)

Setting:
14 homeless shelters in King County, Washington.

Participants:
A total of 1434 study encounters were done in shelter residents and staff, regardless of symptoms.

Intervention:
Two strategies were used for SARS-CoV-2 testing: routine surveillance and contact tracing ("surge testing") events.

Measurements:
The primary outcome measure was test positivity rate of SARS-CoV-2 infection at shelters, determined by dividing the number of positive cases by the total number of participant encounters, regardless of symptoms. Sociodemographic, clinical, and virologic variables were assessed as correlates of viral positivity.

Results:
Among 1434 encounters, 29 (2% [95% CI, 1.4% to 2.9%]) cases of SARS-CoV-2 infection were detected across 5 shelters. Most (*n* = 21 [72.4%]) were detected during surge testing events rather than routine surveillance, and most (*n* = 21 [72.4% {CI, 52.8% to 87.3%}]) were asymptomatic at the time of sample collection. Persons who were positive for SARS-CoV-2 were more frequently aged 60 years or older than those without SARS-CoV-2 (44.8% vs. 15.9%). Eighty-six percent of persons with positive test results slept in a communal space rather than in a private or shared room.

Limitation:
Selection bias due to voluntary participation and a relatively small case count.

Conclusion:
Active surveillance and surge testing were used to detect multiple cases of asymptomatic and symptomatic SARS-CoV-2 infection in homeless shelters. The findings suggest an unmet need for routine viral testing outside of clinical settings for homeless populations.

https://www.acpjournals.org/doi/10.7326/M20-3799
https://www.cidrap.umn.edu/news-perspective/2020/09/news-scan-sep-16-2020

United States

Characteristics and Maternal and Birth Outcomes of Hospitalized Pregnant Women with Laboratory-Confirmed COVID-19 — COVID-NET, 13 States, March 1–August 22, 2020

Source: CDC Morbidity and Mortality Weekly Report (MMWR)

Summary

What is already known about this topic?

Information on the clinical characteristics and birth outcomes of hospitalized U.S. pregnant women with COVID-19 is limited.

What is added by this report?

Among 598 hospitalized pregnant women with COVID-19, 55% were asymptomatic at admission. Severe illness occurred among symptomatic pregnant women, including intensive care unit admissions (16%), mechanical ventilation (8%), and death (1%). Pregnancy losses occurred for 2% of pregnancies completed during COVID-19-associated hospitalizations and were experienced by both symptomatic and asymptomatic women.

What are the implications for public health practice?

Pregnant women and health care providers should be aware of potential risks for severe COVID-19, including adverse pregnancy outcomes. Identifying COVID-19 during birth hospitalizations is important to guide preventive measures to protect pregnant women, parents, newborns, other patients, and hospital personnel.

Pregnant women might be at increased risk for severe coronavirus disease 2019 (COVID-19) (1,2). The COVID-19-Associated Hospitalization Surveillance Network (COVID-NET) (3) collects data on hospitalized pregnant women with laboratory-confirmed SARS-CoV-2, the virus that causes COVID-19; to date, such data have been limited. During March 1–August 22, 2020, approximately one in four hospitalized women aged 15–49 years with COVID-19 was pregnant. Among 598 hospitalized pregnant women with COVID-19, 54.5% were asymptomatic at admission. Among 272 pregnant women with COVID-19 who were symptomatic at hospital admission, 16.2% were admitted to an intensive care unit (ICU), and 8.5% required invasive mechanical ventilation. During COVID-19–associated hospitalizations, 448 of 458 (97.8%) completed pregnancies resulted in a live birth and 10 (2.2%) resulted in a pregnancy loss. Testing policies based on the presence of symptoms might miss COVID-19 infections during pregnancy. Surveillance of pregnant women with COVID-19, including those with asymptomatic infections, is important to understand the short- and long-term consequences of COVID-19 for mothers and newborns. Identifying COVID-19 in women during birth hospitalizations is important to guide preventive measures to protect pregnant women, parents, newborns, other patients, and hospital personnel. Pregnant women and health care providers should be made aware of the potential risks for severe COVID-19 illness, adverse pregnancy outcomes, and ways to prevent infection.

COVID-NET conducts population-based surveillance for laboratory-confirmed COVID-19–associated hospitalizations in 14 states encompassing 99 counties* (3). Thirteen states (California, Colorado, Connecticut, Georgia, Maryland, Michigan, Minnesota, New Mexico, New York, Ohio, Oregon, Tennessee, and Utah) contributed data to this report. Residents of the predefined surveillance catchment area who had a positive molecular test for SARS-CoV-2 during hospitalization or up to 14 days before hospital admission were classified as having a COVID-19–associated hospitalization and were included in COVID-NET surveillance. Persons included in COVID-NET surveillance are referred to as having COVID-19 throughout this report. SARS-CoV-2 testing was performed at the discretion of health care providers or through facility policies dictating uniform or criteria-based testing of patients upon admission. Trained surveillance officers performed medical chart abstractions for a convenience sample of hospitalizations using a standardized case report form. This analysis included women aged 15–49 years who were pregnant at hospital admission. Descriptive statistics were calculated for hospitalized pregnant women with complete chart review and discharge disposition (i.e., discharged or died during hospitalization). Women with one or more signs or symptoms included on the COVID-NET case report form (3) at the time of hospital admission were classified as symptomatic. Birth outcomes were described for pregnancies

completed during a COVID-19–associated hospitalization. Reason for hospital admission was collected starting in June. Data were analyzed using SAS software (version 9.4; SAS Institute). This activity was reviewed by CDC and was conducted consistent with applicable federal law and CDC policy.† Sites obtained approval for COVID-NET surveillance from their state and local institutional review boards, as required.

During March 1–August 22, 2020, COVID-NET identified 7,895 hospitalized women aged 15–49 years with COVID-19; discharge disposition was determined, and chart review was completed for 2,318 (29.4%) (Figure 1). Among 2,255 (97.3%) women with information about pregnancy status, 598 (26.5%) were pregnant, with median age 29 years. Among 577 (96.5%) pregnant women with reported race and ethnicity, 42.5% were Hispanic or Latino (Hispanic), and 26.5% were non-Hispanic Black (Black) (Table).

Among 596 women with COVID-19 whose pregnancy trimester was known, 14 (2.3%), 61 (10.2%), and 521 (87.4%) were hospitalized during the first, second, and third trimesters, respectively. The reason for hospital admission was reported for 324 women: 242 (74.7%) were hospitalized for obstetric indications (including labor and delivery), 61 (18.8%) for COVID-19–related illness, and 21 (6.5%) for other reasons. The most common reason for admission during the first or second pregnancy trimester was COVID-19–related illness (56.8%) and during the third trimester, obstetric indications (81.9%). Among hospitalized pregnant women with COVID-19, 20.6% had at least one underlying medical condition; asthma (8.2%) and hypertension (4.3%) were the most prevalent.

Overall, 272 (45.5%) pregnant women with COVID-19 were symptomatic at the time of hospital admission, and 326 (54.5%) were asymptomatic. Women hospitalized during the first or second trimester were more frequently symptomatic (84.0%) than were those hospitalized during the third trimester (39.9%). Among symptomatic women, the most commonly reported symptoms were fever or chills (59.6%) and cough (59.2%) (Figure 2).

Among 272 hospitalized symptomatic pregnant women, 44 (16.2%) were admitted to an ICU and 23 (8.5%) required invasive mechanical ventilation. Two (0.7%) deaths were reported among symptomatic women. No asymptomatic women were admitted to an ICU, required invasive mechanical ventilation, or died.

At hospital discharge, 458 women (76.6%) with COVID-19 had completed pregnancies, including 448 (97.8%) that resulted in live births and 10 (2.2%) in pregnancy losses (Figure 1). Pregnancy losses occurred among both symptomatic and asymptomatic hospitalized women with COVID-19 (Table). Four pregnancy losses (0.9% of completed pregnancies) occurred at <20 weeks' gestation, five (1.1%) at ≥20 weeks' gestation, and one (0.2%) at unknown gestational age. Among 445 pregnancies resulting in live births with known gestational age at delivery, 87.4% were term births (≥37 weeks' gestation), and 12.6% were preterm (<37 weeks). Among pregnancies resulting in live births, preterm delivery was reported for 23.1% of symptomatic women and 8.0% of asymptomatic women. Two live-born newborns died during the birth hospitalization (Table); both were born to symptomatic women who required invasive mechanical ventilation.

Discussion

One in four women aged 15–49 years who had a COVID-19–associated hospitalization during March 1–August 22, 2020 was pregnant, based on a convenience sample from COVID-NET. Approximately one half of pregnant women were asymptomatic at hospital admission. Among symptomatic pregnant women, 16.2% were admitted to an ICU, 8.5% required invasive mechanical ventilation, and two died during COVID-19–associated hospitalizations; none of these outcomes occurred among asymptomatic pregnant women. Among all pregnancies completed during a COVID-19–associated hospitalization, 2.2% resulted in pregnancy losses. Pregnancy losses occurred among both symptomatic and asymptomatic hospitalized women with COVID-19.

Approximately 5% of women of reproductive age in the general population are pregnant at any given time (1). The proportion of hospitalized women aged 15–49 years with COVID-19 who were pregnant in this

study (26.5%) suggests that pregnant women have disproportionately higher rates of COVID-19–associated hospitalizations compared to nonpregnant women. Although COVID-19 might be more severe in pregnant women, other factors might also explain these higher hospitalization rates. Providers might have a lower threshold for admitting pregnant women for any reason. Some pregnant women with COVID-19 might be admitted solely to give birth. Pregnant women might also have a higher likelihood of being tested for COVID-19 upon admission than do nonpregnant women. Nevertheless, pregnant women account for a substantial proportion of COVID-19–associated hospitalizations among women of reproductive age.

The proportions of hospitalized pregnant women who were Hispanic (42.5%) and Black (26.5%) were higher than the overall proportions of women aged 15–49 years in the COVID-NET catchment area who were Hispanic (15.3%) or Black (19.5%).§ Although the racial and ethnic composition of pregnant women in the catchment area is unknown, this report and an earlier study (1) suggest that pregnant women who are Hispanic or Black might have disproportionately higher rates of COVID-19–associated hospitalization, compared with those of pregnant women of other races and ethnicities. Long standing inequities in the social determinants of health, such as occupation and housing circumstances that make physical distancing challenging, have put some racial and ethnic minority groups at increased risk for COVID-19–associated illness and death (4,5). Better understanding of the circumstances under which Hispanic and Black women of reproductive age are exposed to SARS-CoV-2 could inform prevention strategies.

Most pregnant women with COVID-19 in this study were asymptomatic, similar to findings in settings where universal SARS-CoV-2 testing is conducted upon admission to labor and delivery units (6). Testing policies based on the presence of symptoms might miss many SARS-CoV-2 infections during pregnancy. Early identification of COVID-19 among hospitalized pregnant women can help ensure that health care providers use appropriate personal protective equipment and limit visitors to those essential for patients' well-being and care.¶

The overall proportion of pregnant women with COVID-19 admitted to an ICU (7.4%) was similar to that observed in two European studies (7,8); however, 16.2% of symptomatic pregnant women in this study were admitted to an ICU, indicating that outcomes might be more severe among pregnant women admitted with acute illness than among those admitted for obstetric indications alone.

Although the preterm delivery rate in the study catchment area during the surveillance period is unknown, the prevalence of preterm delivery among live births during COVID-19–associated hospitalizations (12.6%) was higher than that observed in the general U.S. population in 2018 (10.0%) (9). In this study, preterm births occurred approximately three times more frequently in symptomatic pregnant women than in those who were asymptomatic. Preterm newborns might be at increased risk for severe COVID-19 illness, and preventive measures, such as encouraging caretakers to wear a mask and practice hand hygiene, should be emphasized to minimize possible transmission.**

Birth outcomes in this analysis were limited to pregnancies completed during a COVID-19–associated hospitalization. COVID-NET only captured medically attended pregnancy losses and likely underestimates the percentage of pregnancy losses that occur among women with COVID-19. Further prospective data on birth outcomes among women infected during all pregnancy trimesters is needed. CDC is collaborating with state and local health departments to conduct detailed surveillance of pregnant women with COVID-19 and their infants.††

The findings in this report are subject to at least six limitations. First, at the time of analysis, chart abstractions were ongoing and completed for a convenience sample of 29.4% of women aged 15–49 years. Thus, the estimated proportion of hospitalized women with COVID-19 who were pregnant might be biased, because pregnancy status was not yet ascertained for women without completed chart review. Second, pregnant women included in this analysis might not be representative of all pregnant women within the catchment area. Third, COVID-19 cases might have been missed because of testing practices and test availability, which likely varied across time and facilities. Fourth, the reason for hospital admission was unavailable for 45.8% of women, limiting the ability to distinguish between admissions solely for labor and delivery and those for COVID-19–related illness. Fifth, information on obesity as an

underlying prepregnancy condition was not available, so this underlying health condition could not be described. Finally, information on maternal and newborn mortality was only obtained from the maternal medical chart and did not capture outcomes occurring beyond the COVID-19–associated hospitalization.

Severe illness and adverse birth outcomes were observed among hospitalized pregnant women with COVID-19. These findings highlight the importance of preventing and identifying COVID-19 in pregnant women. Pregnant women should avoid close contact with persons with confirmed or suspected COVID-19, maintain 6 feet of distance from nonhousehold members, and take general COVID-19 preventive measures, including wearing masks and practicing hand hygiene.§§ CDC recommends testing newborns born to mothers with COVID-19, isolation of mothers with COVID-19 and their newborns from other hospitalized mothers and newborns, and infection prevention measures for persons caring for newborns who might be exposed to SARS-CoV-2.** Continued surveillance for COVID-19 in pregnant women is important to understand and improve health outcomes for mothers and newborns.
https://www.cdc.gov/mmwr/volumes/69/wr/mm6938e1.htm?s_cid=mm6938e1_e&ACSTrackingID=DM38216&ACSTrackingLabel=MMWR%20Early%20Release%20-%20Vol.%2069%2C%20September%2016%2C%202020&deliveryName=DM38216

United States

SARS-CoV-2 Infection Among Hospitalized Pregnant Women: Reasons for Admission and Pregnancy Characteristics — Eight U.S. Health Care Centers, March 1–May 30, 2020
Source: CDC Morbidity and Mortality Weekly Report (MMWR)

Summary

What is already known about this topic?
Pregnant women might be at increased risk for severe illness from SARS-CoV-2 infection.

What is added by this report?
Prevalences of prepregnancy obesity and gestational diabetes were higher among pregnant women hospitalized for COVID-19–related illness (e.g., worsening respiratory status) than among those admitted for pregnancy-related treatment or procedures (e.g., delivery) and found to have COVID-19. Intensive care was required for 30% (13 of 43) of pregnant women admitted for COVID-19, and one pregnant woman died from COVID-19.

What are the implications for public health practice?
Antenatal counseling emphasizing preventive measures, including use of masks, frequent hand washing, and social distancing, might help prevent COVID-19 among pregnant women, especially those with prepregnancy obesity and gestational diabetes.

Pregnant women might be at increased risk for severe coronavirus disease 2019 (COVID-19), possibly related to changes in their immune system and respiratory physiology* (1). Further, adverse birth outcomes, such as preterm delivery and stillbirth, might be more common among pregnant women infected with SARS-CoV-2, the virus that causes COVID-19 (2,3). Information about SARS-CoV-2 infection during pregnancy is rapidly growing; however, data on reasons for hospital admission, pregnancy-specific characteristics, and birth outcomes among pregnant women hospitalized with SARS-CoV-2 infections are limited. During March 1–May 30, 2020, as part of Vaccine Safety Datalink (VSD)† surveillance of COVID-19 hospitalizations, 105 hospitalized pregnant women with SARS-CoV-2 infection were identified, including 62 (59%) hospitalized for obstetric reasons (i.e., labor and delivery or another pregnancy-related indication) and 43 (41%) hospitalized for COVID-19 illness without an obstetric reason. Overall, 50 (81%) of 62 pregnant women with SARS-CoV-2 infection who were admitted for obstetric reasons were asymptomatic. Among 43 pregnant women hospitalized for COVID-19, 13 (30%) required intensive care unit (ICU) admission, six (14%) required mechanical ventilation, and one died from COVID-19. Prepregnancy obesity was more common (44%) among pregnant women hospitalized for COVID-19 than that among asymptomatic pregnant women hospitalized for obstetric reasons (31%). Likewise, the rate of gestational diabetes (26%) among pregnant women hospitalized for COVID-19 was higher than it was among women hospitalized for obstetric reasons (8%). Preterm delivery occurred in 15% of

pregnancies among 93 women who delivered, and stillbirths (fetal death at ≥20 weeks' gestation) occurred in 3%. Antenatal counseling emphasizing preventive measures (e.g., use of masks, frequent hand washing, and social distancing) might help prevent COVID-19 among pregnant women,§ especially those with prepregnancy obesity and gestational diabetes, which might reduce adverse pregnancy outcomes.

VSD is a collaboration between CDC's Immunization Safety Office and nine U.S. health care organizations serving more than 12 million persons each year. Hospitalizations with a patient diagnosis of COVID-19 were identified using COVID-19 International Classification of Diseases, Tenth Revision, Clinical Modification, (ICD-10-CM)¶ and site-specific internal diagnosis codes during March 1–May 30, 2020. Pregnant women were identified using a validated algorithm based on ICD-9 diagnosis and procedure codes (4) that has been modified for ICD-10. For this study, medical records of women hospitalized with COVID-19 were reviewed by abstractors and adjudicated by a physician to identify the primary reason for hospital admission, pregnancy characteristics, COVID-19 complications, and birth outcomes among women who delivered before July 31, 2020.

Pregnant women with COVID-19 diagnoses were classified into the following three groups based on the primary reason for admission: 1) treatment of COVID-19 without an obstetric reason (e.g., worsening respiratory distress); 2) an obstetric reason, along with symptoms consistent with COVID-19 (e.g., fever, chills, cough, shortness of breath); and 3) an obstetric reason, without COVID-19–compatible symptoms (or with a history of resolved COVID-19), but with a positive test result for SARS-CoV-2 at the time of admission. Demographic and pregnancy characteristics among pregnant women admitted for COVID-19 were compared with those of women admitted for obstetric reasons. Birth outcomes in pregnant women with SARS-COV-2 infection were compared with background rates among all pregnant women in eight VSD sites during the study period. This activity was reviewed by CDC and was conducted consistent with applicable federal law and CDC policy.** SAS software (version 9.4; SAS Institute) was used to conduct all analyses.

During March 1–May 30, among 4,408 persons hospitalized with a COVID-19 diagnosis at VSD sites, 105 (2.4%) pregnant women were identified. SARS-CoV-2 real-time reverse transcription–polymerase chain reaction test results were positive for 104 women. One additional woman, who had a negative SARS-CoV-2 test result, was symptomatic and had close contacts with confirmed COVID-19; she received a clinical diagnosis of COVID-19. Among these 105 pregnant women, 43 (41.0%) were hospitalized for COVID-19 illness and 62 (59.0%) were admitted for obstetric reasons (Table 1). Among the 62 women admitted for obstetric reasons, 12 (19.4%) had COVID-19–compatible symptoms, and 50 (80.6%) were asymptomatic. The median age of all women was 30 years (range = 17–54 years), and 61.9% were Hispanic or Latino (Table 2). ICU admission was required for 14 (13.3%) hospitalized pregnant women, including 13 (30.2%) of the 43 women hospitalized for COVID-19; six of these women required mechanical ventilation, and one, admitted at 15 weeks' gestation, died from COVID-19. The prevalence of prepregnancy obesity (body mass index ≥30 kg/m2) was 36.2% overall and was higher among the 43 women hospitalized for COVID-19 (44.2%) than among the 62 hospitalized for obstetric reasons (30.6%). Similarly, prevalence of gestational diabetes was higher among women hospitalized for COVID-19 (25.6%) than among those hospitalized for obstetric reasons (8.1%).

Among all 105 pregnant women hospitalized with COVID-19, 93 (88.6%) had a pregnancy outcome before July 31 (Table 3), including 79 (84.9%) who delivered during their initial hospitalization and 14 (15.1%) during a subsequent hospitalization. One of the remaining 12 women died during initial hospitalization, and 11 were still pregnant at the time of analysis. Preterm delivery prevalence was 15.1% overall and 12.2% among live births, which is nearly 70% higher than baseline rates in VSD during the study period (8.9% among 43,571 live births and stillbirths in VSD). Stillbirth prevalence (3.2%) was more than four times higher among women with SARS-CoV-2 than the baseline rate in VSD during the study period (0.6%). All three stillbirths were antepartum: one with placental abruption and two with no identified etiology based on adjudication.

Discussion

Among 105 hospitalized pregnant women with COVID-19 diagnoses in VSD during March 1–May 30, 41% were hospitalized because of COVID-19 illness, and 59% were admitted for obstetric reasons. Approximately 80% of those admitted for obstetric reasons were asymptomatic with COVID-19. This percentage is similar to findings from a New York City study that reported universal screening of obstetrics patients on admission and found that among 13.7% of women with SARS-CoV-2–positive test results, 87.9% were asymptomatic (5). Similarly, among pregnant women admitted to a large managed care organization in southern California for labor and delivery who were offered universal screening, the prevalence of SARS-CoV-2 infection was 0.4%, and all women with positive test results were asymptomatic (6).

Compared with background rates of all pregnant women in the VSD population during the same period, the current findings indicate increased percentages of preterm delivery and stillbirths occur among all pregnant women with SARS-CoV-2 infection. Other studies have also found higher rates of preterm delivery and stillbirth in pregnant women with SARS-CoV-2 infection (symptomatic and asymptomatic), compared with those in the general population (2,3).

Higher percentages of prepregnancy obesity and gestational diabetes were identified among pregnant women hospitalized for COVID-19 illness without an obstetric reason, compared with the percentages of these conditions in pregnant women with SARS-CoV-2 infection who were admitted for obstetric reasons. Underlying medical conditions, including obesity and diabetes have been recognized as risk factors for severe COVID-19 disease (7,8). A study of 46 pregnant women with COVID-19 (9) found that nearly all women with severe infection were overweight or obese. This study also identified higher rates of complications in pregnant women with SARS-CoV-2 infection (including the need for ICU admission or mechanical ventilation) and death, which highlight the importance of all pregnant women and their close contacts adhering to COVID-19 prevention measures.

The findings in this report are subject to at least five limitations. First, the number of pregnant women with SARS-CoV-2 infection was small, limiting the power to detect significant differences among comparison groups. Second, during this study period, various screening policies were being implemented across VSD sites. As a result, asymptomatic women with SARS-CoV-2 infection hospitalized during pregnancy might have been missed, especially earlier in the study period. Third, this study did not routinely identify pregnant women with negative SARS-CoV-2 test results. More information is needed to understand whether a universal screening strategy should be considered in the care of pregnant women, and, if so, when in pregnancy (timing and setting) this should be implemented. Fourth, this study did not collect information on prenatal care, which is known to affect pregnancy outcomes. However, VSD's surveillance population is primarily insured and has high rates of standard prenatal care (10), and birth outcomes among pregnant women with SARS-CoV-2 infection were compared with background rates in VSD during the study period. Although studying a primarily insured population might limit generalizability of study findings, VSD does capture publicly insured persons, and includes one large integrated urban safety-net health system†† serving uninsured patients. Finally, this study did not control for important predisposing factors for adverse birth outcomes, such as pregnancy-related conditions, and more information is needed to understand the effects of SARS-CoV-2 infection on pregnancy outcome.

This report addresses gaps in previously reported surveillance data by using a combination of diagnosis codes, medical record review, and physician adjudication to identify various reasons for hospital admission among pregnant women with COVID-19, their pregnancy characteristics, and birth outcomes. This report highlights the importance of antenatal counseling in pregnant women, especially those with prepregnancy obesity and gestational diabetes. Counseling should emphasize preventive measures for all pregnant women and their close contacts, including use of masks, frequent hand washing, social distancing, and avoidance of large gatherings to help prevent SARS-CoV-2 infection and COVID-19–associated pregnancy complications.
https://www.cdc.gov/mmwr/volumes/69/wr/mm6938e2.htm?s_cid=mm6938e2_e&ACSTrackingID=DM38216&ACSTrackingLabel=MMWR%20Early%20Release%20-%20Vol.%2069%2C%20September%2016%2C%202020&deliveryName=DM38216

Study

Case-Control Study of Use of Personal Protective Measures and Risk for Severe Acute Respiratory Syndrome Coronavirus 2 Infection, Thailand
Source: CDC

Abstract
We evaluated effectiveness of personal protective measures against severe acute respiratory disease coronavirus 2 (SARS-CoV-2) infection. Our case-control study included 211 cases of coronavirus disease (COVID-19) and 839 controls in Thailand. Cases were defined as asymptomatic contacts of COVID-19 patients who later tested positive for SARS-CoV-2; controls were asymptomatic contacts who never tested positive. Wearing masks all the time during contact was independently associated with lower risk for SARS-CoV-2 infection compared with not wearing masks; wearing a mask sometimes during contact did not lower infection risk. We found the type of mask worn was not independently associated with infection and that contacts who always wore masks were more likely to practice social distancing. Maintaining >1 m distance from a person with COVID-19, having close contact for <15 minutes, and frequent handwashing were independently associated with lower risk for infection. Our findings support consistent wearing of masks, handwashing, and social distancing to protect against COVID-19.
Evaluation of the effectiveness of mask-wearing to protect healthy persons in the general public from infection with severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), the causative agent of coronavirus disease (COVID-19), is urgently needed (*1*,*2*). On February 27, 2020, during the early stages of the COVID-19 outbreak, the World Health Organization (WHO) announced that wearing a mask of any type was not recommended for asymptomatic persons (*3*). The rationale at that time was to avoid unnecessary cost, procurement burden, and a false sense of security (*3*). Several systematic reviews found no conclusive evidence to support widespread use of masks in public settings to protect against respiratory infectious diseases, such as influenza and severe acute respiratory syndrome (SARS) (*4*–*6*). However, China, South Korea, Japan, Thailand, and other countries in Asia have recommended the use of face masks among the general public since early in the COVID-19 pandemic (*7*). Evidence suggests that persons with COVID-19 can have a presymptomatic period, during which they can be contagious and transmit SARS-CoV-2 to others before symptoms develop (*8*). These findings led to a change in recommendations from the US Centers for Disease Control and Prevention on April 4, 2020, that advised all persons wear a cloth face covering when in public (*9*). On April 6 and June 5, 2020, WHO updated its advice on the use of masks for the general public and encouraged countries that issue the recommendations to conduct research on this topic (*8*).
Thailand has been implementing multiple measures against transmission of SARS-CoV-2 since the beginning of the outbreak (*10*,*11*). The country established thermal screening at airports on January 3, 2020, and detected an early case of COVID-19 outside China in a traveler from Wuhan, China, arriving at Bangkok Suvarnabhumi airport on January 8, 2020 (*10*). Thailand uses Surveillance and Rapid Response Teams (SRRTs), together with village health volunteers, to conduct contact tracing, educate the public about COVID-19, and monitor close contacts of persons with COVID-19 in quarantine (*11*). SRRTs are epidemiologic teams trained to conduct surveillance, investigations, and initial control of communicable diseases, such as SARS and influenza (*12*,*13*). More than 1,000 district-, provincial-, and regional-level SRRTs are working on COVID-19 contact tracing in Thailand.
By February 2020, public pressure to wear masks in Thailand was high. However, medical masks became difficult for the public to procure, and the government categorized medical masks as price-controlled goods. When the Ministry of Public Health (MoPH) designated COVID-19 a dangerous communicable disease, according to the Communicable Disease Act of 2015, government officials were empowered to quarantine case-contacts and close venues (*14*,*15*). On March 3, MoPH recommended public use of cloth face masks (*16*). On March 18, schools, universities, bars, nightclubs, and entertainment venues were closed (*17*). On March 26, when the country was reporting »100–150 new COVID-19 cases per day, the government declared a national state of emergency, prohibited public gatherings, and enforced wearing of face masks by all persons on public transport (*18*). On April 21, MoPH announced 19 new PCR-confirmed COVID-19 cases, bringing the total number of cases to 2,811 (*18*). Given the lack of evidence, we sought to evaluate the effectiveness of mask-wearing, handwashing, social distancing, and other personal protective measures against SARS-CoV-2 infection in public in Thailand.

Discussion

Our findings provide evidence that mask-wearing, handwashing, and social distancing are independently associated with lower risk for SARS-CoV-2 infection in the general public in community settings in Thailand. We observed that wearing masks throughout the period of exposure to someone infected with SARS-CoV-2 was associated with lower risk for infection, but wearing masks only sometimes during the period was not. This evidence supports recommendations to wear masks consistently and correctly at all times in public (*2*,*7*–*9*).

The effectiveness of mask-wearing we observed is consistent with previous studies, including a randomized-controlled trial showing that consistent face mask use reduced risk for influenza-like illness (*28*), 2 case-control studies that found that mask-wearing was associated with lower risk for SARS infection (*29*,*30*), and a retrospective cohort study that found that mask-wearing by index patients or family members at home was associated with lower risk for SARS-CoV-2 infection (*31*). Previous studies found use of surgical masks or similar 12–16-layer cotton reusable masks demonstrated protection against coronavirus infection in the community (*32*), but we did not observe a difference between wearing nonmedical and medical masks in the general population. Our results suggest that wearing nonmedical masks in public can potentially reduce transmission of SARS-CoV-2. Another study found perception of risk of developing COVID-19 can increase a person's likelihood of wearing a medical mask in nonmedical settings (T.D. Huynh, unpub. data, https://www.medrxiv.org/content/10.1101/2020.03.26.20044388v1External Link). However, given supply shortages, medical masks should be reserved for use by healthcare workers.

We found a negative association between risk for SARS-CoV-2 infection and social distancing, consistent with previous studies that found that >1 m physical distancing was associated with a large protective effect and distances of >2 m could be more effective (*32*). Our findings on effectiveness of hand hygiene also were consistent with reports in previous studies (*33*).

In this study, secondary attack rates at different venues varied widely. The household secondary attack rate in our study (16.5%) is comparable with ranges reported previously (11%–23%) (*34*,*35*), and relatively high compared with workplaces (4.9%) and other settings (1.4%). Although quarantine measures can be challenging and sometimes impractical, household members should immediately separate a person who develops symptoms of COVID-19; the sick person should stay in a specific room; use a separate bathroom, if possible; and not share dishes, cups, and other utensils (*36*). All household members should wear masks, frequently wash their hands, and perform social distancing to the extent possible (*37*).

The high number of COVID-19 cases associated with nightclub exposures in Bangkok is comparable to a COVID-19 outbreak associated with the Itaewon nightclub cluster in Seoul, South Korea, during May 2020 (*38*), in which persons visited several nightclubs in the same area during a short period of time. The secondary attack rate in boxing stadiums was high (86%) but similar to a cluster of COVID-19 cases associated with a football match in Italy during February 2020 (*39*). The secondary attack rate of COVID-19 at a choir practice in the United States was reported to be 53.3%–86.7% (*40*). Secondary attack rates in public gathering places with high densities of persons shouting and cheering, such as football and boxing stadiums, are still uncertain but appear to be high.

Clear and consistent public messaging from policy makers likely can prevent a false sense of security and promote compliance with social distancing in Thailand. We found that those who wore masks throughout the time they were exposed to a COVID-19 patient also were more likely to wash their hands and perform social distancing. Traditional and social media outlets can support public health responses by working with governments to provide consistent, simple, and clear messages (*41*). In Thailand, daily briefings from the Centre for COVID-19 Situation Administration provided clear, consistent messages on social distancing, how to put on a mask, and how to wash hands, which might have improved public confidence with the recommendations. Consistent public messages on how to wear masks correctly also are needed, particularly for those who wear masks sometimes or incorrectly, such as not covering both nose and mouth. We found that persons who only intermittently wore masks during exposure also did not practice social distancing adequately.

Our study has several limitations. First, because our findings were based on contacts related to 3 major COVID-19 clusters in Thailand during March 2020, they might not be generalizable to all settings. Second, estimated ORs were conditioned on reported contact with index patients; our study did not evaluate or consider the probability of having contact with other infected persons in the community, which could have occurred. Third, because only 89% of controls were tested, those not tested could have been infected; therefore, cases might have been missed in persons with mild or no symptoms or who did not

report symptoms or seek care or testing. Nonetheless, we believe that misclassification likely was minimal because those who were not tested with RT-PCR were low-risk contacts; the small number likely would not change our main findings and recommendations on personal protective measures. Fourth, identifying every potential contact can be nearly impossible because some persons might have had contact with >1 COVID-19 patient. Hence, our estimated secondary attack rates among contacts with high-risk exposure could be overestimated or underestimated. Fifth, population attributable fraction is based on several assumptions, including causality, and should be interpreted with caution (*42*,*43*). Finally, findings were subject to common biases of retrospective case-control studies, including memory bias, observer bias, and information bias (*44*). To reduce potential biases, we used structured interviews in which each participant was asked the same set of defined questions.

As many countries begin to relax social distancing measures, our findings provide evidence supporting consistent mask-wearing, handwashing, and adhering to social distancing recommendations to reduce SARS-CoV-2 transmission in public gatherings. Wearing nonmedical masks in public could help slow the spread of COVID-19. Complying with all measures could be highly effective; however, in places with a high population density, additional measures might be required.

Clear and consistent public messaging on personal protective recommendations is essential, particularly for targeting those who wear masks intermittently or incorrectly. Our data showed that no single protective measure was associated with complete protection from COVID-19. All measures, including mask-wearing, handwashing, and social distancing, can increase protection against COVID-19 in public settings.

https://wwwnc.cdc.gov/eid/article/26/11/20-3003_article?ACSTrackingID=USCDC_333-DM38200&ACSTrackingLabel=Latest%20Expedited%20Articles%20-%20Emerging%20Infectious%20Diseases%20Journal%20-%20September%2015%2C%202020&deliveryName=USCDC_333-DM38200

Study

Stroke could be first symptom of COVID-19 in patients under 50

Source: Blackburn News

Unique ID: 1007850019

The research team examined data on 160 stroke patients with COVID-19 and determined one of the most concerning symptoms of the virus is the development of large blood clots that can cause blockages in the arteries that lead to the brain causing stroke. Researchers at Western University and Lawson Health Research Institute working to understand the connection between strokes and the novel coronavirus have found approximately 2 per cent of patients admitted to hospital with COVID-19 will suffer a stroke. For nearly half of COVID-19 patients under 50, the first sign of the virus could be a stroke, according to a new London-based study.

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Researchers at Western University and Lawson Health Research Institute working to understand the connection between strokes and the novel coronavirus have found approximately 2 per cent of patients admitted to hospital with COVID-19 will suffer a stroke. As a result of both conditions, 35 per cent of patients will die.

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For patients under the age of 50, nearly 50 per cent had no other visible symptoms of the virus at the time of the stroke.

“One of the most eye-opening findings of this study is that for patients under 50 years old, many were totally asymptomatic when they had a stroke related to COVID-19,” Dr. Luciano Sposato, lead researcher and stroke research chair at Western’s Schulich School of Medicine & Dentistry, said in a statement. “This means that for these patients, the stroke was their first symptom of the disease.”

She stated that understanding the link between COVID-19 and stroke is important for developing an effective treatment.

“The take-home message here for health care providers is that if you are seeing a patient with a stroke, particularly in those under 50 years old with large clots, you need to think of COVID-19 as a potential

cause even in the absence of respiratory symptoms," said Sposato.
Researchers also found older age, other chronic conditions, and the severity of COVID-19 respiratory symptoms are associated with an "extremely elevated" risk of death.
The study was published Tuesday in the online issue of Neurology, the medical journal of the American Academy of Neurology.
https://n.neurology.org/content/early/2020/09/15/WNL.0000000000010851
https://blackburnnews.com/london/london-news/2020/09/16/stroke-first-symptom-covid-19-patients-50/

Domestic Events of Interest

Canada

Drop in Windsor distribution of life-saving naloxone kits during pandemic
Source: CBC
Unique ID: 1007850022

The number of life-saving naloxone kits being distributed in Windsor has seen a significant drop since the COVID-19 pandemic began in March, while overdose-related emergency department visits — and deaths — appear to be increasing.
Tara Gomes, a professor of epidemiology at the University of Toronto, is one of the researchers behind the first-ever study to track naloxone distribution in the province by geographic location.
The study estimates the availability of naloxone, dispensed primarily by pharmacies, has lowered the rate of opioid-related deaths by anywhere from a quarter to half ever since free kits were introduced by the Ontario government in June of 2016.
"In the Windsor area, what we found was that the number of kits that was being dispensed every month has dropped by about half since the COVID-19 pandemic," said Gomes.
About 350 naloxone kits were dispensed every month in Windsor before the pandemic, said Gomes. That number dropped to about 175 in the last few months.
Gomes said these numbers are alarming, since there appears to be an increase in opioid-related deaths in the region.
Forty-seven people died from drug overdoses in Windsor-Essex in 2019. Through the first four months of 2020, there are 19 confirmed deaths.
"We know that the advice during the pandemic is for people to stay home and not move about as much as they have in the past. So, it's likely people are not going to the pharmacy as often," said Gomes.
"One of the real concerns are people are more isolated, so they're using drugs more alone. So they might not even be in a circumstance where naloxone can be administered because you need somebody there to administer it."
Wale Aderinto, a pharmacist and owner of Erie Health and Wellness Pharmacy in Windsor, has seen a decrease in demand at his pharmacy.
He believes it could be a result of the societal shift in focus from the dangers of the opioid crisis to the dangers of COVID-19, which may have reduced the public's awareness of the kits.
"It's important not to lose sight of the dangers posed by overdose and the role that naloxone kits can play in saving lives," said Aderinto.
Aderinto said it's more important than ever to have a kit at your disposal since people are isolated and dealing with the pandemic, making them more vulnerable to overdosing.
Ontario's coroner has already reported a 25 per cent surge in the number of opioid-related deaths since the coronavirus pandemic began, thanks to a combination of increasingly toxic street drugs and pandemic restrictions placed upon outreach workers.
The study suggests only 56 per cent of pharmacies in Ontario carry the free kits and Gomes believes, given how common opioid-based painkillers are whether supplied by a doctor or on the street, more should be done to maximize the reach of the life-saving drug so that naloxone might one day be as common as a first aid kit.
Spike in opioid-related ED visits
The Windsor-Essex County Health Unit has warned of some of the dangers of self-isolating for those dealing with substance abuse.
There have been upticks in emergency department visits due to opioids, with most months of 2020

reporting greater numbers year-over-year. During one two-day span in July alone, there were nine overdose cases, all involving fentanyl.
Last month, the health unit, along with partners involved in the Windsor-Essex Community Opioid and Substance Strategy, began seeking expressions of interest from building owners and landlords to house a safe drug consumption site.
The Consumption and Treatment Services site would offer "wrap-around" services including counselling, primary care, opioid-dependency treatment and other health services as well as being a safe place for people to consume their substances.
https://www.cbc.ca/news/canada/windsor/naloxone-kits-drop-in-distribution-windsor-essex-1.5725857?cmp=rss

Canada
B.C. physicians, nurses can now prescribe safe drug alternatives to battle overdose crisis
Source: globalnews.ca
ID: 1007853249

B.C.'s top doctor has issued a public health order to give physicians and nurse practitioners the ability to prescribe safer pharmaceutical alternatives to help slow the province's overdose crisis.
Provincial health officer Dr. Bonnie Henry said in a release that increasing the number of health professionals authorized to help people at risk for overdose by prescribing alternatives to toxic street drugs will be critical to saving lives and linking more people to treatment and other health and social services.
The order, issued under the Health Professions Act, authorizes registered nurses and registered psychiatric nurses to prescribe pharmaceutical alternatives to street drugs to help separate more people from the poisoned street drug supply to save lives and provide opportunities for ongoing care, treatment and support.
This new standard will include training and education.
"Before the COVID-19 pandemic began, B.C. was making progress and overdose deaths were coming down for the first time since 2012," said Judy Darcy, Minister of Mental Health and Addictions, said in a release.
"Each life lost to overdose is a tragedy and we are taking every preventative measure possible to save more lives and connect more people to treatment and supportive services."
People in B.C. with substance-use disorder and addictions can currently access safer drug alternatives by talking to their doctor, nurse practitioner, community care team or by calling 811.
To date, more than 1,000 people in B.C. have died of an overdose in 2020.

https://globalnews.ca/news/7338724/bc-overdose-crisis-safe-drug-alternatives/

International Events of Interest

United States
Vibrio Vulnificus in Connecticut: Unusual number of infections prompt warning
Source: outbreaknewstoday.com
Unique ID: 1007845417

Connecticut state health officials have issued a warning for the public in shoreline areas about the potential dangers of exposure to salt or brackish water along Long Island Sound, due to an unusually high number of Vibrio vulnificus infections.

Since July, five cases of Vibrio vulnificus infections have been reported to the Department of Public

Health (one infection in July, four in August). The patients are from Fairfield (1), Middlesex (1), and New Haven (3) counties and are between 49 – 85 years of age (median 73); 4 are male, 1 female.

Two patients had septicemia (infection of the bloodstream) and three had serious wound infections. All five cases patients were hospitalized. No deaths have been reported.

All five cases reported exposure to salt or brackish water during activities such as swimming, crabbing, and boating. All five patients had pre-existing wounds or sustained new wounds during these activities which led to the Vibrio infections.

Vibrio vulnificus infection is an extremely rare illness. In the past 10 years, between 2010 – 2019, only seven cases were reported in Connecticut.

V. vulnificus can cause wound infections when open wounds are exposed to warm salt or brackish water (mix of salt and fresh water). The bacteria, once inside the body, can infect the bloodstream causing septicemia. People with a V. vulnificus infection can get seriously ill and need intensive care or limb amputation. About 1 in 5 people with this type of Vibrio infection die, sometimes within a day or two of becoming ill. People at greatest risk for illness from V. vulnificus are those with weakened immune systems and the elderly.

You can reduce your chance of getting a Vibrio wound infection by following these tips:

If you have a wound (including from a recent surgery, piercing, or tattoo), stay out of saltwater or brackish water, if possible. This includes wading at the beach.
Cover your wound with a waterproof bandage if it could come into contact with saltwater, brackish water, or raw or undercooked seafood and its juices. This contact can happen during everyday activities, such as swimming, fishing, or walking on the beach.
Wash wounds and cuts thoroughly with soap and water after they have contact with saltwater, brackish water, raw seafood, or its juices.
http://outbreaknewstoday.com/vibrio-vulnificus-in-connecticut-unusual-number-of-infections-prompt-warning-92837/

United States

Health officials suspect first case of dangerous EEE virus in Barry County resident
Unique ID: 1007845596

BARRY COUNTY, Mich. — Preliminary test results indicated Tuesday that a Barry County resident may have contracted the first case of Eastern Equine Encephalitis in the area.

Michigan Department of Health and Human Services officials said a second set of testing was expected to be completed by the end of the week to confirm the findings.

“This suspected EEE case in a Michigan resident shows this is an ongoing threat to the health and safety of Michiganders and calls for continued actions to prevent exposure, including aerial treatment,” Dr. Joneigh Khaldun, chief medical executive and chief deputy for health at MDHHS, said. “MDHHS continues to encourage local officials in the affected counties to consider postponing, rescheduling or cancelling outdoor activities occurring at or after dusk, particularly those involving children to reduce the potential for people to be bitten by mosquitoes.”

The human case was in addition to 22 confirmed cases in horses from 10 counties throughout the state.

MDHHS representatives said the virus was one of the most dangerous mosquito-borne diseases in the United States, with a 33% fatality rate in humans and a 90% fatality rate in horses, and encouraged Michiganders to protect themselves from mosquito bites by:

Postponing, rescheduling or cancelling outdoor activities occurring at or after dusk, particularly activities

involving children.
Avoiding being outdoors from dusk to dawn when mosquitoes carrying the EEE virus are most active.
Applying insect repellents containing the active ingredient DEET, or other U.S. Environmental Protection Agency-approved product to exposed skin or clothing, and always following the manufacturer's directions for use.
Wearing long-sleeved shirts and long pants when outdoors. Apply insect repellent to clothing to help prevent bites.
Maintaining window and door screening to help keep mosquitoes outside.
Emptying water from mosquito breeding sites around the home, such as buckets, unused kiddie pools, old tires or similar sites where mosquitoes may lay eggs.
Using nets and/or fans over outdoor eating areas.
On Monday, state health officials said an aerial spray would be administered in 10 counties to control the mosquito population, reducing the risk of viral infection.

Aerial treatment: State announces plans to combat EEE virus
Signs of infection include a sudden fever, chills, body and joint aches. While initial symptoms may look a lot like the flu or other illnesses, Khaldun said there are a few symptoms that might indicate you need to seek immediate medical attention.

"Encephalitis is when someone has a high fever, a headache that is not normal, they may actually have neck stillness, they may not be acting like themselves," Khaldun said. "Anyone who has symptoms like that, they definitely should be contacting their doctor and potentially going to an emergency department, especially if someone has a change in their mental status. That is an emergency."

If the infection progresses, it can cause headaches, disorientation, tremors, seizures and paralysis. In the worst cases, permanent brain damage, coma and death may occur. Health officials said people younger than 15 and older than 50 were at the greatest risk of complications from infection.
https://wwmt.com/news/local/health-officials-suspect-first-case-of-dangerous-eee-virus-in-barry-county-resident

Netherlands
West Nile Virus surfaces in the Netherlands for the first time ever
Source: NL Times
Unique ID: 1007849764

A bird found in the Utrecht region tested positive for the West Nile virus, the first time the virus has been found in the Netherlands. The virus is largely harmless to humans in 80 percent of cases, the RIVM said, while the rest are more likely to develop flu-like symptoms including a fever.
"In exceptional cases, an infection can lead to serious neurological complaints. An infection with the virus has already been found in people in the Netherlands, but all these infections had been contracted abroad," the RIVM said.
According to the Centers for Disease Control in the U.S., approximately out ot every 150 human infections develop more serious symptoms which sometimes prove fatal. It is spread by mosquitos who become infected by feeding on infected birds.
The warbler was caught towards the end of August as part of a program organized by the Erasmus Medical Center. The RIVM said that warblers arrive in April and leave for Africa towards the end of the summer. Because this particular bird was captured and tested at the end of the summer, researchers suspect it became infected in the Netherlands.
"The consortium is working on the development of an early warning system as part of a research project. The system must detect the introduction of a number of exotic viruses, including the West Nile virus, as early as possible," the RIVM said.
Over a thousand wild birds have been captured and tested since January. In previous years, birds with West Nile virus antibodies have been found, but never one with an active infection. "Because they were not migratory birds, these birds probably contracted the infection in or around the Netherlands."
West Nile virus has already been found in Germany, European nations in the central and southeastern

regions of the continent. Mosquitos pass the virus on to humans, and other mammals including horses. There is a vaccine against the virus which is used on horses.
https://nltimes.nl/2020/09/16/west-nile-virus-surfaces-netherlands-first-time-ever

DR Congo
Children among latest DRC Ebola cases as outbreak grows to 123 cases
Source: WHO

16 Sept.
Two more Ebola cases were reported in the Democratic Republic of Congo (DRC) Equateur province outbreak, along with two more deaths, the World Health Organization (WHO) African regional office said today on Twitter. The developments lift the overall totals to 123 cases and 50 deaths.

The United Nations Office for the Coordination of Humanitarian Affairs (UN OCHA) said today in an update, posted on ReliefWeb, that a recent case was reported in a newly affected Ngelo Monzoi health area in the Bikoro health zone, raising the number of affected health areas to 40. It also said two infections in children were confirmed on Sep 14, one age 2 months and the other a 5-year-old.

Nearly 30,000 people have been vaccinated since the outbreak, the DRC's 11th involving Ebola, was first detected in early June

https://twitter.com/WHOAFRO/status/1306153061568700422
https://reliefweb.int/report/democratic-republic-congo/rd-congo-note-d-information-humanitaire-epid-mie-de-la-maladie-76

China
Over 3,000 Infected in China's Latest Bacterial Disease Outbreak
Source: theepochtimes.com
ID: 1007853411

Updated: September 16, 2020

Nearly a year after an outbreak of brucellosis, a highly infectious bacterial disease, took hold in Lanzhou city, in China's northwest Gansu Province, the city's health commission said that 3,245 people have tested positive for the disease.

The city's announcement on Sept. 15 comes as an update after a review by the Gansu Provincial Center for Disease Control and Prevention.

According to the announcement, an investigation by provincial and local authorities found that the Lanzhou Biopharmaceutical Plant used expired sanitizers during its brucellosis vaccine production from Jul. 24 to Aug. 20, 2019, which led to inadequate exhaust discharge and sterilization.

The exhaust carried fermented broth which later turned into aerosol. Carried by the wind, the bacteria-bearing air spread to where the Lanzhou Veterinary Research Institute was located. Staff developed antibodies from breathing in waste air in July and August last year.

Brucellosis is a zoonotic disease that mainly affects animals, including livestock and dogs that can transmit the bacteria to humans through direct contact. Symptoms include profuse sweating, and joint and muscular pain. The disease can last a few weeks, or months or even years.

Chinese outlet Caixin reported that ten neighboring residential communities were affected within a radius

of 1 km.

Gao Hong (alias), a local resident of Yanchangpu, told Caixin that she and her family—her husband and their 10-year-old son—were affected. She was misdiagnosed as having a cold, spondyloarthritis, rheumatoid arthritis, and damp fever last September until final results six months ago settled at brucellosis.

She was advised that she had missed the optimum time to treat the disease, and said she was extremely concerned about her young son.

Stress levels among patients have increased amid the CCP (Chinese Communist Party) virus outbreak, with a number having struggled to tackle the two illnesses at the same time. Some parents have been unwilling to tell the truth to their children.

The local authorities said it would penalize all organizations involved, by revoking vaccine production permits, among other actions.

No officials have been legally held responsible for the mass event.

Local authorities have used vague wording to describe the situation. As such, it is unknown what portion of patients continue to suffer from the illness since the onset of the outbreak last year.

https://www.theepochtimes.com/lanzhou-brucellosis-outbreak-update-more-than-3000-cases-confirmed_3501530.html

Researches, Policies and Guidelines

United States

Vaccine candidate fails to reduce *C difficile* infection in phase 3 trial
ID: 1007853109
Source: CIDRAP/Lancet

A phase 3 trial for a bivalent *Clostridioides difficile* toxoid vaccine was terminated because of futility, an international team of investigators led by scientists from Sanofi Pasteur reported yesterday in *The Lancet Infectious Diseases*.

In the observer-blind, randomized controlled trial, which was conducted in 326 hospitals in the United States, Canada, Latin America, Europe, and the Asia-Pacific region, adults 50 years or older with increased risk of *C difficile* infection were randomized 2:1 to receive one dose of Sanofi Pasteur's *C difficile* vaccine candidate (containing toxoids A and B) or one dose of placebo. The primary outcome was the efficacy of the vaccine in preventing symptomatic *C difficile* infection.

From Jul 30, 2013, through Nov 17, 2017, 9,302 participants were enrolled, with 6,201 in the *C difficile* vaccine group and 3,101 in the placebo group. The first planned interim analysis reported 34 *C difficile* infections over 11,697.2 person-years at risk (0.29 infections per 100 person years) in the vaccine group compared with 16 *C difficile* infections over 5,789.4 person-years at risk (0.28 infections per 100 person-years) in the placebo group, indicating a vaccine effectiveness of –5.2% (95% confidence interval [CI], –104.1% to 43.5%). Because of those results, futility was concluded and the trial was terminated

The safety analysis found that 2,847 of 6,113 participants (46.6%) in the vaccine group reported an adverse event within 30 days of injection, compared with 1,282 of 3,057 (41.9%) in the placebo group.

The proportion of participants who had an adverse event leading to study discontinuation was 4.8% in both groups.

The investigators suggest several factors may have played a role in the vaccine not being effective, despite showing good immunogenicity. Among the explanations are that vaccination did not generate appropriate antibody function to effectively neutralize toxin in the intestinal environment. An aging or frail immune system and previous exposure to *C difficile* could also be factors, they said.

"In conclusion, although the candidate vaccine was immunogenic, it failed to reduce the incidence of symptomatic *C difficile* infection in participants at risk," they wrote. "The findings from this trial highlight the important challenges associated with the development of vaccines against bacterial nosocomial infections, and they will inform future vaccine development."

The trial was funded and designed by Sanofi Pasteur.
https://www.cidrap.umn.edu/news-perspective/2020/09/stewardship-resistance-scan-sep-16-2020

https://www.thelancet.com/journals/laninf/article/PIIS1473-3099(20)30331-5/fulltext#%20

United States

New guidelines issued for S aureus prevention, control in NICUs
Source: CIDRAP
Unique ID: 1007845639

The Centers for Disease Control and Prevention (CDC) has issued new recommendations for the prevention and control of Staphylococcus aureus in neonatal intensive care unit (NICU) patients.

The guidelines are based on current understanding of the transmission dynamics of S aureus in the NICU and were developed through a systematic review of the best available literature available through August 2019. The review was guided by questions about the most effective strategies for preventing S aureus transmission from colonized or infected NICU patients, which sampling sites and laboratory assays most effectively identify colonization in NICU patients, and what risk factors exist for S aureus infection in NICU patients.

The guidelines recommend performing active surveillance testing at regular intervals for S aureus colonization in NICU patients when there is increased evidence of infection or in an outbreak setting, and for methicillin-resistant S aureus colonization when there is evidence of ongoing healthcare-associated transmission. Active surveillance can be conducted using either culture-based or polymerase chain reaction detection methods, and samples should be collected from the nostrils. The authors conditionally recommend testing of infants from other newborn care units, and targeted decolonization for colonized NICU patients.

S aureus is the most common healthcare-associated pathogen in US NICUs, with an estimated incidence of up to 45 infections per 100,000 hospitalized infants, and rates of invasive S aureus infection are especially high in preterm and low birthweight infants. While infants may acquire the bacteria as part of their normal developing microbiota, those who are colonized with S aureus are at increased risk of infection.

A companion document from the Society for Healthcare Epidemiology of America (SHEA), published yesterday in Infection Control and Hospital Epidemiology, answers some of the questions that clinicians may have about S aureus detection and prevention in the NICU.

https://www.cambridge.org/core/services/aop-cambridge-core/content/view/B54E657100142EEE0FD4AEE4CC5D824E/S0899823X20000513a.pdf/shea_neonatal_intensive_care_unit_nicu_white_paper_series_practical_approaches_to_staphylococcus_aureus_diseas

e_prevention.pdf
https://www.cdc.gov/infectioncontrol/pdf/guidelines/NICU-saureus-h.pdf

https://www.cidrap.umn.edu/news-perspective/2020/09/news-scan-sep-15-2020

UN

UN report highlights links between 'unprecedented biodiversity loss' and spread of disease

Source: news.un.org
Unique ID: 1007844295

The continued degradation of the environment is increasing the likelihood of diseases spreading from animals to humans, warns a UN report on biodiversity, released on Tuesday.

The fifth edition of the UN's Global Biodiversity Outlook report, published by the Convention of Biological Diversity (CBD), provides an authoritative overview of the state of nature worldwide.

The report notes the importance of biodiversity in addressing climate change, and long-term food security, and concludes that action to protect biodiversity is essential to prevent future pandemics.

Wake-up call

The study acts as a wake-up call, and an encouragement to consider the dangers involved in mankind's current relationship with nature: continued biodiversity loss, and the ongoing degradation of ecosystems, are having profound consequences of human wellbeing and survival.

"As nature degrades," said Maruma Mrema, Executive Director of the Convention on Biological Diversity, "new opportunities emerge for the spread to humans and animals of devastating diseases like this year's coronavirus . The window of time available is short, but the pandemic has also demonstrated that transformative changes are possible when they must be made."

the Tikki Hywood Foundation

Coral Reefs restoration at the coast of Banaire in the Caribbean.

Transitions to a healthier planet

Contained within the report are several recommendations, or "transitions", which map out a scenario for a world in which "business as usual" is halted, and environmental devastation is reversed.

Under the proposals, ecosystems would be restored and conserved; food systems would be redesigned to enhance productivity, whilst minimizing their negative effects; and the oceans would be managed sustainably.

The design of cities also comes under the spotlight, with calls for a reduced environmental footprint in urban areas, and "green infrastructure", making space for nature within built landscapes.

The report amplifies the UN's support for nature-based solutions , hailed as one of the most effective ways of combatting climate change. Alongside a rapid phase-out of fossil fuel use, they can provide positive benefits for biodiversity and other sustainability goals.

And, in relation to health concerns, and the spread of diseases from animals to humans, the report calls for a "One Health" transition, in which agriculture, the urban environment and wildlife are managed in a way that promotes healthy ecosystems and healthy people.

Reacting to the report, UN chief António Guterres said that the transitions represent an unprecedented opportunity to "build back better", as the world emerges from the immediate impacts of the COVID-19 pandemic:

"Part of this new agenda must be to tackle the twin global challenges of climate change and biodiversity loss in a more coordinated manner, understanding both that climate change threatens to undermine all other efforts to conserve biodiversity; and that nature itself offers some of the most effective solutions to avoid the worst impacts of a warming planet."

Biodiversity at UNGA 75

The findings of the Global Biodiversity Outlook will be taken up by Heads of State at the UN Summit on Biodiversity , to be held on 30 September, under the auspices of the General Assembly.

The Summit will highlight the crisis facing humanity from the degradation of biodiversity, and the urgent need to accelerate action on biodiversity for sustainable development. Due to measures designed to restrict the further spread of COVID-19 , the meeting will be held virtually.

A new set of targets, for the period between 2021 and 2030, is currently under negotiation, and is set to be considered at the 15th Conference of Parties of the Convention of Biological Diversity, which is scheduled to be held in Kunming, China, in May 2021.

https://news.un.org/en/story/2020/09/1072292