GPHIN Daily Report for 2020-10-02

Special section on Coronavirus

Canada

Areas in Canada with cases of COVID-19 as of 01 October 2020 at 19:00 pm EDT
Source: Government of Canada

Province, territory or other	Number of confirmed cases	Number of active cases	Number of deaths
Canada	160,535	14,866	9,319
Newfoundland and Labrador	275	3	3
Prince Edward Island	59	2	0
Nova Scotia	1,088	2	65
New Brunswick	200	6	2
Quebec	75,221	6,227	5,850
Ontario	52,248	4,975	2,851
Manitoba	2,029	621	20
Saskatchewan	1,927	144	24
Alberta	18,235	1,596	269
British Columbia	9,220	1,290	235
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

Statement from the Chief Public Health Officer of Canada on October 1, 2020
From: Public Health Agency of Canada
ID: 1007953760

[APG]

Statement

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 158,758 cases of COVID-19 in Canada, including 9,297 deaths. Over the past week, labs across the country tested an average of over 71,000 people daily with 1.8% testing positive. Daily case counts continue to rise with an average of 1,572 new cases being reported daily across Canada during the most recent 7 days. The majority (around 80%) of these cases have been reported by Quebec and Ontario. Both of these provinces have also observed a rise in the number of cases hospitalized over the past few weeks. Nationally, there have been on average 480 individuals with COVID-19 in Canadian hospitals each day and 8 deaths reported daily over the past week.

Today is National Seniors Day (as well as International Day of Older Persons), an occasion for all of us to celebrate older adults across our country. COVID-19 has been especially devastating to older persons and their loved ones. During the initial wave, over 1000 separate outbreaks occurred in long-term care and assisted living homes, accounting for about 20% of confirmed cases and tragically over 80% of all deaths.

Although we are not currently seeing the same levels of transmission among older adults, this population remains at high risk for severe outcomes from COVID-19. Each of us can do our part to lower the risk of transmission to others, including older adults, by consistently following the public health measures we know to be effective. Practise physical distancing, wash your hands frequently, and wear a non-medical mask or face covering in closed spaces, crowded places and close-contact situations where distancing is difficult. Most importantly, stay home and isolate yourself from others if you have symptoms, even mild ones.

The pandemic may also be having a greater impact on the mental health of older populations, causing heightened feelings of loneliness, sadness, distress or hopelessness. Physical distancing has made visits with family and friends very challenging for many. I urge everyone to check in regularly with older family members, friends and the elderly in our communities virtually, by phone, or even by mail or care package. This can go a long way to support a loved one, as well as add to your self-care during this particularly challenging time. It is also important for seniors to stay as physically active as possible, whether at home or by getting outdoors for a walk.

And if you are someone who needs help, know that you are not alone and do not wait to seek out a range of supports. Visit Wellness Together Canada for mental health resources, including access to professional counselling services.

Canadians of all ages, let's work together so that we can all be safe.

For further information on resources for seniors, please visit: https://www.canada.ca/en/public-health/services/diseases/coronavirus-disease-covid-19/resources-older-adults-caregivers.html

Read through my COVID-19 information and resources backgrounder to understand the risks and know the precautions you can take to keep your, your family and others safer."

Contacts

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Search for related information by keyword: HE Health and Safety | Public Health Agency of Canada | Canada | Coronavirus (COVID-19) | media | statements

https://www.canada.ca/en/public-health/news/2020/10/statement-from-the-chief-public-health-officer-of-canada-on-october-1-2020.html

Canada

Cases of COVID-19 confirmed in 81 Ottawa schools

ID: 1007951513

Source: Ottawa Matters

The four school boards in Ottawa are reporting 81 schools with at least one case of COVID-19. The Ottawa-Carleton District School Board is reporting 16 schools with a case of the virus. In total, 14 students and two staff members are affected. See the full list here.

There are 22 schools in the Ottawa Catholic School Board reporting cases. In total, 38 students and six staff members are affected. See the full list here.
Conseil des écoles publiques de l'Est de l'Ontario is reporting 15 schools with cases of COVID-19, affecting 15 students and six staff members. See the full list here.
And Conseil des écoles catholiques du Centre-Est is reporting 28 schools with at least one case of the virus, affecting 43 people.
Meantime, there are currently nine schools in Ottawa reporting outbreaks of COVID-19.
Outbreak status is declared when a school has two or more cases of the virus and a confirmed transmission.
Assumption School: Two student cases
École élémentaire catholique Montfort: One student case and one staff case
École élémentaire publique Séraphin-Marion: Two student cases
École secondaire publique Louis-Riel: Two student cases
Collège catholique Franco-Ouest: Two student cases
Gabrielle Roy Public School: Two student cases
Lester B. Pearson High School: One student case and one staff case
Lycée Claudel Private School: Two student cases
Monsignor Paul Baxter School: Two student cases and two staff cases
https://www.ottawamatters.com/local-news/cases-of-covid-19-confirmed-in-81-ottawa-schools-2757259

Canada

Canada's COVID-19 exposure notification app now available in Manitoba
ID: 1007951636
Source: PM.gc.ca

Ottawa, Ontario
Over the past months, Canadians have been following public health advice and doing their part to help prevent the spread of COVID-19. As we continue to deal with the health and economic impacts of the pandemic, we need to work together to keep people safe and healthy and contain the virus, so we can build a more resilient Canada.
The Prime Minister, Justin Trudeau, and the Premier of Manitoba, Brian Pallister, today announced that people in Manitoba can now receive one-time keys from their health authorities to use with COVID Alert, Canada's COVID-19 exposure notification app. The app helps notify users if they may have been exposed to someone who has tested positive for COVID-19.
The COVID Alert app is free and voluntary, and is another tool to help limit the spread of COVID-19. Users who test positive for COVID-19 will receive a one-time key from their health authority that they can enter into the app. When the key is entered, COVID Alert will notify other users who may have come in close contact with that person for at least 15 minutes, and direct them on next steps based on their provincial public health advice.
To safeguard the confidentiality and privacy of all Canadians, the app uses strong measures to protect any data it collects, and does not track a user's location or collect personally identifiable information. The Privacy Commissioner of Canada was consulted on the development of COVID Alert, and supports its use by Canadians.
COVID Alert is available for download to all Canadians, and one-time keys provided by health authorities are now available to the people of Manitoba, Saskatchewan, New Brunswick, Ontario, and Newfoundland and Labrador. The Government of Canada continues to work with the other provinces and territories to bring their health authorities on board in the coming weeks and months.
Quotes
"The COVID Alert app is a tool that Manitobans can use to help protect themselves, their loved ones, and their communities from COVID-19. As more people use it, we can slow the spread of the virus and help prevent future waves. We will continue to work with other provinces and territories to bring their health authorities on board so as many Canadians as possible can benefit from the app."
"Our government's number one priority is to keep Manitobans safe. The COVID Alert app is an additional measure to help inform Manitobans and Canadians, and limit the spread of COVID-19 in our

communities. I applaud the federal government for their leadership in advancing this important public health tool for the benefit of all Canadians."
The Hon. Brian Pallister, Premier of Manitoba
"Already downloaded by more than 3 million Canadians, this app is an additional tool we can use to protect ourselves and our loved ones. I encourage you to download it and input the one-time key to notify others should you get COVID-19."
“I encourage all Manitobans to download the COVID Alert app. It will assist the amazing work our public health officials and contact tracers have been doing throughout the pandemic.”
The Hon. Cameron Friesen, Manitoba’s Minister of Health, Seniors and Active Living
“Congratulations to the people of Manitoba who now have access to the full functionality of COVID Alert. This secure digital tool is an important part of our public health efforts to limit the spread of COVID-19, and I encourage all Canadians to download it today.”
“People in Manitoba expect us to work together and do everything we can to continue keeping them healthy and safe. This is exactly what we’ve done and it’s why we are making the COVID-19 Alert app available in Manitoba. This app will help keep each other safe and I encourage everyone to download it today.”
The Hon. Dominic LeBlanc, President of the Queen’s Privy Council and Minister of Intergovernmental Affairs
Quick Facts
Since launching, there have been more than 3 million downloads of the app.
COVID Alert is available for Canadians as a free download from the App Store or the Google Play Store.
When a user downloads the app, their phone sends out randomly generated codes via Bluetooth to other smartphone users who have the app and are within approximately two metres. If they test positive for the virus, users can choose to upload their random codes to a central server located in Canada. Once uploaded, the random codes are stored on the server for 15 days, after which they are automatically deleted.
Since the app first launched, more than 504 people have voluntarily input their one-time key to notify others around them after testing positive for COVID-19.
Canadians who want to know more about COVID Alert can call 1-833-784-4397.
The Government of Canada established the COVID-19 Exposure Notification App Advisory Council to ensure the app meets the highest standards in public health outcomes, privacy, and technology. The members of the Council reflect Canada’s regional and cultural diversity, and cover a wide range of expertise, including health, privacy, data governance, science, and innovation. Their advice informs the implementation and rollout of the app.
BlackBerry and the Canadian Centre for Cyber Security completed a security assessment of the app before it was launched. All data provided to the app is securely stored and protected.
The COVID Alert app is continually re-assessed and updated as it rolls out across the country based on provincial needs, user research, and testing. Users who already have the app downloaded should keep both the app and their device’s operating system up-to-date.
COVID Alert is a collaboration between Health Canada, Innovation, Science and Economic Development Canada, the Canadian Digital Service, and the Ontario Digital Service. It builds upon an exposure notification solution developed by Shopify volunteers in coordination with the non-profit Linux Foundation Public Health. It is also the work of a team of developers from across the country.
As part of our commitment to open and transparent government, the Canadian Digital Service is making its work on the app’s development and testing available on Github.
The Canada COVID App is another digital tool that supports Canadians. It allows users to track their symptoms while receiving the latest updates and accessing trusted resources.
Associated Links
https://pm.gc.ca/en/news/news-releases/2020/10/01/canadas-covid-19-exposure-notification-app-now-available-manitoba

Canada

YVR, WestJet, UBC partner on COVID-19 rapid testing pilot - NEWS 1130

Source: citynews1130.com
ID: 1007953667

RICHMOND (NEWS 1130) — The Vancouver International Airport and WestJet will co-pilot a new COVID-19 rapid testing study with UBC.

As part of the pilot project, departing WestJet passengers will be asked whether they would be willing or interested in taking a COVID-19 rapid test before boarding a plane.

The pilot project was announced Thursday, but when it will take flight hasn't been determined.

The goal of the project is to gather data and develop a study regarding health safety at airports. Methodology and testing technologies will be outlined in the coming weeks.

"We hope that working with leading experts like those at UBC will help us to collect, test, and act to prevent the spread of COVID-19 in conjunction with our myriad of other layered safety measures," says Billy Nolen, WestJet vice-president of safety and security.

"We are very pleased to have selected a world-leading research institute, located in our own backyard, to partner with us on this critically important work," adds Tamara Vrooman, president and CEO of Vancouver Airport Authority.

"Working together with UBC and WestJet, we aim to make this pilot project the best of both worlds, bringing together industry experts and world-leading researchers — all in an effort to support aviation safety and provide benefits to our region."

On Thursday, Transport Canada updated requirements for face coverings in airports. Acceptable masks must cover the nose and mouth (fitted disposable or cloth masks). Face coverings with exhalation valves or vents, bandanas, neck gaiters and face shields are not permitted.
https://www.citynews1130.com/2020/10/01/yvr-westjet-ubc-covid-19-rapid-testing/

Canada
Mask requirements at YVR Airport bans valves, vents, bandanas
Source: vancouversun.com

No more valves, vents, neck gaiters, bandanas or plastic face shields will be accepted as face masks in airports beginning Oct. 1.
Transport Canada has updated its standards for personal protective equipment required for anyone moving through an airport.
Acceptable masks must cover the nose and mouth and be fitted, with ear loops around the hears or the back of the head. These can be disposable or cloth.
Face masks with exhalation valves or vents, open-neck triangle bandanas, neck gaiters and plastic face shields are no longer permitted. Travellers wearing these types of masks will not be permitted into airports or on their flight.
Article content continued
NEW TODAY: @Transport_gc has updated their requirements for face coverings in airports. ✅Acceptable masks must cover the nose and mouth (fitted disposable or cloth masks).
❌Face coverings with exhalation valves/vents, bandanas, neck gaiters & face shields are not permitted. pic.twitter.com/lsVa2PfEK0
— Vancouver International Airport (YVR) (@yvrairport) October 1, 2020
Earlier this month, Transport Canada announced it had levied its first fines to passengers refusing to wear a mask on board a flight, which is required by law at this time.

One passenger travelling from Calgary to Waterloo, Ont. was fined $1,000 in June and the second passenger was fined the same amount for refusing a mask on a WestJet flight from Vancouver to Calgary in July.
Wearing a mask in airports and on board flights has been a federal requirement since April 20.
https://vancouversun.com/news/local-news/covid-19-no-more-valves-vents-gaiters-accepted-as-masks-in-airports

Canada
Coronavirus: Ontario government revises school, child care centre screening guidelines
Source: Global News
ID: 1007953648

TORONTO — Ontario is changing its COVID-19 symptom screening guidance for the province's schools and child care centres.
The province is now asking parents to keep their children home from school for 24 hours if they have either a runny nose or headache.
If a child has both of those symptoms they are asked to consult a health-care provider or have a COVID-19 test before returning to school or child care.
Previously, the government had asked that children with either single symptom stay home until they received a negative COVID-19 test or other medical diagnosis.
[Sign up for our Health IQ newsletter for the latest coronavirus updates]
Ontario is also removing abdominal pain or conjunctivitis from its screening list.
Earlier this month, British Columbia removed 10 symptoms from their school screening sheet including runny nose.
https://globalnews.ca/news/7372145/coronavirus-ontario-school-child-care-centre-screening-guidelines/

Canada
5 new cases of COVID-19 a 'wake-up call' for community, say Six Nations health officials
ID: 1007951093
Source: CBC

Public health officials are calling an overnight spike of five new COVID-19 cases on Six Nations Territory a wake-up call for community members.
Ohsweken Public Health has reported three confirmed cases and two probable cases of the virus within 24 hours, according to a media release shared Wednesday evening.
They're the first new cases on the territory since Aug. 10 and bring the total number of cases since the beginning of the pandemic to 21.
"Since moving to stage 2.5 the community are becoming slack with the core health principles," stated Lori Davis Hill, director of Six Nations Health Service.
"Please let these 5 new cases be a stark reminder that the virus is still in and around Six Nations Territory."
Davis Hill urged community members to follow health guidelines in order to keep cases to a minimum.
"My advice would be to conduct yourself as though you have the virus and don't want to spread it, and as if everyone else has the virus and you don't want to get it," she explained.
Health officials are carrying out contact tracing, but say the sudden jump in cases means Six Nations is at the point where cases can be community acquired — meaning the source of the virus can't easily be tracked.
The media release reminds residents that as a large First Nations community it's "automatically at a heightened risk of contracting, spreading and fighting the virus for various reason such as lack of access to clean water, over crowded housing and underlying health conditions."
Community asked to rethink Thanksgiving plans
Before Wednesday's announcement of the new cases, the most recent COVID-19 update shared by Six

Nations was posted on Sept. 25. It showed 16 people had tested positive for the virus since the beginning of the pandemic.
Fifteen of those cases had recovered, while one person had died.
Seventy people were listed as being in self isolation.
Elected chief Mark Hill called for anyone with people more susceptible to the virus living in their household to continually weigh the risks when considering leaving their home or the community.
Six Nations also asked members to tighten their social circles, stay home if sick, wear masks and maintain at least two metres of distance from people who aren't part of their household.
"Please reconsider any Thanksgiving or other plans for gathering with friends and family in the near future," the media release adds.
"We know that everyone wants life to get back to normal, but we need to be extra cautious at this time, especially if you or anyone in your household is vulnerable due to being elderly or have underlying health conditions."
https://www.cbc.ca/news/canada/hamilton/six-nations-covid-new-cases-overnight-1.5745702

Canada
New Rapid Testing For COVID-19 Approved By Health Canada |
Source: Country 94
Published: 2020-10-02 11:21 UTC
Received: 2020-10-02 11:21 UTC (0 minutes)
Unique ID: 1007958074

Health Canada has quickly approved the use of Abbott Rapid Diagnostics COVID-19 tests in Canada. This comes just 24 hours after the federal government signed an agreement for up to 7.9 million of the tests.
Health Minister Patty Hajdu says this testing will be used in very specific settings, “They may be useful for example in long term care settings where there needs to be deeper screening. They may be used in rural and remote communities. That will really be at the determination of the provinces who have access to the technology.”
Hajdu says the government will soon issue a new testing and strategy, “We’ll have very shortly a new national testing and screening strategy with updated information and guidance for all of the provinces and territories. Then the provinces and territories can use that to develop a strategy that works best for them in their jurisdiction.”
Hajdu says Canadians can anticipate even more testing approvals as the regulators get the information they need from the manufacturers.
“As provinces evolve their testing strategies to be in line with provincial testing guidance, that has been agreed upon by all Chief medical Offices of Health, we’re going to start seeing a more efficient used of testing for the right purposes,” Hajdu says.
The new Abbott Rapid Diagnostics COVID-19 tests are a nasal swab-based test will provide results in about 15 minutes.
https://www.country94.ca/2020/10/01/179293/

Canada
Millions of coronavirus rapid tests won’t arrive for months: Health Canada
Source: Global News: Health

Canadians will have to wait until 2021 before millions of the Abbott rapid COVID-19 test are available for use, says Health Canada’s chief medical adviser.
In an interview with Global News Thursday, Dr. Supriya Sharma said while details are still being confirmed, the first Abbott ID NOW tests should arrive in Canada in the next “two to three weeks.”
But they will only number in the hundreds of thousands, with up to 2.5 million arriving “into the early part of 2021,” said Sharma. “It usually happens in waves,” she said, cautioning that much hinges on the company’s ability to manufacture the device and its testing supplies.
On Tuesday, the government announced it had purchased up to 7.9 million of the rapid polymerase chain reaction (PCR) tests, and the next day Health Canada announced its approval.

Read more: Canada has approved another rapid coronavirus test. Here's how it could help
Story continues below advertisement
The test works by detecting the novel coronavirus's DNA and promises to return results in 13 minutes or less.
In terms of who will get those tests when they arrive, Sharma said Health Canada is still in discussions with the provinces and territories and hasn't yet received their specific requests. The allocation decisions are based on a number of factors.
"We work with them and we look at their per capita numbers. We look at the epidemiology of the outbreak in each of the provinces and territories [and] we look at the urban and rural sort of split."
University of Manitoba virologist Jason Kindrachuk is not surprised by that rollout plan, saying something is better than nothing in dealing with the country's backlog of cases.
"You have to, first of all, manufacture all of these, and work on the availability of the companies. You can't force that if it's not there," he said.
"So getting those implemented and then knowing that as we move through the fall that we will have additional supplies coming in, I think is very important for us since we don't really know what we're going to face yet … on into 2021."
But as Canadians wait for the Abbott test, there are questions about whether it's the right test to purchase.
In May of this year, the U.S. Food and Drug Administration flagged concerns about the accuracy of the Abbott ID NOW test, suggesting that it returned an unacceptably high number of false-negative results.
That warning came just days after a study critical of the Abbott ID NOW test was published in the Journal of Clinical Microbiology.
The Trump administration purchased and this week announced it's ready to deploy a different test manufactured by Abbott: the BinaxNOW. It's also a rapid test, but it's an antigen test, which detects the virus's surface protein rather than its DNA.
Thursday, Ontario Premier Doug Ford told reporters the antigen test is the one he wants to see Ottawa approve.
"I really do have confidence that they're going to get this out. And I really look forward to it because it's a game-changer," Ford said.
Brookings Institution Fellow Dr. Kavita Patel says south of the border, everyone is talking about the antigen tests rather than the PCR.
While she stresses PCR tests are considered the gold standard, some of the high false-negative rates have proved to be "not acceptable."
"So as a result, United States policy has shifted towards having wide-scale, low-cost rapid antigen testing," Patel told Global News from Washington, D.C.
Dr. Sharma said she's aware of issues with "previous versions" of the Abbott PCR test, but she cannot speak to the American data. She's confident in Health Canada's approval based on the device and evidence Health Canada received.
Sharma said the data showed the test's sensitivity, or ability to detect COVID-19, with a regular nasal swab was 93 per cent, and even higher using the deeper nasal pharyngeal swab.
"The data that we've seen really supports that level of sensitivity and specificity with the devices and that's why they were authorized."
That American study released back in May found the Abbott test showed "low sensitivity with high false-negative results" when compared to another rapid test, the Cepheid GeneXpert Xpress SARS-CoV-2.
Health Canada has also approved the Cepheid test, but only purchased about one million tests. Some are already in use, including in northern Manitoba.
Global News asked both Health Canada and Public Services and Procurement Canada why they purchased so many fewer tests compared to the Abbott.
"As with virtually all contracts for PPE and other medical supplies, including test kits, the quantities negotiated are based on Canada's needs as well as what the supplier is able to guarantee delivery of. Given the high demand for tests globally, that's precisely why we've pursued multiple agreements with different suppliers for tests," said a spokesperson for Procurement Minister Anita Anand.
Dr. Sharma also pointed to manufacturing capacity as an issue.
"The landscape around these medical devices and these tests are very complicated. It's very complex," said Sharma, stressing Canadians can have confidence in Health Canada's approvals process.
–With files from Marc-André Cossette, Global News

https://globalnews.ca/news/7373108/coronavirus-rapid-tests-health-canada/

Canada
COVID-19 vaccine for general public unlikely before fall 2021: experts - CTV Montreal
Source: CTV Montreal
ID: 1007955026

MONTREAL -- Experts in vaccine development think it's unlikely a vaccine for COVID-19 will become available to the general public before fall 2021, a new survey shows .
Twenty-eight academics working in vaccinology were asked by a team from McGill University to make forecasts about three milestones in the development of a vaccine for the disease.
They say the best-case scenario is June 2021 and worst, July 2022 – but their best guess is September or October 2021.
The experts' opinions contrast statements made by U.S. President Donald Trump during Tuesday night's presidential debate, when he said he disagrees with medical advisors who don't expect a vaccine to become available before 2021.
Trump claimed the issue has become "political" and that the U.S. could have a vaccine before election day on Nov. 3.
"Experts in our survey offered forecasts on vaccine development that were generally less optimistic than the timeline of early 2021 offered by U.S. public officials," said Jonathan Kimmelman, a McGill professor and director of the Biomedical Ethics Unit at the school and the senior author of the paper. "In general they seem to believe that a publicly available vaccine next summer is the best-case scenario with the possibility that it may take until 2022."
https://montreal.ctvnews.ca/covid-19-vaccine-for-general-public-unlikely-before-fall-2021-mcgill-survey-1.5128820

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

United States
Coronavirus (COVID-19) Update: Daily Roundup October 1, 2020 | FDA
Source: www.fda.gov
ID: 1007955331

The U.S. Food and Drug Administration today announced the following actions taken in its ongoing response effort to the COVID-19 pandemic:

- Today, the FDA revised its Emergency Use Authorization (EUA) to reflect changes in the distribution and allocation of the antiviral drug Veklury (remdesivir). More information about the revised EUA can be found here.
- The FDA has issued a warning letter to Kerri Rivera and her company KetoKerri, LLC, for the sale of unapproved and misbranded drugs related to the Coronavirus. Products "KK Black Seed Oil," "KK Breakthrough Vitamin D with Chondroitin & Oleic", "Stonebreaker," "KK EDTA with Selenium and Minerals," "Zeolite," "Ultra Liquid Zeolite," and "DR. FITT FIRE FIGHTERS" make fraudulent claims to mitigate, prevent, treat, or cure COVID-19 in people. The products are unapproved new drugs sold in violation of section 505(a) of the Federal Food, Drug, and Cosmetic Act (FD&C Act), 21 U.S.C. § 355(a), and are also misbranded under section 502 of the FD&C Act, 21 U.S.C. § 352.
- Testing updates:
    - As of today, 265 tests are authorized by FDA under EUAs; these include 210 molecular tests, 51 antibody tests, and 4 antigen tests.

https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-update-daily-roundup-october-1-2020

United States
Trump Administration Announces $20 Billion in New Phase 3 Provider Relief Funding | HHS.gov
Source: www.hhs.gov

ID: 1007955320

Today, under the leadership of President Trump, the U.S. Department of Health and Human Services (HHS), through the Health Resources and Services Administration (HRSA), is announcing $20 billion in new funding for providers on the frontlines of the coronavirus pandemic. Under this Phase 3 General Distribution allocation, providers that have already received Provider Relief Fund payments will be invited to apply for additional funding that considers financial losses and changes in operating expenses caused by the coronavirus. Previously ineligible providers, such as those who began practicing in 2020 will also be invited to apply, and an expanded group of behavioral health providers confronting the emergence of increased mental health and substance use issues exacerbated by the pandemic will also be eligible for relief payments.

Providers can begin applying for funds on Monday, October 5, 2020.

“HHS has worked to ensure that all American healthcare providers receive support from the Provider Relief Fund in a fast and fair way, and this new round helps ensure that we are reaching America’s essential behavioral health providers and takes into account losses and expenses relating to coronavirus,” said HHS Secretary Alex Azar. “We’ve worked with all of the resources we have across HHS to ensure that America’s heroic healthcare providers know they can apply for support.”

HHS has already issued over $100 billion in relief funding to providers through prior distributions. Still, HHS recognizes that many providers continue to struggle financially from COVID-19’s impact. For eligible providers, the new Phase 3 General Distribution is designed to balance an equitable payment of 2 percent of annual revenue from patient care for all applicants plus an add-on payment to account for revenue losses and expenses attributable to COVID-19.

Further, HHS recognizes constraints such as the stay-at-home orders and social isolation have been particularly difficult for many Americans. A recent Centers for Disease Control and Prevention (CDC) report found the prevalence of symptoms of anxiety disorder in the second quarter of 2020 was approximately three times those that reported in the second quarter of 2019 (25.5% versus 8.1%); and the prevalence of depressive disorder was approximately four times that reported in the second quarter of 2019 (24.3% versus 6.5%). Our behavioral health providers have shouldered the burden of responding and confronting this expanded challenge triggered by the pandemic. When traditional face-to-face counseling was restricted and new telehealth flexibilities were put in place in response to the pandemic, many behavioral health providers invested in and adopted - PDF telehealth technologies to continue providing patient care. While some Medicare or Medicaid behavioral health providers have already received prior General Distribution payments, others have not. Working with the Substance Abuse and Mental Health Services Administration (SAMHSA), HRSA developed a list of the nation’s behavioral health providers now eligible for funding, which includes, for example, addiction counseling centers, mental health counselors, and psychiatrists.

Eligibility

HHS is making a large number of providers eligible for Phase 3 General Distribution funding, including:

Providers who previously received, rejected or accepted a General Distribution Provider Relief Fund payment. Providers that have already received payments of approximately 2% of annual revenue from patient care may submit more information to become eligible for an additional payment.

Behavioral Health providers, including those that previously received funding and new providers.

Healthcare providers that began practicing January 1, 2020 through March 31, 2020. This includes Medicare, Medicaid, CHIP, dentists, assisted living facilities and behavioral health providers.

Payment Methodology – Apply Early

All eligible providers will be considered for payment against the below criteria.

All provider submissions will be reviewed to confirm they have received a Provider Relief Fund payment equal to approximately 2 percent of patient care revenue from prior general distributions. Applicants that have not yet received Relief Fund payments of 2 percent of patient revenue will receive a payment that, when combined with prior payments (if any), equals 2 percent of patient care revenue.

With the remaining balance of the $20 billion budget, HRSA will then calculate an equitable add-on payment that considers the following:

A provider’s change in operating revenues from patient care

A provider’s change in operating expenses from patient care, including expenses incurred related to coronavirus

Payments already received through prior Provider Relief Fund distributions.

We know providers want to receive payments shortly after submitting their information. However, this distribution requires cooperation on the part of all applicants. Again, HHS is urging all eligible providers to apply early; do not wait until the last day or week of the application period. Applying early will help to expedite HHS's review process and payment calculations, and ultimately accelerate the distribution of all payments.
All payment recipients will be required to attest to receiving the Phase 3 General Distribution payment and accept the associated Terms and Conditions.
Application Deadline
Providers will have from October 5, 2020 through November 6, 2020 to apply for Phase 3 General Distribution funding. HHS's top priority is ensuring as many providers possible have an opportunity to apply. HHS will continue to host webinars to assist providers through the application process and the call center is also available to address questions.
HHS recognizes the multifaceted challenges of this pandemic cannot be won without frontline healthcare providers focused on containing the virus and delivering holistic care. Funding for this Phase 3 General Distribution was made possible through the bipartisan CARES Act and the Paycheck Protection Program and Health Care Enhancement Act, which allocated $175 billion in relief funds to hospitals and other healthcare providers.
For updates and to learn more about the Provider Relief Program, visit: hhs.gov/providerrelief.
https://www.hhs.gov/about/news/2020/10/1/trump-administration-announces-20-billion-in-new-phase-3-provider-relief-funding.html

United States

Veklury (remdesivir) Now Available Directly from Distributor following Trump Administration's Successful Allocations to States and U.S. Territories | HHS.gov
Source: hhs.gov
ID: 1007955313

Beginning October 1, 2020, American hospitals can purchase Veklury (remdesivir) directly from the drug's distributor. Veklury is an antiviral drug currently authorized for emergency use by healthcare providers to treat hospitalized adult and pediatric patients with suspected or laboratory-confirmed COVID-19. Over the past five months, the U.S. government has overseen the allocation and distribution of Veklury due to drug's limited supply to ensure fair and equitable distribution to COVID-19 patients.
"In the months since Veklury showed promise against COVID-19, President Trump secured the vast majority of the manufacturer's supplies for the American people, part of the administration's work to manage scarce resources needed for fighting COVID-19," said U.S. Department of Health and Human Services (HHS) Secretary Alex Azar. "Over the past five months, HHS rapidly, fairly, and equitably worked to distribute approximately 150,000 treatment courses of donated Veklury and make more than 500,000 treatment courses of the commercial drug available to help treat patients in U.S. hospitals. Now, federal government oversight of the allocation of Veklury is not required because the drug is no longer a scarce resource—a tribute to progress we have made against COVID-19 and to the strength of our partnerships with the private sector."
On October 1, 2020, the U.S. Food and Drug Administration (FDA) revised the Emergency Use Authorization for Veklury removing the U.S. government's role in directing the allocation of the drug. The revised EUA identifies Gilead Sciences, Inc. and its authorized distributors as the responsible parties for the distribution of Veklury.
The current supply of Veklury exceeds market demand as evidenced by recent allocation numbers from HHS' Office of the Assistant Secretary for Preparedness and Response (ASPR). ASPR's records indicate that of the 500,000 treatment courses made available in the United States between July and September 2020, state and territorial health departments accepted 84 percent of their allocations (423,765 treatment courses); however, only 32 percent (160,981 treatment courses) of the total allocation was actually purchased by hospitals in their jurisdictions. Over the course of the project, ASPR allocated over 700,000 treatment courses, which included the reallocation of 200,000 treatment courses that were not initially accepted by state and territorial health departments.
Gilead anticipates producing sufficient quantities of Veklury to meet current needs and future demands from any waves of SARS-CoV-2 infections, the virus that causes COVID-19.

The cost of Veklury will not change in the transition from U.S. government oversight of allocation to direct commercial sales. Hospitals will continue to pay no more than Gilead's wholesale acquisition price (WAC), approximately $3,200 per treatment course.
Generally, patients do not pay directly for hospital-administered drugs like Veklury; rather, for Medicare and most private insurers, the drug's cost is incorporated into the overall treatment costs based on the patient's diagnosis.
AmerisourceBergen will remain the sole distributor of Veklury through the end of the year to ensure consistency and continuity of the distribution process.
Visit the ASPR website for more information about Veklury, the strategy used to allocate and distribute the drug prior to today's action, and how much Veklury was allocated to states and U.S. territories between May and September 2020.
https://www.hhs.gov/about/news/2020/10/01/veklury-remdesivir-available-directly-distributor-following-trump-administrations-successful-allocations.html

United States

HHS Teams Up with The Rockefeller Foundation to Share Best Practices for Increased COVID-19 Testing | HHS.gov
Source: hhs.gov
ID: 1007955304

The U.S. Department of Health and Human Services (HHS) and The Rockefeller Foundation have signed an agreement to identify and share effective approaches for using rapid point-of-care (POC) antigen tests to screen for COVID-19 in communities, with a focus on safely reopening K-12 schools. The partnership establishes a pilot program with select cities and states in The Rockefeller Foundation's Testing Solutions Group (TSG), a network of public officials devoted to rapidly scaling COVID-19 testing, tracing, and tracking in their communities.
"This pilot program will generate real-world evidence, and identify best practices and lessons learned, as well as metrics on how to effectively integrate testing into school opening and reopening for K-12 students and teachers," said ADM Brett Giroir, M.D., HHS assistant secretary for health. "Our collaboration with The Rockefeller Foundation will inform states and territories on how to develop their own roadmaps for safely keeping children in the classroom, which is critical for their physical, emotional, mental, and developmental health."
HHS will provide at least 120,000 Abbott BinaxNOW COVID-19 Ag Card POC SARS-CoV-2 diagnostic tests to pilot sites. The initial pilot cities, selected collaboratively with The Rockefeller Foundation, are Louisville, Ky.; Los Angeles; New Orleans; and Tulsa, Okla. In addition, Rhode Island has been selected as a pilot state.
BinaxNOW is a unique testing option to provide support to K-12 teachers and students, higher education, critical infrastructure, first responders, and other priorities as governors deem fit. The rapid test is easy to use and produces COVID-19 test results in 15 minutes. BinaxNOW is the only antigen rapid POC test authorized by the U.S. Food and Drug Administration that does not require a laboratory-based instrument to test the samples; instead, negative or positive COVID-19 results are determined through a test card.
HHS will distribute the tests through its established approach leveraging the logistics expertise of the Department of Defense. The Rockefeller Foundation will help communities define problems, set policy goals, explore options, and craft solutions to help them fight the pandemic in a science-based manner.
The pilot program will provide essential information on the policies, practices, and behaviors that public sector entities need to successfully adopt practices that enable communities to be more resilient.
The POC testing pilot program will also provide data on how testing strategies can be operationalized in laboratories, retail pharmacies, and other community entities. In addition, the partnership will help build the capacity of communities across the United States to better prepare for future pandemics, especially in low-income and vulnerable communities.
The collaboration between HHS and The Rockefeller Foundation builds upon the Trump Administration's national distribution plan for the Abbott BinaxNOW tests to states, which includes sending millions of BinaxNOW rapid tests to all U.S. states and territories over the next few months. The Federal government purchased 150 million Abbott BinaxNOW diagnostic tests on August 27, 2020 – one day after the FDA issued an Emergency Use Authorization – to ensure that the rapid tests would be distributed expeditiously to priority populations, including vulnerable groups and schools.

The Rockefeller Foundation
For more than 100 years, The Rockefeller Foundation's mission has been to promote the well-being of humanity throughout the world. Today, The Rockefeller Foundation advances new frontiers of science, data, and innovation to solve global challenges related to health, food, power, and economic mobility.
https://www.hhs.gov/about/news/2020/10/01/hhs-teams-up-with-the-rockefeller-foundation-to-share-best-practices-for-increased-covid-19-testing.html

IHR Announcement
IHR Additional Health Measures -COVID-19 - 2 October 2020
Announcement Displayed From: Thursday, October 1, 2020 - 20:14

Additional health measures in relation to the COVID-19 outbreak

02 October 2020

Official statements by States Parties to the International Health Regulations (2005) (IHR)

On 30 January 2020, the Director-General determined that the outbreak of 2019-nCoV, constitutes a Public Health Emergency of International Concern (PHEIC) and issued Temporary Recommendations[1]. On 11 March 2020 the Director-General characterized the COVID-19 situation as a pandemic[2]. Following the 4th IHR Emergency Committee for COVID-19 on 31 July 2020, the Director-General confirmed that the COVID-19 pandemic continues to constitute a PHEIC and issued the following Temporary Recommendations for States Parties:

Share best practices, including from intra-action reviews, with WHO; apply lessons learned from countries that are successfully re-opening their societies (including businesses, schools, and other services) and mitigating resurgence of COVID-19.

Support multilateral regional and global organizations and encourage global solidarity in COVID-19 response.

Enhance and sustain political commitment and leadership for national strategies and localized response activities driven by science, data, and experience; engage all sectors in addressing the impacts of the pandemic.

Continue to enhance capacity for public health surveillance, testing, and contact tracing.

Share timely information and data with WHO on COVID-19 epidemiology and severity, response measures, and on concurrent disease outbreaks through platforms such as the Global Influenza Surveillance and Response System.

Strengthen community engagement, empower individuals, and build trust by addressing mis/disinformation and providing clear guidance, rationales, and resources for public health and social measures to be accepted and implemented.

Engage in the Access to COVID-19 Tools (ACT) Accelerator, participate in relevant trials, and prepare for safe and effective therapeutic and vaccine introduction.

Implement, regularly update, and share information with WHO on appropriate and proportionate travel measures and advice, based on risk assessments; implement necessary capacities, including at points of entry, to mitigate the potential risks of international transmission of COVID-19 and to facilitate international contact tracing.

Maintain essential health services with sufficient funding, supplies, and human resources; prepare health systems to cope with seasonal influenza, other concurrent disease outbreaks, and natural disasters.

In line with provisions of Article 43, WHO is sharing the information officially provided to WHO by States Parties and, since 12 March 2020 also information published by country government websites to reduce the gap between the information reported through the IHR mechanism and the one published by countries on official sources.

As of 02 October 2020, there has been no new State Party that reported on additional health measures that significantly interfere with international traffic since the last announcement published on 25 September 2020. A total of 194 out of 196 States Parties reported to date with Mexico and Nicaragua not reporting any measure.

Moreover, 20 countries provided updates to their previously implemented measures. The distribution by WHO Regions is as follows: AFR: 0 (3 updates), AMR: 0 (1 update), EMR: 0 (0 updates), EUR: 0 (16 updates), SRO: 0 (0 updates), WPR: 0 (0 updates). See table 1.

Regional links below provide for more details on the measures. The information is divided by region, cumulative since the beginning of the EIS updates on travel measures and by country in alphabetical order. Text highlighted in red represents updates to the previously published EIS.

NOTE1: numbers in parenthesis illustrate the number of reports – new or updates - received since 26 March 2020

NOTE 2: (*) designates that the State Party reports on measures directed to other countries in addition to China. As of 17 March, all countries reporting measures, direct these measures to more than one country or to all countries (ie: closure of borders)
NOTE 3: (#) Supporting document to be provided by Country or Regional Office.
NOTE 4%: Measure for Canada was updated in the country report for AMRO on 17 April but not reflected in the respective EIS.
NOTE 5:Eurasian Economic Commission countries: Armenia, Belarus, Kazakhstan, Kyrgyzstan and Russian Federation.

[1] https://www.who.int/news-room/detail/30-01-2020-statement-on-the-second-meeting-of-the-international-health-regulations-(2005)-emergency-committee-regarding-the-outbreak-of-novel-coronavirus-(2019-ncov)

[2] https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020

WHO
The best time to prevent the next pandemic is now: countries join voices for better emergency preparedness
Source: WHO

1 October 2020 News release

COVID-19 will not be the world's last health emergency and there is an urgent need for sustainable health emergency preparedness to deal with the next one. This was the strong sentiment shared by participants of the United Nations General Assembly side-event on 'Sustainable preparedness for health security and resilience: Adopting a whole-of-society approach and breaking the "panic-then-forget" cycle'. The high-level virtual event was co-hosted by Finland, France and Indonesia, along with the World Health Organization (WHO).

Past crises have shown that once an outbreak is under control, governments and donors tend to turn their attention to other pressing concerns. This cycle of "panic-then-forget" has prevented the development of effective health emergency preparedness across the globe. The world needs to break this cycle once and

for all. This week, the world crossed a grim milestone with over a million lives lost to the COVID-19 pandemic, and many more expected to have died from unprecedented disruptions to the health systems.

“Over the years we have had many reports, reviews and recommendations all saying the same thing: the world is not prepared for a pandemic. COVID-19 has laid bare the truth: when the time came, the world was still not ready,” said Dr Tedros Adhanom Ghebreyesus, WHO Director-General, in his opening address. He called for investing in preparedness, with an all-of-government and all-of-society approach. “This will not be the last pandemic, nor the last global health emergency. But with the right political and financial investments now, we can advance health security, prevent and mitigate future pandemics, and protect our future and the future of generations to come,” he said.

Countries spoke of their commitment to health emergency preparedness. “We know that preparedness makes economic sense, and we have developed tools and models for multi-sectoral cooperation. Learning from the pandemic and building on the previous progress should guide our steps to strengthen Health Security and thus help achieve the Sustainable Development Goals,” said Päivi Sillanaukee, Ambassador for Health and Wellbeing, Republic of Finland.

“There is an urgent need to leverage the response to COVID-19 to build, maintain and strengthen sustainable public health capacities for emergency preparedness […] France firmly believes that preparedness deserves to be placed much higher on the foreign policy agenda and we are willing to foster cooperation among Member States to ensure the continued visibility of this topic, whether here in Geneva or at the UNGA in New York,” said Stéphanie Seydoux, Ambassador for Global Health, French Republic.

Health emergency preparedness is part of the larger vision of health for all. In her speech, Indonesian Minister for Foreign Affairs, Retno L.P. Marsudi, reminded participants that “the investment we must make at the national level now is ensuring affordable health care for all. Let us ask ourselves, how many times have we heard of people denying themselves of much needed medical health care due to costs.... The issue of affordable health care for all is at the heart of Indonesia’s chairmanship of the Foreign Policy and Global Health initiative.”

Also sharing their countries’ experience with COVID-19 were the Ministers of Health of the Netherlands, Oman, Senegal and Singapore. Speaking to this issue as well were the Coordinator of the Group of African Ambassadors in Geneva, and Germany’s Deputy Director-General, Federal Foreign Office. The discussion was led by Ambassador Hasan Kleib of Indonesia in Geneva.

Stressing the role of community empowerment was the President of the International Federation of the Red Cross and Red Crescent Societies (IFRC), Mr Francesco Rocca. He said his organization had learned from working with its network of responders in 192 countries that there is an urgent need to invest in preparedness at the community level, to “promote humanitarian action to be as local as possible, as global as necessary […] We call on governments, partners and donors to invest in preparedness at the community level to save lives and alleviate suffering in the next inevitable emergency.”

The role of parliaments and the importance of a multisectoral approach was highlighted by the Secretary-General of the Inter-Parliamentary Union, Mr Martin Chungong. The International Association of National Public Health Institutes, and the European Commission’s Directorate General for Development and Cooperation emphasized the important role played by partner organizations in country and global preparedness and financing.

Mr Sami Kanaan, the Mayor of Geneva, stressed an all-of-society approach. “Local governments must not only be provided with the means to implement policies. They also need to be included in the

international debates that eventually shape solutions to the humanity's most pressing challenges," he said.

Closing the event, Dr Michael Ryan, Executive Director, WHO Health Emergencies Programme, appreciated the participants' remarks, and asked for them to be met with sustained commitment to preparedness. "We cannot, cannot, cannot let the world forget because the next one may not be anything but the worst one," he said. "This (COVID-19) may just be a harbinger of what may come, we are living with too much risk."

This event marked a crucial dialogue among countries, donors and partners on building back better for future emergency preparedness during the current COVID-19 pandemic, and beyond. It comes on the heels of the release of a sobering report by the Global Preparedness and Monitoring Board that also called for urgent action in this area.

According to the report, investments in preparedness would only cost US$ 5 per person annually, whereas the cost of this pandemic is already over US$ 11 trillion and counting.
https://www.who.int/news-room/detail/01-10-2020-the-best-time-to-prevent-the-next-pandemic-is-now-countries-join-voices-for-better-emergency-preparedness

ECDC

Systematic review of the efficacy, effectiveness and safety of newer and enhanced seasonal influenza vaccines
Source: ECDC
Overall the evidence base for the efficacy and effectiveness of newer and enhanced influenza vaccines appears limited at present, with a number of potentially relevant studies identified as ongoing.

It is likely that the use of such vaccines provides greater protection than no vaccination at all, when the usual considerations of circulating strain matching are applied. Evidence regarding the comparability of these vaccines to traditional seasonal influenza vaccines is uncertain with a lack of available literature.

The safety profiles of these vaccines are largely in keeping with that expected when considering their individual compositions and, for the most part, they appear to be well tolerated.

Some suggestions are provided to enhance research conduct and reporting regarding these newer and enhanced influenza vaccines which are anticipated to improve the data coverage overall and facilitate future decision-making regarding the use of such vaccines.
https://www.ecdc.europa.eu/en/publications-data/seasonal-influenza-systematic-review-efficacy-vaccines
https://www.ecdc.europa.eu/sites/default/files/documents/seasonal-influenza-vaccines-systematic-review-efficacy.pdf

ECDC

New tool for the early detection of public health threats from Twitter data: epitweetr
Source: ECDC

News story

1 Oct 2020

ECDC has launched a free, open source interactive tool to help with the automatised early detection of public health threats using Twitter data.

The R-based tool epitweetr allows users to automatically monitor trends of tweets by time, place and topic, with the aim of detecting public health threats early through signals, such as an unusual increase in the number of tweets. It was designed to support public health experts with the early detection of threats

from infectious diseases but can be extended to all hazards and other fields of study by modifying the topics and keywords.

The epitweetr package includes an interactive web application (based on the R package Shiny) with five pages:

1. Dashboard, where a user can visualise and explore tweets, and download the associated outputs and data;
2. Alerts page, where you can view the current alerts and associated information;
3. Geotag evaluation page, where you can evaluate the geolocation algorithm in different tweet fields to manually choose the geolocation threshold;
4. Configuration page, where you can change settings and check the status of the underlying processes;
5. Troubleshooting page, with automatic checks and hints for using epitweetr with all its functionalities.

To make epitweetr as widely available as possible, R was chosen as the computing platform. R is free, open source, and runs on any modern operating system.

epitweetr can be downloaded free of charge from the ECDC website, the CRAN website (for CRAN users) or GitHub (for GitHub users).
https://www.ecdc.europa.eu/en/news-events/new-tool-early-detection-public-health-threats-twitter-data-epitweetr

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

International

As COVID-19 total tops 34 million, World Bank offers vaccine plan for poorer nations
Source: CIDRAP
ID: 1007954276

The global COVID-19 total topped 34 million cases today, as an official from the World Bank announced a $12 billion plan to help lower-income countries buy vaccine and as US lawmakers clung to the hope of a still-elusive stimulus bill to limit the pandemic's economic damage to families and businesses.

The United States added 42,812 more cases to the global total yesterday, which has now reached 34,114,758 cases with 1,016,406 deaths, according to the Johns Hopkins online dashboard.

World Bank plan would fast-track vaccine purchases
At a side event at the United Nations General Assembly yesterday, World Bank President David Malpass said the group is interested in fast-tracking the financing of COVID-19 vaccines, similar to the way it galvanized funding in March to help countries scale up emergency health support.

He announced that he is proposing that the World Bank board make $12 billion available to countries to purchase and deploy COVID-19 vaccine, once regulatory agencies approve them. He said the additional support would target low- to middle-income countries that don't have enough access and would help them alter the course of the pandemic for their people.

Malpass said the approach mirrors past World Bank efforts with vaccines and will signal to vaccine makers that developing countries have multiple ways to buy vaccines. And he added that the World Bank's private-sector arm, called IFC, is investing in vaccine companies that are willing to prioritize developing countries and in efforts to avoid production bottlenecks by securing vials, needles, syringes, and cold-storage capacity.

Global health officials, including those at the World Health Organization (WHO), have emphasized that COVID-19 remains a threat wherever it remains and that rolling out the vaccine to all countries isn't charity, it's the best plan for keeping the world safe.

More increases in some world regions

India yesterday reported nearly 87,000 cases, continuing to lead the world with the most daily cases. The country has the world's second biggest population and, in the weeks ahead, is poised to pass the United States as the country with the most cases.

Despite the ongoing surge, India yesterday allowed schools and movie theaters to reopen, and hard-hit Maharashtra state has fully reopened bars and restaurants, Reuters reported.

In Europe, Poland reported a daily record high of 1,967 new cases today, and health officials said they expect illness levels to continue to rise. In Spain, regional leaders reluctantly ordered a lockdown again for Madrid, following a government ban on nonessential travel to and from the country's capital. And in England, health minister Matt Hancock extended COVID-19 restrictions across a broader part of the country to include Liverpool in the north, part of efforts to curb rising case numbers.

In the Middle East, another region where cases in some countries are spiking, Jordan yesterday recorded a daily record high of 1,767 cases and warned that it might have to go on full lockdown. Two other countries also reported more daily record highs, including the United Arab Emirates for the second day in a row and Israel, which has been on lockdown again since Sep 18.

Elsewhere, cases in the WHO's African region declined 13% in the latest reporting week, the regional office said on Twitter. South Africa leads the region with the most cases, but the country's illnesses declined 21% over the past 7 days.

US lawmakers struggle to finalize coronavirus relief

In the United States, the pandemic continues to take its toll in the economy. The number of people seeing unemployment benefits fell to 837,000 last week, the Associated Press reported, with the Labor Department's latest report showing that US companies are cutting a record number of jobs amid the pandemic's fallout.

In Washington, DC, last ditch efforts are underway to settle on the terms of a new coronavirus relief package, with Congress set to adjourn at the end of the week though the election, the Washington Post reported. House Democrats have scaled back their proposal from $3.4 trillion to $2.2 trillion, and House Speaker Nancy Pelosi, D-Calif., said she may move to a House vote on the package today.

Republicans strongly oppose the bill, though the White House has offered a $1.6 trillion package, which Pelosi rejected as being too small, prompting Trump Administration charges that Pelosi isn't serious about the negotiations. She and Treasury Secretary Steven Mnuchin were slated to meet again to seek common ground today.

In a related development, United Airlines and American Airlines announced that they would start furloughing tens of thousands of employees today, following news that Congress and the White House failed yesterday to come to an agreement on the coronavirus stimulus, the Washington Post said in a separate report. The companies said they could call the employees back if lawmakers reach a deal in the next few days.

In other US developments:

The Food and Drug Administration (FDA) has broadened its investigation into an adverse event that occurred in a British phase 3 trial of AstraZeneca's COVID-19 vaccine, Reuters reported. Officials said they will examine data from earlier trials of similar vaccines developed by the same research group.

On the East Coast, New York City's restaurants reopened yesterday to indoor dining at 25% capacity, though several neighborhoods in Brooklyn and Queens are reporting increasing positivity rates, and Boston postponed its next reopening phase due to increasing cases, which the city's mayor says are mainly among young people and college students.

President Donald Trump is one of the biggest sources of COVID-19 misinformation, according to a study of 38 million articles from around the world by Cornell University researchers. They found that media mentions of Trump in the context of misinformation topics made up 37% of the overall misinformation conversation, more than any other single topic.

https://www.cidrap.umn.edu/news-perspective/2020/10/covid-19-total-tops-34-million-world-bank-offers-vaccine-plan-poorer

United Kingdom
Coronavirus vaccine may not return life to normal until 2023, scientists warn
ID: 1007951235
Source: infosurhoy.com

A Covid-19 vaccine may not help life return to normal until 2023, scientists have warned.
Experts looking at possible rollout concluded it may take up to a year after a jab is possibly approved next Spring to expand it to the general population.
A report has been published by the Royal Society looking at challenges developing, evaluating, manufacturing and distributing a vaccine.
The verdict from its Data Evaluation and Learning for Viral Epidemics (DELVE) group will come as a shock to families desperate for a jab to save us from the pandemic and has big implications for the economy.
The Government has previously suggested a working vaccine could be discovered by the turn of the year.
Author Prof Nilay Shah, expert on chemical engineering at Imperial College London, said: “It doesn’t mean that within a month everyone will be vaccinated.
“We are talking about another six months, nine months or maybe a year.
“It will take quite a long time to rollout the vaccine even once it is approved.”
Rollout would take an unprecedented logistical effort to vaccinate different age groups in GP surgeries and temporary mobile clinics.
It would likely start with the over-80s then vaccinate in five-year age groups going next to the 75 to 80 age group.
Prof Shah said it is likely to take a fortnight to vaccinate each five year age group meaning it will take between seven and nine months to get through the whole population.
The UK’s leading experts warned that while a vaccine may initially help control outbreaks, full population immunity may take a long time after the first one is approved and social distancing is likely with us for the foreseeable future.
Prof Charles Bangham, chair of immunology at Imperial College London, said: “We will have to have some restrictions that last through next year.
“It will be a tapering response.”
https://infosurhoy.com/science/coronavirus-vaccine-may-not-return-life-to-normal-until-2023-scientists-warn/

United Kingdom
Covid: 170 test positive at Cornwall meat plant
ID: 1007951904

Source: BBC

Testing has uncovered 170 cases of Covid-19 among workers at a pork meat processing plant in Cornwall.
Five hundred staff at Pilgrim's Pride in Pool, near Camborne, were tested in a contact tracing exercise by the NHS.
Most of those who tested positive were unaware they had Covid-19 and were not displaying symptoms.
They and those they have been in close contact with are isolating in line with government guidelines, said Cornwall Council.
Cases of Covid-19 in the South West are still below the national average,
latest figures show.
Cornwall remains the area in the region with the highest number of cases.
In the week to Sunday, numbers rose from 115 to 180. The infection rate is 31.5 per 100,000.
"In total, almost 500 employees at the factory have been tested and the vast majority of the cases who tested positive were not displaying symptoms," said Cornwall Council.
Rachel Wigglesworth, interim director for Public Health for Cornwall Council, said: "In finding people who weren't displaying symptoms we have potentially stopped much wider spread in our communities".
Council leader Julian German said "proactive testing" was "helping us to take action quickly to limit the spread of Covid in our communities".
Pilgrim's Pride said in a statement said "from the outset" it had "worked conscientiously to do all we can to protect our workforce and the local community".
Related Topics
Tuesday's ugly and ill-tempered first US presidential debate is being widely condemned.
Published

https://www.bbc.co.uk/news/uk-england-cornwall-54361824

Jordan
Sk.. Warnings of collapse of Jordan's health system
ID: 1007951793
Source: arabic.rt

Jordan's Minister of State for Information, Amjad Al-Amayla, said the epidemiological situation in Jordan is very serious, warning of the possible collapse of the health system in the kingdom.
If the number of CORONA virus infections reaches more than 3,000 active cases, the country will be at risk, and the health system will collapse, he said in a radio interview.
He stressed that hospitals to date are able to deal with corona injuries, pointing out that 90% of cases do not need health care, pointing out that "the government cannot keep life disrupted, and we have to balance the economy and health."
He said the government is dealing with each region individually, noting that it may have to close areas where casualties are high.
According to the update of the Corona platform of the Ministry of Health, 1,158 people are undergoing treatment for the virus in hospitals, while the total number of infections in the Kingdom since the beginning of the pandemic has reached 11,825.
Source: Ammon
https://gphin.canada.ca/cepr/showarticle.jsp?docId=1007951793
https://arabic.rt.com/middle_east/1159114-%D9%83%D9%88%D8%B1%D9%88%D9%86%D8%A7-%D8%AA%D8%AD%D8%B0%D9%8A%D8%B1%D8%A7%D8%AA-%D9%85%D9%86-%D8%A7%D9%86%D9%87%D9%8A%D8%A7%D8%B1-%D8%A7%D9%84%D9%86%D8%B8%D8%A7%D9%85-%D8%A7%D9%84%D8%B5%D8%AD%D9%8A-%D9%81%D9%8A-%D8%A7%D9%84%D8%A3%D8%B1%D8%AF%D9%86/

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

Canada

COVID-19 and long-term care facilities: Does ownership matter? | CMAJ
Source: cmaj.ca
ID: 1007952822

KEY POINTS
Research has shown that for-profit ownership of long-term care (LTC) homes has been relevant to patterns of coronavirus disease 2019 (COVID-19) outbreaks and deaths in Ontario; this is related to building characteristics and chain status of owners.
For-profit ownership has been related to lower LTC staffing levels in research comparing for-profit and nonprofit facilities.
Recent research has shown an association between lower nurse staffing levels and worse COVID-19–related outcomes in LTC facilities.
Long-term care policy should prioritize funding and mandating sufficient staffing levels based on the available evidence.

In related research, Stall and colleagues examined the relation between ownership of a long-term care (LTC) facility and the occurrence, extent and mortality associated with outbreaks of coronavirus disease 2019 (COVID-19) in Ontario's 623 LTC facilities.1 In their analysis, adjusted at the facility level, the authors found no association between ownership and the odds of an outbreak occurrence. They did find, however, that facilities run on a for-profit basis had more extensive outbreaks and more deaths than facilities run on a nonprofit basis, with an even more marked effect when for-profit facilities were compared with facilities that were entirely municipally run. However, when multi-bed room design was added to the model, for-profit ownership status lost its significance for these outcomes, leading the authors to conclude that building upgrades should be an important part of addressing the problems in the LTC sector in Ontario.

In their expanded model, the authors also found that chain status of the LTC facility conferred a significant risk of more extensive outbreak and deaths. Of Ontario's for-profit LTC facilities, 85% are part of a chain (v. 31% of nonprofit, and no chains among municipally run homes), which begs the question of whether for-profit chain status of a facility is a significant and independent risk factor for more extensive outbreaks and deaths, even after controlling for multi-bed rooms. If so, simply ensuring building upgrades, while important, is unlikely to be enough to address systemic deficiencies.

Stall and colleagues' study did not include data on staffing across facility ownership groups. Long-term care staffing is consistently reported in the literature as being an important difference between for-profit, nonprofit and publicly owned facilities. 2,3 A 2011 study of nursing homes in the United States found that the largest for-profit chains had the lowest nursing hours,4 and an earlier Canadian study found that government (health-authority)–owned facilities provided 61 more minutes of staffing per resident day than for-profit facilities.5 A recent report from the Office of the BC Seniors Advocate on government contracts to LTC homes found that the for-profit sector failed to deliver 207 000 hours of care for which it had received funds in 2016/18, compared with the nonprofit sector, which provided 80 000 more hours of care than it was funded to deliver.6 Moreover, research is starting to show that, when it comes to outbreaks of COVID-19, LTC staffing matters..

A recent study of COVID-19 outbreaks in California found that LTC facilities with total staffing levels of registered nurses (RNs) less than the recommended minimum standard (0.75 h per resident day) were twice as likely to have residents with infection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) than adequately staffed facilities.7 A study in Connecticut found that for LTC facilities with at least 1 confirmed case of COVID-19, every 20-minute (per resident day) increase in RN staffing was associated with 22% fewer confirmed cases, and in facilities with at least 1 death from COVID-19, every 20-minute increase in RN staffing significantly predicted 26% fewer deaths.8

Recognizing the importance of staffing characteristics was key to limiting COVID-19 outbreaks in long-term care in BC. Staff were quickly identified as an important vector of transmission, which led to the BC

government limiting staff working across multiple sites by offering the same higher standard of wages and working conditions to all LTC workers.9

This evidence clearly shows that ownership matters when it comes to staffing, and staffing matters when it comes to managing outbreaks of COVID-19 in LTC facilities. Evidence from time-motion studies and modelling have also allowed for easy calculation of the number and types of staff needed to meet resident care needs.9 Ratios of 1 care aide for 10 or more residents are clearly unacceptable to meet the care needs of nearly all residents now admitted to publicly funded LTC homes. Minimum standards should be ratios of 1 personal support worker (care aide) to no more than 5 to 7 residents for day and evening shifts.10 Recommendations for minimum ratios of residents to RNs and licensed practical nurses, adjusted for resident case mix, are also available and evidence informed.11

In preparation for the next wave of COVID-19, public policy should be directed at funding, mandating and enforcing sufficient staffing levels based on the available evidence, not only to address resident care needs, but also to accommodate the added time required for safety-related tasks such as meticulous handwashing, careful donning and doffing of personal protective equipment, and consistent compliance with infection control standards. If requirements to fund adequate levels of staffing affect the bottom lines of for-profit facilities, then it might be time for this care to be turned over to public and nonprofit entities. As O'Neill and colleagues noted, "If increasing quality raises costs more quickly than it does revenues, profits must fall as quality improves. That is, a trade-off between profit and quality would exist."12 Public policy needs to come to terms with this trade-off and intervene on behalf of our most vulnerable seniors.

Footnotes

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Contributors: Both authors contributed to the conception and design of the work, drafted the manuscript, revised it critically for important intellectual content, gave final approval of the version to be published and agreed to be accountable for all aspects of the work.

https://www.cmaj.ca/content/192/33/E961?utm_source=TrendMD&utm_medium=cpc&utm_campaign=CMAJ_TrendMD_0

Canada

Woman leaks cerebral and spinal fluid from her nose after a nasal swab COVID-19 test

Source: CTVNews.ca - Top Stories - Public RSS

ID: 1007953707

TORONTO -- A woman started leaking cerebral fluid out of her nose after she received a COVID-19 test administered with a nasal swab, according to a new case report.

The report published Thursday in the journal JAMA Otolaryngology – Head & Neck Surgery, described a singularly unusual situation, where the nasal swab disturbed a mass in the woman's nasal cavity containing cerebrospinal fluid and brain tissue.

For the patient, a woman in her 40s, it started with a COVID-19 test ahead of an elective hernia surgery. The test was done using a nasal swab that reached deep into the nasal cavity, a common form of testing for COVID-19.

Afterwards, she developed a runny nose in both nostrils, a metallic taste in her mouth, a headache, neck stiffness, and a sensitivity to light, as well as vomiting.

To figure out what was going on, doctors inserted a flexible tube called a scope into the patient's nose. They discovered a mass inside the nose, but not what was causing the fluid leakage.

A CT scan identified a 1.8-centimetre sac-like structure protruding down into the nasal cavity between a breakage in bone. It was an encephalocele -- a term for a condition usually identified in infants, where the bones of the skull do not fuse completely, creating a gap where cerebral fluids and brain tissue can collect in a protruding lump.

Doctors believe the nasal swab damaged this mass within the nose, causing the leakage of cerebrospinal fluid.

Cerebrospinal fluid (CSF) is a clear fluid found around the brain and spinal cord. It helps to protect the brain and spinal cord from injury, and delivers nutrients and removes waste from those systems.
When a CSF leak occurs, it's because something has created a tear or hole in the connective tissue that keeps the CSF surrounding the brain and spine. If too much fluid leaks out, the brain sags inside the head, putting pressure on parts of the skull and causing headaches, a condition known as spontaneous intracranial hypotension.
CSF leaks are rare, but are sometimes misdiagnosed as migraines or other headache disorders, according to Spinal CSF Leak Canada.
When doctors compared their results to a CT scan the patient previously had done in 2017, they found that the encephalocele had existed back then, but was misdiagnosed as paranasal sinus disease, or an inflammation of the sinuses.
The woman also had a medical history of idiopathic intracranial hypertension, which is related to high pressure in the brain due to a buildup of CSF.
And more than 20 years earlier, she had nasal polyps removed, which are soft, noncancerous masses that develop and hang down in the nasal passageway. They can sometimes impact a person's breathing or encourage infections, and thus may need to be removed.
The real problem — the breakage in the skull itself — had gone undiagnosed for years.
As soon as the true problem was identified, doctors operated in order to reduce the mass. To close the hole in the bone that had allowed the sac-like protrusion to form, they used a soft tissue skin graft, which serves as a scaffold for cells to incorporate the graft into the bone.
"To our knowledge, this is the first report of an iatrogenic CSF leak after a nasal swab for COVID-19," the case report stated.
The report added that surgical trauma is the cause for CSF leaks up to 58 per cent of the time, but stressed that the swab itself had not caused the hole in the patient's bone itself.
"This patient had an undiagnosed skull base defect at the fovea ethmoidalis that was present on imaging dating back to 2017," the report continued. "We therefore theorize that the swab itself did not result in a violation of the bony skull base, but rather the invasive test caused trauma to the patient's preexisting encephalocele."
The report noted that it is common to screen patients for COVID-19 before they get non-related surgeries, and also that COVID-19 tests with nasal swabs are increasingly common in the United States.
"As the number of daily COVID-19 nasal and nasopharyngeal swab specimen collection procedures increases, a greater burden is placed on the health care system to properly train clinicians and even the general public to safely perform nasal and nasopharyngeal swab testing," the report stated.
They suggested that alternative testing methods than nasal swabs be used for patients with a history of sinus issues or skull base defects.
https://www.ctvnews.ca/health/coronavirus/woman-leaks-cerebrospinal-fluid-from-her-nose-after-a-nasal-swab-covid-19-test-1.5127908
https://jamanetwork.com/journals/jamaotolaryngology/article-abstract/2771362?resultClick=1

United States
Higher risk of COVID-19 death found in psychiatric patients
Source: CIDRAP
ID: 1007954263

In the first known study of COVID-19 psychiatric patients and mortality, a JAMA Network Open study yesterday showed that patients with diagnosed psychiatric disorders have significantly higher risk of death.

The cohort study of 1,685 patients at Yale New Haven Health System, a five-hospital system in the Northeast, studied patient mortality data from Feb 15 through May 27 using a Kaplan-Meier statistical analysis to compare survival rates. The study identified 473 patients (28%) previously diagnosed as having psychiatric disorders.

The overall mortality rate for all patients was 18.9%, with 318 hospital deaths. COVID-19–positive patients with psychiatric diagnoses had a significantly higher risk of hospital death, with a 4-week mortality rate of 44.8%, versus 31.5% for non-psychiatric patients.

Patients with psychiatric diagnoses tended to be older, female, white, non-Hispanic, with other medical comorbidities. After adjusting for demographic characteristics, comorbidities, and hospital location, psychiatric patients had a 1.5 times higher risk of death (hazard ratio, 1.5; 95% confidence interval, 1.1 to 1.9; P = 0.003).

"The finding is similar to previous findings: individuals with concurrent psychiatric and medical diagnoses had poorer outcomes and higher mortality," the study authors wrote.

The authors noted that psychiatric disorders are associated with shortened life expectancy in general—by as much as 10 years—but it is unclear why psychiatric illness predisposes patients to COVID-19–related mortality. There may be an association of psychiatric disorders with inflammatory processes, immune function, or an increased risk from psychotropic medications, the authors suggest.

https://www.cidrap.umn.edu/news-perspective/2020/10/news-scan-oct-01-2020
https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2771037

United States
COVID-19 spread freely aboard USS Theodore Roosevelt, report shows
Source: CIDRAP
ID: 1007954206

The COVID-19 outbreak on board the USS Theodore Roosevelt aircraft carrier that ultimately infected more than 1,200 sailors and killed one, leading to the firing of its captain and the resignation of the Navy's top official, shows how easily the virus spreads in close quarters, according to a research letter published today in JAMA Network Open.

In the case series, the US Army Public Health COVID-19 Task Force analyzed data from 736 of 4,800 USS Theodore Roosevelt sailors diagnosed as having COVID-19 and placed in isolation at Naval Base Guam from Mar 31 to Apr 15. Sailors who tested negative for coronavirus and those without symptoms were quarantined in single hotel rooms, and those who developed symptoms were moved to isolation.

The outbreak, which peaked on Mar 30 with 30 new cases and ultimately infected 25% of the crew members, involved 736 of the 4,085 sailors on board (18%) by mid-April. Of all infected sailors, 590 (80.2%) were symptomatic for a median of 7 days. The other 146 sailors remained without symptoms for the entire study period. Six sailors were hospitalized.

Median patient age was 25 years, and 572 (77.7%) were men. The most common symptom was cough, followed by cold-like symptoms, loss of smell, headache, loss of taste, and fever.

Desperate pleas, public outcry
The 1,092-foot, 100,000-ton aircraft carrier had left its base in San Diego for the western Pacific on Jan 17, according to the US Naval Institute. To prevent the coronavirus from spreading onboard, the crew began handwashing, hand sanitizer, and surface bleaching protocols, known as "bleach-a-palooza," on Feb 2.

The COVID-19 outbreak was discovered in late March, about 2 weeks after a 4-day stop in Da Nang, Vietnam, which the US Centers for Disease Control and Prevention classified as "low risk," despite

confirmation of coronavirus cases there. Part of the stop, starting on Mar 5, involved a 400-person reception at a hotel.

Captain Brett Crozier, who eventually tested positive for the coronavirus, told his superiors on Mar 26 that he wanted to clear the ship to prevent spread of the virus because the sailors could not physical distance or individually quarantine on the ship, but he was met with resistance.

On Mar 30, Crozier emailed three Navy admirals and seven other captains with a plan to evacuate the ship. After the San Francisco Chronicle obtained a copy of the email and published it the next day, Acting Secretary of the Navy Thomas Modly fired Crozier, although most of the crew were ordered ashore.

On Apr 5, Modly flew to Guam to give a speech over a public address system to the USS Theodore Roosevelt crew in which he criticized Crozier as "too naïve or too stupid to be a commanding officer." The speech, as well as Crozier's firing, generated a furor, and Modly resigned on Apr 7. Crozier was not reinstated, and the aircraft carrier eventually left Guam in early June before returning to California.

Lessons for congregate settings
The study authors said that COVID-19 is difficult to distinguish from other respiratory infections without specific testing in young people living in a confined space, and asymptomatic and presymptomatic transmission limits the effectiveness of screening for symptoms in the absence of testing, wearing a face mask, and physical distancing. The ship initially had no testing kits on board.

"Finally, the rapid increase in case number as incubating cases disembarked, followed by the precipitous decrease in cases, suggests that the shore-based nonpharmaceutical interventions interrupted a probable acceleration in case incidence that would have likely resulted in a substantial disease burden," the investigators wrote.

"Lessons learned from the USS [Theodore Roosevelt] COVID-19 outbreak may have applicability in other congregate settings staffed by essential workers and in understanding clinical features of the illness in younger adult populations."

Ships as breeding grounds for outbreaks
In an invited commentary in the same journal, John Malone, MD, MPH, an epidemiologist with the San Diego County Health and Human Services Agency, noted that sailors on board the USS Theodore Roosevelt sleep and work in very close quarters with linear fan forced-flow ventilation, which can spread particles through the air.

In such settings, he said, COVID-19 will continue to cause outbreaks, because wearing face coverings, washing hands, and physical distancing are not enough to contain the spread.

The US military, Malone noted, now uses premovement sequestration, which is like a quarantine although the participants have no known exposure to COVID-19, with 14-day movement restrictions to lower the risk of outbreaks.

"Unfortunately, the COVID-19 outbreak on the USS Theodore Roosevelt will be remembered by the removal of the Commanding Officer and April 7, 2020, resignation of the Secretary of the Navy instead of the many lessons learned regarding a highly contagious respiratory virus in ships with closely confined spaces and linear airflow systems," he said.
https://www.cidrap.umn.edu/news-perspective/2020/10/covid-19-spread-freely-aboard-uss-theodore-roosevelt-report-shows

Germany

[APG]

SARS-CoV-2 samples may escape detection because of a single point mutation in the N gene
Source: eurosurveillance.org
ID: 1007953692

We found that a single nucleotide polymorphism (SNP) in the nucleoprotein gene of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) from a patient interfered with detection in a widely used commercial assay. Some 0.2% of the isolates in the EpiCoV database contain this SNP. Although SARS-CoV-2 was still detected by the other probe in the assay, this underlines the necessity of targeting two independent essential regions of a pathogen for reliable detection.
https://www.eurosurveillance.org/content/10.2807/1560-7917.ES.2020.25.39.2001650#html_fulltext

United Kingdom

Researchers call for loss of smell to be recognized globally as a symptom of COVID-19
Source: eurekalert.org
ID: 1007954241

Four out of five people experiencing the recent loss of smell and/or taste tested positive for COVID-19 antibodies--and of those who tested positive, 40 percent did not have cough or fever, reports a new study in PLOS Medicine by Prof. Rachel Batterham at University College London and colleagues.

COVID-19 can cause loss of taste and smell, but the prevalence of COVID-19 antibodies in people reporting these symptoms is unknown, and the significance of loss of smell and/or taste as a predictor of COVID-19 is not well understood. To estimate the seroprevalence of SARS-CoV-2 antibodies in people with acute loss of their sense of smell and/or taste, researchers enrolled 590 people self-reporting a loss of taste/smell in the previous month. Following verification of symptoms via a telemedicine consultation, 567 participants with smell and/or taste loss participants underwent a SARS-CoV-2 antibodies test.

78% had SARS-CoV-2 antibodies, and participants with loss of smell were almost 3 times more likely to have SARS-CoV-2 antibodies compared to those with loss of taste, suggesting that a loss of smell is a highly specific symptom of COVID-19. Of the 78% of participants testing positive for antibodies, 40% had neither cough nor fever. While the study had limitations, such as the self-reporting of smell/taste changes and the lack of a control group, the researchers believe the evidence indicates that loss of smell should be taken into greater consideration in COVID-19 public health measures such as testing, case isolation, and treatment strategies.

These findings also have significant implications for policy makers globally, as most countries do not recommend self-isolation and testing based on acute loss of smell/taste. This study suggests that an over-reliance on cough and fever as the main symptoms of COVID-19 may be flawed and that loss of smell needs to be urgently recognized globally as a key symptom of COVID-19.

Prof. Rachel Batterham, who led the study, said "Early self-recognition of COVID-19 symptoms by the members of the public, together with rapid self-isolation and PCR testing are vital in order to limit spread of the disease. Currently, most countries around the world do not recognize sudden loss of smell as a symptom of COVID-19.

78% of participants in our community-based study with sudden onset loss of smell or taste had SARS-CoV-2 antibodies. The vast majority had mild symptoms and 40% did not report having a fever or cough. Our findings suggest that people who notice a loss in their ability to smell every day house-hold odors such as garlic, coffee and perfumes should self-isolate and seek PCR testing. Loss of sense of smell needs to be recognized globally by policy makers as a key symptom of COVID-19."
https://www.eurekalert.org/pub_releases/2020-10/p-rcf092920.php
https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1003358

Brazil

Cats develop immunity after coronavirus infection, study suggests; discovery can collaborate with vaccine; Research from Colorado State University in the United States also shows that dogs and felines do not develop the disease

Source: O Globo Tempo Real
ID: 1007952892

RIO — A study published this week in the scientific journal Pnas (Proceedings of the National Academy of Sciences) shows that dogs and cats can be infected by the new coronavirus, although neither species develop the disease. However, what caught the researchers' attention was the fact that felines develop an immune response to the virus, which can help in the development of a vaccine for humans.
Environment: With natural heritage at risk from burning, Brazil is the country where plant species are most discovered
The study reports that dogs, in addition to not getting sick, do not transmit the virus and do not produce immunity. Infected cats released the infectious virus orally and nasally for five days after infection, being able to infect other felines through direct contact.
Inpe:
Pantanal has worst rate of fires since 1998
After contracting SARS-CoV-2, these animals were able to develop a more protective and strong immune response, avoiding further reinfection. However, there is still no information on the duration of this immunity.
"Cats develop significant neutralizing antibodies and are resistant to reinfection, although the duration of immunity in them is not currently known. This can be a useful model for subsequent vaccine testing for both human and animal candidate vaccines," the research says.
Covid-19: Modern vaccine induces antibodies in elderly, study shows
The study was developed by scientists at the School of Veterinary Medicine at Colorado State University in the United States. They recalled that although the coronavirus implications for the animals are still widely unknown, there is no evidence to date that cats or dogs can transmit SARS-CoV-2 to humans.
The authors of the study note that while nearly one million people have died with Covid-19 worldwide, there are only a few reports of animals that have contracted the virus.
https://gphin.canada.ca/cepr/showarticle.jsp?docId=1007952892
Study: https://www.pnas.org/content/early/2020/09/28/2013102117
https://www.nytimes.com/2020/09/29/science/cats-coronavirus-immunity.html

Germany

No clear link between school opening and COVID surge, study finds

Source: National Post
ID: 1007952093

LONDON — Widespread reopening of schools after lockdowns and vacations is generally not linked to rising COVID-19 rates, a study of 191 countries has found, but lockdown closures will leave a 2020 “pandemic learning debt” of 300 billion missed school days.
The analysis, by the Zurich-based independent educational foundation Insights for Education, said 84% of those 300 billion days would be lost by children in poorer countries, and warned that 711 million pupils were still out of school.
“It’s been assumed that opening schools will drive infections, and that closing schools will reduce transmission, but the reality is much more complex,” said IfE’s founder and chief executive Randa Grob-Zakhary.
The vast majority – 92% – of countries that are through their first wave of COVID-19 infections have started to reopen school systems, even as some are seeing a second surge.

IfE found that 52 countries that sent students back to school in August and September – including France and Spain – saw infection rates rise during the vacation compared to when they were closed.
In Britain and Hungary, however, infection levels dropped after initial school closures, remained low during the holidays, and began rising after reopening.
https://nationalpost.com/pmn/health-pmn/no-clear-link-between-school-opening-and-covid-surge-study-finds-2

India

Gene mutation behind different COVID-19 death rates among Indian states, study finds
ID: 1007951302
Source: Tribune India

New Delhi, October 1
Variation in a genetic mutation among Indians may be the main reason behind the difference in the death rates due to COVID-19 across various states of the country, says a study that could inform new policies for controlling the novel coronavirus pandemic.
An international team, led by researchers at Banaras Hindu University (BHU) in Uttar Pradesh, analysed mutations in the gene responsible for the expression of the Angiotensin Converting Enzyme 2 (ACE2), a protein on the surface of cells which is believed to act as a gateway for the novel coronavirus into the human body.
Recent studies have effectively demonstrated that the ACE2 is encoded by a gene located on the X chromosome.
In the journal Frontiers in Genetics, the researchers looked at the frequency of this mutation described as rs2285666 haplotype among various states of India.
Their spatial analysis showed that in India, frequency of this haplotype, or a combination of mutations, varied between 33-100 per cent across different regions.
The researchers, for the first time, also ascertained a significant positive correlation for the mutation with the lower infection and case-fatality ratio (CFR) among Indian populations.
Gyaneshwer Chaubey, Professor at the Department of Zoology, BHU said the variations identified reduce the susceptibility of a person against the novel coronavirus.
"If in a region more people with this haplotype will be present, the infectiousness of the virus would likely be lesser," Chaubey, who led the study, told PTI.
For example, he noted that statewise Maharashtra and Gujarat have the lowest frequency of the gene mutation of about 30-40 per cent while the Northeastern region with a 75-100 per cent mutation in the gene has the highest frequency.
"People in Western India are more susceptible to the disease than those in Central India or East India or South India or Northeast India," Chaubey added.
The study adds important potential implications to understanding the transmission patterns of SARS-CoV-2 in various world populations, said Anshika Srivastava from BHU, who was also a part of the research team.
The researchers noted that as far as policies to control the pandemic are concerned, the study suggests a single rule may not be effective in all the states.
They also observed that in India as well as in Bangladesh, the tribal populations have a higher frequency of this haplotype than the caste populations.
"If we look at casts vs tribals, tribals have higher frequency than the caste groups," said Chaubey, adding it is likely that the tribal populations will be less susceptible than the caste populations to the viral disease.
Additionally, he noted that the virus strains present in India may also be responsible to contribute to the higher death rates, adding that the team is working on the infectiousness of various virus strains present in India in an ongoing study.
Since the beginning, it has been hypothesised, and later observed that coronavirus is affecting people differently.
In their previous research, published in the journal PLOS ONE, the team analysed the whole genome data of the ACE2 gene from various world populations, focusing on South Asia.
They found that Indians were more closer to East and Southeast Asians, whereas from the ancestry point of view, Indians usually remained closer to Europeans than East and Southeast Asians.

"This unexpected info helped us to explore more about the mutations and haplotypes present among Indians. We found out that the rs2285666 associated haplotype increases the ACE2 expression," he said.
"In other words this mutation reduces the susceptibility against coronavirus," said Chaubey.
Noting that the mutation among Indians is 60 per cent and 20 per cent in Europeans, Chaubey said this implies that the Indians are less susceptible to COVID-19 than Europeans and Americans.
"Surprisingly, we found out that the geographic distribution of this haplotype was highly correlated with the number of cases as well as CFR (death rate)," said Chaubey.
"Where frequency of this genetic factor was high, the cases and CFR were less and vice versa," he noted.
Although data have been accumulating, the expression of ACE2 gene variation affecting host susceptibility among the various world populations is not yet known.
"Genetically, most South Asians are more related with West Eurasian populations rather than with East Eurasians, whereas for this gene the result is contradictory," Professor George van Driem of University of Bern in Switzerland, a co-author on the previous study, added.
The researchers said there are a few studies on the ACE2 gene by other groups, but all of them have looked at the frequency differences of various mutations, whereas the team has used more powerful haplotype based analysis. PTI
https://www.tribuneindia.com/news/nation/gene-mutation-behind-different-covid-19-death-rates-among-indian-states-study-finds-149426

Study
Coronavirus: People with Neanderthal genes are at higher risk for Covid-19, study claims
ID: 1007951236
Source: infosurhoy.com

From having an underlying health condition to being obese, a number of risk factors have been shown to increase your risk of coronavirus.
Now, researchers at Karolinska Institutet and Max Planck Institute for Evolutionary Anthropology claim that people with Neanderthal genes are also at higher risk of developing severe Covid-19.
In the study, the team analysed a gene cluster on chromosome 3, and found that people with a certain version of this gene cluster were three times more likely to have severe Covid-19.
A further analysis revealed that this version is very similar to the DNA sequences of 50,000-year-old Neanderthals from Croatia.
Hugo Zeberg, who led the study, said: “It turns out that this gene variant was inherited by modern humans from the Neandertals when they interbred some 60,000 years ago.
“Today, the people who inherited this gene variant are three times more likely to need artificial ventilation if they are infected by the novel coronavirus SARS-CoV-2.”
The study also revealed considerable differences in how common this genetic risk variant is in different parts of the world.
According to the researchers, it’s particularly common among people in South Asia, while in Europe around one in six carry the risk variant.
Meanwhile, the risk variant is almost non-existent in Africa and East Asia.
Svant Paabo, director of the the Max Planck Institute for Evolutionary Anthropology, said: “It is striking that the genetic heritage from the Neandertals has such tragic consequences during the current pandemic.
“Why this is must now be investigated as quickly as possible.”
https://infosurhoy.com/science/coronavirus-people-with-neanderthal-genes-are-at-higher-risk-for-covid-19-study-claims/

Study
Study suggests COVID-19 infects majority of bad dreams
Unique ID: 1007950310
Source: Medical Xpress

Washington, Oct. 1 -- : In a paper published in Frontiers in Psychology, scientists used artificial intelligence to help analyze the dream content of close to a thousand people and found that the novel coronavirus had infected more than half of the distressed dreams reported.
The researchers crowdsourced sleep and stress data from more than 4,000 people during the sixth week of the COVID-19 lockdown in Finland. About 800 respondents also contributed information about their dreams during that time - many of which revealed shared anxiety about the pandemic.
"We were thrilled to observe repeating dream content associations across individuals that reflected the apocalyptic ambience of COVID-19 lockdown," said lead author Dr Anu-Katriina Pesonen, head of the Sleep & Mind Research Group at the University of Helsinki.
"The results allowed us to speculate that dreaming in extreme circumstances reveal shared visual imagery and memory traces, and in this way, dreams can indicate some form of shared mindscape across individuals," added Pesonen.
"The idea of a shared imagery reflected in dreams is intriguing," she added.
Pesonen and her team transcribed the content of the dreams from Finnish into English word lists and fed the data into an AI algorithm, which scanned for frequently appearing word associations.
The computer built what the researchers called dream clusters from the "smaller dream particles" rather than entire dreams.
Eventually, 33 dream clusters or themes emerged. Twenty of the dream clusters were classified as bad dreams, and 55 percent of those had pandemic-specific content.
Themes such as failures in social distancing, coronavirus contagion, personal protective equipment, dystopia, and apocalypse were rated as pandemic specific.
For example, word pairs in a dream cluster labeled "Disregard of Distancing" included mistake-hug, hug-handshake, handshake-restriction, handshake-distancing, distancing-disregard, distancing-crowd, crowd-restriction and crowd-party.
"The computational linguistics-based, AI-assisted analytics that we used is really a novel approach in dream research. We hope to see more AI-assisted dream research in future. We hope that our study opened the development towards that direction," Pesonen said.
The study also offered some insights into the sleep patterns and stress levels of people during the pandemic lockdown. For instance, more than half of respondents reported sleeping more than before the period of self-quarantine, though 10 percent had a harder time falling asleep and more than a quarter reported more frequent nightmares.
Not surprisingly, more than half of study participants reported increases in stress levels, which were more closely linked to patterns like fitful sleep and bad dreams. Those most stressed-out also had more pandemic-specific dreams.
The research could provide valuable insights for medical experts who are already assessing the toll the coronavirus is having on mental health. Sleep is a central factor in all mental health issues, according to Pesonen.
"Repeated, intense nightmares may refer to post-traumatic stress. The content of dreams is not entirely random, but can be an important key to understanding what is the essence in the experience of stress, trauma, and anxiety," she said.
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https://medicalxpress.com/news/2020-10-covid-infects-majority-bad.html
https://www.frontiersin.org/articles/10.3389/fpsyg.2020.573961/full

Domestic Events of Interest

Canada

Outbreak of unknown respiratory illness at Riverview Manor in Peterborough
ID: 1007947361
Source: mykawartha

An unknown respiratory illness has been discovered at Riverview Manor Long Term Care in Peterborough.

On Monday, Sept. 28, Peterborough Public Health published that a new outbreak had been declared at

the Peterborough long-term care facility.

This comes the same day as a second COVID-19 outbreak was declared at Peterborough's Fairhaven Long Term Care.

Over the prior weekend, another unknown respiratory illness that affected seven patients and one staff member, was declared over.

According to the health unit, the onset of the first case at Riverview was recorded on Thursday, Sept. 24.

Peterborough This Week has reached out for more information on this outbreak from the health unit, and is waiting to hear back.

This is the second time Riverview Manor has had an outbreak during the pandemic, as the first was in April during the height of the first wave of COVID-19. That outbreak would be declared over by the health unit during the Summer.
https://www.mykawartha.com/news-story/10211345-outbreak-of-unknown-respiratory-illness-at-riverview-manor-in-peterborough/

Canada

Sprout recalls continue amidst investigation of Salmonella outbreak
Source: Food Recalls – Food Safety News
ID: 1007955346

Fresh sprouted microgreens associated with a Salmonella outbreak were distributed more widely than originally thought. Canadian officials report the recalled sprouts were sent to Nova Scotia in addition to Ontario and British Columbia.
The wider distribution of the Sunsprout brand sprouts is of particular concern because the recalled products have a shelf life through Oct. 13. This is the fourth recall notice related to the microgreens, all of which include alfalfa sprouts.
https://gphin.canada.ca/cepr/showarticle.jsp?docId=1007955346

International Events of Interest

IHR Announcement

26th Meeting of the International Health Regulations (IHR) Emergency Committee for Polio convened by the WHO Director-General on 14 October 2020
Announcement Displayed From: Friday, October 2, 2020 - 11:14

26th Meeting of the International Health Regulations (IHR) Emergency Committee for Polio convened by the WHO Director-General on 14 October 2020

The Director-General is convening the 26th Meeting of the Emergency Committee for Polio under the International Health Regulations on **14 October 2020**. The meeting is only open to Members of the Emergency Committee and to other experts informing the Committee.
The objectives of the meeting include :

1. To review the international spread of poliovirus since the 25th Emergency Committee meeting, the steps taken by affected countries to implement the Temporary Recommendations, and steps by partner agencies in support of affected countries; and
2. To provide views to the Director-General on the current risk of international spread of polio and recommendations to mitigate the risk.

A WHO statement giving an account of the meeting and its conclusions, will be posted on the WHO public website.
Information about the IHR Emergency Committee can found at the following link: https://www.who.int/groups/poliovirus-ihr-emergency-committee

IHR Announcement

Poliomyelitis (Circulating vaccine-derived poliovirus and Wild Poliovirus) – Global update

Announcement Displayed From: Friday, October 2, 2020 - 12:29

Poliomyelitis (Circulating vaccine-derived poliovirus and Wild Poliovirus) – Global update

02 October 2020

Between 1 January and 30 September 2020, there have been several countries affected by poliomyelitis including circulating vaccine-derived poliomyelitis type 1 and 2 (cVDPV1 and cVDPV2) and wild poliovirus type 1 (WPV1) globally. This announcement is a weekly update on the status of cVDPV and WPV1 in these affected countries.

Between 24 and 30 September 2020, there have been one WPV1 in Acute Flaccid Paralysis (AFP) cases and 11 WPV1 positive environmental samples reported in Afghanistan and Pakistan. Moreover, during the same period, there have been 18 cVDPV2 in AFP cases and 8 cVDPV2 positive environmental samples reported in Pakistan, Cameroon, Democratic Republic of the Congo, Guinea and Sudan. Below is the description of the reported cases by country:

- Afghanistan: two WPV1 positive environmental samples
- Pakistan: one WPV1 in AFP case, 9 WPV1 positive environmental samples, three cVDPV2 in AFP cases and two cVDPV2 positive environmental samples
- Cameroon: one cVDPV2 in AFP case and one cVDPV2 positive environmental sample
- Democratic Republic of the Congo: six cVDPV2 in AFP cases
- Guinea: seven cVDPV2 in AFP cases
- Sudan: one cVDPV2 in AFP case and five cVDPV2 positive environmental samples

Please find below the link to the weekly global polio update published by the global polio eradication initiative (GPEI) that includes an update on polio (WPV 1, cVDPV1, and cVDPV2) case count for this week (between 24 and 30 September 2020) and cumulative case count by country since 1 January 2019.
http://polioeradication.org/polio-today/polio-now/this-week/

Public Health Response

The Global Polio Eradication Initiative (GPEI) is continuing to support countries in their response implementation, including field, virological, and epidemiological investigations, strengthening surveillance for acute flaccid paralysis and evaluating the extent of virus circulation. GPEI staff in countries are supporting on adjusting routine immunization and outbreak response to the prevailing COVID-19 situation.

In 2019 and early 2020, the Global Polio Eradication Initiative developed the Strategy for the Response to Type 2 Circulating Vaccine-derived Poliovirus 2020-2021, an addendum to the Polio Endgame Strategy 2019-2023 to more effectively address the evolving cVDPV2 epidemiology, which will drive outbreak response in 2020 and 2021. Necessary adaptations of delivery strategy and timelines are continuously being made.

Accelerating the development of novel oral polio vaccine type 2 (nOPV2) and enabling its use is an important step forward for GPEI. The new vaccine is anticipated to have a substantially lower risk of seeding new type 2 vaccine-derived polioviruses compared to mOPV2.

WHO risk assessment

The continued spread of existing outbreaks due to circulating vaccine-derived poliovirus type 2 as well as the emergence of new type 2 circulating vaccine-derived polioviruses points to gaps in routine immunization coverage as well as the insufficient quality of outbreak response with monovalent oral polio vaccine type 2. The risk of further spread of such strains, or the emergence of new strains, is magnified by an ever-increasing mucosal-immunity gap to type 2 poliovirus on the continent, following the switch from trivalent to bivalent oral polio vaccine in 2016.

The detection of cVDPV2s underscores the importance of maintaining high routine vaccination coverage everywhere to minimize the risk and consequences of any poliovirus circulation. These events also underscore the risk posed by any low-level transmission of the virus. A robust outbreak response is needed to rapidly stop circulation and ensure sufficient vaccination coverage in the affected areas to

prevent similar outbreaks in the future. WHO will continue to evaluate the epidemiological situation and outbreak response measures being implemented.

The COVID-19 pandemic is continuing to affect the global polio eradication effort. Given that operationally polio vaccination campaigns are close-contact activities, they are incompatible with the current global guidance on physical distancing regarding the COVID-19 response efforts. As such, the programme has taken a very difficult decision to temporarily delay immunization campaigns. The overriding priority is to ensure the health and safety of health workers as well as communities. All GPEI recommendations are in line with those on essential immunization and are available here.

The programme has implemented a two-pronged approach to minimise the risk of an increase in polio cases, particularly in areas which are affected by the disease and possibly a spread of the virus to other areas.
i) The programme will continue, to the extent possible, its surveillance activities to monitor the evolution of the situation.
ii) The programme aims to return to action in full strength including with vaccination campaigns, as rapidly as is safely feasible. The timing will depend on the local situation and the programme will then need to operate in the context of the respective countries national health systems risk assessments and priorities. Comprehensive, context-specific plans to resume efforts are being developed, to be launched whenever and wherever the situation allows.

In many countries, polio assets (e.g., personnel, logistics, operations) are assisting national health systems to respond to the COVID-19 pandemic and help ensure the crisis is dealt with as rapidly and effectively as possible.

WHO advice
It is important that all countries, in particular those with frequent travels and contacts with polio-affected countries and areas, strengthen surveillance for acute flaccid paralysis (AFP) cases in order to rapidly detect any new virus importation and to facilitate a rapid response. Countries, territories and areas should also maintain uniformly high routine immunization coverage at the district level to minimize the consequences of any new virus introduction.
WHO's International Travel and Health recommends that all travellers to polio-affected areas be fully vaccinated against polio. Residents (and visitors for more than 4 weeks) from infected areas should receive an additional dose of OPV or inactivated polio vaccine (IPV) within 4 weeks to 12 months of travel.
As per the advice of an Emergency Committee convened under the International Health Regulations (2005), efforts to limit the international spread of poliovirus remains a Public Health Emergency of International Concern (PHEIC). Countries affected by poliovirus transmission are subject to Temporary Recommendations. To comply with the Temporary Recommendations issued under the PHEIC, any country infected by poliovirus should declare the outbreak as a national public health emergency and consider vaccination of all international travelers.

For more information:
- Global Polio Eradication Initiative: http://polioeradication.org/
- Polio Factsheet: https://www.who.int/topics/poliomyelitis/en/
- WHO/UNICEF estimates of national routine immunization: https://apps.who.int/immunization_monitoring/globalsummary/timeseries/tswucoveragedtp3.html
- GPEI Public health emergency status: http://polioeradication.org/polio-today/polio-now/public-health-emergency-status/
- International travel and health: https://www.who.int/ith/en/
- Vaccine-derived polioviruses: http://polioeradication.org/polio-today/polio-prevention/the-virus/vaccine-derived-polio-viruses/
- Use of OPV in the context of COVID-19: http://polioeradication.org/wp-content/uploads/2020/03/Use-of-OPV-and-COVID-20200421.pdf

- Guiding principles for immunization activities during the COVID-19 pandemic: https://apps.who.int/iris/handle/10665/331590
- WHO guidance document - COVID-19: Operational guidance for maintaining essential health services during an outbreak: https://www.who.int/publications-detail/covid-19-operational-guidance-for-maintaining-essential-health-services-during-an-outbreak

United States

CDC investigating Salmonella outbreaks linked to pet bearded dragons, pet hedgehogs
Source: US CDC
ID: 1007954110

CDC is investigating two separate multistate Salmonella illness outbreaks, one linked to contact with pet bearded dragons and one linked to contact with pet hedgehogs. It's important to always wash your hands thoroughly with soap and water after handling your pet, especially animals that are commonly known to spread Salmonella to humans such as small mammals and reptiles.

Salmonella infections linked to contact with pet bearded dragons

Key Points

CDC and multiple states are investigating an outbreak of 13 Salmonella Muenster infections in 8 states. Seven ill people, out of 11 people with information, have been hospitalized. No deaths have been reported.
Investigation findings link these outbreaks to contact with pet bearded dragons. Ten of 13 ill people interviewed (77%) reported contact with a bearded dragon before getting sick.
Ill people reported purchasing bearded dragons from various pet stores in multiple states, but a common supplier has not been identified.
This investigation is ongoing and CDC will provide more information as it becomes available
Salmonella infections linked to contact with pet hedgehogs

Key Points

CDC and multiple states are investigating an outbreak of 32 Salmonella Typhimurium infections in 17 states. Five people were hospitalized. No deaths have been reported.
Investigation findings link the outbreaks to contact with pet Sixteen of 23 ill people interviewed (70%) reported contact with pet hedgehogs before becoming sick.
This outbreak strain is the same as outbreaks linked to hedgehogs in 2012 and in 2019.
A common source of hedgehogs has not been identified. Ill people reported buying hedgehogs from various sources, including pet stores, breeders, and
This investigation is ongoing and CDC will provide more information as it becomes available.
Safe handling of pet bearded dragons and hedgehogs:

Always wash hands thoroughly with soap and water right after touching your pet or anything in its environment.
Don't kiss or snuggle your pet because this can spread Salmonella germs to your face and mouth and make you
Keep your pet out of your kitchen and other areas where you eat, store, or prepare food.
Clean items you use to care for your pet outside the house, if possible. If you clean the items indoors, clean them in a laundry sink or bathtub. Make sure to thoroughly disinfect the area right after.
Don't let children younger than 5 touch the bearded dragon or hedgehog because young children are more likely to have severe Salmonella illness.
Before bringing home a new pet, research the pet's needs and see if it's a good fit for your family.

About Salmonella:

Most people infected with Salmonella develop diarrhea, fever, and stomach cramps 6 hours to 6 days after being exposed to the bacteria.
The illness usually lasts 4 to 7 days, and most people recover without treatment.
In some people, the illness may be so severe that the patient is hospitalized. Salmonella infection may spread from the intestines to the bloodstream and then to other parts of the body.
Children younger than 5, adults 65 and older, and people with weakened immune systems are more likely to have severe illness.
If you have questions about cases in a particular state, please call that state's health department.
https://www.cdc.gov/media/releases/2020/s1001-salmonella-bearded-dragons-hedgehogs.html

Democratic Republic of the Congo
Monkeypox Cases Reported
ID: 1007951319
Source: reliefweb

From 1 January through 13 September 2020, a total of 4,594 suspected cases of monkeypox, including 171 deaths (case fatality ratio 3.7%), have been reported in 127 health zones from 17 out of 26 provinces in the Democratic Republic of the Congo. The first epidemic peak was observed at the beginning of March 2020 (epi week 10), with 136 cases reported weekly (Figure1). From 1 January through 7 August, the Institut National de Recherche Biomédicale (INRB) received 80 samples from suspected cases of monkeypox, of which 39 samples were confirmed positive by polymerase chain reaction. Four out of the 80 specimens were skin lesions (crusts/vesicles), the remaining samples were blood. There is no further information at this time regarding the outcome of these 80 patients whose samples were tested. Confirmatory testing remains ongoing.
During the same period in 2019, 3,794 suspected cases and 73 deaths (CFR 1.9%) were reported in 120 health zones from 16 provinces while a total of 2,850 suspected cases (CFR 2.1%) were reported in 2018.
The provinces reporting the highest number of suspected cases include Sankuru with 973 (21.2%) suspected cases, Mai-Ndombe with 964 (21%) suspected cases, Equateur with 586 (12.8%) suspected cases, Tshuapa with 520 (11.3%) suspected cases and Mongala with 518 (11.3%) suspected cases (Figure 2). From 1 January to 13 September, Kwilu province is reporting the highest case fatality ratio of 16.7% (1 death/6 suspected cases), followed by Tshopo 8.1% (17 deaths/211 suspected cases), and Mai-Ndombe 7.8% (75 deaths/964 suspected cases).
Active outbreaks in Mai-Ndombe province (located south of Equateur province, in the north west side of the country) have been reported since January 2020. The outbreak in Inongo health zone (Mai-Ndombe province) is one of the most concerning outbreaks where one-fourth of its territory is affected. This outbreak has been ongoing since June 2020, comprising 65% of the total number of suspected cases with an estimated case fatality ratio of 10%. Moreover, Inongo health zone borders Bikoro health zone (Equateur province); Equateur province is the location of the current Ebola outbreak, and now also a monkeypox outbreak.
Within the Democratic Republic of the Congo, majority of suspected cases (58%) are above the age of five; however, the case fatality ratio for children under the age of five is higher at 4.2% (80 deaths/1,907 suspected cases) as compared to 3.4% in cases over the age of five (91 deaths/2,687 suspected cases).
Monkeypox cases were reported in health zones which are also experiencing multiple disease outbreaks, including measles, polio due to cVDPV, malaria, cholera, and COVID-19, in addition to an ongoing Ebola virus disease outbreak in Equateur Province which continues to experience armed conflict and violence.
The security situation in the Democratic Republic of the Congo remains unstable, further disrupting surveillance efforts and response activities. Affected regions for this outbreak continue to experience armed conflict and population displacements.
Potential exposure might be linked to proximity to the forest with many possible animal reservoirs,

including for hunting activities.
With global circulation of the virus causing COVID-19 and ongoing insecurity in the region, there is a risk of disruption of access to health care due to the COVID-19 related burden on the health system. As of 16 September 2020, a total of 10,401 cases of COVID-19 including 267 deaths were reported in the DRC.
Public health response WHO is working with national authorities to obtain more information about cases and laboratory capacity. Investigation and confirmation of suspected cases will help to further understand the range of the virus in DRC.
Technical support is being provided to the Ministry of Health to rapidly develop and implement a comprehensive response plan to strengthen surveillance at national and local levels, including further outbreak investigation and response activities.
One major challenge to the current emergency includes inadequate funding to respond to the multiple ongoing outbreaks in the country. Weaknesses of surveillance and laboratories, along with a high number of refugees crossing the border from Kasai province into Angola, could all contribute to further spread of the outbreak.
The support of partners such as the Centers for Disease Control and Prevention (CDC), United Nations High Commissioner for Refugees (UNHCR) and non-governmental organizations (NGOs) will be critical for the control of this outbreak.
WHO risk assessment Monkeypox is a sylvatic zoonosis with incidental human infections that occur sporadically in the rain forests of Central and West Africa. It is caused by the monkeypox virus (MPXV) which belongs to the Orthopoxvirus family, the same group of viruses as smallpox.
There are two distinct clades of monkeypox virus, the Congo Basin clade and the West African clade. Monkeypox due to the Congo Basin clade virus has seen reported mortality of up to 10% of cases, whereas the West African clade usually displays fatal outcomes in less than 1% of cases. HIV infection appears to increase the risk of death in people infected with monkeypox virus.
The animal reservoir remains unknown. However, evidence suggests that native African rodents may be potential sources. Contact with live and dead animals through hunting and bush meat are presumed drivers of human infection. The disease is self-limiting with symptoms usually resolving within 14-21 days. Severe cases occur more commonly among children and immunocompromised population, particularly persons with HIV, and are related to the extent of virus exposure, patient health status and severity of complications. The case fatality ratio has varied between epidemics but has been between 1% and 10% in documented events. There is no specific treatment licensed for monkeypox and a recently approved vaccine is not yet widely available for the public sector.
Since identification of the first human case of monkeypox in 1970 in the Democratic Republic of the Congo (then known as Zaire) in a 9-month-old boy, and until the year 1986, 95% of cases worldwide were reported in the DRC. Cases of monkeypox have also been reported from other African countries - Benin, Cameroon, the Central African Republic, Gabon, Côte d'Ivoire, Liberia, Nigeria, the Republic of the Congo, Sierra Leone, and South Sudan. In 2003, an outbreak occurred in the United States of America following the importation of infected animals. Single imported cases were identified in Israel and the United Kingdom in 2018, and in Singapore in 2019, all following diagnosis in travelers from Nigeria. In the UK, a secondary case was confirmed in a health worker.
With the eradication of smallpox and the subsequent cessation of routine smallpox vaccination, human monkeypox has appeared with increasing frequency in unvaccinated populations.
The risk is assessed as high at national level, moderate at regional level, and low at global level.
WHO advice Several orthopoxviruses, and specifically the monkeypox virus, circulate in wildlife populations and sporadically spill over to affect human beings. Reducing contacts with and reliance on wildlife will enhance disease prevention efforts for zoonoses that affect wildlife, including monkeypox. Strengthening cross-border collaboration with neighboring countries (Republic of Congo, DRC and Central African Republic) including sharing of data and information is needed.
Residents and travelers to endemic areas / countries should avoid contact with sick, dead or live animals that could harbor monkeypox virus (rodents, marsupials, primates) and should refrain from eating or handling bush meat. The importance of hand hygiene using soap and water, or alcohol-based sanitizer should be emphasized. Hand washing stations and infection control initiatives such as use of

disinfectants should be put in place in hospital settings. Any illness during travel or upon return should be reported to a health professional, including information about all recent travel and immunization history. Timely contact tracing, surveillance measures and raising awareness among health care providers are essential to preventing secondary cases and effective management of monkeypox outbreaks. Infection control in health facilities is crucial. Health-care workers caring for patients with suspected or confirmed monkeypox should implement standard, contact and droplet infection control precautions.
Samples taken from people and animals with suspected monkeypox virus infection should be handled by trained staff working in suitably equipped laboratories. Confirmation of monkeypox depends on the type and quality of the specimen and the type of laboratory test. Thus, specimens should be packaged and shipped in accordance with national and international requirements. Polymerase chain reaction (PCR) is the preferred laboratory test given its accuracy and sensitivity. For this, optimal diagnostic samples for monkeypox are from skin lesions - the roof or fluid from vesicles and pustules, and dry crusts. PCR blood tests are often inconclusive because of the short duration of viremia relative to the timing of specimen collection after symptoms begin. Serology is not indicated to detect acute infection. For these reasons, blood should not be routinely collected from patients unless part of research or a wider outbreak investigation which includes identifying previous cases.
Vaccinia vaccine used during the smallpox eradication program was also protective against monkeypox. Some countries and WHO maintain emergency stockpiles of smallpox (vaccinia) vaccine. A new safer third generation vaccinia vaccine (known as modified vaccinia Ankara vaccine) approved in 2019 for prevention of monkeypox is not yet widely available for the public sector. Antiviral agents are also being developed.
WHO does not recommend any restriction for travel to and trade with Democratic Republic of the Congo based on available information at this point in time.
https://reliefweb.int/report/democratic-republic-congo/monkeypox-democratic-republic-congo-disease-outbreak-news-1-october

Democratic Republic of the Congo

Three more fatal Ebola cases reported in DRC outbreak; 128 cases, 53 fatal
Source: CIDRAP
ID: 1007954219

Three retrospective probable Ebola deaths from July have been added to the total in the Democratic Republic of the Congo (DRC) Equateur province, the United Nations Office for the Coordination of Human Affairs (UN OCHA) said in a statement today.

The development lifts the outbreak total to 128 cases and 53 deaths. The three additional probable cases are all in Bolomba health zone, including one in Boyenge health area, which had not previously reported any confirmed or probable cases. UN OCHA also said response teams and medical supplies arrived in Lusengo health zone, the newest affected area in the outbreak.

The outbreak in Equateur province was first detected in June in the same area where an Ebola outbreak in 2018 sickened 54 people, 33 of them fatally.

https://www.cidrap.umn.edu/news-perspective/2020/10/news-scan-oct-01-2020
https://reliefweb.int/report/democratic-republic-congo/rd-congo-note-d-information-humanitaire-epid-mie-de-la-maladie-89

Researches, Policies and Guidelines

Canada

Announcement: Membership of the Reference Group for the Appropriate Review of Indigenous Research

ID: 1007951583
Source: cihr-irsc.gc.ca

CIHR, NSERC, and SSHRC welcome all members of the newly established tri-agency Reference Group for the Appropriate Review of Indigenous Research (Reference Group). Following an expression of interest process launch in early 2020, eighteen individuals have been selected to provide advice and guidance on the development and implementation of culturally appropriate review approaches and practices for research conducted by and with First Nations, Inuit and Métis Peoples. Collectively, the appointees have a deep cultural understanding of Indigenous research and Indigenous Knowledges. They bring together the broad perspectives of youth, Knowledge Keepers and academics (at various career stages), as well as representation from First Nations, Inuit, and Métis Peoples including northern, urban, and on-reserve realities, gender equity and geographic locations. The agencies and Indigenous communities across Canada will benefit from the diversity and collective wisdom of the Reference Group.
Formation of the Reference Group is an important step in implementing the agencies' strategic plan: Setting new directions to support Indigenous research and research training in Canada: Strategic Plan 2019-2022. Co-developed with First Nations, Inuit, and Métis Peoples, the plan will guide development of new models of support of Indigenous research and research training in Canada. It reflects the agencies' and the Canada Research Coordinating Committee's (CRCC) commitment to respond to the Truth and Reconciliation Commission of Canada's call to establish a new relationship with Indigenous Peoples—one that creates a more equal society that respects the value of traditional knowledge systems and is based on mutual respect.
Members
Myrle Ballard, University of Manitoba
Suzy Basile, Université du Québec en Abitibi-Témiscamingue
Amber Bedard, University of Calgary
Aimée Craft, University of Ottawa
Catherine Dussault, Student, Quebec
Kimberly Fairman, Institute for Circumpolar Health Research
Heather Igloliorte, Concordia University
Lawrence Ignace, Yukon
Rebekah Jacques, Western University
Logan MacDonald, University of Waterloo
Georgina Martin, Vancouver Island University
Denise McDonald, University of Alberta
Lorrilee McGregor, Northern Ontario School of Medicine - Laurentian & Lakehead Universities
Julian Robbins, Ontario Federation of Indigenous Friendship Centres
Margaret Robinson, Dalhousie University
Raven Sinclair, University of Regina (Saskatoon Campus)
Suzanne Stewart, University of Toronto
Matthew Wildcat, University of Alberta
https://cihr-irsc.gc.ca/e/52136.html

International

Scientists discover bacteria linked to post-infectious hydrocephalus in infants
ID: 1007951281
Source: news-medical.net

Scientists at the Center for Infection and Immunity (CII) at Columbia University Mailman School of Public Health have discovered bacteria linked to post-infectious hydrocephalus (PIH), the most common cause of pediatric hydrocephalus worldwide. Results of the study led by Pennsylvania State University with CII scientists and clinical colleagues in Uganda are published in the journal Science Translational Medicine.
Hydrocephalus is the most common indication for neurosurgery in children. Of the estimated 400,000 new cases each year, about half are estimated to be post-infectious, with the largest number of cases in low- and middle-income countries, especially sub-Saharan Africa. Neonatal sepsis often precedes PIH,

although the manifestations of hydrocephalus typically emerge in the months following the neonatal period as cerebrospinal fluid accumulates so that cranial expansion garners medical attention. These infants typically die in early childhood without advanced surgical management.
Study co-first author Brent L. Williams, PhD, assistant professor of epidemiology at CII, examined cerebrospinal fluid (CSF) taken from 100 consecutive cases of PIH and control cases of non-post-infectious hydrocephalus (NPIH) in infants in Uganda, testing the samples for evidence of bacterial and fungal microorganisms. He found Paenibacillus species (bacteria) in CSF linked to cases of PIH, not controls. Williams further quantitated Paenibacillus species in infant CSF samples, finding a high burden of these bacteria in infected patients.
The findings were subsequently independently confirmed, and a strain of Paenibacillus was isolated and characterized through further testing by Steven Schiff, MD, the study's senior author, and colleagues at Pennsylvania State University. The researchers also found that Paenibacillus quantity was associated with clinical measures of hydrocephalus based on brain imaging scores, as well as potential signs of infection based on immune cell counts in patients.
Co-senior author W. Ian Lipkin, MD, John Snow Professor and CII Director, noted that "this discovery has the potential to reduce morbidity and mortality of this central nervous system disease in millions of children in sub-Saharan Africa by shifting treatment from surgery to antibiotics and vaccines."
Now that we have identified a pathogen that may be responsible for some cases of post-infectious hydrocephalus, we can develop new, more sensitive tests to quickly detect an infection, assess its severity, identify the source of such infections, and hopefully provide targeted treatments to prevent the development of hydrocephalus."
Source:
Columbia University's Mailman School of Public Health
Journal reference:
Paulson, J.N., et al. (2020) Paenibacillus infection with frequent viral coinfection contributes to postinfectious hydrocephalus in Ugandan infants. Science Translational Medicine. doi.org/10.1126/scitranslmed.aba0565.
https://stm.sciencemag.org/content/12/563/eaba0565

Brent L. Williams, PhD, Assistant Professor of Epidemiology at CII
https://www.news-medical.net/news/20200930/Scientists-discover-bacteria-linked-to-post-infectious-hydrocephalus-in-infants.aspx

Netherlands

Autochthonous dengue in two Dutch tourists visiting Département Var, southern France, July 2020 separator commenting unavailable
Source: eurosurveillance.org
ID: 1007953678

Summary Volume 25, Issue 39, 01/Oct/2020

Volume 25, Issue 39, 01/Oct/2020

We report dengue virus (DENV) infection in two Dutch tourists who visited Département Var, southern France, in July and August 2020. As some autochthonous dengue cases have occurred in Europe in recent years, awareness among physicians and public health experts about possible intermittent presence of DENV in southern Europe is important to minimise delay in diagnosis and treatment. Quick diagnosis can lead to timely action to contain the spread of vector-borne diseases and minimise transmission.
https://www.eurosurveillance.org/content/10.2807/1560-7917.ES.2020.25.39.2001670#abstract_content