

GPHIN Daily Report for 2020-08-20

Special section on Coronavirus

Canada

Areas in Canada with cases of COVID-19 as of 19 August 2020 at 07:00 pm EDT

Source: Government of Canada

Province, territory or other	Number of confirmed cases	Number of active cases	Number of deaths
Canada	123,490	4,619	9,049
Newfoundland and Labrador	268	2	3
Prince Edward Island	44	4	0
Nova Scotia	1,076	5	64
New Brunswick	186	12	2
Quebec	61,316	1,349	5,729
Ontario	40,972	965	2,792
Manitoba	763	223	12
Saskatchewan	1,586	154	22
Alberta	12,501	1,107	227
British Columbia	4,745	798	198
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?topic=tilelink#a1>

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

Canada

Statement from the Chief Public Health Officer of Canada on August 19, 2020

From: [Public Health Agency of Canada](#)
ID: 1007666076

Statement

August 19, 2020 - Ottawa, ON - Public Health Agency of Canada

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

"There have been 123,154 cases of COVID-19 in Canada, including 9,045 deaths. 89% of people have now recovered. Labs across Canada have tested 4,880,172 people for COVID-19 to date. Over the past week, an average of over 48,700 people were tested daily, with 0.8% testing positive. Over the last several weeks, national daily case counts have ranged from 350 to 500 cases, with just over 390 cases being reported daily during the most recent 7 days.

As public health authorities and Canadians continue with our collective effort to limit the spread of COVID-19, we are closely monitoring disease activity indicators such as daily case counts, number of cases hospitalised and the percentage of people testing positive in order to inform, adjust and adapt our actions as needed.

Currently, our efforts indicate that we are keeping COVID-19 spread under manageable control. Average daily case counts continue fall in the range of 350 to 500 new cases daily across the country. With reduced reporting over the weekend, Monday saw the usual jump in COVID-19 case reporting, with 785 new cases reported. However, the 7-day rolling average smooths out the weekend lows and Monday high to an average of 391 cases reported daily over the past 7 days, which is within the current range.

We will continue to see new cases as COVID-19 circulates in Canada and worldwide, but we've also improved our ability to manage spread going forward. We've built up capacity across health, public health, and laboratory systems and economic and social spaces have been modified to reduce exposure risks as they have reopened. Most importantly, we have all learned the importance of key public health measures like physical distancing, hand hygiene and extra layering with non-medical masks and other precautions to reduce our risk of infection and spreading the virus.

As we continue with reopening, including very importantly our schools, this won't be 2019's back to work and school, but back to modified spaces, adapted routines, and mitigation protocols that are an integral part of our cautious approach to reopening to keep the COVID-19 infection rate down. There will be uncertainties ahead but we have shown strength and adaptability throughout and Canada's children will continue to show their resilience as they get back to in-school learning and socializing that is key to helping them achieve their best long-term outcomes.

Today, I also want to acknowledge another group of resilience builders. Throughout the COVID-19 crisis, humanitarians have been working to protect those at high risk of COVID-19 and build resilience in communities across Canada and around the world. Today on World Humanitarian Day, I want to salute these real-life heroes who live and work among us.

Lets all thank them, along with all our essential workers, today and everyday. We can all make their job that much easier by brushing up on our COVID-19 Know How and doing our part to keep the infection rate low. Understanding the risks, following local public health guidance and taking appropriate precautions will help us make informed decisions to keep us, our families, and our communities safer. You can find additional information and guidance [here](#)."

Contacts

Media Relations

Public Health Agency of Canada
613-957-2983
hc.media.sc@canada.ca

Search for related information by keyword: [HE Health and Safety](#) | [Public Health Agency of Canada](#) | [Health Canada](#) | [Canada](#) | [Coronavirus \(COVID-19\)](#) | [media](#) | [statements](#)
<https://www.canada.ca/en/public-health/news/2020/08/statement-from-the-chief-public-health-officer-of-canada-on-august-19-2020.html>

Canada

[APG]

Family doctors worried about COVID-19 and flu season want clear guidance from public health

Source: CTVNews.ca - Health - Public RSS

Published: 2020-08-19 19:57 UTC

Received: 2020-08-19 19:57 UTC (0 minutes)

Unique ID: 1007666275

TORONTO -- Is it a cold? The flu? Or is it COVID-19? Canadian doctors may have no choice but to test everyone with respiratory symptoms this coming fall as students and parents anxiously gear up to go back to school in a few short weeks.

Doctors across the country, worried about the daunting unknowns in the weeks and months ahead, are asking for guidance from public health officials as their offices prepare for the potential onslaught of cold and flu season during what is expected to be another wave of coronavirus infections. Part of the concern is over protocol and process, but also access to care for patients should family practices and clinics need to close because of an outbreak.

"We are not going to be able to tell the difference between what influenza is, potentially what a common cold is, and what COVID is," said Dr. Iris Gorfinkel, a family physician in Toronto, with PrimeHealth Clinical Research.

"For that reason all patients with any flu-like symptoms will have to get screened for COVID-19."

Doctors with the Canadian Medical Association (CMA) say they are hearing a lot of concerned physicians asking questions about how to tackle the next few months and believe a plan is necessary.

"Reopening up our schools is an experiment in real life," said CMA President Dr. Sandy Buchman.

"We really don't know yet how it's going to turn out. So in this experiment I feel we have to be very proactive in ensuring we have the capacity to test, trace, and isolate quickly."

Doctors' questions include: should patients exhibiting respiratory symptoms be sent straight to COVID testing centres? Should they be triaged differently? What about headaches, diarrhea, unexplained chest pains or shortness of breath? And what should doctors do if they or their own children get sick?

These concerns are top of mind for many doctors like Gorfinkel, who says these symptoms make up a large portion of the patients she sees as a family doctor. Meanwhile, she is also a parent herself with three children the youngest of whom is in high school* .

"She is now going into grade 10. Am I worried? Am I concerned? Absolutely," Gorfinkel said of her youngest daughter, who worries about her potential to become a super spreader.

"If she were asymptomatic and transmitted it to me, I may not have any idea that I'm potentially infectious to others."

And what if it was a classmate that tested positive? All these scenarios raise questions about whether Gorfinkel should be regularly tested, and if so, how often.

Hospital staff are generally expected to get tested every week, but there are currently no guidelines on how often asymptomatic health-care workers should be tested, she said.

And if a doctor does test positive, they have to close their practice and go into quarantine for two weeks. Patients who were in direct contact with the doctor in the prior two weeks need to be notified and tested as well.

"If I were feeling fine and asymptomatic, I would carry on virtual care from home, but that would put an end to the in-person visits for the next two weeks."

The incoming CMA president has also been fielding similar concerns.

"Do I stay away from the office? From the hospital? Concern is really around care for our patients being able to not have too much of a disruption," said Fredericton-based Dr. Ann Collins, the CMA's president-elect.

"What about the surgeon whose little girl is sent home from daycare with symptoms? Does she cancel her OR list? There are all kinds of care-related concerns."

Collins, a family doctor for more than 30 years, says there is confusion and "lack of clarity early on about who to turn to, to find out about these pragmatic, day to day concerns."

Meanwhile, some doctors say masks, gloves, and gowns are still in short supply.

"It varies by jurisdiction, but we are still hearing from doctors that they don't yet have a full supply or they're still having to purchase it themselves," said CMA's Buchman.

At the same time, emergency room doctors say they already get easily overwhelmed during normal cold and flu seasons. What will happen to hospital ERs if family doctors choose not to see patients with respiratory symptoms, or if they close clinics because of COVID-19 outbreaks?

Dr. Alan Drummond from the Canadian Association of Emergency Physicians calls it a “double edged sword” if there’s both a flu and COVID outbreak.

“We have survived the first part of the pandemic,” said Drummond.

“Now’s the time to say OK, we don’t know if a second wave is coming or if this surge is going to increase suddenly, but we now have the wherewithal to plan. So let’s start planning.”

<https://www.ctvnews.ca/health/coronavirus/family-doctors-worried-about-covid-19-and-flu-season-want-clear-guidance-from-public-health-1.5070548>

Canada

Employee at south Barrie Canadian Tire tests positive for COVID-19

Source: Barrie 360

Published: 2020-08-18 22:13 UTC

Received: 2020-08-19 12:38 UTC (+14 hours 25 minutes)

Unique ID: 1007663223

Facebook Twitter

The Simcoe Muskoka District Health Unit is aware of a reported case of COVID-19 involving a worker at the south end Canadian Tire in Barrie.

At a media briefing Tuesday, Dr. Charles Gardner had few details except that an investigation had been launched to determine how the individual got the virus. Contact tracing is also underway.

The case is not the one posted by the health unit on Tuesday which involves a Barrie man who contracted the illness through a close contact.

<https://barrie360.com/employee-at-south-barrie-canadian-tire-tests-positive-for-covid-19/>

Canada

Group of Dofasco workers in self-isolation after colleague tests positive for COVID-19

Source: TheSpec.com

Published: 2020-08-18 19:08 UTC

Received: 2020-08-19 12:37 UTC (+17 hours 29 minutes)

Unique ID: 1007663210

Group of Dofasco workers in self-isolation after colleague tests positive for COVID-19

By Sebastian Bron Spectator Reporter

Tue., Aug. 18, 2020timer1 min. read

A group of Dofasco employees have been told to self-isolate after a worker on the galvanizing line tested positive for COVID-19.

Spokesperson Marie Verdun said “less than 10” workers were identified as potential close contacts of the case, who tested positive Aug. 13. The person last worked a shift on Aug. 9.

“Because our colleague has close contact (away from work) with an employee in the iron-making business unit, additional colleagues there have also been advised to self-isolate,” Verdun said in an emailed statement.

The new infection brings Dofasco’s total case count amid the pandemic to nine.

Seven of the cases were company employees and two were third-party contractors. None of the cases were connected to each other, Verdun said.

One case, a worker in the material handling and logistics unit, tested positive for COVID-19 after an autopsy examination May 10. He was 60.

The city recorded four new positive cases of COVID-19 on Tuesday, bringing its total case count to 951. About 90 per cent of cases — 858 — have been resolved, while 48 cases remain active.

Sebastian Bron is a Hamilton-based reporter at The Spectator. Reach him via email: sbron@thespec.com

<https://www.thespec.com/news/hamilton-region/2020/08/18/group-of-dofasco-workers-in-self-isolation-after-colleague-tests-positive-for-covid-19.html>

Canada

Quebec outlines plan for second COVID-19 wave

Source: YorkRegion.com

Published: 2020-08-19 14:08 UTC

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Unique ID: 1007664246

MONTREAL — Each long-term care home in Quebec will have a single person responsible and accountable for its response to COVID-19, Health Minister Christian Dube said Tuesday as he moved to shore up the vulnerable sector ahead of a potential second wave of the novel coronavirus.

Health-care staff will also be prevented from working in more than one seniors centre and unknowingly carrying the virus into multiple facilities, the health minister said.

Speaking to reporters in Quebec City, Dube said the government was giving itself six weeks to execute the multi-pronged action plan he announced Tuesday that he said will ensure a swifter, more nimble response if cases rise again.

Many of the measures to be put in place by the end of September are aimed at avoiding a second disaster in the long-term care sector, which accounted for the bulk of the province's 5,727 deaths attributed the virus.

A key component of the plan is to name a manager who will lead each of the province's roughly 400 long-term care homes. Quebec Premier Francois Legault has said that at the beginning of the pandemic, one person was often responsible for multiple long-term care facilities, creating confusion and diffusing accountability.

The new managers, who will each be assisted by an infection-control specialist, will be responsible for ensuring government directives are followed. "I don't want any more excuses that it's not clear," Dube said. He promised that managers who do not follow directions would face consequences, although he did not say what they would be.

Dube stressed that the existing managers of long-term care homes were not responsible for the failures of the first wave, which exposed the weaknesses of a system he described as fragile and under-resourced.

Rather, he said, many managers were unable to respond to the pandemic due to a combination of staff shortages, lack of training and infection control, and directives that were unevenly applied, all of which he expects the new plan to address.

"The elected officials as well as the managers will be accountable," he said. "But what we want to do with the action plan, with the amounts we're talking about, is to have managers and elected officials to work with the right tools."

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Dube's strategy also includes rapid mass testing, maintaining access to surgeries, and ensuring the province has enough medical equipment to cover a potential second wave.

"With the virus, our best weapon is agility and speed," he said.

Dube also announced an additional \$106 million for public health, which will allow regional health establishments to hire some 1,000 full-time workers to help with contact tracing, infection control and administering an eventual vaccine.

The government has already hired 10,000 orderlies, who are expected to enter the workforce in the next few weeks.

Seniors Minister Marguerite Blais said Tuesday many of the elements of the action plan will have a lasting positive effect on the long-term care sector. She said the government will present a longer-term policy on the seniors facilities this fall.

Meanwhile, Quebec reported on Tuesday 46 new COVID-19 cases and six additional deaths linked to the novel coronavirus.

The number of hospitalizations remained unchanged at 145 while the number of people in intensive care increased by two to 27.

Quebec has been by far the hardest-hit Canadian province, with 61,252 COVID-19 infections since the beginning of the pandemic.

While new cases have been declining in recent weeks, Dube warned the virus is still circulating in the province.

He said the current "period of calm" was not a sign the virus was gone, but rather a chance to prepare for a likely rise in infections in the fall.

Dube said Quebec has successfully contained recent outbreaks, suggesting the province is better prepared to move quickly if a second wave comes.

This report by The Canadian Press was first published Aug. 18, 2020.

By Morgan Lowrie, The Canadian Press

<https://www.yorkregion.com/news-story/10140908-quebec-outlines-plan-for-second-covid-19-wave/>

Canada

Coronavirus: UofT launches Institute for Pandemics after donation

Source: Toronto | Globalnews.ca

Published: 2020-08-19 15:13 UTC

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Unique ID: 1007664404

TORONTO – The University of Toronto says it has launched a pandemic institute to help shape government responses to the COVID-19 crisis.

The university says the institute will focus on working with public health workforces to help with pandemic preparation and recovery.

It says the institute will also help with Canada's capacity to model infectious diseases.

[Sign up for our Health IQ newsletter for the latest coronavirus updates]

The academic body will study how the pandemic has worsened inequality between the rich and poor around the world.

Dean Adalsteinn Brown says academics have the freedom to move faster than governments and are politically neutral, allowing them to help respond quickly to emerging threats.

The Institute for Pandemics was launched after a \$1 million donation from Toronto philanthropist Sabina Vohra-Miller

<https://globalnews.ca/news/7285725/coronavirus-university-of-toronto-institute-for-pandemics/>

Canada

Ontario reports 102 new COVID-19 cases, Toronto strip club patron tests positive for virus

Source: CBC News

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Unique ID: 1007664402

Ontario is reporting 102 new cases of COVID-19 Wednesday, one day after the province saw its highest daily increase of the month, Health Minister Christine Elliott says.

On Tuesday, Ontario reported 125 new cases of the illness, the most on any single day since the end of July.

On Wednesday, Elliott says, 30 of the province's 34 public health units reported five or fewer cases, while 17 reported no new cases at all.

Meanwhile in Toronto, the city's public health agency says a patron at a strip club has tested positive for COVID-19, following an earlier announcement that an employee there had the coronavirus.

Toronto Public Health said it has attempted to contact all of the approximately 550 people who may have come into contact with the Brass Rail employee who tested positive.

It says the patron who tested positive is from a region outside Toronto, and officials are in touch with the corresponding health unit.

The case remains under investigation and local public health authorities will be following up with the individual to request information on all possible sources of investigation.

The agency is asking anyone who attended the Brass Rail Tavern from August 4th to 8th to monitor themselves for COVID-19 symptoms.

Toronto Public Health says the strip club is now following pandemic operating guidelines, after an initial investigation found the venue was not following rules.

The agency says it is completing routine inspections of adult entertainment venues throughout the city.
<https://www.cbc.ca/news/canada/toronto/patron-of-toronto-strip-club-patron-tests-positive-for-covid-19-hundreds-potentially-exposed-1.5691818?cmp=rss>

Canada

Parents, staff will be notified of COVID-19 cases at schools, promises OPH

Source: CBC News

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Unique ID: 1007664310

Ottawa Public Health (OPH) says it will be transparent with educators and parents of children who may have come in contact with a positive COVID-19 case at school, even when an outbreak hasn't been declared.

During a teleconference Tuesday, Vera Etches, Ottawa's medical officer of health, said an outbreak will be declared when two people at a single school test positive, and both cases are found to have a link to the school environment. The policy is in line with provincial draft guidelines, she said.

That definition is a departure from how OPH has defined outbreaks at other institutions so far during the pandemic. At long-term care homes and daycares, for example, a single confirmed case prompts officials to declare an outbreak and is publicized online.

Etches said all outbreaks at schools will be similarly reported to the general public; however, if just one case is discovered at a school, a public health nurse will phone all potential contacts to notify them of next steps and whether they also require testing.

"Everyone understands that parents want as much information as possible," Etches said.

"Locally in Ottawa, what's important is having the information you need to protect your family and make decisions yourselves. So really, for those parents in a school where there is one case, and it's not declared an outbreak, we will be communicating with the parents who need to know that."

First death in August declared

OPH reported the city's first COVID-19-related death this month, bringing the total number of fatalities since the pandemic began to 265.

Tuesday's update marks the first death in the city since July 28.

There are eight new cases of COVID-19 in Ottawa, for a total of 108 active cases. Twenty-one more cases have been marked as resolved, for a total now standing at 2,355.

OPH reported two new outbreaks at long-term care homes in the city after one staff member tested positive at Residence Saint-Louis, and another at Billingwood Manor. There are now five institutional outbreaks in Ottawa.

Twelve people remain hospitalized with COVID-19, with one patient currently in intensive care.

Province processed 23K tests Monday

Ontario is reporting 125 new cases of the illness, a slight uptick from recent days.

Ontario's health minister said that's mostly attributed to localized increases, with 17 new cases in Peel, 27 in Toronto and 28 in Windsor-Essex.

Christine Elliott added 27 of the province's 34 public health units reported five or fewer cases on Monday. Sixteen reported no new cases.

Provincewide, 23,000 tests for COVID-19 were processed Monday.

<https://www.cbc.ca/news/canada/ottawa/new-covid-19-death-ottawa-8-cases-1.5690673>

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

United States

COVID-19 in Newly Resettled Refugee Populations

Source: CDC

Updated Aug. 19, 2020

Refugees to the United States, especially those who are recently resettled, may be in living or working conditions that put them at risk of getting COVID-19. Some refugees also have limited access to health care, as well as certain underlying medical conditions that put them at higher risk of more severe illness from COVID-19, compared to the rest of the U.S. population.

A refugee is someone who has been forced to flee their country because of a well-founded fear of persecution for reasons of race, religion, nationality, or political opinion. Nearly 750,000 refugees resettled in the United States from 2008 to 2019, and thousands more have resettled since then.

Refugees are eligible for U.S. government-funded resettlement help, including healthcare benefits such as short-term health insurance for up to 8 months after arrival, and a medical exam within 90 days of arrival. The impact of COVID-19 on the lives of resettled refugees remains unknown, as COVID-19 is a new disease. Meeting the healthcare and everyday needs of refugees, especially during health emergencies, can help keep communities safe.

Guidance for Refugees Upon Arrival in the United States



Welcome Booklet for Refugees

- [Amharic pdf icon](#)[PDF - 8 pages]
- [Arabic pdf icon](#)[PDF - 8 pages]
- [Burmese pdf icon](#)[PDF - 8 pages]
- [Dari pdf icon](#)[PDF - 8 pages]
- [English pdf icon](#)[PDF - 8 pages]
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- [Ukrainian pdf icon](#)[PDF - 8 pages]

Refugees come from diverse regions of the world, and professionals working with them need to understand the health risks in the countries they are departing, including the risk of COVID-19. One resource is CDC's [Travel Health Notices](#), which notifies travelers and other audiences about the risk of COVID-19 in destinations around the world. Learn how CDC determines the [level of a country's COVID-19 Travel Health Notice](#).

Public health professionals, community organizations, resettlement agencies, and healthcare providers can assist refugees arriving in the United States by providing them with information they need to protect themselves from COVID-19.

- CDC's [After You Travel](#) recommendations for inbound international travelers provides useful information for arriving refugees.
- When talking with newly arrived refugees, local refugee health partners and resettlement agency staff should reiterate concepts in the Welcome booklet for refugees and provide them with local and state COVID-19 information and contact information for healthcare providers.

What Can Be Done for Refugee Health During the COVID-19 Pandemic

Groups that want to help refugees and those who already serve refugees can share culturally sensitive resources on COVID-19 prevention, symptoms, and self-management. The Department of Health and Human Services, Office of Refugee Resettlement (ORR) provides a list of key [state contactsexternal icon](#) who can connect to these partners.

[Communication Resources for Migrants, Refugees, and Other Limited-English-Proficient Populations](#)

Public health professionals can:

- Collect data about the sociodemographic and clinical characteristics of refugees who have COVID-19 to understand risk and identify appropriate methods to communicate prevention and control messages to refugee communities.
- Share information and work with resettlement agencies and other partners, such as health care systems and education, faith-based, employer, transportation, and housing organizations to find ways to break down social and economic barriers that block COVID-19 prevention efforts.
- Create health promotion multimedia materials in different languages that are appropriate for different cultures and/or literacy levels. These materials should be in print and online formats, including social media, so partners can use what is appropriate for their local refugee groups.
- Communicate often about COVID-19 with partners that assist refugees to learn about the impact of the disease on different refugee groups. Use these findings to better understand cultural, economic, social, and health factors among refugees that may have implications for them during the COVID-19 pandemic. Make sure the tailored communication is, clear, transparent, and credible.
- Provide background information for [healthcare professionals and health systems](#) to understand key demographic, cultural, and health characteristics of specific refugee groups resettling in the United States and health care considerations for these populations, such as [CDC's Refugee Health Profiles](#) and the [CDC's Refugee Health Guidelines](#).

Community organizations and resettlement agencies can:

[Resources for Refugee Resettlement Service Providers](#)

- [Share COVID-19 resources](#) that are culturally sensitive for community, work, school, and home settings.
- Train community health workers in refugee communities to educate people about COVID-19 and link refugees to free or low-cost services.
- Work across different businesses and services to connect refugees with services, such as grocery delivery support or temporary housing, that help them [practice social distancing](#), especially when individuals or household members become sick or test positive for COVID-19.
- Work with partners to connect refugees with the community resources they need when refugees become sick or test positive for COVID-19, including medicines, healthcare providers, and mental health services.
- Help refugees get access to items to help prevent the spread of COVID-19, such as masks, soap, hand sanitizer, or household cleaners.

Healthcare systems and healthcare providers can:

- Provide language interpretation services in all relevant settings, such as phone triage and intake, inpatient units, and outpatient services.
- Learn about patients' barriers to COVID-19 prevention, and then work with resettlement agencies and other partners to reduce them.

- Reach out to patients and gather their updated contact information, preferred method of communication, and a plan for staying in contact if someone in their home gets sick with COVID-19.
- Where possible, incorporate telemedicine into health care settings if refugees have the means and are able to conduct virtual clinic visits.
- [Share resources](#) that use a culturally sensitive approach to educate patients about the impact of COVID-19, how to stay protected, and how to get care safely when needed.
- Connect newly arrived refugees who have [underlying medical conditions](#) to community partners that can help them develop and continue with their [care plans](#) and help them get needed supplies and medicines.

Why Refugees May Be at Higher Risk During COVID-19 Outbreak

Due to social and economic conditions, resettled refugees face many of the same challenges that lead to poorer health for some [racial and ethnic minority groups in the United States](#). Refugees also face the challenges of a new healthcare system and finding health information they can understand.

Living conditions and personal circumstances



What Refugees Can do if They are at Increased Risk of Severe Illness from COVID-19

- [Amharicpdf icon](#)
- [Arabicpdf icon](#)
- [Burmesepdf icon](#)
- [Daripdf icon](#)
- [Englishpdf icon](#)
- [Farsipdf icon](#)
- [Frenchpdf icon](#)
- [Haitian Creolepdf icon](#)
- [Karenpdf icon](#)
- [Kinyarwandapdf icon](#)
- [Nepalipdf icon](#)
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For many resettled refugees, their living conditions may make it hard to prevent getting sick with COVID-19, or to seek treatment if they do get sick.

- Several generations residing in one house can make it hard to [protect older family members](#), as well as those of any age who have certain underlying medical conditions, such as diabetes or asthma. This may also make it difficult to isolate those who are sick, especially if living space is small, such as an apartment or a small house.
- Living in neighborhoods (urban or rural) that are far from healthcare, grocery stores or pharmacies can make it harder to get care if sick, and more difficult to stock up on medicines or other supplies.
- Lack of personal transportation such as a car can make it difficult to get to healthcare facilities, work, or stores. Refugees rely on public transportation such as buses, ride share, and trains, which are limited in some areas, especially during the current pandemic.
- Lack of access to television, radio, or Internet can make it difficult to get information about COVID-19. Refugees may not be able to read or understand English.
- Not yet being integrated into the community can limit potential support and links to friends, religious leaders, or community organizations.

Work circumstances

With the help of resettlement agencies, refugees often work in entry-level jobs, where the type of work, and workplace policies, can increase the risk of getting sick with COVID-19. Two factors may increase risk:

- **Being a critical worker:** The risk of infection may be greater for refugee workers in essential industries, such as meat-packing plants, grocery stores, and factories. These workers often are required to be at the job site despite outbreaks in their communities, and many can't afford to stay home. Some of these kinds of jobs require public contact and close contact among fellow workers, increasing the risk of getting or spreading COVID-19.
- **Not having sick leave:** Refugees without paid sick leave may be more likely to keep working when they are sick or be exposed to someone who is sick with COVID-19—which means that they are more likely to spread COVID-19 to other workers, including other refugees who oftentimes work in the same facilities.

Underlying medical conditions and lower access to care

Some refugees have underlying medical conditions and face barriers to healthcare, which may put them at higher risk of COVID-19. These include:

- **Lack of health insurance:** Refugees can access healthcare in the early resettlement period, with the help of resettlement agencies. However, after their short-term health insurance expires, up to 50% of refugees may be uninsured.
- **Language barriers:** Language barriers can affect healthcare access at every stage, from making an appointment, to relaying health concerns, to filling a prescription, or to taking medicine as prescribed. Language barriers may also prevent refugees from getting COVID-19 information that is not written using common everyday words with visuals and culturally relevant. Healthcare providers, clinics, or community groups can provide interpretation services to help fill these gaps.
- **Underlying medical and mental health conditions:** Compared to the general U.S. population, refugees may have certain underlying medical conditions (for example, diabetes) that put them at higher risk of more severe illness from COVID-19, as well as mental health conditions (e.g., post-traumatic stress disorder and depression). These conditions may be poorly controlled due to many years without regular preventative care.
- **Stigma and perceived discrimination:** These issues may prevent refugees from seeking care or being honest with their healthcare providers about their health needs.

Despite these barriers, refugees have the support of resettlement agencies, community groups, [state refugee coordinator](#)[external icon](#), and healthcare providers. State, local, and community response to COVID-19 should include working with these resource groups in their COVID-19 response efforts, who are trusted members of refugee communities.

Helpful Resources:

[COVID-19 in Racial and Ethnic Minority Groups](#)

[Households Living in Close Quarters: How to Protect Those That Are Most Vulnerable](#)

[Guidance for Large or Extended Families Living in the Same Household. \(Living in Shared Housing\)](#)

[Print Resources](#)

[CDC Refugee Health Profiles](#)

[CDC Resources in Languages Other than English](#)

[HHS Administration for Children & Families Office of Refugee Resettlement \(ORR\) Key Contact List](#)[external icon](#)

[HHS Administration for Children & Families Office of Refugee Resettlement: Refugees](#)[external icon](#)

[NIH HealthReach: Health Information in Many Languages](#) [external icon](#)

[People at Higher Risk for Severe Illness](#)

[Stress and Coping](#)

<https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/refugee-populations.html>

United States

COVID-19 Employer Information for Rail Transit Operators

Source: CDC

Updated Aug. 18, 2020

Coronavirus disease 2019 (COVID-19) is a respiratory illness (see list of [symptoms](#)) caused by a virus called SARS-CoV-2.

Here's what we currently know:

- The main way the virus [spreads](#) is from person to person through respiratory droplets when people cough, sneeze or talk.
- You may also be able to get COVID-19 by touching a surface or object that has the virus on it, and then touching your face, mouth, nose, or eyes.
- The virus may be spread by people who do not have symptoms.

COVID-19 can sometimes cause serious health problems. [People at increased risk for severe illness](#) include:

- Older adults
- People of any age who have certain underlying medical conditions

As a rail transit operator employer, your workforce might come into contact with the virus when

- In [close contact](#) (within about 6 feet) with other people at the worksite, which can include passengers, coworkers, transit station, and maintenance workers.
- Touching or handling high-contact surfaces and equipment, and then touching their face, mouth, nose, or eyes.

How You Can Protect Your Staff and Others and Slow the Spread

Evaluate your workplace to identify scenarios where workers cannot maintain [social distancing](#) of at least 6 feet from each other and/or customers. Use appropriate combinations of controls following the [hierarchy of controls](#) to address these situations to limit the spread of COVID-19. A committee of both workers and management staff may be most effective at recognizing all scenarios.

While protecting workers, it is important to note that control recommendations or interventions to reduce risk to spreading COVID-19 must be compatible with any safety programs and personal protective equipment (PPE) normally required for the job task. Approaches to consider may include the following:

Create a COVID-19 Workplace Health and Safety Plan

Review the [CDC Interim Guidance for Businesses and Employers](#) and the [Resuming Business Toolkit](#) for guidelines and recommendations that all employers can use to protect their employees.

- Identify an on-site workplace coordinator who will be responsible for COVID-19 assessment and control.
 - When developing plans, include all employees in the workplace, for example: staff, utility employees, relief employees, janitorial staff, supervisory staff, rail transit operators, transit station workers, and transit maintenance workers.
 - Develop plans to communicate with passengers entering the transit vehicle regarding modifications to work or service processes.
 - Notify all workers that any COVID-19 concerns should be directed to the identified coordinator.
- Implement flexible sick leave and supportive policies and practices.
 - Develop policies that encourage sick employees to stay at home without fear of reprisals, and ensure employees are aware of these policies.
 - If contractors are employed in the workplace, develop plans to communicate with the contracting company regarding modifications to work processes.

- Consider conducting daily in-person or virtual health checks (e.g., symptom and/or temperature screening) of employees on scheduled workdays.
 - Screening options could include having employees self-screen prior to arriving at work or having on-site screening by taking employees' temperatures and assessing other potential symptoms prior to beginning work. (see CDC [Interim Guidance for Businesses and Employers](#))
 - Make sure employees can maintain at least 6 feet of distance while waiting for screening.
 - Make employee health screenings as private as possible and maintain confidentiality of each individual's medical status and history.

Take action if an employee is suspected or confirmed to have COVID-19.

- Immediately separate employees who report with or develop symptoms at work from other employees and arrange for private transport home. These employees should self-isolate and contact their health care provider immediately.
- Close off any areas used for prolonged periods of time by the sick person.
- Perform [cleaning and disinfection](#) after anyone suspected or confirmed to have COVID-19 has been in the workplace. Cleaning staff should clean and disinfect offices, bathrooms, common areas, and shared electronic equipment used by the ill person, focusing especially on frequently touched surfaces. If other workers do not have access to these areas or items, wait 24 hours (or as long as possible) before cleaning and disinfecting.
- Employees who test positive for COVID-19 should immediately notify their employer of their results.
 - Sick employees should follow [CDC recommended steps](#) to self-isolate or seek care. Employees should not return to work until they meet the criteria to [discontinue home isolation](#), in consultation with healthcare providers.

Develop hazard controls using [the hierarchy of controls](#) to prevent infection among workers. You may be able to include a combination of controls noted below.

- **Engineering Controls (Isolate people from the hazards)**
Alter the workspace using engineering controls to prevent exposure to the virus that causes COVID-19.
 - Where possible, establish physical barriers between coworkers and between workers and passengers.
 - Use strip curtains, plastic barriers, or similar materials to create impermeable dividers or partitions.
 - Close or limit access to common areas where employees are likely to congregate and interact, such as break rooms, parking lots, and in entrance/exit areas.
 - Consider making foot-traffic single direction in narrow or confined areas in the transit vehicle to encourage single-file movement at a 6-foot distance.
 - Use visual cues such as floor decals, colored tape, and signs to remind workers to maintain distance of 6 feet from others, including at their workstation and in break areas.
 - Consider these cues for passengers as well, such as at the entry doors.
 - Place hand sanitizers with at least 60% alcohol in multiple locations throughout the transit vehicle for workers and passengers.
 - Use touch-free stations where possible.
 - Make sure restrooms are well stocked with soap and paper towels.
- **Administrative Controls (Change the way people work)**
Provide training and other administrative policies to prevent the spread of COVID-19.
 - All workers should have a basic understanding of COVID-19, [how the disease is thought to spread](#), what the [symptoms](#) of the disease are, and what measures can be taken to [prevent or minimize transmission](#) of the virus that causes COVID-19.
 - Trainings should include the importance of social distancing (maintaining a distance of 6 feet or more when possible), [wearing cloth face coverings or masks](#) appropriately, [covering coughs and sneezes](#), [washing hands](#), [cleaning and disinfecting frequently](#) touched surfaces, not sharing personal items or tools/equipment unless absolutely necessary, and not touching their face, mouth, nose, or eyes.

- Workers should be encouraged to go home or stay home if they feel sick. Ensure that sick leave policies are flexible and consistent with public health guidance, and that employees are aware of and understand these policies.
- Consider maintaining small groups of workers in teams (cohorting) to reduce the number of coworkers each person is exposed to.
- [Clean and disinfect frequently touched surfaces.](#)
 - If surfaces are visibly dirty, clean them using a detergent or soap and water before you disinfect them.
 - Use products that are [EPA-registered external icon, diluted household bleach solutions](#), or alcohol solutions with at least 70% alcohol, appropriate for surface disinfection.
- Provide employees adequate time and access to soap, clean water, and single use paper towels for handwashing.
 - Remind employees to [wash their hands](#) often with soap and water for at least 20 seconds. If soap and water are not available, they should use hand sanitizer with at least 60% alcohol.
 - Provide hand sanitizer, tissues and no touch waste baskets at the cash registers and in the restrooms.
- Maintain social distancing (at least 6 feet) in the transit vehicle, including at entry doors.
- Limit the number of people in the transit vehicle at one time. (Consult state and local guidance if available.)
- Remind employees that people may be able to [spread](#) COVID-19 even if they do not show symptoms. Consider all close interactions (within 6 feet) with employees, passengers, and others as a potential source of exposure.
- [Post signs and reminders](#) at entry doors and in strategic places providing instruction on social distancing, hand hygiene, use of cloth face coverings or masks, and cough and sneeze etiquette. Signs should be accessible for people with disabilities, easy to understand, and may include signs for non-English speakers, as needed.
- Communication and training should be easy to understand, in preferred language(s) spoken or read by the employees and include accurate and timely information.
 - Emphasize use of images (infographics) that account for language differences.
 - Training should be reinforced with signs (preferably infographics), placed in strategic locations. CDC has free, simple [posters available to download](#) and print, some of which are translated into different languages.
- Strongly encourage the use cloth face coverings or [masks](#) as appropriate.
 - Cloth face coverings or masks are intended to protect other people—not the wearer —by helping to keep the wearer’s respiratory droplets from reaching others. Because they were not specifically designed and tested to protect the people wearing them, cloth face coverings or masks are not considered personal protective equipment (PPE).
 - Train employees how to put on and take off cloth face coverings or [masks](#) to avoid contamination.
 - Cloth face coverings or masks should be [washed](#) after each use.
 - Employees should consider carrying a spare cloth face covering or mask.
 - Cloth face coverings or masks should not be worn if their use creates a new risk (i.e. interference with driving or vision, or contributions to heat-related illness) that exceeds their COVID-19 related benefits of slowing the spread of the virus. Cloth face coverings or masks should also not be worn by anyone who has trouble breathing or is unable to remove the covering or mask without assistance. CDC provides information on [adaptations and alternatives](#) that should be considered when cloth face coverings or masks may not be feasible.
- -
 - Consider requiring visitors to the workplace (service personnel, passengers) to also wear cloth face coverings or masks.
- **Personal Protective Equipment (PPE)**

PPE is the last step in the hierarchy of controls because it is more difficult to use effectively than other measures. To be protective and not introduce an additional hazard, the use of PPE requires characterization of the environment, knowledge of the hazard, training, and consistent correct use. This is why special emphasis is given to administrative and engineering controls when addressing occupational hazards, including when applying guidance to slow the spread of SARS-CoV-2.

In the current COVID-19 pandemic, use of PPE such as surgical masks or N95 respirators is being prioritized for healthcare workers and other medical first responders, as recommended by current [CDC guidance](#).

How You Can Help Your Staff and Others Cope with Stress

Mental health is an important component of worker safety and health. The COVID-19 pandemic has created new challenges in the ways many people work and interact with others, which may lead to increased feelings of stress, anxiety, and depression.

Information and resources about mental health, recognizing signs of stress, taking steps to build resilience and manage stress, and knowing where to go if you, your staff, or others need help are available [here](#).

Where can I get more information?

You, as the employer, are responsible for responding to COVID-19 concerns and informing employees of the hazards in your workplace. You can utilize these additional sources for more information on reducing the risk of exposures to COVID-19 at work:

- [CDC Interim Guidance for Businesses and Employers to Plan and Respond to Coronavirus Disease 2019 \(COVID-19\)](#)
- [CDC Cleaning and Disinfecting Your Facility](#)
- [CDC Reopening Guidance for Cleaning and Disinfecting Public Spaces, Workplaces, Businesses, Schools, and Homes](#)
- [NIOSH Workplace Safety and Health Topic: COVID-19](#)
- [CDC COVID-19](#)
- [OSHA COVID-19 external icon](#)
- [OSHA Guidelines on Preparing Workplaces for COVID pdf iconexternal icon](#)
- [General Business Frequently Asked Questions](#)
- CDCINFO: 1-800-CDC-INFO (1-800-232-4636) | TTY: 1-888-232-6348 | website: www.cdc.gov/info
- For passenger-related questions, please refer to the [Interim Guidance for Mass Transit Administrators](#).

<https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/rail-transit-operator.html>

United States

Coronavirus (COVID-19) Update: Daily Roundup August 18, 2020

Source: FDA

For Immediate Release:

August 18, 2020

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

- The FDA is providing two new flowcharts and supporting information on respirators:
 - For health care providers and facilities: [Considerations for Selecting Respirators for Your Health Care Facility](#)
 - For manufacturers and distributors: [Manufacturing and Distributing Respirators for Health Care Use in the United States Under an Existing Emergency Use Authorization \(EUA\) During the COVID-19 Pandemic](#)
- The FDA has updated its [COVID-19 Resources for Health Professionals](#) page to include the [CURE ID app](#). CURE ID allows clinicians to quickly and easily share their experiences treating COVID-19 patients and patients with other difficult-to-treat infectious diseases.
- Testing updates:
 - To date, the FDA has currently authorized 217 tests under EUAs; these include 176 molecular tests, 39 antibody tests, and 2 antigen tests.

The FDA, an agency within the U.S. Department of Health and Human Services, protects the public health by assuring the safety, effectiveness, and security of human and veterinary drugs, vaccines and other biological products for human use, and medical devices. The agency also is responsible for the safety and security of our nation's food supply, cosmetics, dietary supplements, products that give off electronic radiation, and for regulating tobacco products.

<https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-update-daily-roundup-august-18-2020>

United States

FDA's emergency approval of blood plasma as COVID-19 treatment on hold

Source: NYT Financial Post

Published: 2020-08-19 15:11 UTC

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Unique ID: 1007664379

The emergency approval of blood plasma as a potential COVID-19 treatment by the U.S. Food and Drug Administration has now been put on hold, the New York Times reported on Wednesday, citing two senior administration officials.

A group of top federal health officials including Anthony Fauci have argued that the emerging data on the treatment was too weak, the report said, adding that an emergency approval could still be granted in the near future. (<https://nyti.ms/31aFBzb>)

The authorization is on hold for now as more data is reviewed, the NYT reported, citing Clifford Lane, the clinical director at the National Institute of Allergy and Infectious Diseases, part of the National Institute of Health.

The FDA and NIH did not immediately respond to Reuters' requests for comment.

People who survive an infectious disease like COVID-19 are left with blood plasma containing antibodies, or proteins the body's immune system created, to fight off a virus. This can be transfused into newly infected patients to try to aid recovery.

An FDA emergency-use authorization could allow faster access to a therapy for the pandemic.

(Reporting by Trisha Roy in Bengaluru; Editing by Saumyadeb Chakrabarty)

<https://financialpost.com/pmnbusiness-pmn/fdas-emergency-approval-of-blood-plasma-as-covid-19-treatment-on-hold-nyt>

United States

New Report: An Interim Framework for COVID-19 Vaccine Allocation and Distribution in the U.S.

Source: mailchi.mp

Published: 2020-08-19 14:54 UTC

Received: 2020-08-19 14:54 UTC (0 minutes)

Locations: United States

Unique ID: 1007664311

Dear Journalist,

New report providing an ethical framework for making decisions about allocation and distribution of a COVID-19 vaccine during the initial period when such a vaccine has first been authorized for use and is still in limited supply.

The report, , proposes specific tiers of high-priority candidates for receiving a first vaccine based on this framework, including recognizing the contributions of essential workers who have been overlooked in previous allocation schemes:

Tier 1 includes those:

Most essential in sustaining the ongoing COVID-19 response.

At greatest risk of severe illness and death, and their caregivers.

Most essential to maintaining core societal functions.

Tier 2 includes those:

Involved in broader health provision.

Facing greater barriers to access care if they become seriously ill.

Contributing to maintenance of core societal functions.

Whose living or working conditions give them elevated risk of infection, even if they have lesser or unknown risk of severe illness and death.

The framework is guided by the following ethical principles, which the report authors believe should guide COVID-19 vaccine allocation and help identify more specific policy goals and objectives around vaccine policies:

Promotion of the common good, by promoting public health while enabling social and economic activity.

The importance of treating individuals fairly and promoting social equity, for example by addressing racial and ethnic disparities in COVID-19 mortality, and by recognizing the contributions of essential workers who have been overlooked in previous allocation schemes.

The promotion of legitimacy, trust and a sense of community ownership over vaccine policy, while respecting the diversity of values and beliefs in our pluralist society.

You can access the new report here. Media can quote directly from the report or can reach out for an interview with co-author Dr. Eric Toner. Immediate availability, however, is limited.

Margaret Miller, MSc

Director of Communications

Johns Hopkins Center for Health Security

Johns Hopkins Bloomberg School of Public Health

www.jhsph.edu | <http://www.centerforhealthsecurity.org/>

Interim Framework for COVID-19 Vaccine Allocation and Distribution in the United States

<https://www.centerforhealthsecurity.org/our-work/publications/interim-framework-for-covid-19-vaccine-allocation-and-distribution-in-the-us>

<https://mailchi.mp/b7e557b96043/new-report-a-national-plan-to-enable-comprehensive-covid-19-case-finding-and-contact-tracing-in-the-us-1574557?e=a14308e40d>

https://www.centerforhealthsecurity.org/our-work/pubs_archive/pubs-pdfs/2020/200819-vaccine-allocation.pdf

United States

Covid-19 vaccine application would not be mandatory in U.S., White House says

Source: CE NoticiasFinancieras

ID: 1007666682

Anthony Fauci, an epidemiological physician and White House adviser, said Wednesday that when a coronavirus vaccine exists, its application will not be forced by the federal government in the United States, although it may be mandatory by local standards for children. "We can't force or try to force people to get drained, we've never done it," Fauci, a member of the group that advises the White House during the health emergency, said in a video chat with George Washington University. "We can make it mandatory for certain groups, such as medical staff, but we cannot do it for the general population," he continued, setting the example of the National Institutes of Health, where nurses cannot care for patients unless they have received the flu vaccine during the season of that disease. A few hours earlier, the Australian prime minister announced that any coronavirus vaccine will be mandatory in that country, unless otherwise medically indicated. The federal structure of the United States, and

the rejection of part of the population to measures such as the obligation to wear a mask, make mandatory vaccination unlikely for all people. "It would be uncontrollable and inappropriate," insisted Fauci.

Read in addition: Covid-19 vaccine developed by Cuba will be tested in humans

However, that does not preclude the obligation for children to access school in any of the 50 states. This currently occurs with several vaccines such as measles, with medical and, in several states, religious exemptions. The Trump administration has pre-ordered hundreds of millions of doses and invested in projects from six companies that develop potential vaccines, and has ensured that the dosages will be free.

<https://gphin.canada.ca/cepr/showarticle.jsp?docId=1007666682>

United States

Coronavirus (COVID-19) Update: Daily Roundup August 19, 2020 | FDA

Source: FDA

ID: 1007667492

The U.S. Food and Drug Administration today announced the following actions taken in its ongoing response effort to the COVID-19 pandemic: **The FDA issued the third Emergency Use Authorization (EUA) for a COVID-19 antigen test. An antigen test is a diagnostic test that quickly detects fragments of proteins found on or within the virus by testing samples collected from the patient's nasal cavity using swabs.** The EUA was issued for LumiraDX UK Ltd.'s LumiraDx SARS-CoV-2 Ag Test, and authorized the test for use in high and moderate complexity laboratories certified Under the Clinical Laboratory Improvement Amendments (CLIA), as well as at the point-of-care (i.e., patient care settings) operating under a CLIA Certificate of Waiver, Certificate of Compliance, or Certificate of Accreditation. **The FDA posted frequently asked questions for consumers about UV lights and lamps. Consumers may be interested in purchasing ultraviolet-C (UVC) lamps to disinfect in the home or similar spaces. The FDA is providing answers to consumers' questions about the use of these lamps for disinfection during the COVID-19 pandemic.**

Testing updates:
To date, the FDA has currently authorized 218 tests under EUAs; these include 176 molecular tests, 39 antibody tests, and 3 antigen tests. **The FDA, an agency within the U.S. Department of Health and Human Services, protects the public health by assuring the safety, effectiveness, and security of human and veterinary drugs, vaccines and other biological products for human use, and medical devices.** The agency also is responsible for the safety and security of our nation's food supply, cosmetics, dietary supplements, products that give off electronic radiation, and for regulating tobacco products.

<https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-update-daily-roundup-august-19-2020>

United States

COVID-19 Planning Considerations: Guidance for School Re-entry

Source: American Academy of Pediatrics

Critical Updates on COVID-19 / Clinical Guidance / COVID-19 Planning Considerations: Guidance for School Re-entry

The purpose of this guidance revision is to continue to support communities, local leadership in education and public health, and pediatricians collaborating with schools in creating policies for school re-entry during the coronavirus disease 2019 (COVID-19) pandemic that foster the overall health of children, adolescents, educators, staff, and communities and are based on available evidence. Along with our colleagues in the field of education, the American Academy of Pediatrics (AAP) strongly advocates for additional federal assistance to schools throughout the United States, with no restrictions regarding their plans for in-person versus virtual learning. Regardless, in places in the United States with high levels of community transmission of severe acute respiratory syndrome-coronavirus 2 (SARS-CoV-2), the virus that causes COVID-19, where in-person learning is not possible, these schools will also need more assistance, not less, to support the additional staffing needs, alternative learning sites, hybrid educational models, and child care.

Schools and school-supported programs are fundamental to child and adolescent development and well-being and provide our children and adolescents with academic instruction, either in person or virtually; social and emotional skills; safety; reliable nutrition; physical/speech therapy and mental health services; and opportunities for physical activity, among other benefits. Schools also serve as critical centers in communities by supporting adult-focused activities (such as job training, neighborhood meetings, and parenting classes) as well as ensuring safe places for children and adolescents to be while parents or guardians are working, which in turn supports the local economy.

Beyond supporting the educational development of children and adolescents, schools play a critical role in addressing racial and social inequity. As such, it is critical to reflect on the differential impact the COVID-19 pandemic and the associated school closures have had on different racial and ethnic groups and vulnerable populations. The AAP condemns the persistent racial and social inequities that exist within the US educational system. The disparities in school funding, quality of school facilities, educational staffing, and resources for enriching curriculum between schools have been exacerbated by the pandemic. Families

rely on schools to provide child care; a safe, stimulating space for children to learn; opportunities for socialization; and access to school-based mental, physical, and nutritional health services. Without adequate support for families to access these services, disparities will likely worsen, especially for children who are English language learners, children with disabilities, children living in poverty, and children of African American/Black, Latinx/Hispanic, and Native American/Alaska Native origin.i,ii

For children and adolescents in virtual learning models, educational disparities may widen further. According to the Pew Research Center, 1 in 5 teenagers are not able to complete schoolwork at home because of lack of a computer or internet connection.iii This technological “homework gap” disproportionately affects Black, Hispanic, and low-income families.3

The AAP strongly recommends that school districts promote racial/ethnic and social justice by promoting the well-being of all children in any school-reopening plan, particularly children living in marginalized communities. To address these disparities, federal, state, and local governments should allocate resources to provide equitable access to educational supports. These recommendations are provided, acknowledging that our understanding of the COVID-19 pandemic is changing rapidly.

Any school re-entry policies should consider the following key principles:

To be able to open schools safely, it is vitally important that communities take all necessary measures to limit the spread of the SARS-CoV-2.

School policies must be flexible and nimble in responding to new information, and administrators must be willing to refine approaches when specific policies are not working.

Schools must take a multi-pronged, layered approach to protect students, teachers, and staff. By using different approaches, these layers of protection will make in-person learning safe and possible.

It is critically important to develop strategies that can be revised and adapted depending on the level of viral transmission and test positivity rate throughout the community and in the schools, recognizing the differences between school districts, including urban, suburban, and rural districts.

School districts must be in close communication and coordinate with state and/or local public health authorities, school nurses, local pediatric practitioners, and other medical experts.

School re-entry policies should be practical, feasible, and appropriate for child and adolescent's developmental stage and address teacher and staff safety.

Special considerations and accommodations to account for the diversity of youth should be made, especially for vulnerable populations, including those who are medically fragile or complex, live in poverty, have developmental challenges, or have disabilities, with the goal of safe return to school. These youth and their families should work closely with their pediatrician using a shared decision-making approach regarding return to school.

Pediatricians, families, and schools should partner together to collaboratively identify and develop accommodations when needed for any child or adolescent with unique medical needs.

Children and adolescents who need customized considerations should not be automatically excluded from school unless required in order to adhere to local public health mandates or because their unique medical needs would put them at increased risk for contracting COVID-19 during current conditions in their community.

School policies should be guided by supporting the overall health and well-being of all children, adolescents, their families, and their communities but should also look to create safe working environments for educators and school staff. This focus on overall health and well-being includes addressing the behavioral/mental health needs of students and staff.

These policies should be consistently communicated in languages other than English, if needed, based on the languages spoken in the community, to avoid marginalization of parents/guardians who are of limited English proficiency or do not speak English at all.

Federal, state, and local funding should be provided for all schools so they can provide all the safety measures required for students and staff. Funding to support virtual learning and provide needed resources must be available for communities, schools, and children facing limitations implementing these learning modalities in their home (eg, socioeconomic disadvantages) or in the event of school re-closure because of resurgence of SARS-CoV-2 in the community or a school outbreak.

With the above principles in mind, the AAP strongly advocates that all policy considerations for the coming school year should start with a goal of having students physically present in school. Unfortunately, in many parts of the United States, there is currently uncontrolled spread of SARS-CoV-2. Although the AAP strongly advocates for in-person learning for the coming school year, the current widespread circulation of the virus will not permit in-person learning to be safely accomplished in many jurisdictions. The importance of in-person learning is well-documented, and there is already evidence of the negative impacts on children because of school closures in the spring of 2020. Lengthy time away from school and associated interruption of supportive services often results in social isolation, making it difficult for schools to identify and address important learning deficits as well as child and adolescent physical or sexual abuse, substance use, depression, and suicidal ideation. This, in turn, places children and adolescents at considerable risk of morbidity and, in some cases, mortality. Beyond the educational impact and social impact of school closures, there has been substantial impact on food security and physical activity for children and families. The disproportionate impact this has had on Black, Latinx, and Native American/Alaskan Native children and adolescents must also be recognized.

Policy makers and school administrators must also consider the mounting evidence regarding COVID-19 in children and adolescents, including the role they may play in transmission of the infection. SARS-CoV-2 appears to behave differently in children and adolescents than other common respiratory viruses, such as influenza, on which much of the current guidance regarding school closures is based. Although children and adolescents play a major role in amplifying influenza outbreaks, to date, this does not appear to be the case with SARS-CoV-2. Although many questions remain, the preponderance of evidence indicates that children and adolescents can become infected and are less likely to be symptomatic and less likely to have severe disease resulting from SARS-CoV-2 infection.^{iv} We continue to learn more about the role children play in transmission of SARS-CoV-2. At present, it appears that children younger than 10 years may be less likely to become infected and less likely to spread infection to others, although further studies are needed.^v More recent data suggest children older than 10 years may spread SARS-CoV-2 as efficiently as adults, and this information should be part of the considerations taken in determining how to safely and effectively open schools. Additional in-depth studies are needed to truly understand the infectivity and transmissibility of this virus in anyone younger than 18 years, including children and adolescents with disabilities and medical complexities. Policies to mitigate the spread of COVID-19 within schools must be balanced with the previously noted known harms to children, adolescents, families, and the community that come with keeping children at home.

Finally, policy makers and school administrators should acknowledge that COVID-19 policies are intended to mitigate, not eliminate, risk. No single action or set of actions will completely eliminate the risk of SARS-CoV-2 transmission, but implementation of several coordinated interventions can greatly reduce that risk. For example, where physical distance cannot be maintained, students (older than 2 years) and staff should wear cloth face coverings (unless medical or developmental conditions prohibit use). In the following sections, some general principles are reviewed that policy makers and school administrators should consider as they safely plan for the coming school year. For all of these, engagement of the entire school community, including teachers and staff, regarding these measures should begin early, ideally at least several weeks before the start of the school year.

Since this guidance was first released, there have been several other documents released by the Centers for Disease Control and Prevention (CDC), National Association of School Nurses, and the National Academy of Sciences, Engineering, and Medicine. All these documents are consistent regarding the importance of considering the degree to which SARS-CoV-2 is circulating in a community in making school re-opening policies. In many places in the United States at the present time, opening schools to in-person learning for all students is likely not feasible because of widespread community transmission and high levels of positivity in testing. Even in these communities, though, in-person learning should still be the goal and may be feasible as the epidemiology improves. Countries that have been able to successfully open schools have had low rates of community SARS-CoV-2 circulation. This guideline is intended to augment, not replace, guidance from the CDC and others and should be used in concert with other guidance. Ultimately, the decision to re-open schools to in-person learning should be based on the guidance of local and state public health authorities and school administrators.

Physical Distancing Measures

Physical distancing, sometimes referred to as social distancing, is simply the act of keeping people separated with the goal of limiting spread of contagion between individuals. It is fundamental to lowering the risk of spread of SARS-CoV-2, as the primary mode of transmission is through respiratory droplets by persons in close proximity. There is a conflict between optimal academic and social/emotional learning in schools and strict adherence to current physical distancing guidelines. For example, the CDC recommends that schools "space seating/desks at least 6 feet apart when feasible." In many school settings, 6 feet between students is not feasible without drastically limiting the number of students. Some countries have been able to successfully reopen schools after first controlling community-wide spread of SARS-CoV-2 while using 3 feet of distance between students without increases in community spread.^{vi} Physical distance between desks should follow current public health guidance. In the absence of specific guidance, desks should be placed at least 3 feet apart, and ideally 6 feet apart. If desks are spaced less than 6 feet apart, face coverings should be strongly encouraged and adhere to public health guidance. In many jurisdictions, face coverings are mandatory for children in public settings, including schools. Schools should weigh the benefits of strict adherence to a 6-foot spacing rule between students with the potential downside if remote learning is the only alternative. Further, while these guidelines support the concept of cohorting, strict adherence to a specific size of student groups (eg, 10 per classroom, 15 per classroom, etc) should be discouraged, because the size of cohorts will vary depending on many factors specific to individual schools and even individual classrooms.

Given what is known about SARS-CoV-2 transmission dynamics, adults within schools should maintain a distance of 6 feet from other people as much as possible, particularly around other adult staff. For all of the below settings, physical distancing by and among adults is strongly recommended, and meetings and curriculum planning should take place virtually or outside if possible. In addition, other strategies to increase adult-adult physical distance in time and space should be implemented, such as staggered drop-offs and pickups, and drop-offs and pickups outside when weather allows. Parents should, in general, be discouraged from entering the school building. Physical barriers, such as plexiglass, should be considered in reception areas and employee workspaces where the environment does not accommodate physical distancing. Congregating in shared spaces, such as staff lounge areas, should not be allowed given the increasing evidence that these types of spaces have increased rates of transmission because of close proximity and lax adherence to masking recommendations.

The recommendations in each of the age groups below are not instructional strategies but are guidance to optimize the return of students to schools in the context of physical distancing guidelines and the developmentally appropriate implementation of the strategies. Educational experts may have preference for one or another of the guidelines based on the instructional needs of the classes or schools in which they work.

Pre-Kindergarten (Pre-K)

In Pre-K, the relative impact of physical distancing among children is likely small based on current evidence, and it is certainly difficult to implement. Therefore, Pre-K program planning should focus on more effective risk mitigation strategies for this population. These strategies include hand and cough hygiene, infection prevention education for staff and families, adult physical distancing from one another, adults and children wearing face coverings, cohorting, and spending time outdoors.

Higher-priority strategies:

Cohort classes to minimize crossover among children and adults within the school; the exact size of the cohort may vary, often dependent on local or state health department guidance.

Utilize outdoor spaces when possible.

Limit unnecessary visitors into the building.

Lower-priority strategies:

Cloth face coverings for children in the Pre-K setting

Encourage families to practice wearing cloth face coverings with children while at home. Support modeling by teachers and parents.

Reducing classmate interactions/play in Pre-K–aged children may not provide substantial COVID-19 risk reduction.

Elementary Schools

Higher-priority strategies:

Children should wear cloth face coverings

Practice by children and good modeling by adults will help children be more successful at wearing cloth face coverings at younger ages.

Desks should be placed at least 3 feet apart, and ideally 6 feet apart when feasible.

If this reduces the amount of time children are present in school, harm may outweigh potential benefits.

Cohort classes to minimize crossover among children and adults within the school.

Utilize outdoor spaces when possible.

Lower-priority strategies:

The risk reduction of reducing class sizes in elementary school-aged children may be outweighed by the challenge of doing so.

Similarly, reducing classmate interactions/play in elementary school-aged children may not provide enough COVID-19 risk reduction to justify potential harms.

Secondary Schools

There is likely a greater impact of physical distancing on risk reduction of COVID-19 in secondary schools than early childhood or elementary education. There are also different barriers to successful implementation of many of these measures in older age groups, as the structure of school is usually based on students changing classrooms. Suggestions for physical distancing risk mitigation strategies when feasible:

Universal face coverings in middle and high schools, particularly when not able to maintain a 6-foot distance (students and adults).

Planned avoidance of close physical proximity in cases of increased exhalation (singing, exercise, band); these activities are safest outdoors and spread out.

Desks should be placed at least 3 feet apart, and ideally 6 feet apart when feasible.

Cohort classes if possible, limit cross-over of students and teachers to the extent possible.

Ideas that may assist with cohorting:

Block schedules (with fewer classes in a given day and electives truncated to shortened time periods).

Eliminate use of lockers or assign them by cohort to reduce need for hallway use across multiple areas of the building.

This strategy would need to be implemented in conjunction with planning to ensure that students are not carrying home an unreasonable number of books on a daily basis and may vary depending on other cohorting and instructional decisions schools are making.

Have teachers rotate into different classrooms instead of students when feasible.

Utilize outdoor spaces when possible.

Teachers and other adult staff should maintain a distance of 6 feet from students when possible and if not disruptive to educational process.

Restructure elective offerings to allow small groups within one classroom. This may not be possible in a small classroom.

Special Education

Every child and adolescent with a disability is entitled to a free and appropriate education and is entitled to special education services based on their individualized education program (IEP). Students receiving special education services may be more negatively affected by distance-learning and may be disproportionately impacted by interruptions in regular education. It may not be feasible, depending on the needs of the individual child and adolescent, to adhere both to distancing guidelines and the criteria outlined in a specific IEP. Attempts to meet physical distancing guidelines should meet the needs of the individual child and may require creative solutions, often on a case-by-case basis. Additional safety measures for teachers and staff working with students with disabilities may need to be in place to ensure optimal safety for all.

Adult Staff and Educators

Universal cloth face coverings at all times.

Particular avoidance of close physical proximity to other adults and children.

Desks should be placed 6 feet away from students if feasible.

Cohort teachers with classes if possible, limit cross-over of students and teachers to the extent possible.

Recognizing certain teachers must cross-over to multiple classes, such as specials teachers, special educators, and secondary school teachers.

Use plexiglass in front and around desks particularly if unable to be 6 feet away from students.

Physical Distancing in Specific Enclosed Spaces

Buses

Encourage alternative modes of transportation for students who have other safe options, including walking or biking.

Ideally, for students riding the bus, symptom screening would be performed prior to them being dropped off at the bus stop.

Having bus drivers or monitors perform these screenings is problematic, as they may face a situation in which a student screens positive yet the parent has left, and the driver would be faced with leaving the student alone or allowing the student on the bus.

Assigned seating; if possible, assign seats by cohort (same students sit together each day).

Tape marks showing students where to sit.

Face coverings should be worn at all times, particularly if 6 feet distance cannot be maintained.

Driver should be a minimum of 6 feet from students; driver must wear face covering; consider physical barrier for driver (eg, plexiglass).

Minimize number of people on the bus at one time within reason.

Consider altering start and end times at different grades to allow fewer students on the bus at a time.

Adults who do not need to be on the bus should not be on the bus.

Have windows open if weather allows.

Ensure adequate cleaning of buses between uses.

Hallways

Consider creating one-way hallways to reduce close contact.

Place physical guides, such as tape, on floors or sidewalks to create one-way routes.

Where feasible, keep students in the classroom and rotate teachers instead.

Stagger class periods by cohorts for movement between classrooms if students must move between classrooms to limit the number of students in the hallway when changing classrooms.

Assign lockers by cohort or eliminate lockers altogether.

Playgrounds

Enforcing physical distancing in an outside playground is difficult and may not be the most effective method of risk mitigation. Emphasis should be placed on maintaining classroom cohorts of students and limiting the size of groups participating in playground time (eg, mixing of cohorts). Outdoor transmission of virus is known to be much lower than indoor transmission. If playground equipment is being used, it should be part of cleaning plans implemented by schools.

Meals/Cafeteria

School meals play an important part in addressing food security for children and adolescents and, as was observed in the early stages of the pandemic, were crucial sources of food and nutrition to children, adolescents, and their families. Regardless of whether children are participating in in-person or distance learning, school districts must continue to provide food security to all students. This may require enacting strong policies and procedures to ensure access to all students. Decisions about how to serve meals must take into account the fact that in many communities there may be more students eligible for free and reduced meals than prior to the pandemic.

Consider having students cohorted, potentially in their classrooms, especially if students remain in their classroom throughout the day.

Create separate lunch periods to minimize the number of students in the cafeteria at one time.

Use unused or underutilized spaces for lunch/break times.

Use outdoor spaces when possible.

Create an environment that is as safe as possible from exposure to food allergens.

Encourage children and adults to wash their hands or use hand sanitizer before and after eating.

Face Coverings and Personal Protective Equipment (PPE)

Cloth face coverings protect others if the wearer is infected with SARS-CoV-2 and is not aware. Cloth face coverings may offer some level of protection for the wearer. Evidence continues to mount on the importance of universal face coverings in interrupting the spread of SARS-CoV-2.vii,viii,ix Universal face covering use in schools for children older than 2 years is recommended. It is important to note many children, even those with medical conditions, are able to safely and effectively wear face coverings with adequate practice and support as well as modeling from adults. School staff and older students (those who attend middle or high school) should be able to wear cloth face coverings safely and consistently and should be encouraged to do so. Children younger than 2 years and anyone who has trouble breathing or is unconscious, incapacitated, or otherwise unable to remove a face covering without assistance should not wear cloth face coverings.

For certain populations, the use of cloth face coverings by teachers may impede the education process. These include students who are deaf or hard of hearing, students receiving speech/language services, young students in early education programs, and English language learners. Although there are products (eg, face coverings with clear panels in the front) to facilitate their use among these populations, these products may not be available in all settings.

Students and families should be taught how to properly wear (cover nose and mouth) a cloth face covering, to maintain hand hygiene when removing for meals and physical activity, and to replace and maintain (wash daily) a cloth face covering.

School health staff should be provided with appropriate medical PPE to use in health suites. This PPE should include universal N95 masks, surgical masks, gloves, disposable gowns, and face shields or other eye protection. School health staff should be aware of the CDC guidance on infection control measures. Asthma treatments using inhalers with spacers should be used rather than nebulizer treatments whenever possible, because nebulizer treatments are aerosol-generating procedures, which increase risks to others. The CDC recommends that nebulizer treatments at school should be reserved for children who cannot use or do not have access to an inhaler (with spacer or spacer with mask) for a respiratory emergency. Schools should work with families and health care providers to assist with obtaining an inhaler and spacer for students with limited access. In addition, schools should work to develop and implement asthma action plans, which may include directly observed controller medication administration in schools to promote optimal asthma control. In those rare cases in which a student can only use a nebulizer, school health staff should wear gloves, an N95 facemask (when available), gown, and eye protection. Staff should be trained on proper donning and doffing procedures and follow the CDC guidance regarding precautions when performing this aerosol-generating procedure. Nebulizer treatments should be performed in a space that limits exposure to others and with minimal staff present. Rooms should be well-ventilated, or treatments should be performed outside. After the use of the nebulizer, the room should undergo routine cleaning and disinfection.

School staff working with students who are unable to wear a cloth face covering or who are unable to manage secretions and who must be in close proximity to these students should wear a surgical mask in combination with a face shield.

Cleaning and Disinfection

The main mode of COVID-19 spread is from person to person, primarily via droplet transmission. For this reason, strategies for infection prevention should center around this form of spread, including physical distancing, face coverings, and hand hygiene. Given the challenges that may exist in children and adolescents effectively adhering to recommendations, it is critical that staff consistently set a good example for students by modeling behaviors around physical distancing, face coverings, and hand hygiene. Infection via fomites is less likely. However, because the virus may survive on certain surfaces for some time, it is possible to get infected after touching a virus contaminated surface and then touching the mouth, eyes, or nose. Frequent handwashing as a modality of containment is vital.

The additional cleaning requirements because of the COVID-19 pandemic will require additional resources for schools both in supplies and potential in staffing. Cleaning should be performed per established protocols followed by disinfection when appropriate. Normal cleaning with soap and water decreases the

viral load and optimizes the efficacy of disinfectants. When using disinfectants, the manufacturers' instructions must be followed, including duration of dwell time, use of PPE if indicated, and proper ventilation. The use of the Environmental Protection Agency (EPA)-approved disinfectants against COVID-19 is recommended (EPA List N). When possible, only products labeled as safe for humans and the environment (eg, Safer or Designed for the Environment), containing active ingredients such as hydrogen peroxide, ethanol, citric acid, should be selected from this list, because they are less toxic, are not strong respiratory irritants or asthma triggers, and have no known carcinogenic, reproductive, or developmental effects.

When EPA-approved disinfectants are not available, alternative disinfectants such as diluted bleach or 70% alcohol solutions can be used. Children should not be present when disinfectants are in use and should not participate in disinfecting activities. Most of these products are not safe for use by children, whose "hand-to-mouth" behaviors and frequent touching of their face and eyes put them at higher risk for toxic exposures. If disinfection is needed while children are in the classroom, adequate ventilation should be in place and nonirritating products should be used. Disinfectants such as bleach and those containing quaternary ammonium compounds or "Quats" should not be used when children and adolescents are present, because these are known respiratory irritants.

In general, elimination of high-touch surfaces is preferable to frequent cleaning. For example, classroom doors can be left open rather than having students open the door when entering and leaving the classroom, or the door can be closed once all students have entered followed by hand sanitizing. As part of increasing social distance between students and surfaces requiring regular cleaning, schools could also consider eliminating the use of lockers, particularly if they are located in shared spaces or hallways, making physical distancing more challenging. If schools decide to use this strategy, it should be done within the context of ensuring that students are not forced to transport unreasonable numbers of books back and forth from school on a regular basis.

When elimination of use of high-touch surfaces is not possible, surfaces that are used frequently, such as drinking fountains, door handles, sinks and faucet handles, etc, should be cleaned and disinfected at least daily and as often as possible. Bathrooms, in particular, should receive frequent cleaning and disinfection. Shared equipment including computer equipment, keyboards, art supplies, and play or gym equipment should also be disinfected frequently. Hand washing should be promoted before and after touching shared equipment. Computer keyboard covers can be used to facilitate cleaning between users. Routine cleaning practices should be used for indoor areas that have not been used for 7 or more days or outdoor equipment. Surfaces that are not high-touch, such as bookcases, cabinets, wall boards, or drapes should be cleaned following standard protocol. The same applies to floors or carpeted areas.

Outdoor playgrounds/natural play areas only need routine maintenance, and hand hygiene should be emphasized before and after use of these spaces. Outdoor play equipment with high-touch surfaces, such as railings, handles, etc, should be cleaned and disinfected regularly if used continuously.

Alternative Disinfection Methods

The efficacy of alternative disinfection methods, such as ultrasonic waves, high-intensity UV radiation, and LED blue light against COVID-19 virus is not known. The EPA does not routinely review the safety or efficacy of pesticidal devices, such as UV lights, LED lights, or ultrasonic devices. Therefore, the EPA cannot confirm whether, or under what circumstances, such products might be effective against the spread of SARS-CoV-2.x

Testing and Screening

Virologic testing is an important part of the overall public health strategy to limit the spread of COVID-19. Virologic testing detects the viral RNA from a respiratory (usually nasal) swab specimen. The CDC does not recommend universal testing of students and staff. Testing all students for acute SARS-CoV-2 infection prior to the start of school is not feasible in most settings at this time. Even in places where this is possible, it is not clear that such testing would reduce the likelihood of spread within schools. It is important to recognize that virologic testing only shows whether a person is infected at that specific moment in time. It is also possible that the nasal swab virologic test result can be negative during the early incubation period

of the infection. So, although a negative virologic test result is reassuring, it does not mean that the student or school staff member is not going to subsequently develop COVID-19. Stated another way, a student who is negative for COVID-19 on the first day of school may not remain negative throughout the school year.

A student or school staff member who has had a known exposure to COVID-19 (eg, close contact –within 6 feet for at least 15 minutes – with an individual with laboratory-confirmed SARS-CoV-2 infection or illness consistent with COVID-19), according to CDC guidelines, should self-quarantine for 14 days from the last exposure. In every case, local health officials should make the determination on quarantine and contact tracing. However, depending on current community viral case rates, local health authorities may make differing recommendations regarding contact tracing and/ or school exclusion or school closure.

Another type of testing is serologic blood testing for antibodies to SARS-CoV-2. At the current time, serologic testing should not be used for individual decision-making and has no place in considerations for entrance to or exclusion from school. CDC guidance regarding antibody testing for COVID-19 is that serologic test results should not be used to make decisions about grouping people residing in or being admitted to congregate settings, such as schools, dormitories, or correctional facilities. Additionally, serologic test results should not be used to make decisions about returning people to the workplace. The CDC states that serologic testing should not be used to determine immune status in individuals until the presence, durability, and duration of immunity is established. The AAP recommends this guidance be applied to school settings as well.

Schools should have a policy regarding symptom screening for teachers and staff and what to do if a student or school staff member becomes sick with symptoms. Temperature checks and symptom screening are a frequent part of many reopening processes to identify symptomatic persons to exclude them from entering buildings and business establishments. The list of symptoms of COVID-19 infection has grown since the start of the pandemic and the manifestations of COVID-19 infection in children, although similar, is often not the same as that for adults. First and foremost, parents should be instructed to keep their child at home if they are ill, and staff members should stay home if they are ill. Any student or staff member with a fever of 100.4 degrees or greater or symptoms of possible COVID-19 virus infection should not be present in school. School policies regarding temperature screening and temperature checks must balance the practicality of performing these screening procedures for large numbers of students and staff with the information known about how children manifest and transmit COVID-19 infection, the risk of transmission in schools, and the possible lost instructional time to conduct the screenings. At this time, the CDC currently does not recommend universally screening students at school, because screening may fail to identify a student who has a SARS-CoV-2 infection and may overidentify students with different common childhood illnesses. Schools should develop plans for rapid response to a student or staff member with fever who is in the school regardless of the implementation of temperature checks or symptom screening prior to entering the school building.

In lieu of temperature checks and symptom screening being performed after arrival to school, methods to allow parent performing and reporting of symptoms and temperature checks performed at home may be considered. Resources and time may necessitate this strategy at most schools. The epidemiology of disease in children along with evidence of the utility of temperature screenings in health systems may further justify this approach. Procedures using texting apps, phone systems, or online reporting rely on parent report and may be most practical but possibly unreliable, depending on individual family's ability to use these communication processes, especially if not made available in their primary language or lack of electronic forms of communication. School nurses or nurse aides should be equipped to measure temperatures for any student or staff member who may become ill during the school day and should have an identified area to separate or isolate students who may have COVID-19 symptoms.

COVID-19 manifests similarly to other respiratory illness in children. Although children manifest many of the same symptoms of COVID-19 infection as adults, some differences are noteworthy. According to the CDC, children may be less likely to have fever, may be less likely to present with fever as an initial symptom, and may have only gastrointestinal tract symptoms. A student or staff member excluded because of symptoms of COVID-19 should contact their health care provider to discuss testing and medical care. In the absence of testing, students or staff should follow local health department guidance for exclusion.

Ventilation

The primary mode of transmission of SARS-CoV-2 appears to be by droplet transmission by people in close proximity. There are emerging studies on the possible role of airborne transmission. Although it is possible that there may be this type of transmission in some settings, the preponderance of evidence at this time suggests that this is not a primary mode of transmission. For example, the reproductive number of SARS-CoV-2 is in the range of other viruses known to be transmitted primarily by respiratory droplets, such as influenza. Further, simple face masks appear to be quite effective for decreasing the likelihood of transmission of SARS-CoV-2, in contrast with known airborne pathogens such as measles. With this in mind, mitigation efforts should focus on prevention of droplet transmission. Proper ventilation, however, does have a role in preventing the spread of any respiratory pathogen. Heating, air conditioning, and ventilation (HVAC) systems should be inspected for optimal functioning, filters should be within their service life, and MERV-13 (minimum efficiency reporting value) efficiency filtration should be used, if the equipment allows.^{xi,xii} Demand-controlled ventilation (DVC) should be disabled when possible, and the system should run continuously to improve air exchanges in the school building.

Other Considerations

On-site School-Based Health Services

On-site school health services, including school-based health centers, should be supported if available, to complement the pediatric medical home and to provide pediatric acute, chronic, and preventive care. Collaboration with school nurses will be essential, and school districts should involve school health services staff early in the planning phase for reopening and consider collaborative strategies that address and prioritize immunizations and other needed health services for students, including behavioral health, vision screening, hearing, and reproductive health services.

Vision Screening

Vision screening practices should continue in school whenever possible. Vision screening serves to identify children who may otherwise have no outward symptoms of blurred vision or subtle ocular abnormalities that, if untreated, may lead to permanent vision loss or impaired academic performance in school. Personal prevention practices and environmental cleaning and disinfection are important principles to follow during vision screening, along with any additional guidelines from local health authorities.

Hearing Screening

Safe hearing screening practices should continue in schools whenever possible. School screening programs for hearing are critical in identifying children who have hearing loss as soon as possible so that reversible causes can be treated and hearing restored. Children with permanent or progressive hearing loss will be habilitated with hearing aids to prevent impaired academic performance in the future. Personal prevention practices and environmental cleaning and disinfection are important principles to follow during hearing screening, along with any additional guidelines from local health authorities.

Education

The impacts of lost instructional time and social emotional development on children and adolescents should be anticipated, and schools will need to be prepared to adjust curricula and instructional practices accordingly without the expectation that all lost academic progress can be caught up. Plans to make up for lost academic progress because of school closures and distress associated with lost academic progress and the pandemic in general should be balanced by a recognition of the likely continued distress of educators and students that will persist when schools reopen. If the academic expectations are unrealistic, school will likely become a source of further distress for students (and educators) at a time when they need additional support. It is also critical to maintain a balanced curriculum with continued physical education and other learning experiences rather than an exclusive emphasis on core subject areas. In addition, continued improvement of remote learning practices should be encouraged, and further funding should be provided by federal and local governments to provide further support (eg, universal free broadband internet).

Students with Disabilities

The impact of loss of instructional time and related services, including mental health services as well as occupational, physical, and speech/language therapy during the period of school closures is significant for students with disabilities. All students, but especially those with disabilities, may have more difficulty with the social and emotional aspects of transitioning out of and back into the school setting. As schools prepare for reopening, school personnel should develop a plan to ensure a review of each child and adolescent with an IEP to determine the needs for compensatory education to adjust for lost instructional time as well as other related services. In addition, schools can expect a backlog in evaluations; therefore, plans to prioritize those for new referrals as opposed to re-evaluations will be important. Many school districts require adequate instructional effort before determining eligibility for special education services. However, virtual instruction or lack of instruction should not be reasons to avoid starting services such as response-to-intervention (RTI) services, even if a final eligibility determination is postponed.

Behavioral Health/Emotional Support for Children and Adolescents

Schools should anticipate and be prepared to address a wide range of mental health needs of children and staff when schools reopen. Preparation for infection control is vital and admittedly complex during an evolving pandemic. But the emotional impact of the pandemic, grief because of loss, financial/employment concerns, social isolation, and growing concerns about systemic racial inequity — coupled with prolonged limited access to critical school-based mental health services and the support and assistance of school professionals — demands careful attention and planning as well. Schools should be prepared to adopt an approach for mental health support, and just like other areas, supporting mental health will require additional funding to ensure adequate staffing and the training of those staff to address the needs of the students and staff in the schools.

Schools should consider providing training to classroom teachers and other educators on how to talk to and support children during and after the COVID-19 pandemic. Students requiring mental health support should be referred to school mental health professionals.

Suicide is the second leading cause of death among adolescents or youth 10 to 24 years of age in the United States. In the event distance learning is needed, schools should develop mechanisms to evaluate youth remotely if concerns are voiced by educators or family members and should be establishing policies, including referral mechanisms for students believed to be in need of in-person evaluation, even before schools reopen.

School mental health professionals should be involved in shaping messages to students and families about the response to the pandemic. Fear-based messages widely used to encourage strict physical distancing may cause problems when schools reopen, because the risk of exposure to COVID-19 may be mitigated but not eliminated. Communicating effectively is especially critical, given potential adaptations in plans for in-person or distance learning that need to occur during the school year because of changes in community transmission of SARS-CoV-2.

When schools do reopen, plans should already be in place for outreach to families whose students do not return for various reasons. This outreach is especially critical, given the high likelihood of separation anxiety and agoraphobia in students. Students may have difficulty with the social and emotional aspects of transitioning back into the school setting, especially given the unfamiliarity with the changed school environment and experience. Special considerations are warranted for students with pre-existing anxiety, depression, and other mental health conditions; children with a prior history of trauma or loss; and students in early education who may be particularly sensitive to disruptions in routine and caregivers. Students facing other challenges, such as poverty, food insecurity, and homelessness, and those subjected to ongoing racial inequities may benefit from additional support and assistance.

Schools need to incorporate academic accommodations and supports for all students who may still be having difficulty concentrating or learning new information because of stress or family situations that are compounded by the pandemic. It is important that school personnel do not anticipate or attempt to catch up for lost academic time through accelerating curriculum delivery at a time when students and educators may find it difficult to even return to baseline rates. These expectations should be communicated to educators, students, and family members so that school does not become a source of further distress.

Mental Health of Staff

The personal impact on educators and other school staff should be recognized. In the same way that students are going to need support to effectively return to school and to be prepared to be ready to process the information they are being taught, teachers cannot be expected to be successful at teaching children without having their mental health needs supported. The strain on teachers this year as they have been asked to teach differently while they support their own needs and those of their families has been significant, and they will be bringing that stress back to school as schools reopen. Resources such as Employee Assistance Programs and other means to provide support and mental health services should be established prior to reopening. The individual needs and concerns of school professionals should be addressed with accommodations made as needed (eg, for a classroom educator who is pregnant, has a medical condition that confers a higher risk of serious illness with COVID-19, resides with a family member who is at higher risk, or has a mental health condition that compromises the ability to cope with the additional stress).

Although schools should be prepared to be agile to meet evolving needs and respond to increasing knowledge related to the pandemic and may need to institute partial or complete closures when the public health need requires, school leaders should recognize that staff, students, and families will benefit from sufficient time to understand and adjust to changes in routine and practices. During a crisis, people benefit from clear and regular communication from a trusted source of information and the opportunity to dialogue about concerns and needs and feel they are able to contribute in some way to the decision-making process. Change is more difficult in the context of crisis and when predictability is already severely compromised.

Food Insecurity

In 2018, 11.8 million children and adolescents (1 in 7) in the United States lived in a food-insecure household.^{xiii} The coronavirus pandemic has led to increased unemployment and poverty for America's families, which will likely increase even further the number of families who experience food insecurity.^{xiv} School re-entry planning must consider the many children and adolescents who experience food insecurity already (especially at-risk and low-income populations) and who will have limited access to routine meals through the school district if schools remain closed. The short- and long-term effects of food insecurity in children and adolescents are profound.^{xv} In the early months of the pandemic, many families were not able to pick up the food provided through schools despite the school's attempt to reach all families. Given low participation in pick-up food programs this spring in some school districts, school districts should coordinate meal delivery in accessible locations and consider providing multiple days' worth of meals to reduce the burden on families. Plans should be made prior to the start of the school year for how students participating in free- and reduced- meal programs will receive food in the event of a school closure or if they are excluded from school because of illness or SARS-CoV-2 infection.

Immunizations

Existing school immunization requirements should be maintained and not deferred because of the current pandemic. In addition, although influenza vaccination is generally not required for school attendance, in the coming academic year, it should be highly encouraged for all students and staff. The symptoms of influenza and SARS-CoV-2 infection are similar and taking steps to prevent influenza will decrease the incidence of disease in schools, and the related lost educational time and resources needed to handle such situations by school personnel and families. School districts should consider requiring influenza vaccination for all staff members.

Pediatricians should work with schools and local public health authorities to promote childhood vaccination messaging well before the start of the school year. It is vital that all children receive recommended vaccinations on time and get caught up if they are behind as a result of the pandemic. The capacity of the health care system to support increased demand for vaccinations should be addressed through a multifaceted collaborative and coordinated approach among all child-serving agencies including schools.

Organized Activities

It is likely that sporting events, practices, and conditioning sessions as well as other extracurricular activities will be limited in many locations. The AAP Interim Guidance on Return to Sports helps pediatricians inform families on how best to ensure safety when considering a return to sports participation. Preparticipation

evaluations should be conducted in alignment with the AAP Preparticipation Physical Evaluation Monograph, 5th ed, and state and local guidance.

Resources

Coalition to Support Grieving Students

Using Social Stories to Support People with I/DD During the COVID-19 Emergency

Social Stories for Young and Old on COVID-19

Additional Information

AAP Guidance Related to Childcare During COVID-19

AAP Guidance on Providing Pediatric Well-Care During COVID-19

AAP Guidance on Cloth Face Coverings

AAP Guidance on Testing

AAP Guidance on Use of Personal Protective Equipment (PPE)

COVID-19 Interim Guidance: Return to Sports

Information for Parents on HealthyChildren.org: Returning to School During COVID-19

List of latest AAP News articles on COVID-19

Pediatrics COVID-19 Collection

AAP COVID-19 Advocacy Resources (Login required)

Centers for Disease Control and Prevention: Considerations for Schools

Centers for Disease Control and Prevention: School Decision Tree

Centers for Disease Control and Prevention: Parent Decision Making Tool

Centers for Disease Control and Prevention: Activities and Initiatives Supporting the COVID Response

Centers for Disease Control Schools and Childcare - Plan, Prepare, & Respond

Centers for Disease Control and Prevention: Information for Pediatric Healthcare Providers

References

[1] Levinson M, Cevik M, Lipsitch M. Reopening primary schools during the pandemic. *N Engl J Med*. July 29, 2020. Available at: <https://www.nejm.org/doi/full/10.1056/NEJMms2024920?query=TOC>.

[2] National Academies of Sciences, Engineering, and Medicine 2020. Reopening K-12

Schools During the COVID-19 Pandemic: Prioritizing Health, Equity, and Communities. Washington, DC: The National Academies Press; 2020. Available at: <https://doi.org/10.17226/25858>.

[3] Pew Research Center. As schools close due to the coronavirus, some U.S. students face a digital 'homework gap'. March 16, 2020. Available at: <https://www.pewresearch.org/fact-tank/2020/03/16/as-schools-close-due-to-the-coronavirus-some-u-s-students-face-a-digital-homework-gap/>

[4] Kaiser Family Foundation. What Do We Know About Children and Coronavirus Transmission? July 29, 2020. Available at: <https://www.kff.org/coronavirus-covid-19/issue-brief/what-do-we-know-about-children-and-coronavirus-transmission/>

[5] Park YJ, Choe YJ, Park O, et al. Contact tracing during coronavirus disease outbreak, South Korea, 2020. *Emerg Infect Dis*. 2020;26(10). Available at: <https://doi.org/10.3201/eid2610.201315>

[6] Melnick H, Darling-Hammond L, Leung M, et al. Reopening schools in the context of COVID-19: Health and safety guidelines from other countries (policy brief). Palo Alto, CA: Learning Policy Institute; 2020. Available at: <https://learningpolicyinstitute.org/product/reopening-schools-covid-19-brief>

[7] Rodriguez-Palacios A, Cominelli F, Basson AR, Pizarro TT, Ilic S. Textile masks and surface covers-a spray simulation method and a "universal droplet reduction model" against respiratory pandemics. Published 2020 May 27. *Front Med (Lausanne)*. 2020;7:260. Available at: doi:10.3389/fmed.2020.00260

[8] World Health Organization. Advice on the use of masks in the context of COVID-19. June 2020. Available at: https://apps.who.int/iris/bitstream/handle/10665/332293/WHO-2019-nCov-IPC_Masks-2020.4-eng.pdf?sequence=1&isAllowed=y

[9] Centers for Disease Control and Prevention. Use of Masks to Help Slow the Spread of COVID-19. Available at: <https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/diy-cloth-face-coverings.html>

[10] Centers for Disease Control and Prevention. Cleaning and Disinfecting Your Facility. Available at: <https://www.cdc.gov/coronavirus/2019-ncov/community/disinfecting-building-facility.html>

[11] American Academy of Pediatrics, Council on School Health. Schools. In: Etzel RA, Balk SJ, eds. Pediatric Environmental Health. 4th ed: Itasca, IL: American Academy of Pediatrics; 2019: 163-187

[12] US Environmental Protection Agency. Supports Healthy Indoor Environments in Schools During COVID-19 Pandemic. Available at: <https://www.epa.gov/iaq-schools/epa-supports-healthy-indoor-environments-schools-during-covid-19-pandemic>

[13] Coleman-Jensen A, Rabbit MP, Gregory CA, Singh A. Household Food Security in the United States in 2018. Economic Research Report No. (ERR-270). Washington, DC: US Department of Agriculture Economic Research Service; September 2019. Available at: <https://www.ers.usda.gov/publications/pub-details/?pubid=94848>

[14] Dunn CG, Kenney E, Fleischhacker SE, Bleich SN. Feeding low-income children during the Covid-19 pandemic. *N Engl J Med.* 2020;382:e40. Available at: <https://www.nejm.org/doi/full/10.1056/NEJMp2005638>

[15] American Academy of Pediatrics, Council on Community Pediatrics and Committee on Nutrition. Promoting food security for all children. *Pediatrics.* 2015;136(5):e1431-e1438. Available at: <https://doi.org/10.1542/peds.2015-3301>.

Interim Guidance Disclaimer: The COVID-19 clinical interim guidance provided here has been updated based on current evidence and information available at the time of publishing. Guidance will be regularly reviewed with regards to the evolving nature of the pandemic and emerging evidence. All interim guidance will be presumed to expire in December 2020 unless otherwise specified.

<https://services.aap.org/en/pages/2019-novel-coronavirus-covid-19-infections/clinical-guidance/covid-19-planning-considerations-return-to-in-person-education-in-schools/>

WHO

Timeline: WHO's COVID-19 response

Source: WHO

WHO has posted its interactive COVID-19 response timeline.

Notes:

1. This timeline uses data from WHO's [COVID-19 Dashboard](#) on cases reported by countries, territories and areas to WHO. Text for listings has been taken from the [Timeline of WHO's response to COVID-19](#).
2. Caution must be taken when interpreting all data presented, and differences between information products published by WHO – such as the [WHO COVID-19 Situation Reports](#) – national public health authorities, and other sources using different inclusion criteria and different data cut-off times are to be expected.
3. While steps are taken to ensure accuracy and reliability, all data are subject to continuous verification and change. All counts are subject to variations in case detection, definitions, laboratory testing, and reporting strategies between countries, states and territories. Data last updated 23 July 2020.

Click on the action circles below the chart to find out more.

<https://www.who.int/emergencies/diseases/novel-coronavirus-2019/interactive-timeline#>

WHO

Considerations for quarantine of contacts of COVID-19 cases

Source: WHO

Interim guidance

19 August 2020 | COVID-19: Infection prevention and control / WASH



[Download \(367.3 kB\)](#)

Overview

The purpose of this document is to offer guidance to Member States on quarantine measures for individuals in the context of COVID-19. It is intended for those responsible for establishing local or national policy for quarantine of individuals, and adherence to infection prevention and control measures.

[https://www.who.int/publications/i/item/considerations-for-quarantine-of-individuals-in-the-context-of-containment-for-coronavirus-disease-\(covid-19\)](https://www.who.int/publications/i/item/considerations-for-quarantine-of-individuals-in-the-context-of-containment-for-coronavirus-disease-(covid-19))

IHR Announcement

COVID-19 / Member States Information Session on Thursday 20 August 2020

Announcement Displayed From: Thursday, August 20, 2020 - 08:57

Find below the details for the information session scheduled for Thursday 20 August 2020 (Member States and Missions briefing) 12:30-14.30 CET.

Dial by your location

+41 22 591 00 05 Switzerland

+1 646 558 8656 US (New York)

+1 213 338 8477 US (Los Angeles)

Meeting ID: 962 4146 3521

Password: 54450017

Find your local number: <https://who.zoom.us/j/abkekCUGwJ>

PAHO

Countries must expand services to cope with mental health effects of COVID-19 pandemic, PAHO Director says

Source: PAHO

ID: 1007663891

18 Aug 2020

Washington, D.C. August 18, 2020 (PAHO) – Countries in the Americas should expand and invest in mental health services to cope with the effects of the COVID-19 pandemic, Pan American Health Organization Director Carissa F. Etienne said today.

“The COVID-19 pandemic has caused a mental health crisis in our region at a scale we’ve never seen before. It’s a perfect storm in every country, as we see growing needs and reduced resources to address them. It is urgent that mental health support is considered a critical component of the pandemic response,” she said.

“Mental health and domestic violence services are essential services, and we must place emphasis on addressing the gaps that have been laid bare by the pandemic. Today, I ask countries to take the steps required to ensure everyone can receive the care they need and deserve,” Etienne told a press briefing.

Dr Etienne noted that coronavirus cases in the Americas have reached almost 11.5 million and over 400,000 people have died. “The Americas have approximately 13% of the world’s population, but 64% of officially reported global deaths,” she said.

The pandemic is having a serious impact on health workers, who are working longer hours than ever before and risking their own lives as hospitals struggle to maintain sufficient Personal Protective Equipment. “After months of operating in crisis mode, our health professionals are facing burnout, anxiety and depression,” she said.

The most effective steps are to hire and train more health workers and integrate mental health and psychosocial support within primary health care systems so they’re easily accessible to those who need them most, she added.

“Everyone who needs mental health support should feel comfortable asking for help. No one should have to suffer alone and without professional support, especially now. Naturally, some of the same concepts apply to domestic violence. These services must be accessible and integrated at the local level; we need innovations to reach and support survivors, and it is paramount to fight stigma. Violence is never acceptable, and survivors of domestic violence should not be blamed.”

Carissa F. Etienne, PAHO/WHO Director

“The real extent of domestic violence during COVID-19 is likely under-estimated, as survivors are stuck at home and support and outreach services are interrupted. With reduced contact to friends and family or barriers in access to services and shelters, we’re leaving survivors with nowhere to go. The costs of violence are extraordinarily high, so support to survivors cannot be put on hold, Etienne said.

PAHO has been helping countries to strengthen policies and services and expand online learning for health workers so they know how to identify and support survivors of violence during the pandemic, she said, and some places using novel approaches to ensure survivors of violence can ask for help discreetly, such as through code words or hand signals.

Patients who have tested positive for COVID-19 also experience insomnia, delirium or even depression, Etienne said. Many persons are overwhelmed with fear of developing severe illness, others are understandably worried for their lives, Etienne noted. Initial research indicates that as much as a third of patients recovering from COVID-19 can have enduring changes in their mood and suffer from anxiety or depression.

Mental health illness is a silent epidemic that has affected the Americas well before COVID-19, with depression and anxiety listed as two of the leading causes of disability. The region also has the second-highest level of alcohol consumption in the world. Emergencies can worsen these conditions, she said.

During the pandemic, Etienne said, “Many of us have felt fearful of infection or anxiety if we are sick; grief as our loved ones have succumbed to the virus; uncertainty about the future, as jobs and life as we knew it came under threat; overwhelmed by the news and misinformation; and lonely or isolated after weeks or even months of social distancing. We are all suffering – especially those affected by pre-existing mental health conditions.”

“We must step up so those living with mental health conditions as well as survivors of violence have the resources and support they need. This pandemic reminds us, like never before, that good mental health is necessary for the wellbeing of individuals and societies,” the PAHO director added.

Contacts

Leticia Linn

Sebastian Oliel

Ashley Baldwin

<https://www.paho.org/en/news/18-8-2020-countries-must-expand-services-cope-mental-health-effects-covid-19-pandemic-paho>

ECDC

Population-wide testing of SARS-CoV-2: country experiences and potential approaches in the EU/EEA and the United Kingdom

Source: ECDC

ID: 1007664251

Technical report

19 Aug 2020

Cite:

Citation Link

TwitterFacebookLinkedInMail

This document summarises country experiences and perspectives relating to the objective and application of different population-wide testing approaches and discusses the options in the context of the EU/EEA and the UK. The testing of all individuals in a specific setting as part of an outbreak investigation (e.g. related to an occupational setting) or a research study are not considered to be population-wide testing in the context of this document. Details on the screening of particular targeted populations (e.g. testing of pregnant women on labour and delivery wards, testing of residents and staff in long-term care facilities, testing of all patients prior to surgery, etc.) are also not included in this document.

Executive summary

Different population-wide testing approaches have already been used in various countries, including household testing, individual testing and the testing of incoming travellers, irrespective of whether or not they are displaying symptoms.

Factors that need to be considered prior to implementation of any population-wide testing strategy which is to include all individuals are the epidemiological situation, costs, logistics, technical feasibility, resource availability, contact tracing capabilities, barriers to testing, potential false positivity and timely notification. Population-wide testing strategies can complement other public health measures and are more effective when paired with case isolation and contact tracing.

<https://www.ecdc.europa.eu/en/publications-data/population-wide-testing-sars-cov-2-country-experiences-and-potential-approaches>

<https://www.ecdc.europa.eu/sites/default/files/documents/covid-19-population-wide-testing-country-experiences.pdf>

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

United States

Florida School District Sees Over 300 Students and Teachers Quarantined Just One Week After Opening

Source: www.newsweek.com

Published: 2020-08-19 15:21 UTC

Received: 2020-08-19 15:21 UTC (0 minutes)

Unique ID: 1007664471

A Florida school district has sent more than 300 students and teachers into quarantine after discovering possible coronavirus cases in classrooms, just one week after opening for in-person learning.

The Martin County School District, located north of Palm Beach, began its school year August 11. In a school board meeting Tuesday, officials revealed the numbers of students and teachers currently in quarantine.

The most recently available data, as of August 17, shows that 292 students and 14 teachers from at least five Martin County schools were in quarantine for possible coronavirus infection, officials said. The district announced at around 7 p.m. Tuesday that 29 additional students from one of the high schools must immediately enter quarantine and transition to remote learning.

Superintendent Laurie Gaylord suggested that some parents could be sending their children into schools for in-person learning while showing COVID-19-like symptoms or even awaiting a test result.

"I want to reinforce the fact that people need to take the personal responsibility in this," Gaylord said. "If your children are sick, please do not send them to school."

Carol Ann Vitani, a health officer for the Florida Department of Health in Martin County, reminded families that the entire household must go into quarantine if one member tests positive for the virus.

"If anyone in your household is COVID-19 positive, do not send your children to school," she said.

Face coverings are required in all schools, as Martin County officials passed an emergency ordinance July 7 mandating that masks be worn in all public spaces. But that's not enough to eliminate the virus's spread entirely.

In an August 14 interview with WPTV, Gaylord said the district had anticipated having to deal with coronavirus cases once the school year began, as more than 60 percent of the district's student population elected to go back to classrooms.

"We know that this is gonna happen," Gaylord said. "There are gonna be children that do exhibit symptoms." Newsweek contacted the Martin County School District for comment but did not hear back in time for publication.

Martin County is not the only school district grappling with coronavirus case surges among students and staff.

The Cherokee County School District in Georgia had to quarantine 826 students and 42 teachers just six days into the school year. The district's most recently available data show the numbers grew to nearly 2,500 students and 62 staffers in quarantine as of August 18.

In Mississippi, 71 out of its 82 counties have reported coronavirus cases just within their schools, Dr. Thomas Dobbs, a state health officer, said at a press conference Monday. The state had 589 teachers and 2,035 students under quarantine as of August 17, he said.

https://www.newsweek.com/florida-school-district-sees-over-300-students-teachers-quarantined-just-one-week-after-opening-1526148?utm_source=Public&utm_medium=Feed&utm_campaign=Distribution

Netherlands

Total Number Of COVID-19 Infected Mink Farms In Netherlands Rises To 36 – Reports

Source: UrduPoint

Published: 2020-08-19 15:17 UTC

Received: 2020-08-19 15:17 UTC (0 minutes)



Unique ID: 1007664428

COVID-19 has been found at three more mink farms across the Netherlands, taking the total number of such infected farms in the country to 36, media reported on Wednesday

MOSCOW (UrduPoint News / Sputnik - 19th August, 2020) COVID-19 has been found at three more mink farms across the Netherlands, taking the total number of such infected farms in the country to 36, media reported on Wednesday.

According to the Dutch news website, more than 1.6 million infected mink have been killed to stop the spread of the virus, which represents 30 percent of all animals kept on the Netherlands' 128 mink farms.

The first outbreak at a Dutch mink farm was detected in April in North Brabant.

In May, the Ministry of Agriculture confirmed the first two cases  and so far the only ones  of a mink infecting a human with the coronavirus.

The government responded by launching a policy of animal culling at infected farms and long-term isolation at non-infected farms. In parallel, monitoring and strict sanitary protocols have been put in place.

In 2013, the Netherlands began eliminating its fur cultivating farms with the outlook of finishing by 2024.

<https://www.urdupoint.com/en/world/total-number-of-covid-19-infected-mink-farms-1005919.html>

Greece

Greece Extends Entry Ban for Non-EU Citizens Until August 31

Source: SchengenVisalInfo.com

Published: 2020-08-19 12:06 UTC

Received: 2020-08-19 12:08 UTC (+2 minutes)

Unique ID: 1007662962

Greece's government has decided to extend the entry ban for internationals outside the European Union, until August 31, the Hellenic Civil Aviation Authority (HCCA) has announced.

According to the Greece authorities, the decision was taken in a bid to stop the spread of COVID-19, SchengenVisaInfo.com reports.

However, citizens of the following 11 countries are exempted from the ban: Australia, Georgia, Canada, New Zealand, Japan, South Korea, Rwanda, Thailand, Uruguay, the United Arab Emirates and Tunisia.

Other exemptions from the ban, according to the Hellenic Civil Aviation Authority include:

EU/Schengen Zone nationals, as well as their spouses or citizens with whom they have entered into a cohabitation agreement, and their (underage) children.

Medical and nursing staff as well as professionals and researchers in the field of health.

EU/Schengen Area long-term residents and third-country nationals who obtain a residence permit in the EU/Schengen Zone.

Members of government missions and diplomatic or consular authorities.

Military and security personnel together with the staff of the General Secretariat for Civil Protection.

Persons employed in the field of transport, including aircraft crews, seafarers, hired flight personnel firefighters and crews.

Drivers of lorries (and their necessary personnel) passing through Greece in order to transport goods.

Students, transit passengers, elderly carers and people with disabilities, and seasonal agricultural workers.

Earlier this month, Deputy Health Minister Vasilis Kotzamanis announced that the country is conducting 9,000 COVID-19 tests daily, at the country's entry points.

Amid the COVID-19 pandemic, Greece had banned flights to and from Albania, Turkey and North Macedonia until July 31, according to an aviation directive (NOTAM) of the Hellenic Civil Aviation Authority. Last month, Greece's government opened its doors for the residents of 14 third-countries, considered safe by the Coronavirus situation.

Up to this point, a total of 7,472 persons tested positive for the Coronavirus, in Greece, while, 232 persons have died.

<https://www.schengenvisa.info.com/news/greece-extends-entry-ban-for-non-eu-citizens-until-august-31/>

United Kingdom

72% of Covid cases report no symptoms when tested

Source: Metro

Published: 2020-08-19 08:15 UTC

Received: 2020-08-19 10:00 UTC (+1 hours 45 minutes)

Unique ID: 1007662570

LESS than a third of people who tested positive for coronavirus reported any symptoms, figures show.

Just 28 per cent of positive Covid-19 cases said they had symptoms at the time of their swab test or at preceding or subsequent tests, the Office for National Statistics (ONS) reports.

The remaining 72 per cent of positive cases either did not report having any of the specific or general symptoms or did not answer the questions.

'This suggests there is a potentially large number of asymptomatic cases, but it is important to note that symptoms were self-reported rather than professionally diagnosed,' the ONS said. Symptoms people were asked to report included fever, muscle ache, fatigue, sore throat, cough, shortness of breath, headache, nausea or vomiting, abdominal pain, diarrhoea, loss of taste with loss of smell.

The ONS stressed its analysis was based on 165 people who had tested positive and any false positives could have an effect on the results.

People in one-person households were estimated to be about twice as likely to test positive than those in two-person households. The ONS said there was no evidence to suggest those living in larger households were at higher or lower risk of testing positive. 'We will investigate why those in one-person households might be more likely to test positive in a future article,' it added.

Meanwhile, the World Health Organization has said it is concerned that young people are 'increasingly' driving the virus's spread and putting the vulnerable at risk. 'The epidemic is changing,' WHO regional director Takeshi Kasai told a briefing. 'People in their 20s, 30s and 40s are increasingly driving the spread. Many are unaware they are infected.'

<https://gphin.canada.ca/cepr/showarticle.jsp?docId=1007662570>

Brazil

Brazil Reports Decelerating Coronavirus Contagion for First Time

Source: Rio Times Online

Unique ID: [1007670515](https://riotimesonline.com/brazil-news/miscellaneous/covid-19/brazil-reports-decelerating-coronavirus-contagion-for-first-time/)

RIO DE JANEIRO, BRAZIL - For the first time in almost four months, Brazil reported coronavirus transmission under control, according to calculations by Imperial College's epidemic control center. For the week that began on Sunday, August 16th, the contagion rate - which points to how many people each infected person on average transmits the pathogen - has been calculated at 0.98.

This means that every 100 people infected with the novel coronavirus spread the pathogen to 98 others, which in turn spread the pathogen to 96, which in turn spread the pathogen to 94, slowing down the spread. However, the new . . .

<https://riotimesonline.com/brazil-news/miscellaneous/covid-19/brazil-reports-decelerating-coronavirus-contagion-for-first-time/>

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

Canada

Study shows how COVID-19 may be transmitted onboard flights

Source: CTVNews.ca COVID - all news tag driven

Published: 2020-08-19 00:43 UTC

Received: 2020-08-19 00:44 UTC (+1 minutes)

Unique ID: 1007659609

TORONTO -- As passengers begin to return to airports in larger numbers, masks strapped on and hand sanitizer abounding, one question still remains murky: what is the risk of catching COVID-19 on a flight?

A recent case study is providing insight into who is potentially at risk of contracting COVID-19 on an airplane if there are infectious individuals onboard, and how seating position and airflow could play a role.

Released Tuesday as a research letter in The Journal of the American Medical Association (JAMA), the research looked specifically at one single commercial airline flight from Tel Aviv, Israel, to Frankfurt, Germany, on March 9.

Researchers believe at least two individuals contracted COVID-19 from other passengers on the flight.

"In our study, both passengers with likely onboard transmission were seated within 2 rows of an index case," the research stated.

But the story starts seven days before the plane ever left the ground. Out of 102 passengers on the Boeing 737-900 flight, 24 were members of the same tourist group.

Starting a week before their flight, the entire tourist group had contact with a hotel manager who would later test positive for COVID-19.

None of these individuals had received a COVID-19 diagnosis prior to boarding the flight.

Once the plane touched down in Germany, the passengers went through a medical evaluation. The 24 tourists received a throat swab to test for the novel coronavirus and additional interviews were set up with passengers four to five weeks later.

Seven people from the tourist group tested positive for COVID-19 during that first throat swab at the airport, making them the "index cases". Four of them had been experiencing symptoms on the plane, two had yet to experience symptoms, and one would remain completely asymptomatic.

Anyone seated on the plane within two rows of these seven passengers, as well as anyone else throughout the plane who reported symptoms, were offered antibody tests in the weeks after the flight.

Of the 78 remaining passengers who had been exposed to the tourist group on the plane, 71 consented to follow-up interviews.

One passenger reported testing positive through a throat or nose swab taken 4 days after the flight, and didn't recall having displayed any symptoms. An antibody test and a plaque reduction neutralization test (PRNT) confirmed both had positive results.

The passenger did not believe they had come into contact with anyone who had COVID-19 before or after the flight, making the flight itself the likely site of where they contracted the virus.

The individual who makes up the second likely case of transmission experienced a headache, muscle aches, and hoarseness starting five days after the flight and quarantined themselves. An antibody test detected the novel coronavirus, although the PRNT results to double check the antibody test were “borderline.”

A third person experiencing symptoms had previous contact with a COVID-19 patient, meaning it was not clear whether they could have contracted COVID-19 before they got on the plane.

A detailed look at the seating chart shows that the two likely cases of transmission were seated across the aisle and within two rows from the index cases.

Three of the index cases who were symptomatic on the plane were sitting right next to each other on the right side of the plane, just one row behind one of the likely cases of transmission, who was seated in the aisle seat on the left side of the plane.

But those who likely contracted the virus were not just those who were closest to the index cases.

The second likely transmission was a passenger sitting in the far window seat on the left side of the plane, with two seats and the aisle in-between them and the index cases, all of whom were seated on the right side of the plane. The person sitting in the middle seat next to them, closer to the index cases, did not test positive, according to the research.

“The airflow in the cabin from the ceiling to the floor and from the front to the rear may have been associated with a reduced transmission rate,” the researchers stated. They noted that for previous viruses, such as SARS and influenza, transmission has been found to extend beyond the two row perimeter that researchers look at most closely in these cases.

“Our findings do not rule out airborne transmission of SARS-CoV-2 in an airplane cabin.”

It’s important to note that the flight studied was in the air long before airlines were taking precautions to prevent the spread of COVID-19, such as requiring passengers to wear masks for flights. None of the index cases were wearing masks.

“It could be speculated that the rate may have been reduced further had the passengers worn masks,” the researchers wrote.

The number of people who have actually contracted COVID-19 on an airplane is believed to be relatively small so far considering that individuals with COVID-19 are still taking flights into Canada and between provinces.

Eighteen of the flights arriving to Canada from international destinations since the start of August alone had people on board with COVID-19.

A study published in late July also showed that those travelling on a train are at risk for contracting COVID-19, and that the most dangerous seats are those directly across from or beside an infected person.

<https://www.ctvnews.ca/health/coronavirus/study-shows-how-covid-19-may-be-transmitted-onboard-flights-1.5069587>

United States

Coronavirus mystery of US fishing boat crew with ‘neutralising antibodies’

Source: South China Morning Post

Published: 2020-08-19 07:42 UTC

Received: 2020-08-19 12:39 UTC (+4 hours 57 minutes)

Locations: King County, Seattle, , Washington

Unique ID: 1007663247

- A coronavirus outbreak on a Seattle fishing boat may offer scientists insight into immunity
- However, the research does not necessarily show people cannot catch Covid-19 twice

Three crew of a Seattle fishing boat who were found to have antibodies able to neutralise the new coronavirus remained uninfected in an outbreak that swept through the ship, sickening most people on board, researchers have reported.

The small real-world study, which has not been peer-reviewed, is among the first in humans to suggest a link between neutralising antibodies – those that stop the virus latching onto host cells – and protection from infection.

Researchers from the University of Washington and Fred Hutchinson Cancer Research Centre in Seattle screened 120 of 122 people before they boarded the 'American Dynasty' fishing vessel in May, testing both for active virus and for antibodies in the blood that would indicate a previous or ongoing infection.

None of the crew tested positive for the virus, but six had some antibodies and of those, three had evidence of neutralising antibodies.

More than two weeks after the boat set sail, it returned to shore with an infected crew member who needed hospital treatment.

Researchers then tested all the crew over several weeks and found that 85 per cent – 104 crew members – were infected.

But none of the three with neutralising antibodies tested positive, nor did they report any symptoms during the outbreak.

"Therefore, the presence of neutralising antibodies from prior infection was significantly associated with protection against reinfection," the authors of the study said.

American Seafoods, which owns the ship, said the company had partnered with the University of Washington on its testing programme.

"We hope that their study will be beneficial to the broader scientific community in learning more about Covid-19," said Valentina Zackrone, chief human resources officer at American Seafoods, according to The Seattle Times.

Scientists have not been able to run direct human tests to find out about the protection conferred by neutralising antibodies, because of ethical concerns over potential severity and long term impacts of the virus, the study authors said.

Danny Altmann, a professor of immunology at Imperial College London, said the new study, though small, was a "remarkable, real-life, human experiment at a time when we've been short of hard-line, formal, proof that neutralising antibodies genuinely offer protection from reinfection" – although that had been predicted by animal testing.

"In short, it's good news. Who knew immunology research on fishing boats could be so informative?" he added.

But the research does not necessarily show people cannot catch Covid-19 twice.

The three crew who had weaker antibodies before setting sail all tested positive on return – although researchers said their initial results could have been a false positive or sign of early infection.

In a commentary on the study, Jonathan Ball, a professor of molecular virology at University of Nottingham, said it "suggests that individuals who have had a prior exposure to virus are susceptible to reinfection unless they have appreciable levels of neutralising antibodies".

Ball, who was not linked to the research, said this "gives us an important insight into the type of immunity that might protect from future infection", but it does not show whether past exposure can protect against severe infection in people who do not develop neutralising antibodies.

<https://www.scmp.com/news/world/united-states-canada/article/3097964/coronavirus-mystery-us-fishing-boat-crew>

United Kingdom

10,000 people now signed up to COVID-19 immunity study

Source: Public Health England

ID: 1007664278

A nationwide effort led by PHE to find out whether people who had COVID-19 can get infected again has now recruited 10,000 health workers from across the NHS.

Published 19 August 2020

Last updated 19 August 2020 — see all updates

From: Public Health England

COVID illustration showing ultrastructural morphology exhibited by coronaviruses

A nationwide effort led by Public Health England (PHE) to solve the mystery of whether people who had COVID-19 can get infected again hit a key recruitment milestone today, Wednesday 19 August 2020.

10,000 health workers from across the NHS have now signed up to take part in PHE's 'SIREN' (SARS-CoV-2 Immunity & REinfection Evaluation) study, which is exploring whether specific COVID-19 antibodies provide immunity.

Scientists do not yet know if people who have been infected in the past are protected from becoming sick again, or how long any protection lasts.

Professor Susan Hopkins from Public Health England, said:

Every day we learn more and more about the impacts of becoming infected with COVID-19, but we don't know if you can get it again, if you can pass it on, or if you develop immunity. We urgently need to find out the answers to these questions as rapidly as possible.

I can't overstate how grateful we are to the ten thousand NHS doctors, nurses, cleaners and porters who have signed up so far to help improve our knowledge about this new infection.

Lord Bethell, Health Minister said:

Understanding our body's response to COVID-19 is a critical step in beating this horrible virus. That's why this clinical study, one of the largest in the world, is so important. It will help us understand the mystery of our antibody response to COVID-19.

The study will follow participants for at least 12 months, with regular blood and swab tests and will also explore how factors like ethnicity, age or gender affect the chances of infection and the extent of any immunity. Preliminary results are expected before the winter.

All 4 nations from across the UK will eventually be involved. Recruitment in Scotland, Wales and Northern Ireland is due to begin in the coming weeks.

<https://www.gov.uk/government/news/10-000-people-now-signed-up-to-covid-19-immunity-study>

United States

COVID-19 Among American Indian and Alaska Native Persons — 23 States, January 31–July 3, 2020

Source: CDC

Early Release / August 19, 2020 / 69

Related Pages

Sarah M. Hatcher, PhD¹; Christine Agnew-Brune, PhD¹; Mark Anderson, MD¹; Laura D. Zambrano, PhD¹; Charles E. Rose, PhD¹; Melissa A. Jim, MPH¹; Amy Baugher, MPH¹; Grace S. Liu, MPH^{1,2}; Sadhna V. Patel, MPH¹; Mary E. Evans, MD¹; Talia Pindyck, MD¹; Christine L. Dubray, MD¹; Jeanette J. Rainey, PhD¹; Jessica Chen, PhD¹; Claire Sadowski, MPH^{1,3}; Kathryn Winglee, PhD¹; Ana Penman-Aguilar, PhD¹; Amruta Dixit, PhD⁴; Eudora Claw, MPH⁴; Carolyn Parshall, MPH⁴; Ellen Provost, DO⁵; Aurimar Ayala, MPH⁶; German Gonzalez, MD⁷; Jamie Ritchey, PhD⁸; Jonathan Davis, PhD⁸; Victoria Warren-Mears, PhD⁹; Sujata Joshi, MSPH⁹; Thomas Weiser, MD^{9,10}; Abigail Echo-Hawk, MA¹¹; Adrian Dominguez, MS¹¹; Amy Poel, MPH¹¹; Christy Duke, MPH¹²; Imani Ransby, MPH¹²; Andria Apostolou, PhD^{13,14}; Jeffrey McCollum, DVM¹³

[\(View author affiliations\)](#)

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Summary

What is already known about this topic?

American Indian and Alaska Native (AI/AN) persons appear to be disproportionately affected by the COVID-19 pandemic; however, limited data are available to quantify the disparity in COVID-19 incidence, severity, and outcomes among AI/AN persons compared with those among other racial/ethnic groups.

What is added by this report?

In 23 states with adequate race/ethnicity data, the cumulative incidence of laboratory-confirmed COVID-19 among AI/AN persons was 3.5 times that among non-Hispanic white persons. A large percentage of missing data precluded analysis of some characteristics and outcomes.

What are the implications for public health practice?

Adequate health care and public health infrastructure resources are needed to support a culturally responsive public health effort that sustains the strengths of AI/AN communities. These resources would facilitate the collection and reporting of more complete case report data to support evidence-based public health efforts.

Although non-Hispanic American Indian and Alaska Native (AI/AN) persons account for 0.7% of the U.S. population,* a recent analysis reported that 1.3% of coronavirus disease 2019 (COVID-19) cases reported to CDC with known race and ethnicity were among AI/AN persons (1). To assess the impact of COVID-19 among the AI/AN population, reports of laboratory-confirmed COVID-19 cases during January 22[†]–July 3, 2020 were analyzed. The analysis was limited to 23 states[§] with >70% complete race/ethnicity information and five or more laboratory-confirmed COVID-19 cases among both AI/AN persons (alone or in combination with other races and ethnicities) and non-Hispanic white (white) persons. Among 424,899 COVID-19 cases reported by these states, 340,059 (80%) had complete race/ethnicity information; among these 340,059 cases, 9,072 (2.7%) occurred among AI/AN persons, and 138,960 (40.9%) among white persons. Among 340,059 cases with complete patient race/ethnicity data, the cumulative incidence among AI/AN persons in these 23 states was 594 per 100,000 AI/AN population (95% confidence interval [CI] = 203–1,740), compared with 169 per 100,000 white population (95% CI = 137–209) (rate ratio [RR] = 3.5; 95% CI = 1.2–10.1). AI/AN persons with COVID-19 were younger (median age = 40 years; interquartile range [IQR] = 26–56 years) than were white persons (median age = 51 years; IQR = 32–67 years). More complete case report data and timely, culturally responsive, and evidence-based public health efforts that leverage the strengths of AI/AN communities are needed to decrease COVID-19 transmission and improve patient outcomes.

Individual COVID-19 case reports submitted to CDC using the CDC COVID-19 case report form[¶] and through the National Notifiable Diseases Surveillance System^{**} during January 22–July 3, 2020 were analyzed. Laboratory-confirmed^{††} and probable^{§§} COVID-19 cases are reported by state and local health jurisdictions based on reports submitted by health care providers and laboratories. Cases with missing report date were excluded. Probable cases (12,081) and cases among persons repatriated to the United States from Wuhan, China (two cases), and the Diamond Princess cruise ship (41 cases) (2) were also excluded. Analysis was limited to the 23 states with >70% complete race/ethnicity information and five or more laboratory-confirmed cases each among AI/AN and white persons. Arizona, which accounts for at least one third of all COVID-19 cases among AI/AN persons nationwide, was excluded from analysis because >30% of race/ethnicity data were missing. Because approximately 2.3 million of 5.2 million AI/AN persons identify with multiple races (3), AI/AN race/ethnicity was classified as either AI/AN alone or in combination with other races and ethnicities. White (non-Hispanic) was chosen as the comparator group to avoid comparing rates among AI/AN persons to other marginalized populations that experience similar health disparities. Whereas previous reports focused on COVID-19 incidence among black and Hispanic persons, the race/ethnicity categorization in this analysis maximized these data to allow for the calculation of more stable RR estimates. A generalized estimating equations Poisson regression model was used to calculate cumulative incidence (cumulative cases per 100,000 population), RRs, and 95% CIs for AI/AN and white race/ethnicity categories. Generalized estimating equations models, which perform well for estimating rates with correlated data, were used to account for nonindependence (i.e., clustering) by state (4). CDC's National Center for Health Statistics (NCHS) postcensal bridged-race estimates were used as population denominators (5). Symptoms, underlying health conditions, hospitalizations, intensive care unit (ICU) admissions, and deaths were not analyzed because a large percentage of these data were missing. Analyses were conducted using SAS software (version 9.4; SAS Institute).

Among the 1,613,949 laboratory-confirmed COVID-19 cases voluntarily reported to CDC during January 22–July 3, 2020, 424,899 (26.3%) were reported by the 23 included states. Among these cases, 340,059 (80.0%) had complete race/ethnicity data, including 9,072 (2.7%) among AI/AN persons and 138,960 (40.9%) among white persons. These cases represented 51% of 17,709 reported cases among AI/AN persons and 41% of 339,789 reported cases among whites in all U.S. states and territories. Among the 340,059 cases with complete race/ethnicity data, the cumulative incidence among AI/AN persons was 594 cases per 100,000 (95% CI = 203–1,740), 3.5 (95% CI = 1.2–10.1) times that among white persons (169 per 100,000; 95% CI = 137–209). The magnitude of this reported RR estimate is affected by the elevated RR in New Mexico (RR = 14.9).^{¶¶} Median age among AI/AN and white patients was 40 years (IQR = 26–56 years) and 51 years (IQR = 32–67 years), respectively. AI/AN persons with COVID-19 tended to be younger than white persons with COVID-19: a higher proportion of AI/AN patients were aged <18 years

(12.9%) and a smaller proportion were aged ≥ 65 years (12.6%), compared with white patients aged < 18 and ≥ 65 years (4.3% and 28.6%, respectively) ([Table](#)).

Completeness of data on underlying health conditions (e.g., cardiovascular disease and diabetes), symptoms, hospitalization status, ICU admission, and death was lower for AI/AN patients than for white patients. Data on underlying health conditions were available for 762 (8.4%) AI/AN patients and 37,993 (27.3%) white patients, and symptom data were available for 998 (11.0%) AI/AN patients and 39,225 (28.2%) white patients. Whereas hospitalization status, ICU admission status, and vital status (i.e., outcome of death) were known for 78.9%, 26.7%, and 74.4%, respectively, of white COVID-19 patients, this information was available for approximately one third of those percentages of AI/AN patients (24.2%, 9.4%, and 22.5%, respectively). Because of the high prevalence of these missing data elements among AI/AN patients, analysis to identify overall prevalence, possible risk factors for COVID-19, and patient outcomes was not possible.

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Discussion

In 23 states with sufficient COVID-19 patient race/ethnicity data, the overall COVID-19 incidence among AI/AN persons was 3.5 times that among white persons. Although this disparity is mostly influenced by the elevated RR in New Mexico, variability in the RR among states is reflected in the wide confidence interval (95% CI = 1.2, 10.1). Among 345,093 COVID-19 cases meeting the study inclusion criteria, 2.7% of cases occurred in AI/AN persons, more than twice the percentage of non-Hispanic AI/AN cases reported in CDC COVID-19 case surveillance data from all states (1.3%) (1). However, this analysis included AI/AN persons who identified as multiple races and ethnicities, which increased AI/AN case identification by 4%, from 8,691 to 9,072 cases in the 23 states. The higher proportion of AI/AN persons in this analysis is also the result of the more completely reported race/ethnicity data in these states.

Historical trauma and persisting racial inequity have contributed to disparities in health and socioeconomic factors between AI/AN and white populations that have adversely affected AI/AN communities; these factors likely contribute to the observed elevated incidence of COVID-19 among the AI/AN population (6). The elevated incidence within this group might also reflect differences in reliance on shared transportation, limited access to running water, household size, and other factors that might facilitate COVID-19 community transmission (6). Although the elevated prevalence of underlying health conditions among AI/AN persons is well documented (7,8), in this analysis, data on underlying health conditions were unknown or missing for 91.6% of AI/AN patients compared with 72.7% of white patients, preventing examination of the association between underlying health conditions and COVID-19 incidence. The excessive absence of data among AI/AN persons represents an important gap in public health data for AI/AN persons and suggests a need for additional resources to support case investigation and reporting infrastructure in AI/AN communities.

The findings in this report are subject to at least three limitations. First, data are presented as reported to CDC through a passive case surveillance system. Case data are voluntarily reported to CDC by states without active case finding. The high prevalence of missing data on symptoms, underlying health conditions, hospitalization, ICU admission, and death precluded the analysis of these characteristics and outcomes. Missing data likely reflect state, local, and tribal health jurisdictions' ability to collect these data given their current case loads, incomplete reporting to CDC, or both. Second, this analysis represents an underestimate of the actual COVID-19 incidence among AI/AN persons for several reasons. Reporting of detailed case data to CDC by states is known to be incomplete; therefore, this analysis was restricted to 23 states with more complete reporting of race and ethnicity. As a result, the analysis included only one half of reported laboratory-confirmed COVID-19 cases among AI/AN persons nationwide, and the examined states represent approximately one third of the national AI/AN population.*** In addition, AI/AN persons are commonly misclassified as non-AI/AN races and ethnicities in epidemiologic and administrative data sets, leading to an underestimation of AI/AN morbidity and mortality (9). Finally, the NCHS bridged-race estimates used as population denominators are known to inflate the Hispanic AI/AN population in the United States, resulting in the underestimation of mortality rates among AI/AN populations that include Hispanic AI/AN persons (10).

Despite these limitations, these findings suggest that the AI/AN population in the 23 examined states, particularly AI/AN persons aged < 65 years, has been disproportionately affected by the COVID-19 pandemic, compared with the white population. More complete case information is needed to more effectively guide the public health response to COVID-19 among the AI/AN population. The collection of this information can be facilitated by more consistent, complete, and accurate collection and reporting by

providers, reporting laboratories, and local, state, federal, and tribal public health practitioners, and ensuring the resources to do so. Race/ethnicity data should be collected following best practices for AI/AN data collection, including allowing for the reporting of multiple races and ethnicities and providing adequate training about asking about race and ethnicity in a culturally sensitive manner.^{§§§} Further, among federally recognized tribes, AI/AN race is a political status that confers access to health care services under treaty obligations of the U.S. government^{¶¶¶}; these findings highlight the important contribution of adequate health care and public health infrastructure resources to culturally responsive public health efforts intended to sustain the strengths of AI/AN communities.

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Corresponding author: Sarah M. Hatcher; eocevent458@cdc.gov.

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¹CDC COVID-19 Response Team; ²Association of Schools and Programs of Public Health, Washington, DC; ³Oak Ridge Institute for Science and Education, Oak Ridge, Tennessee; ⁴Albuquerque Area Southwest Tribal Epidemiology Center, Albuquerque, New Mexico; ⁵Alaska Native Tribal Health Consortium's Alaska Native Epidemiology Center, Anchorage, Alaska; ⁶California Rural Indian Health Board, Inc., California Tribal Epidemiology Center, Roseville, California; ⁷Great Lakes Inter-Tribal Epidemiology Center, Lac du Flambeau, Wisconsin; ⁸Inter Tribal Council of Arizona, Inc., Tribal Epidemiology Center, Phoenix, Arizona; ⁹Northwest Portland Area Indian Health Board, Northwest Tribal Epidemiology Center, Portland, Oregon; ¹⁰Portland Area Indian Health Service, Portland, Oregon; ¹¹Seattle Indian Health Board, Urban Indian Health Institute, Seattle, Washington; ¹²United South and Eastern Tribes, Inc., Tribal Epidemiology Center, Nashville, Tennessee; ¹³Indian Health Service, Rockville, Maryland; ¹⁴SciMetrika, LLC, McLean, Virginia.

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* Based on 2018 U.S. Census single-race estimates for non-Hispanic AI/AN (<https://wonder.cdc.gov/Single-Race-v2018.HTML>). This represents a subset of the AI/AN population. The total AI/AN population (AI/AN alone or in combination with other races/ethnicities) constitutes 1.4% of the United States population (<https://wonder.cdc.gov/Bridged-Race-v2019.HTML>). Some have estimated the AI/AN population to constitute up to 1.7% of the United States population ([https://www.census.gov/history/pdf/c2010br-10.pdfpdf iconexternal icon](https://www.census.gov/history/pdf/c2010br-10.pdfpdf%20iconexternal%20icon)).

† The first laboratory-confirmed case in the 23 analyzed states was reported on January 31, 2020.

§ Alabama, Alaska, Florida, Iowa, Kansas, Kentucky, Maine, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Mexico, North Carolina, Ohio, Oregon, Tennessee, Utah, Wisconsin, and Wyoming.

¶ <https://www.cdc.gov/coronavirus/2019-ncov/php/reporting-pui.html>.

** <https://wwwn.cdc.gov/nndss>; <https://wwwn.cdc.gov/nndss/covid-19-response.html>.

†† A laboratory-confirmed COVID-19 case was defined as a person with a positive test result for SARS-CoV-2, the virus that causes COVID-19, from a respiratory specimen, using real time reverse transcription–polymerase chain reaction testing.

§§ According to the Council of State and Territorial Epidemiologists position statement Interim 20-ID-01, a probable case must 1) meet clinical criteria and epidemiologic criteria with no confirmatory laboratory testing performed; 2) have presumptive laboratory evidence, including detection of specific antigen or antibody in a clinical specimen, and meet clinical criteria or epidemiologic criteria; or 3) meet vital records criteria with no confirmatory laboratory testing performed. ([https://cdn.ymaws.com/www.cste.org/resource/resmgr/2020ps/interim-20-id-01_covid-19.pdfpdf iconexternal icon](https://cdn.ymaws.com/www.cste.org/resource/resmgr/2020ps/interim-20-id-01_covid-19.pdfpdf%20iconexternal%20icon)).

¶¶ New Mexico accounts for 6,130 (68%) of the AI/AN cases but 16% of the total AI/AN population of the 23 states analyzed.

*** <https://wonder.cdc.gov/Bridged-Race-v2018.html>.

§§§ [https://www.uihi.org/resources/best-practices-for-american-indian-and-alaska-native-data-collection/external icon](https://www.uihi.org/resources/best-practices-for-american-indian-and-alaska-native-data-collection/external%20icon).

¶¶¶ [https://www.ihs.gov/aboutihs/external icon](https://www.ihs.gov/aboutihs/external%20icon).

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References

1. Stokes EK, Zambrano LD, Anderson KN, et al. Coronavirus disease 2019 case surveillance—United States, January 22–May 30, 2020. *MMWR Morb Mortal Wkly Rep* 2020;69:759–65. [CrossRefexternal icon](#) [PubMedexternal icon](#)
2. National Institute of Infectious Diseases. Field briefing: Diamond Princess COVID-19 cases. Tokyo, Japan: National Institute of Infectious Diseases; 2020. [https://www.niid.go.jp/niid/en/2019-ncov-e/9407-covid-dp-fe-01.htmexternal icon](https://www.niid.go.jp/niid/en/2019-ncov-e/9407-covid-dp-fe-01.htmexternal%20icon)
3. Norris T, Vines PL, Hoeffel EM. The American Indian and Alaska Native population: 2010. Suitland, MD: US Department of Commerce, US Census Bureau; 2012. [https://www.census.gov/prod/cen2010/briefs/c2010br-10.pdfpdf iconexternal icon](https://www.census.gov/prod/cen2010/briefs/c2010br-10.pdfpdf%20iconexternal%20icon)
4. Hanley JA, Negassa A, Edwardes MD, Forrester JE. Statistical analysis of correlated data using generalized estimating equations: an orientation. *Am J Epidemiol* 2003;157:364–75. [CrossRefexternal icon](#) [PubMedexternal icon](#)
5. CDC, National Center for Health Statistics. Vintage 2018 bridged-race postcensal population estimates. Atlanta, GA: US Department of Health and Human Services, CDC, National Center for Health Statistics; 2019. https://www.cdc.gov/nchs/nvss/bridged_race/data_documentation.htm
6. Sequist TD. The disproportionate impact of COVID-19 on communities of color. *NEJM Catalyst* 2020. Epub July 6, 2020. [https://catalyst.nejm.org/doi/full/10.1056/CAT.20.0370external icon](https://catalyst.nejm.org/doi/full/10.1056/CAT.20.0370external%20icon)
7. CDC. Vital Signs: Native Americans with diabetes. Atlanta, GA: US Department of Health and Human Services, CDC; 2017. <https://www.cdc.gov/vitalsigns/aian-diabetes/index.html>
8. Melkonian SC, Jim MA, Haverkamp D, et al. Disparities in cancer incidence and trends among American Indians and Alaska Natives in the United States, 2010–2015. *Cancer Epidemiol Biomarkers Prev* 2019;28:1604–11. [CrossRefexternal icon](#) [PubMedexternal icon](#)
9. Haozous EA, Strickland CJ, Palacios JF, Solomon TGA. Blood politics, ethnic identity, and racial misclassification among American Indians and Alaska Natives. *J Environ Public Health* 2014;2014:321604. [CrossRefexternal icon](#) [PubMedexternal icon](#)
10. Jim MA, Arias E, Seneca DS, et al. Racial misclassification of American Indians and Alaska Natives by Indian Health Service contract health service delivery area. *Am J Public Health* 2014;104(Suppl 3):S295–302. [CrossRefexternal icon](#) [PubMedexternal icon](#)

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TABLE. Demographic characteristics and data quality among laboratory-confirmed COVID-19

cases, by race/ethnicity — 23 states,* January 31–July 3, 2020



Characteristic	No. (%)	
	American Indian and Alaska Native [†] (N = 9,072)	White, non-Hispanic (N = 138,960)
Age group, yrs		
Median (IQR)	40 (26–56)	51 (32–67)
0–18	1,171 (12.9)	6,000 (4.3)
19–44	4,091 (45.1)	50,772 (36.5)
45–54	1,384 (15.3)	19,923 (14.3)
55–64	1,284 (14.2)	22,518 (16.2)
≥65	1,141 (12.6)	39,737 (28.6)
Missing	1 (—)	10 (—)
Sex		
Female	4,819 (53.5)	72,921 (52.6)
Male	4,181 (46.5)	65,701 (47.4)
Missing	72 (—)	338 (—)
Symptoms known[§]		

TABLE. Demographic characteristics and data quality among laboratory-confirmed COVID-19



cases, by race/ethnicity — 23 states,* January 31–July 3, 2020

	No. (%)	
Characteristic	American Indian and Alaska Native[†] (N = 9,072)	White, non-Hispanic (N = 138,960)
Yes	998 (11.0)	39,225 (28.2)
No	8,074 (89.0)	99,735 (71.8)
Underlying health conditions known[¶]		
Yes	762 (8.4)	37,993 (27.3)
No	8,310 (91.6)	100,967 (72.7)
Hospitalization status** known^{††}		
Yes	2,197 (24.2)	109,638 (78.9)
No	6,875 (75.8)	29,322 (21.1)
ICU admission status known^{††}		
Yes	855 (9.4)	37,150 (26.7)
No	8,217 (90.6)	101,810 (73.3)
Death status known^{††}		
Yes	2,039 (22.5)	103,371 (74.4)
No	7,033 (77.5)	35,589 (25.6)

Abbreviations: COVID-19 = coronavirus disease 2019; ICU = intensive care unit; IQR = interquartile range.

* Alabama, Alaska, Florida, Iowa, Kansas, Kentucky, Maine, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Mexico, North Carolina, Ohio, Oregon, Tennessee, Utah, Wisconsin, and Wyoming.[†] Alone or in combination with other races and ethnicities.[§] Symptoms were classified as “known” if any of the following symptoms were reported as present or absent: fever (measured >100.4°F [38°C] or subjective), cough, shortness of breath, wheezing, difficulty breathing, chills, rigors, myalgia, rhinorrhea, sore throat, chest pain, nausea or vomiting, abdominal pain, headache, fatigue, diarrhea (≥3 loose stools in a 24-hour period), or other symptom not otherwise specified on the form.[¶] Underlying health conditions were classified as “known” if any of the following conditions were reported as present or absent: diabetes mellitus, cardiovascular disease (including hypertension), severe obesity (body mass index ≥40 kg/m²), chronic renal disease, chronic liver disease, chronic lung disease, immunocompromising condition, autoimmune condition, neurologic condition (including neurodevelopmental, intellectual, physical, visual, or hearing impairment), psychologic/psychiatric condition, and other underlying medical condition not otherwise specified.^{**} Includes hospitalization with or without ICU admission.^{††} Hospitalization, ICU admission, and death status were considered known if the response was “yes” or “no” (not “missing” or “unknown”).

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United States

Hackensack Meridian Health Observational Study Identifies Drug that Improves Survival in Sickest COVID-19 Patients

Source: Hackensack Meridian Health

Unique ID: 1007665578

EDISON, N.J., Aug. 19, 2020 /PRNewswire/ -- Researchers at Hackensack Meridian Health, New Jersey's largest and most comprehensive health network, have utilized its statewide observational database of more than 5,000 hospitalized COVID-19 patients to show that a drug normally used in rheumatoid arthritis and cancer treatments, tocilizumab, improves hospital survival in critically-ill patients admitted to the intensive care unit (ICU).

The findings were published in *The Lancet Rheumatology* on Aug. 14, and Hackensack Meridian Health researchers have updated the U.S. Food and Drug Administration and other national leaders of the findings to potentially accelerate improved outcomes.

"Our clinicians and researchers at Hackensack Meridian Health have moved quickly and intelligently since the start of this global health crisis," said Robert C. Garrett, FACHE, chief executive officer of Hackensack Meridian Health. "Their work in treating this terrible virus, and learning more about it each day, continues to benefit thousands of patients as the pandemic continues."

The study included 630 patients who were admitted to the ICUs of 13 Hackensack Meridian Health hospitals from March 1 to April 22 -- the height of the pandemic in New Jersey. Among other treatments, tocilizumab was considered for off-label usage for the patients whose respiratory symptoms were declining; many of whom were requiring mechanical ventilator support. In the observational study 210 patients received tocilizumab, and the other 420 did not.

COVID-19 has three phases: the early or viral phase (with fast viral replication), the pulmonary phase (marked by inflammation and pneumonia as the body tries to fight the virus in the lungs) and the inflammatory phase (in which excessive inflammation reaches and affects many organs and patients are often in the ICU). As part of both the pulmonary and inflammatory phases the immune system is "supercharged" and secretes in the blood numerous cytokines, particularly interleukin (IL)-6, which induces further inflammation. Tocilizumab is a monoclonal antibody, which binds and blocks the interleukin (IL)-6 receptor and helps dampen the inflammatory response. The activity of tocilizumab was first shown in chimeric antigen receptor (CAR) T-cell therapy, where a similar phenomenon of overactive and growing T cells induce a "cytokine storm." This provided a rationale to try tocilizumab in COVID-19 patients.

The findings showed a statistically-significant decrease in hospital-related deaths among the patients who received the tocilizumab: a roughly 36 percent decrease in hospital-related mortality among the ICU patients who received the drug, as compared with patients in the ICU who didn't receive it. The data from the outcomes was adjusted to account for multiple factors, including comorbidities, and was assessed using statistical survival models.

Importantly, it appeared that higher levels of a blood test marker of inflammation, C-reactive protein, could predict which ICU patients might benefit most from the tocilizumab therapy, potentially allowing doctors to tailor therapy to those most in need.

"These real-time findings have helped to point us the way forward," said Ihor Sawczuk, M.D., FACS, Hackensack Meridian Health regional president, Northern Market and chief research officer. "Our clinicians and scientists were at the forefront of COVID research from the beginning of the pandemic."

The results are based on evidence collected in the HMH Universal Observational Database for COVID-19, or RE-COV-RY, which compiles outcomes from 13 Hackensack Meridian Health hospitals throughout New Jersey, using electronic health records (EHRs).

The outcomes division of the John Theurer Cancer Center (JTCC) at Hackensack University Medical Center, under the leadership of Dr. Stuart Goldberg and Dr. Andrew Ip, created a database to guide the

analysis of more than 3,000 patients admitted to Hackensack Meridian Health facilities for urgent care. The database has been used to constantly assess COVID-19 treatments over the last several months, including the most promising and high-profile drugs and interventions.

"We need to know more as soon as possible," said Stuart Goldberg, M.D., hematologist-oncologist and chief of the Division of Outcomes and Value Research at John Theurer Cancer Center at Hackensack University Medical Center in New Jersey. "Our database has allowed us to rapidly expand our knowledge of COVID-19 throughout the Hackensack Meridian Health hospital network. We are moving fast to help guide interventions -- and potentially save lives."

The lead co-authors on this study are John Theurer Cancer Center hematologist-oncologists Andrew Ip, M.D., from the Division of Outcomes and Value Research and Noa Biran, M.D., from the Division of Myeloma. Both had experience with tocilizumab as part of the JTCC active CAR-T cell transplant program and recognized the potential of this immune modulating therapy in COVID-19.

"This is a great example of our science having impact far beyond cancer," said Andre Goy, M.D., M.S., physician-in-chief of Oncology, Hackensack Meridian Health.

The research work was done in partnership with Georgetown University's Biostatistics Department, as part of the collaboration with the Georgetown Lombardi Comprehensive Cancer Center and its National Cancer Institute (NCI)-designated Consortium, of which Hackensack Meridian Health is part.

The results are observational, and not yet fully proven, according to the authors. A large multinational Phase 3 (randomized and placebo-controlled) clinical trial of tocilizumab is currently underway, with HMH investigators also participating in that effort. But Hackensack Meridian Health's real-world observational study offers early indicators of potential effectiveness of the monoclonal antibody.

SOURCE Hackensack Meridian Health

/CONTACT: Seth Augenstein, 908-447-3705, seth.augenstein@hackensackmeridian.org

/Web site: <http://www.hackensackmeridianhealth.org>

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United States

Decontamination methods can damage N95 masks

Source: Infectious Disease News

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Some decontamination methods — specifically, methods using high concentrations of gas plasma hydrogen peroxide — can substantially damage N95 masks after only one process, according to study data published in *Infection Control & Hospital Epidemiology*.

"As this pandemic took hold, it was clear our supply chains were unable to keep up with N95 demand that would be needed to keep frontline clinical workers safe. In response, the FDA approved a series of decontamination methods, virtually overnight, with no further respirator performance testing required," Richard E. Peltier, PhD, associate professor of environmental health sciences at the University of Massachusetts, told Healio.

"These respirators are, and have always been, designed to be disposable," Peltier said. "As a scientist who is both an atmospheric chemist and an environmental health scientist, I was skeptical that all these methods that FDA assumed would be safe would work. It turns out that some methods do damage respirators and leak particles through the N95 mask material, and someone wearing this decontaminated respirator would never know it."

For their study, Peltier and colleagues obtained N95 respirators — mostly 3M brand 1860 or 1860S models — from hospitals that were using various decontamination techniques. To test the effects that decontamination had on the masks, the researchers placed the respirators on a foam-covered mannequin inside an exposure chamber "and flooded it with polydispersed combustion aerosol."

"Air was sampled through the mask at 85 L/minute and alternated between chamber and mask-occluded sampling, consistent with a method in our prior work," they wrote. "Aerosol samples were delivered to a scanning mobility particle sizer ... which characterized particle size distribution from 16.8 nm to 650 nm and provides much more detailed respirator performance information than standard filtration efficiency testing."

They burned incense in a separate combustion chamber and delivered diluted incense aerosol to the exposure chamber. They decontaminated the respirators off-site using standard hospital protocols.

The study demonstrated that decontamination methods including ultraviolet light treatments are safe for respirator treatment for several repeated cycles, Peltier explained. However, after nine cleanings, the masks begin to fail. Peltier said some methods that use high-concentration gas plasma hydrogen peroxide a "very harsh decontamination method" can damage the respirators immediately.

"But there are still perhaps a dozen other types of decontamination treatments being used by hospital groups and government contractors that have not been adequately evaluated," Peltier said. "And by that I mean an independent assessment of respirator performance."

He said workers, and occupational hygienists tracking disease "need to be vigilant in monitoring respirator performance."

"Using personal protective equipment that hasn't been independently vetted could pose a risk to respirator wearers. We know that some methods of decontaminating cause irreparable damage, so we would be wise to be more proactive in protecting our front line from this hazard across all decontamination techniques."

<https://www.healio.com/news/infectious-disease/20200818/decontamination-methods-can-damage-n95-masks>

United States

MIT researchers created a reusable face mask that works like an N95 respirator

Source: CTV News

ID: 1007667127

Scottie Andrew

Contact

Published Wednesday, August 19, 2020 12:21PM EDT

A prototype of the iMASC, a new silicone mask that can be safely reused without fear of contamination. (MIT)

SHARE

Nurses and doctors have gone to creative extremes to reuse the same masks, gloves and scrubs they need to treat contagious coronavirus patients. But if a prototype mask created by researchers proves widely effective, it may be a safer alternative for health-care workers.

Researchers from the Massachusetts Institute of Technology and Brigham and Women's Hospital in Boston have developed the iMASC, a new silicone mask that can be safely reused without fear of contamination. Researchers still need to analyze how effectively it catches viral particles, but it's a promising step toward addressing the critical health care supply shortages.

The iMASC offers a level of protection comparable to N95 respirator masks, its creators say. That's partially because it uses an N95 filter without all the additional material of N95 masks that catches particles.

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The masks are based on the shape of a typical N95 mask, too, but they're made with a silicone rubber that can be sterilized after each use. The dual filters that cover the mouth can be replaced after each use, too, the researchers said.

In a study about the iMASC published in the British Medical Journal Open, researchers said shortages of personal protective equipment, or PPE, in hospitals created a "critical need" for reusable safety gear.

So they tried their hand at a N95-style mask. They 3D printed the material and tested its use among nurses and physicians, who scored the mask for breathability, fit and ease of filter replacement.

Researchers asked the health care workers, all from Brigham and Women's Hospital, how the mask stacked up to the tried-and-true N95 mask, and most of them said they either had no preference or preferred the new mask, the researchers said in a release

PPE shortages force doctors to reuse contaminated equipment

N95 masks are considered the most effective face covering and can catch up to 95% of particles. But they're not made to be sterilized and reused.

But health care workers have had to reuse them anyway due to shortages of the masks and other PPE, like scrubs and gloves. Physicians have had to reuse potentially contaminated gear, which could expose them or their patients to coronavirus. It's the alternative to not using protection at all, even if reusing PPE poses some risk.

It's a risk researchers don't want health care workers to take. Peter Tsai, the man who invented the N95 mask's filtering fabric, has come out of retirement to test sterilization methods. A group of Duke University researchers developed their own method of decontamination in March using hydrogen peroxide. The Duke team's biocontamination method takes hours to complete, requires equipment many hospitals don't have and can only be used up to 20 times for the same mask. The MIT researchers said they knew they needed to create a more versatile process -- or product.

Your coronavirus back-to-school questions answered

"One of the key things we recognized early on was that in order to help meet the demand, we needed to really restrict ourselves to methods that could scale," said Dr. Giovanni Traverso, an assistant professor of mechanical engineering at MIT and a gastroenterologist at Brigham and Women's Hospital.

The researchers used several different sterilization methods on iMASC, including running them through an autoclave (steam sterilizer), putting them in an oven, and soaking them in both bleach and isopropyl alcohol.

The silicone material was undamaged after each test.

The MIT team is working on a new version of the mask, which they'll test to see if it can efficiently filter viral particles. In the meantime, hospital workers -- and people who work at essential businesses and schools that plan to reopen -- are urging local, state and federal leaders to provide more PPE to protect their health.

Aug. 24-27: Republican National Convention

Sept. 14: New Brunswick election

Sept. 23: Speech from the Throne

<https://www.ctvnews.ca/health/coronavirus/mit-researchers-created-a-reusable-face-mask-that-works-like-an-n95-respirator-1.5070575>

China

COVID-19 antibody levels vary widely in recovered patients

Source: CIDRAP

ID: 1007666716

A study published yesterday in JAMA Internal Medicine of 175 patients who recovered from mild COVID-19 reveals wide variation in the levels of antibodies against the novel coronavirus, ranging from very high levels in 2 patients to undetectable levels in 10—but no significant difference in illness duration.

Researchers from Fudan University in Shanghai, China, measured antibody levels in COVID-19 patients released from Shanghai Public Health Clinical Center after being hospitalized from Jan 24 to Feb 26. Of the 175 patients, 165 (94%) had significantly higher levels of COVID-19 antibodies than 13 uninfected controls in the convalescent phase of infection. Antibody levels were medium-low in 29 patients (17%), medium-high in 69 patients (39%), and high in 25 patients (14%).

Age, sex, inflammatory response

The investigators detected neutralizing antibodies in patients 4 to 6 days after symptom onset, and levels peaked 4 to 11 days later. Antibody levels were significantly higher in the 56 older (60 to 85 years) and 63

middle-aged subjects (40 to 59 years) than in 56 younger patients (15 to 39 years). The 10 patients with undetectable antibodies were younger (median age, 34 years), and 8 of them were women. At hospital release, significantly higher antibody levels were found in 82 men (47%) than in 93 women (53%).

Among the 117 patients with 2-week follow-up data, the median antibody level was substantially lower than the median level at hospital release, and the 56 men (48%) still had significantly elevated antibody levels compared with the 61 women (52%). Antibody levels in patients with undetectable antibody levels at hospital release remained undetectable at follow-up.

At hospital admission, antibody levels were correlated with those of C-reactive protein (indicating inflammatory response) but not with lymphocyte counts (indicating immune response to infection). Low lymphocyte levels and high C-reactive protein levels have been associated with poor COVID-19 outcomes. Compared with younger subjects, older and middle-aged patients had significantly lower lymphocyte counts and higher C-reactive protein levels at hospitalization, indicating weaker immune response and stronger inflammatory response to the coronavirus.

Role of convalescent plasma, vaccines in immunity

While neutralizing antibodies are considered important to infectious disease recovery and protection against future infection, whether they confer immunity against future COVID-19 infection and how long that immunity might last is unknown.

The use of convalescent plasma, or the transfer of blood plasma from recovered coronavirus patients to non-infected patients to confer immunity, is based on the premise that COVID-19 antibodies can provide protection against infection, but its durability is unknown.

The authors said that the variability of neutralizing antibody levels in recovered COVID-19 patients highlights the need to evaluate and adjust antibody levels in convalescent plasma before administration, should it prove efficacious.

They also pointed out that their finding that older COVID-19 patients tend to have higher antibody levels yet worse outcomes leads them to question the assumption that antibodies protect against future coronavirus infection. "The potential clinical implications of these findings for vaccine development and future protection from infection are unknown," they wrote.

In an editor's note in the same journal, Mitchell Katz, MD, of NYC Health + Hospitals, noted that older patients, men, and those with stronger inflammatory responses—who have typically had poor COVID-19 outcomes—had higher antibody levels than other subjects in the study, "suggesting that the higher titers of antibodies do not necessarily lead to higher recovery rate."

Katz called for research into whether certain groups of people need higher antibody levels to recover and whether higher levels of antibodies result in more protection against the virus in terms of vaccines.

"In this study, 10 of 175 patients had undetectable antibody levels despite documented infection," he wrote. "Are these patients susceptible to future infection, or do they have protection based on their infection sensitizing killer T cells or memory B cells? Answers to these pointed questions can lead to better protection when faced with this still largely unknown adversary."

<https://www.cidrap.umn.edu/news-perspective/2020/08/covid-19-antibody-levels-vary-widely-recovered-patients>

Cuba

Test of a Cuban Covid-19 vaccine to begin soon | Miami Herald

Source: Miami Herald

Unique ID: 1007666676

Summary: The vaccine, Soberana 01, was produced by the state-run Finlay Institute of Vaccines and will be tested during a phase I and II trial involving 676 adults between 19 and 80 years old. Cuba will start testing its own COVID-19 vaccine candidate next week, according to the official Cuban registry of clinical trials. If the results are good, the process can continue to a phase II trial to determine if the medication works.

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The vaccine, Soberana 01, was produced by the state-run Finlay Institute of Vaccines and will be tested during a phase I and II trial involving 676 adults between 19 and 80 years old. The results will not be published until February 2021.

A phase I clinical trial evaluates a drug's side effects and toxicity. If the results are good, the process can continue to a phase II trial to determine if the medication works.

It's unclear if a late-stage, phase III trial, usually involving thousands of people to test a vaccine's effectiveness and safety in a larger population, will follow. According to the data published on the register, the Cuban study will assess both safety and the resulting immune response.

The study will be a "randomized controlled, double-blind trial," meaning doctors and participants will not know who will be injected with the vaccine candidate. Recipients will be selected randomly. Those in the control group will get another vaccine produced in Cuba against meningitis.

www.miamiherald.com

<https://www.miamiherald.com/news/nation-world/world/americas/cuba/article245076330.html>

Domestic Events of Interest

Canada, Ontario

Feds funding 2 safe drug supply sites in Toronto amid worsening opioid overdose crisis

Source: CBC | Toronto News

ID: 1007666719

The federal government is set to announce funding for two new safe drug supply programs in Toronto — a move that comes amid a worsening opioid overdose crisis that has left dozens dead across the city this year alone.

The Emergency Safer Supply Program and the Downtown East Collaborative Emergency Safer Supply Program are "innovative new harm reduction approaches" based in Toronto, according to a news release from federal officials on Wednesday.

The two sites, operated by community organizations Parkdale Queen West Community Health Centre and South Riverdale Community Health Centre, are providing clients with reliable pharmaceutical opioids as an alternative to potentially-deadly illegal drugs, the release continues.

So far, 2020 has been a particularly deadly stretch for opioid-related deaths in Toronto.

More than 130 suspected overdose deaths have been reported so far this year by Toronto Public Health, including 27 in July alone — marking a grim new record since the city first began tracking this data.

"We are definitely concerned about the toxic drug supply and increasing overdoses that we've seen in Toronto," the city's associate medical officer of health Dr. Vinita Dubey said on Wednesday, noting her team has been pushing for more initiatives to curb the crisis.

In response to questions from CBC News, Mayor John Tory called the deaths "tragic" and "avoidable," and said he welcomed the anticipated federal announcement regarding safe supply sites.

"But there's much more to be done," he added, suggesting more treatment programs and other supports for drug users are needed from all levels of government.

Drug supply 'more toxic' during pandemic

Earlier this year, Toronto's Medical Officer of Health Dr. Eileen de Villa publicly asked the federal government to increase funding for a "spectrum of safer supply initiatives" alongside other measures to mitigate the opioid crisis that has claimed thousands of lives across the country.

Jason Altenberg, CEO of the South Riverdale Community Health Centre, which provides harm reduction services in Toronto's east end, previously told CBC News there's a clear connection between the COVID-19 pandemic and the spike in overdose deaths.

The drug supply grew "more potent, more toxic, more unpredictable" as global supply chains broke down, leading to potentially-deadly combinations of drugs circulating in the community, he said in June.

The pandemic also saw more people using drugs alone, as local harm reduction services shuttered or reduced capacity, Altenberg added.

Given the ongoing death toll, advocates have long been calling for safe supply sites as a way to provide drug users with reliable options to curb overdose-related deaths.

There has been an unprecedented spike in opioid overdoses in Canada during the COVID-19 pandemic, with a 25 per cent increase in Ontario and a 39 per cent increase in British Columbia. 1:59

In British Columbia, where new safe supply prescribing guidelines were issued at the start of the pandemic, so far more than 1,300 people have accessed safe, prescription alternatives to illicit drugs.

Provincial officials in Ontario have not opted for the safe supply route, but do fund more than a dozen consumption sites where clients can use their own drugs under staff supervision.

The federal funding amount for the two new Toronto safe supply sites has yet to be disclosed, with the official announcement scheduled for Thursday morning.

Local MPs Arif Virani for Parkdale-High Park, Adam Vaughan for Fort York, Julie Dzerowicz for Davenport, and Nathaniel Erskine-Smith for Beaches-East York will all be on hand alongside Toronto councillor and board of health chair Joe Cressy.

<https://www.cbc.ca/news/canada/toronto/feds-funding-2-safe-drug-supply-sites-in-toronto-amid-worsening-opioid-overdose-crisis-1.5692191?cmp=rss>

Canada, ON

2020 sees large swath of London and Middlesex listed as Lyme disease risk area

Source: Global News

ID: 1007667591

The Middlesex-London Health Unit says a massive yearly increase in the presence of blacklegged ticks resulted in a large portion of the region being added to the province's Lyme disease risk area map.

According to the health unit, the number of blacklegged ticks, also known as deer ticks, observed in the region has ballooned nearly eightfold in three years from 12 in 2018 to 95 in 2020. The number is based on blacklegged ticks submitted to the health unit and those found by "dragging," which is a surveillance measure involving "dragging a white flannel cloth over and around vegetation where ticks may be present." In 2019, the region covered by the MLHU was not listed as a hot spot on Public Health Ontario's annual Lyme disease estimated risk areas map, but a yellow circle now covers much of the region on the province's 2020 map.

The health unit says the increase serves as a reminder to be cautious of ticks when enjoying the outdoors. Health officials recommend using insect repellent that contains DEET for protection.

Every year, #MLHU is finding more and more blacklegged #ticks. That's why a large portion of London and @CountyMiddlesex is now identified as a Lyme disease "risk area" by @PublicHealthON. More blacklegged ticks = a higher risk of #LymeDisease. /1 pic.twitter.com/07M0xUOePh

Pest expert and Fanshawe College professor Mike Maris notes that just because someone gets bitten by a tick, it doesn't necessarily mean they will then get Lyme disease.

"In the same way that we know mosquitoes carry West Nile Virus, but not every mosquito does. And people get bit by mosquitoes all the time without contracting West Nile virus. It's important to remember that most tick bites won't actually lead to Lyme disease," he told Global News.

"The problem is that the stakes are quite high, right? Because Lyme disease can be quite a debilitating infection."

Maris says ticks are generally found in wooded areas and long grass. Like the health unit, he recommends using insect repellent that contains DEET.

"After you go out in those areas — if you go for a walk in the woods or in the long grass — just make sure that you have a look for the ticks. The trick can be to try and find them because they can be quite small. We're talking about a tick before it engorges and starts feeding. It'll be the size of like, say, a sesame seed," he said.

"You might have to get a friend to help you look for them, especially in the scalp and other areas that you wouldn't be able to see yourself."

Further information can be found on the MLHU's website.

<https://globalnews.ca/news/7286511/mlhu-london-middlesex-lyme-disease-risk-2020/>

Canada, ON

Vaccine clinics offered after hep A cases in Burk's Falls, Sundridge and South River

Source: CBC | Sudbury News

ID: 1007667589

The North Bay Parry Sound District Health Unit is holding vaccine clinics, after an increase in the number of cases of hepatitis A in the South River, Sundridge and Burk's Falls areas.

Usually, the district sees three cases every five years but since January there have been six, says Elizabeth Mete, the temporary manager of the Vaccine Preventable Diseases Program.

Hepatitis A is a virus that affects the liver. It is spread when people neglect to wash their hands after using the washroom or changing diapers and contaminating food, drinks or surfaces with feces.

"So essentially if an infected person was handling food or beverages, or touched a surface that you then touched, and you inadvertently touched your mouth or mucous membranes, that's how it's transmitted," says Mete.

Mete said the virus is also spread through sexual activity and shared drug equipment.

The health unit hasn't identified any links among the cases in the area.

Mete says hand hygiene is important and vaccination is the best way to prevent the infection.

The North Bay Parry Sound District Health Unit will be holding two vaccine clinics, one in South River on Aug. 26 and one in Burk's Falls on Aug. 31.

<https://www.cbc.ca/news/canada/sudbury/vaccines-hepatitis-a-north-bay-hygiene-feces-contamination-1.5692859?cmp=rss>

International Events of Interest

United States (Update)

Outbreak of *Salmonella* Newport Infections Linked to Onions

Source: CDC

Illustration with a triangle and exclamation mark and text reading Food Safety Alert

Updated August 18, 2020 at 6:00 PM ET

CDC, public health and regulatory officials in several states, Canadaexternal icon, and the U.S. Food and Drug Administrationexternal icon (FDA) are investigating a multistate outbreak of *Salmonella* Newport infections linked to onions. View the list of recalled onions and foods containing recalled onions here.

Recall and Advice to Consumers, Restaurants, and Retailers

Illustration of a clipboard with check marks on it.

At A Glance

Reported Cases: 869

States: 47

Hospitalizations: 116

Deaths: 0

Recall: Yes

Various onions on a wooden table.

Do not eat, serve, or sell recalledexternal icon onions from Thomson International, Inc., and other companies or foods made with recalled onions. Recalled onion types include red, white, yellow, and sweet yellow varieties.

Foods made with recalled onions such as cheese dips or spreads, salsas, and chicken salads have also been recalled. Foods were sold at multiple grocery store chains. View the list of recalled onions and foods here.

Check your home for recalled onions and recalled foods from Thomson International, Inc. and other companies, including Food Lion, Giant Eagle, Kroger, Publix, Ralph's, Trader Joe's, and Walmart onions.

If you can't tell where your onions are from, don't eat them. Throw them away.

If you used recalled onions to make any other food or don't know where those onions were from, don't eat the food. Throw it away, even if some of it was eaten and no one got sick.

Wash and sanitize any surfaces that may have come in contact with onions or their packaging, such as countertops, storage bins, refrigerator drawers, knives, and cutting boards.

When you order food from a restaurant or shop for food, check with the restaurant or grocery store to make sure they are not serving or selling recalled onions from Thomson International, Inc. or other companies, or any foods prepared with recalled onions, including foods such as salads, sandwiches, tacos, salsas, and dips.

If they don't know where their onions are from, don't buy the product or order the food.

Advice to Restaurants, Retailers, and Suppliers

Restaurants and retailers should not serve or sell recalled onions or foods prepared with these onions.

Check the list of recalled products.

If you don't know where your onions are from, don't serve or sell them.

Clean and sanitize all surfaces that onions have come in contact with, including cutting boards, countertops, slicers, utensils, and storage bins.

Suppliers, distributors, and others in the supply chain should not ship or sell recalled onions from Thomson International, Inc. or other companies.

Suppliers and distributors that repackage raw onions should clean and sanitize any surfaces and storage bins that may have come in contact with recalled onions.

View the list of recalled onions and foods here.

Symptoms of Salmonella Infection

Illustration of a person with stomach pain.

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 needs to be hospitalized. Salmonella infection may spread from the intestines to the bloodstream and then to other places in the body.

Children younger than 5 years, adults 65 years and older, and people with weakened immune systems are more likely to have a severe illness.

For more information, see Symptoms of Salmonella Infection.

Take these steps if you have symptoms of a Salmonella infection:

Talk to your healthcare provider.

Write down what you ate in the week before you started to get sick.

Report your illness to your local health department.

The health department will likely call you for an interview to ask you about foods you ate in the week before you got sick.

Assist public health investigators by answering their questions when they contact you.

Latest Outbreak Information

Illustration of a megaphone.

Since the last case count update on August 7, 2020, an additional 229 ill people have been reported in this outbreak, including 9 from 4 new states: Arkansas, Hawaii, Rhode Island, and Texas.

On August 12, cheese dips and spreads were recalled from the following stores: Kroger^{external icon}, Kroger Mid-Atlantic^{external icon}, Kroger Delta Division^{external icon}, Fry's Food Stores^{external icon}, Fred Meyer^{external icon}, and Smith's^{external icon}.

See the full list of recalled onions and foods.

A total of 869 people infected with the outbreak strain of Salmonella Newport have been reported from 47 states.

116 hospitalizations have been reported. No deaths have been reported.

Epidemiologic and traceback information showed that red onions are a likely source of this outbreak. Due to the way onions are grown and harvested, other onion types, such as, white, yellow, or sweet yellow, may also be contaminated.

This investigation is ongoing. CDC will provide more information as it becomes available.

Investigation Details

August 18, 2020

As of August 18, 2020, a total of 869 people infected with the outbreak strain of Salmonella Newport have been reported from 47 states. A list of the states and the number of cases in each can be found on the Map of Reported Cases page.

Illnesses started on dates ranging from June 19, 2020, to August 4, 2020. Ill people range in age from less than 1 to 102 years, with a median age of 40. Fifty-six percent of ill people are female. Of 468 ill people with information available, 116 hospitalizations have been reported. No deaths have been reported.

Illnesses might not yet be reported due to the time it takes between when a person becomes ill and when the illness is reported. This takes an average of 2 to 4 weeks. Please see the Timeline for Reporting Cases of Salmonella Infection for more details.

Whole genome sequencing analysis of 48 isolates from ill people did not predict any antibiotic resistance. Standard antibiotic susceptibility testing of 3 clinical isolates by CDC's National Antimicrobial Resistance Monitoring System (NARMS) laboratory also showed no resistance.

Whole genome sequencing analysis shows that an outbreak of Salmonella Newport infections in Canada^{external icon} is related genetically to this outbreak in the United States. This means that people in both of these outbreaks are likely to share a common source of infection.

Investigation of the Outbreak

Epidemiologic and traceback ^{pdf icon}[PDF – 1 page] information indicates that red onions are a likely source of this outbreak. Due to the way onions are grown and harvested, other onion types, such as, white, yellow, or sweet yellow, may also be contaminated.

In interviews, ill people answered questions about the foods they ate and other exposures in the week before they became ill. Eighty-eight percent of people reported eating onions or dishes likely containing onions in the week before their illness started. Of the 68 cases who were asked what types of onions they ate, 46 (68%) ate any white onions, 45 (66%) ate any red onions, and 33 (49%) ate any yellow onions in the week prior to illness. Most ill people ate more than one type of onion in the week before illness.

Many ill people were identified as part of illness clusters. An illness cluster is defined as two or more people who do not live in the same household who report eating at the same restaurant location, attending a common event, or shopping at the same location of a grocery store in the week before becoming ill. Investigating illness clusters can provide critical clues about the source of an outbreak. If several unrelated ill people ate or shopped at the same location of a restaurant or store within several days of each other, it suggests that the contaminated food item was served or sold there.

Twenty-eight illness clusters have been identified in 10 states. Information was collected on 21 of the 28 clusters at restaurants and grocery stores. Information from these clusters shows that many ill people ate red onions and other types of onions. Investigations conducted by states and FDA identified that all 21 restaurants and grocery stores served or sold red, yellow, or white onions. Sixteen of the 21 clusters served red onions, 12 served yellow onions, and 10 served white onions.

The traceback information collected from several of these illness clusters identified Thomson International, Inc., of Bakersfield, California, as a likely source of red onions. Due to the way onions are grown and harvested, other onion types, such as white, yellow, or sweet yellow, may also be contaminated. Traceback is ongoing to determine if other onions are linked to the outbreak.

On August 1, 2020, Thomson International, Inc. voluntarily recalled^{external icon} red, yellow, white, and sweet yellow onions because they may be contaminated with Salmonella.

Other companies have also recalled onions or foods made with recalled onions. See the full list of recalled products ^{here}.

Consumers, restaurants, and retailers should not eat, serve, or sell recalled onions from Thomson International, Inc. or other companies, nor should they eat or sell other foods made with recalled onions.

CDC will provide updates when more information is available.
<https://www.cdc.gov/salmonella/newport-07-20/index.html>

United States

US salmonella outbreak linked to onions expanding

Source: www.freshplaza.com

Published: 2020-08-19 15:31 UTC
Received: 2020-08-19 15:31 UTC (0 minutes)
Unique ID: 1007664595

Now 47 states are reporting cases - more articles recalled

A salmonella outbreak in the US, linked to recalled onions, has spread to 47 states. Cases and hospitalizations have increased. On Tuesday, the Food & Drug Administration said that it is analyzing samples collected at Thomson International of Bakersfield, California, which has recalled all red, white, yellow and sweet yellow onions shipped to all 50 states and the District of Columbia from May 1 to Aug. 1. In its update Tuesday, the Centers for Disease Control and Prevention said the number of reported cases of salmonella newport illnesses had grown to 869 cases, with 116 hospitalizations in 47 states (only Oklahoma, Louisiana, and Vermont have not had cases). No deaths have been reported.

The initial recall involved bulk onions distributed to wholesalers, restaurants, and retail stores in all 50 states under brand names such as Thomson Premium, TLC Thomson International, Kroger, Food Lion, and Onions 52.

Source: eu.usatoday.com

<https://www.freshplaza.com/article/9241776/us-salmonella-outbreak-linked-to-onions-expanding/>

WHO

World Humanitarian Day 2020: A tribute to aid workers on the front lines

Source: WHO

ID: 1007664090

19 August 2020 News release Geneva/New York

Amid a global pandemic, unprecedented needs and growing insecurity, aid workers and health-care responders are staying and delivering to the world's most vulnerable people.

Last year was the most violent on record for humanitarians, with 483 attacked, 125 killed, 234 wounded and 124 kidnapped. The UN condemns all attacks on humanitarians.

OCHA and partners present the inspiring stories of humanitarian #RealLifeHeroes who are stepping up to meet the challenges.

Today, World Humanitarian Day, the world honours all humanitarians – many working in their own communities – who are going to extraordinary lengths in extraordinary times to help women, men and children whose lives are upended by crises and the global COVID-19 pandemic.

The dedication, perseverance and self-sacrifice of these real-life heroes represent the best of humanity as they respond to the COVID-19 crisis and the massive increase in humanitarian needs it has triggered.

First responders are often people in need themselves — refugees, members of civil-society organizations and local health workers. They bring food, shelter, health care, protection and hope to others amid conflict, displacement, disaster and disease.

But humanitarian workers are being tested like never before, struggling with unprecedented movement restrictions and insufficient resources as needs are outpacing funds.

And all too often, they risk their own lives to save the lives of others.

In recent weeks alone, despicable attacks have killed aid workers in Niger and Cameroon, and since the onset of the pandemic, scores of health workers have come under attack across the world.

According to Humanitarian Outcomes' Aid Worker Security Database, major attacks against humanitarians last year surpassed all previous years on record. A total of 483 relief workers were attacked, 125 killed, 234 wounded and 124 kidnapped in 277 separate incidents. This is an 18 per cent increase in the number of victims compared to 2018.

This is the eleventh World Humanitarian Day, designated by the UN General Assembly. It falls on the day of the attack on the UN compound in Baghdad on 19 August 2003, which claimed the lives of 22 people

including the Secretary-General's Special Representative for Iraq, Sergio Vieira de Mello. Since then, nearly 5,000 humanitarians have been killed, wounded or abducted, and the 2010-2019 decade experienced a 117 per cent increase in attacks compared to 2000-2009.

A surge in attacks against health workers was recorded in 2019, including strikes against medics in Syria and shootings of Ebola workers in the Democratic Republic of the Congo (DRC).

Most of the attacks occurred in Syria, followed by South Sudan, DRC, Afghanistan and the Central African Republic. Mali and Yemen both saw a doubling of major attacks from the previous year. The UN condemns these attacks, and it calls for accountability for perpetrators and justice for survivors. Relief workers cannot be a target.

Mark Lowcock, the Under-Secretary-General for Humanitarian Affairs and Emergency Relief Coordinator, said: "To humanitarian workers everywhere doing important, courageous work on the front lines we say Thank You. You are saving lives every day, and as new challenges and crises are piling on to existing ones, your perseverance is an inspiration. Your protection is also paramount to making sure we can deliver to people most in need. The best way to pay tribute to humanitarian workers is by funding their work and ensuring their safety."

This year's World Humanitarian Day comes as the world fights the COVID-19 pandemic. To pay tribute to the efforts of humanitarians, OCHA and its partners present the personal stories of some of the #RealLifeHeroes who are stepping up to meet the challenges, particularly local humanitarian workers.

They include refugees who as health workers are playing essential roles in the pandemic response; Ebola health workers who are stepping in to fight COVID-19; and doctors and nurses who continue to provide critical health care to women and children.

Read their inspiring stories here: www.worldhumanitarianaday.org

For media: Photos, videos, and social media assets

About World Humanitarian Day

In 2008, the United Nations General Assembly designated 19 August as World Humanitarian Day to raise awareness about humanitarian assistance worldwide and to pay tribute to the people who risk their lives to provide it. World Humanitarian Day was commemorated for the first time on 19 August 2009.

<https://www.who.int/news-room/detail/19-08-2020-world-humanitarian-day-2020-a-tribute-to-aid-workers-on-the-front-lines>

Europe

Increase in African swine fever cases in some pig facilities in Eastern Europe

Source: Agriland.ie

www.agriland.ie

Published: 2020-08-19 12:20 UTC

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The number of cases of African swine fever in Europe is on the rise after large-scale outbreaks of the disease were found in eastern European pig facilities.

A report from the Department for Environment, Food and Rural Affairs in the UK stated that Poland has reported 19 outbreaks in domestic pig herds.

According to the Pig Progress report (July 2020), African swine fever is present across "one third of the Polish land area".

Russia reportedly announced a fourfold increase in cases in July, having gone from just six confirmed cases to 25.

Romania currently has by far the largest number of cases, with 395 confirmed cases of African swine fever thus far in 2020. Russia is next on the list.

African swine fever in Ireland

Here in Ireland, the Department of Agriculture, Food and the Marine has stated that “Ireland is free of African swine fever and it is in all of our interests to keep it that way, as an outbreak of the disease would have a huge impact on the Irish pig industry here”.

The department also explained that although African swine fever “does not affect humans or other animal species and meat from affected pigs does not pose any food safety risk, the virus can survive for months or even years in pork and pork meat products, including cured meats, hams, sausages and salamis”.

According to the department, if pigs eat food waste that contains infected meat it “will cause an outbreak of the disease”.

The department outlined the following precautions to reduce the spread of African swine fever:

Do not bring meat products into Ireland from outside the EU;

Do not bring meat or meat products onto Irish pig farms;

Always use a secure bin to dispose of waste food, so that it cannot be accessed by farm animals, wild animals or wild birds.

The department also asserted that it is illegal to feed food waste containing meat to farm animals, as it can spread African swine fever as well as other diseases such as foot-and-mouth disease.

<https://www.agriland.ie/farming-news/outbreak-of-african-swine-fever-cases-in-pig-facilities-across-europe/>

United States

Health officials link salmonella outbreak to fresh peaches

Source: KAAL-TV

ID: 1007667340

Updated: August 19, 2020 10:42 PM

(ABC 6 News) - State health and food safety officials are warning Minnesota and Iowa consumers not to eat fresh, whole peaches supplied by Wawona Packing Company and purchased at retail locations including Aldi and Target after linking Salmonella infections to the produce.

U.S. Centers for Disease Control and Prevention, the U.S. Food and Drug Administration and several other states are investigating a multi-state outbreak of Salmonella Enteritidis infections linked to consumption of fresh, whole peaches supplied by Wawona Packing Company.

Overall, 68 cases of Salmonella Enteritidis infection have been identified in nine states, 23 of those cases in Minnesota alone. The investigation is ongoing and more cases may be detected.

Health officials recommend throwing out or returning fresh, whole peaches supplied by Wawona Packing Company. Other peaches (including frozen or canned peaches) are not known to be affected.

Approximately 700-975 Salmonella infections are reported each year in Minnesota.

<https://www.kaaltv.com/rochester-minnesota-news/minnesota-iowa-peaches-recall-latest/5833167/?cat=10151>

Researches, Policies and Guidelines

United States

HHS Expands Access to Childhood Vaccines during COVID-19 Pandemic

Source: U.S. Department of Health and Human Services

FOR IMMEDIATE RELEASE

August 19, 2020

Contact: HHS Press Office
202-690-6343
media@hhs.gov

The U.S. Department of Health and Human Services (HHS) [issued a third amendment - PDF](#) to the Declaration under the Public Readiness and Emergency Preparedness Act (PREP Act) to increase access to lifesaving childhood vaccines and decrease the risk of vaccine-preventable disease outbreaks as children across the United States return to daycare, preschool and school.

"Today's action means easier access to lifesaving vaccines for our children, as we seek to ensure immunization rates remain high during the COVID-19 pandemic," said HHS Secretary Alex Azar. "The Trump Administration has worked to allow pharmacists—alongside all of America's heroic healthcare workers—to practice at the top of their license, empowering the public with more options to protect their health and well-being."

The amendment authorizes State-licensed pharmacists (and pharmacy interns acting under their supervision to administer vaccines, if the pharmacy intern is licensed or registered by his or her State board of pharmacy) to order and administer vaccines to individuals ages three through 18 years, subject to several requirements:

- The vaccine must be approved or licensed by the Food and Drug Administration (FDA).
- The vaccination must be ordered and administered according to the CDC's Advisory Committee on Immunization Practices (ACIP) immunization schedules.
- The licensed pharmacist must complete a practical training program of at least 20 hours that is approved by the Accreditation Council for Pharmacy Education (ACPE). This training program must include hands-on injection technique, clinical evaluation of indications and contraindications of vaccines, and the recognition and treatment of emergency reactions to vaccines.
- The licensed or registered pharmacy intern must complete a practical training program that is approved by the ACPE. This training program must include hands-on injection technique, clinical evaluation of indications and contraindications of vaccines, and the recognition and treatment of emergency reactions to vaccines.
- The licensed pharmacist and licensed or registered pharmacy intern must have a current certificate in basic cardiopulmonary resuscitation.
- The licensed pharmacist must complete a minimum of two hours of ACPE-approved, immunization-related continuing pharmacy education during each State licensing period.
- The licensed pharmacist must comply with recordkeeping and reporting requirements of the jurisdiction in which he or she administers vaccines, including informing the patient's primary-care provider when available, submitting the required immunization information to the State or local immunization information system (vaccine registry), complying with requirements with respect to reporting adverse events, and complying with requirements whereby the person administering a vaccine must review the vaccine registry or other vaccination records prior to administering a vaccine.
- The licensed pharmacist must inform his or her childhood-vaccination patients and the adult caregivers accompanying the children of the importance of a well-child visit with a pediatrician or other licensed primary care provider and refer patients as appropriate.

The above requirements are consistent with many States that already permit licensed pharmacists to order and administer vaccines to children.

A May 2020 Centers for Disease Control and Prevention (CDC) report found a troubling drop in routine childhood immunizations as a result of families staying at home. While families followed public health warnings about going out, an unfortunate result was many missed routine vaccinations. This decrease in childhood-vaccination rates is a public health threat and a collateral harm caused by the COVID-19 pandemic.

"As a pediatric critical care physician who has treated critically ill children suffering from vaccine preventable diseases, I know first-hand the devastation to the child – and to the family and community – of a death or severe brain damage that could have been avoided by a safe and effective vaccine," said HHS Assistant Secretary for Health Brett P. Giroir, M.D. "The cornerstone of public health, vaccines, makes these dreaded diseases preventable. As we expand options during the COVID-19 response, we are also reminding

parents, grandparents, and caretakers that there is no substitute for a critically important well-child visit with a pediatrician or other licensed primary care provider when available.”

HHS is expanding access to childhood vaccines to avoid preventable diseases in children, additional strains on the healthcare system, and any further increase in avoidable adverse health consequences—particularly if such complications coincide with an additional resurgence of COVID-19.

For CDC guidance on Routine Vaccination during the COVID-19 Outbreak, click [here](#).

For more information on National Immunization Awareness Month, click [here](#).

For the latest CDC Immunization Schedule, click [here](#).

For clinical resources on vaccines, including continuing education training on best practices, click [here](#).

To view the Notice of Amendment, click [here - PDF](#).*

* This content is in the process of Section 508 review. If you need immediate assistance accessing this content, please submit a request to digital@hhs.gov. Content will be updated pending the outcome of the Section 508 review.

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<https://www.hhs.gov/about/news/2020/08/19/hhs-expands-access-childhood-vaccines-during-covid-19-pandemic.html>

United States

FDA Releases NARMS Strategic Plan, Announces October 2020 NARMS Virtual Public Meeting

Source: U.S. Food and Drug Administration

August 18, 2020

Today, the U.S. Food and Drug Administration, in cooperation with the U.S. Centers for Disease Control and Prevention (CDC), and the U.S. Department of Agriculture’s Food Safety and Inspection Service (USDA-FSIS), its partners in the National Antimicrobial Resistance Monitoring System (NARMS), is releasing the [NARMS Strategic Plan: 2021-2025](#). The NARMS program examines bacteria isolated from humans (through CDC data), raw retail meats (through FDA data), and animals at slaughter (through USDA-FSIS data) to analyze and report on patterns of resistance to the most important antimicrobial agents.

Additionally, FDA is announcing that registration is now open for the 2020 Public Meeting of the National Antimicrobial Resistance Monitoring System, which will be held virtually on October 13 and 14, 2020. The purpose of the NARMS Public Meeting 2020 is to share the NARMS Strategic Plan: 2021-2025 with stakeholders and to encourage discussion.

The NARMS Strategic Plan: 2021-2025 lists the program’s strategic goals and objectives, as well as its challenges and opportunities. A central theme of the new NARMS Strategic Plan is [One Health](#), which is a collaborative, multisectoral, and transdisciplinary approach to health—working at the local, regional, national, and global levels—with the goal of achieving optimal health outcomes recognizing the interconnection between people, animals, plants, and their shared environment. In accord with the principles of One Health, NARMS is expanding its testing to include environmental water samples through a collaboration with the U.S. Environmental Protection Agency and animal pathogens through collaborations with FDA’s Veterinary Laboratory Investigation and Response Network (Vet-LIRN) and USDA’s Animal and Plant Health Inspection Service (APHIS). The NARMS Strategic Plan: 2021-2025 is a roadmap for NARMS activities over the next five years.

Registration is now open for the October 13 and 14, 2020, NARMS Public Meeting and will remain open through 4:00 p.m. ET on September 22, 2020. Due to the COVID-19 pandemic, the public meeting will be held as a live virtual webcast.

Time at the meeting will be devoted to comments from the public and the FDA has opened a docket (docket number: FDA-2020-N-1764) for additional comments. Comments will be accepted starting August 19, 2020. For more information and to register for the virtual public meeting, visit the [2020 NARMS Public Meeting webpage](#).

Additional Information:

- [NARMS Strategic Plan: 2021-2025](#)
- [2020 NARMS Public Meeting](#)
- [The National Antimicrobial Resistance Monitoring System](#)
- [Supporting Antimicrobial Stewardship in Veterinary Settings: Goals for Fiscal Years 2019-2023](#)

https://www.fda.gov/animal-veterinary/cvm-updates/fda-releases-narms-strategic-plan-announces-october-2020-narms-virtual-public-meeting?utm_campaign=8-18-2020-NARMS&utm_medium=email&utm_source=Eloqua

Japan

Combo therapy may prevent blood vessel complications in children with Kawasaki disease

Source: medicalxpress.com

Published: 2020-08-19 12:28 UTC

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Unique ID: 1007663086

Adding corticosteroids to standard intravenous (IV) immunoglobulin treatment for children with Kawasaki disease judged to be at higher risk of developing blood vessel complications made initial treatment more successful and prevented these complications, according to new research published today in the Journal of the American Heart Association, an open access journal of the American Heart Association.

"Early diagnosis and prompt treatment are important for children with Kawasaki disease to prevent the development of cardiac complications," said lead author Ryusuke Ae, M.D., Ph.D., an assistant professor in the department of public health at the Center for Community Medicine at Jichi Medical University in Shimotsuke, Japan. The study was conducted during 2018-2019 when Dr. Ae was a guest researcher at the U.S. Centers for Disease Control and Prevention (CDC) and is a collaboration between the CDC and Jichi Medical University.

Kawasaki disease, which occurs most often in children younger than 5 years old, causes inflammation of the blood vessels, particularly the coronary arteries that supply fresh blood to the heart muscle. In developed countries, Kawasaki disease is a leading cause of heart disease in children born without heart defects and the cause is unknown. The criteria for diagnosis is when a child has a fever for five days or longer (unless interrupted by treatment) along with multiple other defining symptoms that can include a rash over the abdomen, swollen and red hands and feet, bloodshot eyes, swollen lymph glands, and redness and swelling of the mouth, lips, throat and tongue. Kawasaki disease occurs in children of all races and ethnicities; however, it is more common among Asian children regardless of where they live.

"As the blood vessel wall becomes enlarged, the inside of the vessel may narrow. Blood clots may form, blocking the artery and potentially leading to a heart attack. Children who have such vessel wall complications may require long-term follow-up after the onset of Kawasaki disease," said Ae.

Standard treatment for Kawasaki disease includes IV immunoglobulin with aspirin. However, for an estimated 17% of Kawasaki disease patients, initial IV immunoglobulin treatment is not effective, increasing their risk of cardiac complications. In recent years, it has become more common to add corticosteroids to the initial treatment approach; however, researchers have reached different conclusions about which approach is best.

In this study, the largest of its kind to-date, researchers analyzed real-world data on children with Kawasaki disease in Japan to determine whether the more intensive combination approach could heal children faster and prevent cardiac complications among those considered more vulnerable to treatment failure and long-term complications. In this study, patients were deemed at higher risk if initial treatment was predicted to be ineffective based on standing scoring systems, if the child was less than one year old or had elevated blood test results.

Researchers identified 1,593 Kawasaki disease patients under the age of 18 who were first treated with standard IV immunoglobulin with aspirin. Outcomes were compared with another set of 1,593 Kawasaki disease patients who were likely to have been initially treated with corticosteroids in combination with the standard therapy. Patients were matched for age, sex and how quickly treatment was started after symptoms appeared, with care taken to account for other factors that could bias results.

Compared with standard IV immunoglobulin treatment, the researchers found:

Initial combination treatment (immunoglobulin plus aspirin and corticosteroids) reduced the need for a second course of therapy by 35%.

Initial combination treatment reduced the risk of coronary artery abnormalities by 47%.

Delivering a low-dosage of corticosteroids over many days was more beneficial than a high-dose pulse over fewer days or typically just one day.

"It was surprising to see the dramatic results of our analysis. Clinicians should consider initial combination treatment with multiple-dose corticosteroids for high-risk Kawasaki disease patients," Ae said.

Limitations of the study included that researchers did not have precise information on the type, dose and duration of corticosteroid therapy because of the way initial data was recorded.

The same combination treatment of immunoglobulin and corticosteroids has been recently used to treat children with multisystem inflammatory syndrome (MIS-C), a new condition associated with COVID-19 infection that has some symptoms like Kawasaki disease. While MIS-C is seen in children with COVID-19, it is rare.

More information: Ryusuke Ae et al, Corticosteroids Added to Initial Intravenous Immunoglobulin Treatment for the Prevention of Coronary Artery Abnormalities in High-Risk Patients With Kawasaki Disease, Journal of the American Heart Association (2020). DOI: 10.1161/JAHA.119.015308
<https://www.ahajournals.org/doi/10.1161/JAHA.119.015308>

Provided by American Heart Association

<https://medicalxpress.com/news/2020-08-combo-therapy-blood-vessel-complications.html>

China

New Chinese Viral Encephalitis Vaccine Shows Dual Protection

Source: UrduPoint

Published: 2020-08-19 12:24 UTC

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Unique ID: 1007663030

WUHAN, (UrduPoint / Pakistan Point News - 19th Aug, 2020) :Researchers from the Wuhan Institute of Virology under the Chinese academy of Sciences announced that they have developed a new encephalitis vaccine, and laboratory tests suggest it can protect against two lethal mosquito-borne diseases with just one dose.

The vaccine candidate can target both Japanese encephalitis virus (JEV) and West Nile virus (WNV). It induced robust immune responses in mice, exhibiting high levels of safety and efficacy, according to the researchers.

The study was published earlier this month in npj Vaccines, an open-access online journal of the Nature Research portfolio.

JEV is the leading cause of viral encephalitis in the Asia-Pacific area, causing nearly 68,000 cases of Japanese encephalitis each year with the case fatality rates averaging around 30 percent.

Even those who survive the disease often suffer from permanent neuronal disorders such as cognitive, motor and behavioral impairments.

No effective antiviral therapeutics against JEV are available, and vaccines are therefore the only effective approach to prevent JEV infection. However, current JEV vaccines require repeated doses to achieve adequate protection, said the study.

WNV is a disease transmitted to people mainly by mosquito bites. According to the researchers, it can cause severe diseases in elderly and weak individuals. Since its emergence in New York in 1999, the virus has been reported in many other regions, including Africa, Europe and West Asia.

<https://www.urdupoint.com/en/miscellaneous/new-chinese-viral-encephalitis-vaccine-shows-1005591.html>

United States

Coronavirus Could Result in 1.5 Million Unsafe Abortions Worldwide, Report Finds

Source: www.newsweek.com

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Consequences of the novel coronavirus pandemic could force at least 1.5 million more women to seek unsafe abortions worldwide, according to new estimates.

The figure appeared in a Tuesday report published by Marie Stopes International (MSI), a global reproductive care organization that provides contraception and safe abortions to women in 37 countries. As lockdown measures implemented in response to COVID-19 made accessing the organization's usual services more difficult, almost 2 million women and girls were left without options for legitimate reproductive care.

Data included in MSI's report suggested that lost services between January and June could lead to as many as 900,000 unintended pregnancies and 3,100 pregnancy-related deaths across the world, in addition to unsafe abortions. Those numbers compound the incidences of each circumstance that existed prior to the global health crisis, and only account for barriers to accessing MSI's programs.

Women in India felt the most significant impacts of lost services previously offered by MSI. Tuesday's report noted 1.3 million fewer women had access to reproductive care, and roughly 920,000 fewer women had access to safe abortion and post-abortion services, due to the nation's lockdown. The organization expects an additional 1 million women will undergo unsafe abortions in India as a result, and an estimated 2,600 more will die from complications related to pregnancy.

"Women's needs do not suddenly stop or diminish during an emergency—they become greater. And as doctor I have seen only too often the drastic action that women and girls take when they are unable to access contraception and safe abortion," said Dr. Rashmi Ardey, the director of clinical services for MSI's initiatives in India, in a statement alongside the organization's most recent report.

"This pandemic has strained healthcare services all over the world, but sexual and reproductive healthcare was already so under prioritised that once again women are bearing the brunt of this global calamity," Ardey continued.

MSI partnered with governments and non-profit organizations in several nations in efforts to expand access to reproductive care during the pandemic, advocating for safe abortion and post-abortion services to be classified as essential work. Still, with laws heavily restricting abortion access, or banning altogether, still effective in dozens of countries, the organization said global leaders need to do more to protect women's health.

"Governments need to take immediate action to overturn the restrictive, and colonial, penal codes which restrict women's legal access to abortion," Bethan Cobley, director of policy and partnerships at MSI, said in a statement to Newsweek on Wednesday. "Until these legal barriers are overturned health systems will be unable to adapt to respond to pandemic such as Covid-19 and women will have to endure the indignity of unintended pregnancy or risks their lives seeking unsafe procedures."

The pandemic has affected a number of leading reproductive care organizations. Planned Parenthood, the largest reproductive health care provider in the United States, shifted many of its services to prioritize remote consultations as clinics closed earlier this year.

Some Planned Parenthood sites cut hours or suspended walk-in appointments as the national outbreak persisted, while others closed entirely and began referring patients to different locations or providers instead. The organization outlines procedures still offered and shares resources about how and where to receive contraception and safe abortion services in guidance shared to its website.

Newsweek reached out to Planned Parenthood for comments but did not receive a reply in time for publication.

Report:

<https://www.mariestopes.org/news/2020/8/press-release-19m-clients-lost-access-to-our-services-due-to-covid-19/?page=0>

https://www.newsweek.com/coronavirus-could-result-15-million-unsafe-abortions-worldwide-report-finds-1526155?utm_source=Public&utm_medium=Feed&utm_campaign=Distribution

United States

Study reveals how opioid use can trigger deafness

Source: Free Press Journal

Unique ID: [1007665452](#)

Study reveals how opioid use can trigger deafness

By Sneha

Opioids are a class of drugs that include the illegal drug heroin, synthetic opioids such as fentanyl, and pain relievers available legally by prescription, such as oxycodone, hydrocodone, codeine, morphine, and many others.

Study reveals how opioid use can trigger deafness

New York: Opioid use -- particularly in high doses can be very harmful, say researchers, adding that opioid receptors in the inner ear can cause partial or full hearing loss.

Opioids are a class of drugs that include the illegal drug heroin, synthetic opioids such as fentanyl, and pain relievers available legally by prescription, such as oxycodone, hydrocodone, codeine, morphine, and many others.

The study, published in *The Journal of Medical Toxicology*, reviewed records from the New Jersey Poison Control Centre from 1999 to 2018 to determine the association between opioid use and degrees of hearing loss.

The research team from Rutgers University (RU) in the US, identified 41 people with opioid exposure who experienced full or partial hearing loss or tinnitus, likely caused by toxicity to the ear.

According to the team, more than half had used heroin, followed by oxycodone, methadone and tramadol; 88 per cent had only one known exposure.

The findings showed that most people reported the condition affecting both ears, with 12 people experiencing deafness, 15 partial or total loss of hearing acuity, 10 tinnitus and four a mix of symptoms.

While some people may regain their hearing, the loss could be permanent with others -- 21 per cent of those reporting the condition had no improvement in hearing when they were discharged from the hospital.

"The delicate structures of the inner ear are very susceptible to injury if oxygen supply is insufficient, as well as to the direct effect of toxins like opioids," said co-author Lewis Nelson from RU.

Although the study found a link with heroin, toxicity to the ear can occur with every opioid. "This study supports what has been found in animal studies, which is that any opioid can cause hearing loss," said study author Diane Calello from the New Jersey Poison Control Center.

"This might be because we already have built-in opioid receptors, or binding sites, in the inner ear. Activating them may trigger this injury in some patients," she said. The researchers said health care providers should be aware of the association with opioid use when evaluating a patient with hearing loss.

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<https://www.freepressjournal.in/health/study-reveals-how-opioid-use-can-trigger-deafness>

The study: <https://link.springer.com/article/10.1007/s13181-020-00785-5>