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More social discontent than pandemic-related risk perception in Colombia

Understanding risk perception is important during the COVID-19 pandemic because it allows governments to predict the psychological response of citizens and define the best public health strategies. Most people accepted strong mobility restrictions when they perceived high risk of infection with SARS-CoV-2 and death related to COVID-19.¹ In several Latin American countries, long lockdowns did not fully stop viral transmission because of high poverty rates, unemployment, and continued delivery of essential public services that forced a large part of the population to continue working outside their homes.² In addition to issues associated with the pandemic, Colombian society had several complaints and denunciations of social inequality, violence, and injustice, which were expressed with great force during the so-called 21–23 N, a social movement led by university students between Nov 21 and Nov 23, 2019.³ People's perception of the pandemic risk caused these protests to stop. However, social discontent remained latent.

Since mid-April, 2021, the number of incident SARS-CoV-2 cases in Colombia had increased to the highest level since the start of the pandemic. This rise was accompanied by an increase in deaths and in intensive care unit admissions. In this context, the Colombian Government proposed a tax reform that once again exacerbated social discontent, which generated social protests that have not stopped since April 28, 2021. These protests caused the government to withdraw the tax reform and the congress to stop a health reform. In general, the social protests have been peaceful, but violent demonstrations were seen in some cities and have resulted in thousands of people being injured with more than 50 deaths as of May 22, 2021.⁴

Currently, Colombia is a clear example of a society that fears hunger, absence of work, violence, lack of education, and other social problems more than SARS-CoV-2 infection. The potential impact of social protests on the transmission of SARS-CoV-2 is to be determined. Social protest occurs despite government and civilian speeches that instil fear of contagion. Colombians request that all types of violence stop, and that international organisations carry out oversight of the serious events that occur in Colombia.

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COVID-19: counting migrants in

Rohini Mathur and colleagues¹ present important data highlighting increased SARS-CoV-2 infection rates among minority ethnic people in the UK, including people reporting as South Asian and Black, yet use of these broad ethnic categories consistently fails to capture the dynamics of contemporary migration. These categories include a highly heterogeneous group of settled minority ethnic people born in the UK, alongside more recently arrived migrants, including an increasing



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proportion of low-skilled labour migrants, refugees, undocumented migrants, and others who have a particular profile of risk factors for SARS-CoV-2 infection.²

The effect on migrant populations can be seen in analyses from the few countries that do collect health data by country of birth. In what is likely to be an under-reporting of the true situation, in Sweden, for example, 32% of people testing positive for COVID-19 (from the start of the pandemic to May 7, 2020) were migrants, mainly from Turkey, Ethiopia, and Somalia.³ In Norway, 42% were migrants, according to the Norwegian COVID-19 national datasets as of April 27, 2020, and the highest proportion of these migrants were born in Somalia.⁴ In Ontario, Canada, 44% of people testing positive for COVID-19 were migrants (to June 13, 2020), with refugees more likely to test positive (10%) compared with other migrants (8%) and Canadian-born people (3%); lower proficiency in the English language was linked to lower levels of COVID-19 testing.⁵ Migrants also seem to be over-represented in COVID-19-related hospitalisations and deaths.² Studies from Sweden⁶ and Italy⁷ report a higher risk of COVID-19 deaths in migrants from low-income and middle-income countries; adjusting for sociodemographic characteristics, migrant men from the Middle East and north Africa had a 3-times higher mortality from COVID-19 than people born in Sweden.⁶ In Italy, migrants were more likely to be diagnosed late, hospitalised, and admitted to an intensive care unit.⁷

These findings are highly concerning and probably reflect the fact that migrants make up a substantial proportion of front-line workers and many live in deprived areas in overcrowded accommodation, including camps and detention centres where multiple COVID-19 outbreaks have been reported. Importantly, many thousands of migrants across Europe are excluded

from health systems, or have reduced access to health services and public health messaging. In June, 2021, the European Centre for Disease Prevention and Control published an overview of these migrant datasets;⁸ the report also includes emerging data from Sweden and Norway showing particularly low COVID-19 vaccine uptake rates in migrants, including people from north Africa, Iraq, and Somalia. At-risk migrant communities merit greater consideration in policy and planning going forward, requiring a coordinated intersectoral response to support initiatives to reduce transmission and to facilitate timely and equitable vaccine uptake.

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Department of Error

Haas EJ, Angulo FJ, McLaughlin JM, et al. Impact and effectiveness of mRNA BNT162b2 vaccine against SARS-CoV-2 infections and COVID-19 cases, hospitalisations, and deaths following a nationwide vaccination campaign in Israel: an observational study using national surveillance data. *Lancet* 2021; **397**: 1819–29—In table 2 of this Article, the number of cases of SARS-CoV-2 infection in unvaccinated participants aged 45–64 years should have been 19 579; the incidence rates per 100 000 person-days should have been <0.1 for COVID-19-related hospitalisation in fully vaccinated participants aged 16–44 years and for COVID-19-related death in fully vaccinated participants aged 45–64 years; the total person-days for all outcomes in unvaccinated participants (footnote †) should have been 88 938 310 for age 16–44 years, 22 734 104 for age 45–64 years, 8 403 722 for age ≥65 years, and 120 076 136 for all ages; and the total person-days for all outcomes in fully vaccinated participants (footnote ‡) should have been 77 280 829 for age 16–44 years, 67 027 668 for age 45–64 years, 57 573 686 for age ≥65 years, and 201 882 183 for all ages. In table 4, the incidence rates per 100 000 person-days should have been <0.1 for COVID-19-related death in fully vaccinated participants aged 45–64 years and for COVID-19-related death in fully vaccinated participants of all ages; the total person-days for all outcomes in unvaccinated participants (footnote †) should have been 88 938 310 for age 16–44 years, 22 734 104 for age 45–64 years, 8 403 722 for age ≥65 years, and 120 076 136 for all ages; and the total person-days for all outcomes in fully vaccinated participants (footnote ‡) should have been 61 397 072 for age 16–44 years, 57 734 915 for age 45–64 years, 51 302 672 for age ≥65 years, and 170 434 659 for all ages. In figure 2, the date range in the title should have been “Dec 1, 2020, to April 3, 2021”. These corrections have been made to the online version as of July 15, 2021.

Rosenstock J, Wysham C, Frias JP, et al. Efficacy and safety of a novel dual GIP and GLP-1 receptor agonist tirzepatide in patients with type 2 diabetes (SURPASS-1): a double-blind, randomised, phase 3 trial. *Lancet* 2021; **398**: 143–55—The appendix of this Article has been corrected. These corrections have been made to the online version as of July 15, 2021.