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regions were at different stages of the pandemic at the time the lockdown was implemented, the synchrony in regional peaks strongly suggests that the lockdown, rather than the natural course of the epidemic, explains the peak in hospital admissions. Moreover, most regions were experiencing exponential growth in hospital admissions (appendix), such that saturation of local intensive care units might have occurred in those regions in the absence of any lockdown.

Lockdown therefore appears to have been successful not only in alleviating the burden on the intensive care units of the two most severely affected regions of France, but also in preventing uncontrolled epidemics in other regions. These simple observations support results from other studies which have estimated the impact of lockdown on SARS-CoV-2 spread to be strong.²⁻⁵ Enforcement of public health and social measures in combination with important testing, tracing, and isolating capacities will be critical in case of an epidemic rebound to avoid re-introducing a lockdown—a situation for which the economic cost and broader impact on society are considerable.

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Is COVID-19 being used as a weapon against Indigenous Peoples in Brazil?

To corroborate the Editors¹ appeal for Indigenous Peoples' right to self-determination as fundamental to ensure their health, we wish to draw attention to the dire situation faced by Indigenous populations in the Amazon, and mainly in Brazil.

Since the conquest of the region by the Europeans, the history of the Amazon has been marked by epidemics that ravaged native populations. These calamities, recent or old, have left an indelible mark in the memory of communities: several Amerindian groups have been completely wiped out by exogenous diseases like measles and smallpox; others have barely survived, with mortality rates sometimes exceeding 98% (ie, worse than medieval plague and Spanish flu).² The arrival of the COVID-19 epidemic in Indigenous territories therefore revives painful memories and well justified fears.

Indigenous communities are not vulnerable in themselves; they have been made fragile by the legacy and persistence of colonial practices. In the Amazon, the COVID-19 pandemic has encountered a failing public health system. Worse still, in some communities, the transmission of severe acute respiratory syndrome

coronavirus 2 has started with health professionals infected and not tested before leaving for isolated localities.

Today, according to the Brazil's Indigenous People Articulation, more than 27 000 Indigenous people have been infected with COVID-19, of which 806 have died from the disease (situation as of Sept 15, 2020), giving a mortality rate of 3%. This pandemic already affects 146 different Indigenous groups across the country.³

On Aug 5, 2020, the Supreme Federal Court recognised the failure of the government of President Bolsonaro to deal with the effects of the epidemic on Indigenous communities.³ The latter was ordered to put in place an emergency plan for the benefit of the Indigenous populations, as well as to adopt the necessary measures to remove invaders from their territories (illegal miners and loggers are not only vectors of diseases, but also cause environmental destruction, in particular through mercury pollution).⁴ Faced with inaction from the Brazilian Government, some nations, such as the Paiteir Suruí and Parque Indígena do Xingu peoples, have placed themselves in voluntary isolation since March, 2020.

Only two solutions exist to ensure the survival of Indigenous peoples in the wake of this COVID-19 crisis. First, build public health policies in partnership with Indigenous peoples, and which are respectful of local perspectives on diseases and their treatments. And second, respect the right to self-determination recognised by the 2007 UN Declaration on the Rights of Indigenous Peoples. In the absence of these solutions, we will watch these Indigenous peoples die from afar.

We declare no competing interests.

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For Articulation of Indigenous Peoples of Brazil COVID-19 data see http://emergenciaindigena.apib.info/dados_covid19/



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COVID-19: leaving no one behind in Latin America

The pledge to leave no one behind has been essential in making the plight of refugees more visible¹ and in highlighting the need to include migrants and refugees in national health-care systems.

In Latin America, vulnerability in contexts of human mobility does not usually reside in refugee camps. This multidimensional, layered vulnerability is everywhere, dispersed and invisible, because migrants are physically present in communities yet excluded in every other way. Migrants might not be in camps or in detention, but their situation is ever more precarious. They have little access to social protection and health care,^{2,3} they are informal workers most likely to suffer abuse from their employers or lose their source of income,⁴ they are marginalised and overcrowded in overpopulated urban settings or in rural areas where the virus will inevitably spread, and they are experiencing the many aspects of poverty.⁵

More importantly, migrants experiencing social vulnerability largely contribute to making lockdowns possible: they are couriers who deliver meals, they are fruit and vegetable pickers, and they are domestic workers. Leaving no one behind means considering the quiet struggle of vulnerable immigrants who make

things happen as the rest of the population retreat into their homes, exposing themselves to contagion, usually with no protection and the threat of losing everything if they stop working.

Leaving no one behind in Latin America during the COVID-19 pandemic means that governments and employers alike should take responsibility for immigrants' welfare, through immediate actions and social, public health, and immigration policies in the long term.

We declare no competing interests.

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Savarirayan R, Tofts L, Irving M, et al. Once-daily, subcutaneous vosoritide therapy in children with achondroplasia: a randomised, double-blind, phase 3, placebo-controlled, multicentre trial. *Lancet* 2020; **396**: 684–92—In this Article, the spelling of author Daniel Hoernschemeyer's name was incorrect. This correction has been made to the online version as of Oct 8, 2020.

Shahar-Nissan K, Pardo J, Peled O, et al. Valaciclovir to prevent vertical transmission of cytomegalovirus after maternal primary infection during pregnancy: a randomised, double-blind, placebo-controlled trial. *Lancet* 2020; **396**: 779–85—In this Article, the eighth sentence of the final paragraph of the Results section should read "Overall, participants in the valaciclovir group had a lower odds of any cytomegalovirus-related morbidity compared with the placebo group (OR 0.38, 95% CI 0.09–1.56)." This correction has been made to the online version as of Oct 8, 2020.

Barbaro RP, MacLaren G, Boonstra PS, et al. Extracorporeal membrane oxygenation support in COVID-19: an international cohort study of the Extracorporeal Life Support Organization registry. *Lancet* 2020; **396**: 1071–78—The appendix of this Article has been corrected as of Oct 8, 2020.

The Lancet COVID-19 Commissioners, Task Force Chairs, and Commission Secretariat. Lancet COVID-19 Commission Statement on the occasion of the 75th session of the UN General Assembly. *Lancet* 2020; **396**: 1102–24—In the Declaration of interests section of this Commission Statement, statements have been added for Joseph Allen and John Thwaites, and the statement for Jessamy Bagenal has been removed. This correction has been made to the online version as of Oct 8, 2020, and the printed version is correct.