

British Columbia (BC) COVID-19 Situation Report

Week 26: June 26- July 02, 2022

Data for week 26 (June 26 - July 02, 2022) may differ from the data published in the BCCDC weekly report. Data was extracted on July 10, 2022 for this situation report compared to July 13, 2022 for the latest weekly report.

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Appendix 14	Age-specific incidence rates between week 25 and week 26 increased or remained stable in all age groups. Incidence rates increased the most in the 80+ year-olds from 69 per 100K in week 25 to 84 per 100K in week 26.
	The number of people in hospital with a positive COVID-19 test decreased from 209 in week 25 to 181 in week 26. In week 26, 60+ year-olds had the highest number of people in hospital with a positive COVID-19 test, with 65 hospitalizations in 60-79 year-olds and 71 hospitalizations in 80+ year-olds.
	The weekly number of deaths from any cause among people testing positive for COVID-19 decreased from 34 in week 25 to 30 in week 26. Similar to previous weeks, 80+ year-olds had the highest number of deaths from any cause among people testing positive for COVID-19 (18 deaths) in week 26. From week 14 to week 22 where the UCD has been reported for at least 95% of the post-transition deaths, an average of 44% of these deaths had an UCD as COVID-19.
	In week 26, based on earliest symptom onset date (if unavailable, then outbreak declared date is used), 4 new care facility outbreaks were declared in acute care.

BELOW ARE IMPORTANT NOTES relevant to the interpretation of cases, hospitalizations, and deaths:

- Due to changes in testing strategies in BC in 2022 focusing on targeted higher risk populations, current case counts are an underestimate of the true number of COVID-19 cases in BC. This underestimation has increased compared to the period prior to the emergence of the Omicron variant in BC.
- Hospital data include admissions for people who test positive for COVID-19 through hospital screening practices, regardless of the reason for admission. Therefore, reported hospitalizations overestimate the true number of people who are hospitalized specifically due to COVID-19 infection.
- Pre-transition (case line list) deaths include COVID-19 related deaths reported by Health Authorities up to April 1, 2022. As of April 2, 2022, post-transition (automated linkage) deaths include people who died from any cause recorded in Vital Statistics within 30 days of their first positive COVID-19 lab result date. Deaths reported after the system transition use a broader definition and will overestimate the true number of deaths due to COVID-19 since death registration is recorded before the underlying cause of death is determined. Due to the change in data source for death data, the number of pre-transition deaths should not be compared to the number of post-transition deaths.

BELOW ARE IMPORTANT NOTES relevant to the interpretation of data displayed in this bulletin:

- Cases include lab confirmed, lab probable, and epi-linked cases. Case definition can be found at [http://www.bccdc.ca/health-professionals/clinical-resources/case-definitions/covid-19-\(novel-coronavirus\)](http://www.bccdc.ca/health-professionals/clinical-resources/case-definitions/covid-19-(novel-coronavirus)). Cases include those reported in Health Authority case line lists and positive laboratory results in the Provincial Laboratory Information Solution (PLIS) up to April 1, 2022. As of April 2, 2022, only positive laboratory results in the PLIS are included and cases who are residents from outside of BC are not included.
 - Episode date is defined by date of illness onset when available. When illness onset date is unavailable, earliest laboratory date is used (collection or result date); if also unavailable, then public health case report date is used. As of April 2, 2022, episode date reflects earliest laboratory date (collection or result date) only. Analyses based on episode date may better represent the timing of epidemic evolution. Episode-based tallies for recent weeks are expected to increase as case data are more complete.
 - Surveillance date is defined by lab result date, if unavailable, then public health case report date is used. As of April 2, 2022, surveillance date reflects lab result date only. The weekly tally by surveillance date includes cases with illness onset date in preceding weeks.
 - Hospitalizations include those reported by Health Authorities up to April 1, 2022. As of April 2, 2022, hospitalizations are defined as individuals who test positive for COVID-19 and are hospitalized as recorded in the PHSA Provincial COVID-19 Monitoring Solution (PCMS). Hospitalizations for individuals 0-19 years-old are reported by linked hospitalization episodes from the PCMS since the beginning of the pandemic. Episode date for hospitalization is defined by admission date, if unavailable, surveillance date is used.
 - Critical care admissions (HAU, ICU, and critical care surge beds) include individuals who test positive for COVID-19 and are in critical care admission as recorded in the PCMS. Episode date for critical care admission is defined by critical care admission date, if unavailable, surveillance date is used. Previously only ICU admissions were presented in this report. Critical care admissions comprises a broader category than ICU admissions and therefore, the number of critical care admissions should not be compared to number of ICU admissions from previous weeks.
 - Deaths include COVID-19 related deaths reported by Health Authorities up to April 1, 2022. As of April 2, 2022, deaths are any COVID-19 lab positive cases who died from any cause recorded in Vital Statistics within 30 days of their first positive lab result date. Episode date for death is defined by death date, if unavailable, surveillance date is used.
 - As of April 2, 2022, data on Health Authority outbreaks are compiled from outbreak files provided by the Health Authorities.
 - Laboratory PLOVER data include Medical Service Plan (MSP) funded (e.g. clinical diagnostic tests) and non-MSP funded (e.g. screening tests) specimens.
 - Per capita rates/incidences for year 2020 are based on Population Estimates 2020 (n= 5,147,772 for BC overall), for year 2021 are based on PEOPLE 2021 estimates (n= 5,194,137 for BC overall), and for year 2022 is based on PEOPLE 2021 estimates (n= 5,263,772 for BC overall).
 - Data sources include Health Authority case line lists, PHSA Provincial COVID-19 Monitoring Solution (PCMS), Vital Statistics, laboratory PLOVER data, and aggregate outbreak files from Health Authorities.
 - Integrated case data (including surveillance variables created using Health Authority case line lists, PCMS, and Vital Statistics) were extracted on July 10, 2022, laboratory PLOVER data on July 11, 2022, and Health Authority outbreak files on July 06, 2022.
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A. COVID-19 case counts and epidemic curves

Due to changes in testing strategies in BC in 2022 focusing on targeted higher risk populations, current case counts are an underestimate of the true number of COVID-19 cases in BC. This underestimation has increased compared to the period prior to the emergence of the Omicron variant in BC. Up to week 26, there have been 375,418 cases for a cumulative incidence of 7,132 per 100K (Table 1, Figure 1). The provincial incidence by episode date was 15 per 100K (780 cases) in week 26, which increased from 12 per 100K in week 25. Incidence by episode date may increase as data become more complete in recent weeks.

As shown in Figure 2, incidence rates from week 25 to week 26 increased in all HAs except Vancouver Island Health (VIHA), where the incidence rate remained stable at 15 per 100K. Incidence rates increased the most in the Fraser Health (FH) and Interior Health (IH) from 13 per 100K in week 25 to 17 per 100K in week 26 and from 9 per 100K in week 25 to 12 per 100K in week 26, respectively. In week 26, the highest incidence rate was in FH at 17 per 100K.

Table 1. Episode-based case tallies by Health Authority, BC, Jan 15, 2020 (week 3) – Jul 02, 2022 (week 26) (N= 375,418)

Case tallies by episode date	Health Authority of Residence					Outside Canada	Total
	FH	IH	VIHA	NH	VCH		
Week 26, case counts	342	101	134	37	166	0	780
Cumulative case counts	165,403	66,829	36,626	30,483	75,686	391	375,418
Week 26, cases per 100K population	17	12	15	12	13	NA	15
Cumulative cases per 100K population	8,323	8,067	4,161	9,959	5,998	NA	7,132

Figure 1. Episode-based epidemic curve (bars), surveillance date (line) and Health Authority (HA), BC Sept 13, 2020 (week 38) – Jul 02, 2022 (week 26) (N= 367,571)

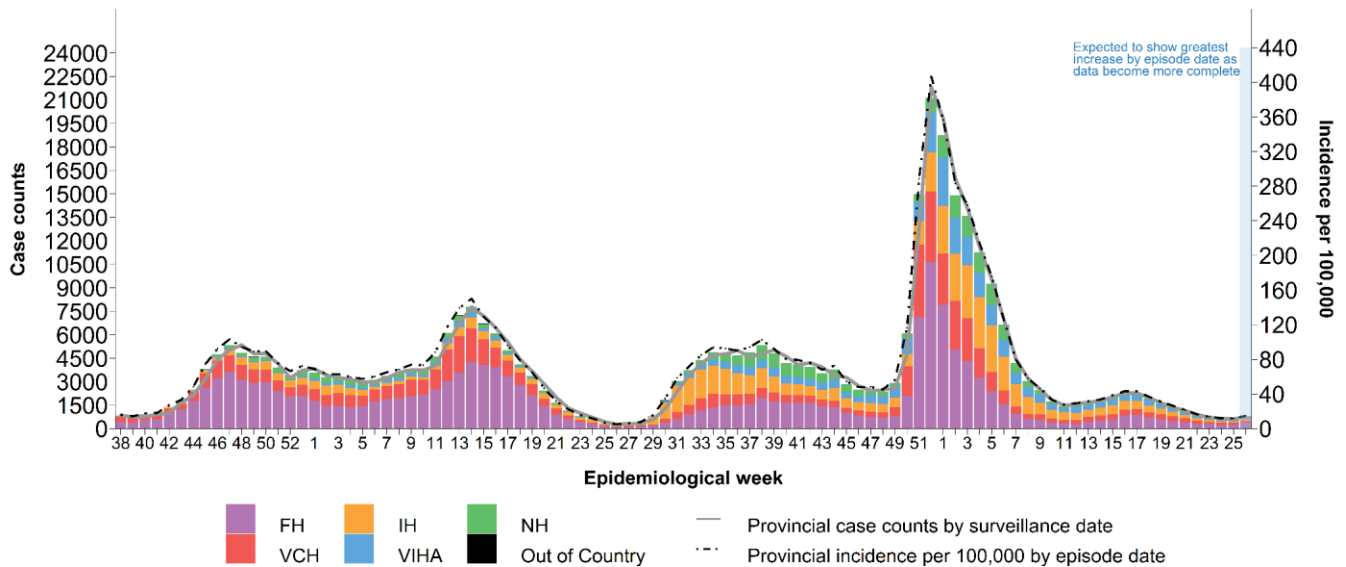
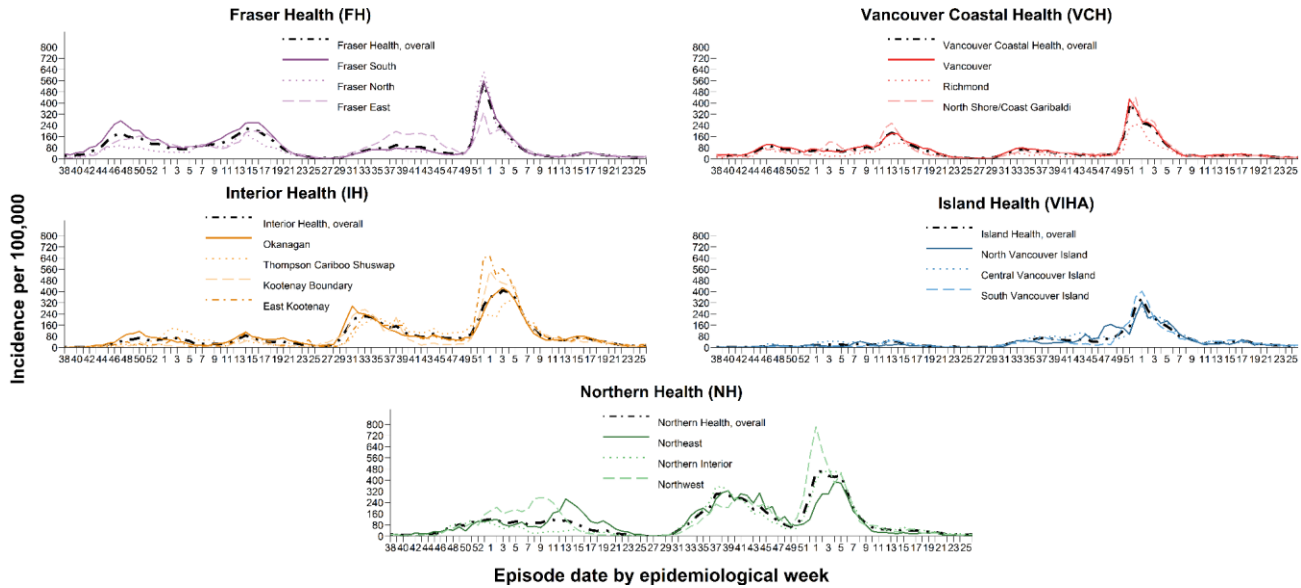


Figure 2. Weekly episode-based incidence rates by HA and health service delivery area (HSDA), BC Sept 13, 2020 (week 38) – Jul 02, 2022 (week 26) (N= 367,571)

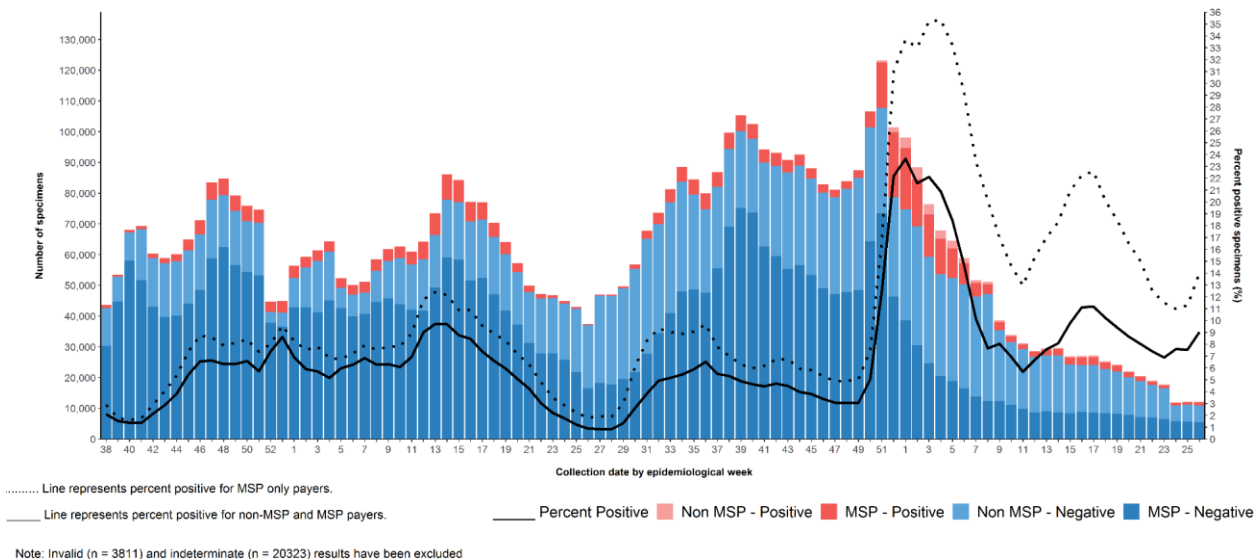


B. Test rates and percent positive

[COVID-19 testing guidelines](#) recommend testing for people who have COVID-19 symptoms, and are at risk of more severe disease or live/work in high-risk settings. As shown by the darker-colored bars and dotted line in [Figure 3](#), the number of MSP-funded specimens remained stable at ~6,400 in week 25 and week 26, and the percent positivity of MSP-funded specimens increased from 11.3% in week 25 to 14.0% in week 26.

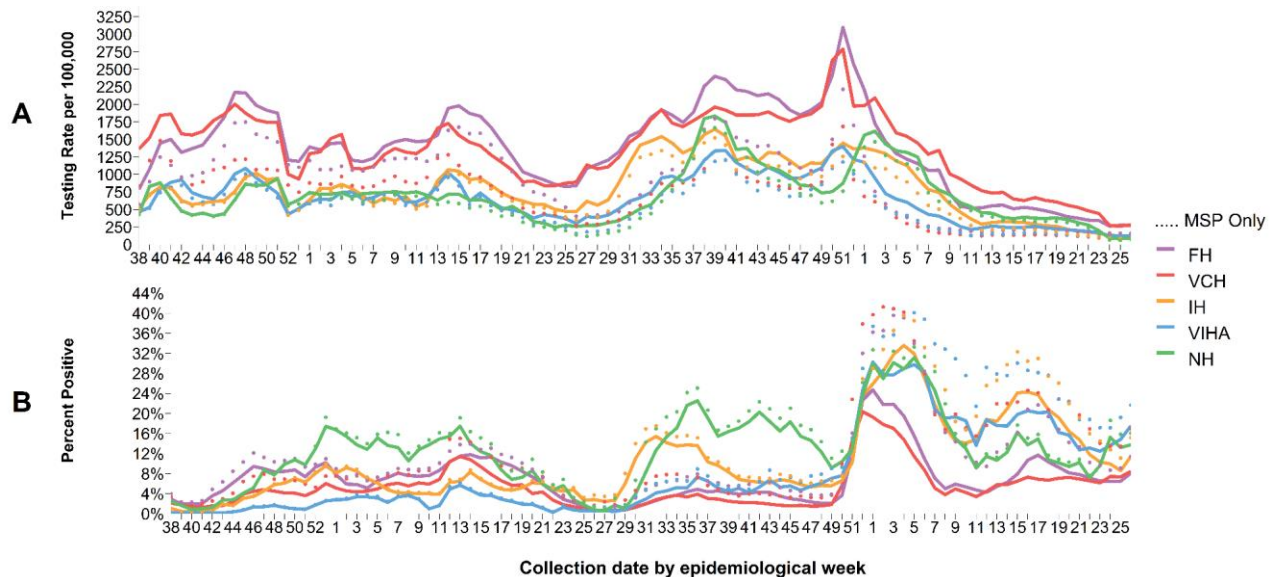
As shown by the dotted lines in [Figure 4](#), the per capita testing rates for MSP-funded specimens (dotted lines in Panel A) increased or remained stable in all HAs except VIHA, where it decreased from 92 per 100K in week 25 to 90 per 100K in week 26. In week 26, FH had the highest testing rate at 162 per 100K. The percent positivity (dotted lines in Panel B) for MSP-funded specimens increased or remained stable in all HAs. In week 26, percent positivity ranged from 11.4% in FH to 21.7% in VIHA.

Figure 3. Number of specimens tested and percent SARS-CoV-2 positive, by collection week, BC Sept 13, 2020 (week 38) – Jul 02, 2022 (week 26)



Note: Invalid (n = 3811) and indeterminate (n = 20323) results have been excluded

Figure 4. Testing rates and percent SARS-CoV-2 positive by Health Authority and collection week, BC Sept 13, 2020 (week 38) – Jul 02, 2022 (week 26)



Data source: Laboratory PLOVER data

C. Age profile – Testing and cases

Testing rates and percent positivity by age group

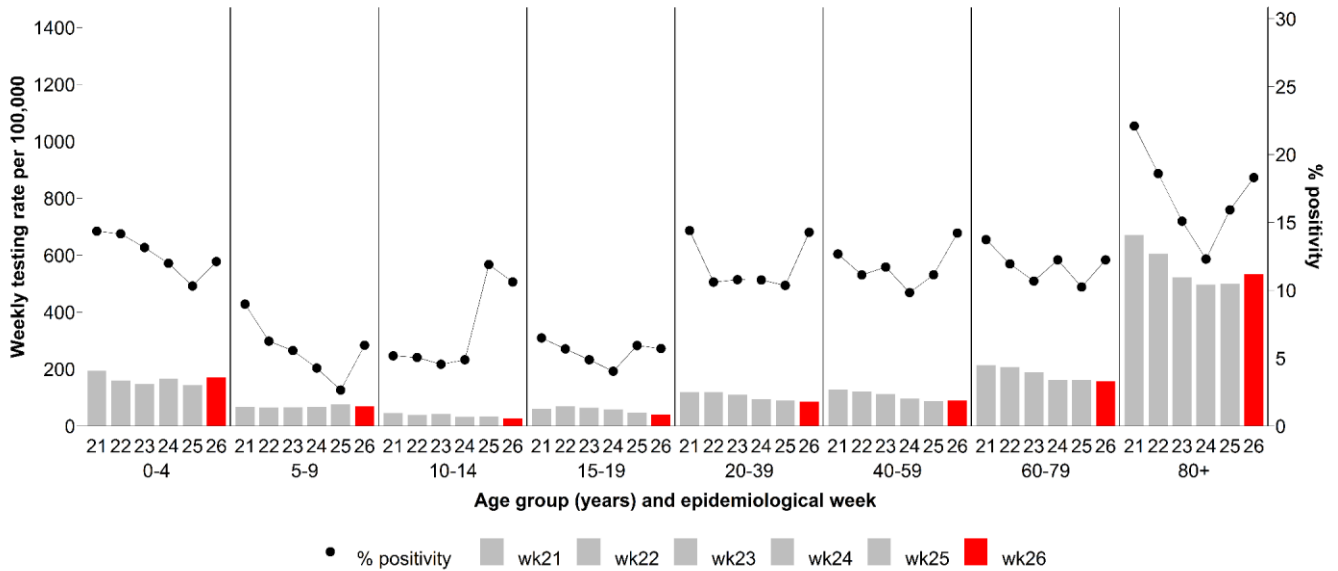
As shown by the bars in [Figure 5](#), the per capita testing rates for MSP-funded specimens between week 25 and week 26 decreased or remained stable in all age groups except in the 0-4 and 80+ year-olds, where testing rates increased from 144 per 100K in week 25 to 171 per 100K in week 26 and from 499 per 100K in week 25 to 533 per 100K in week 26, respectively.

As shown by the black dots in [Figure 5](#), percent positivity between week 25 and week 26 increased in all age groups except in the 10-14 and 15-19 year-olds. Percent positivity decreased in 10-14 year-olds from 11.9% in week 25 to 10.6% in week 26 and remained stable in 15-19 year-olds at 5.9% in week 25 and 5.7% in week 26. Percent positivity increased the most in 5-9 and 20-39 year-olds, where it increased from 2.7% in week 25 to 6% in week 26 and from 10.4% in week 25 to 14.3% in week 26, respectively. In week 26, percent positivity ranged from 5.7% in 15-19 year-olds to 18.3% in 80+ year-olds.

Case distribution and weekly incidence by age group

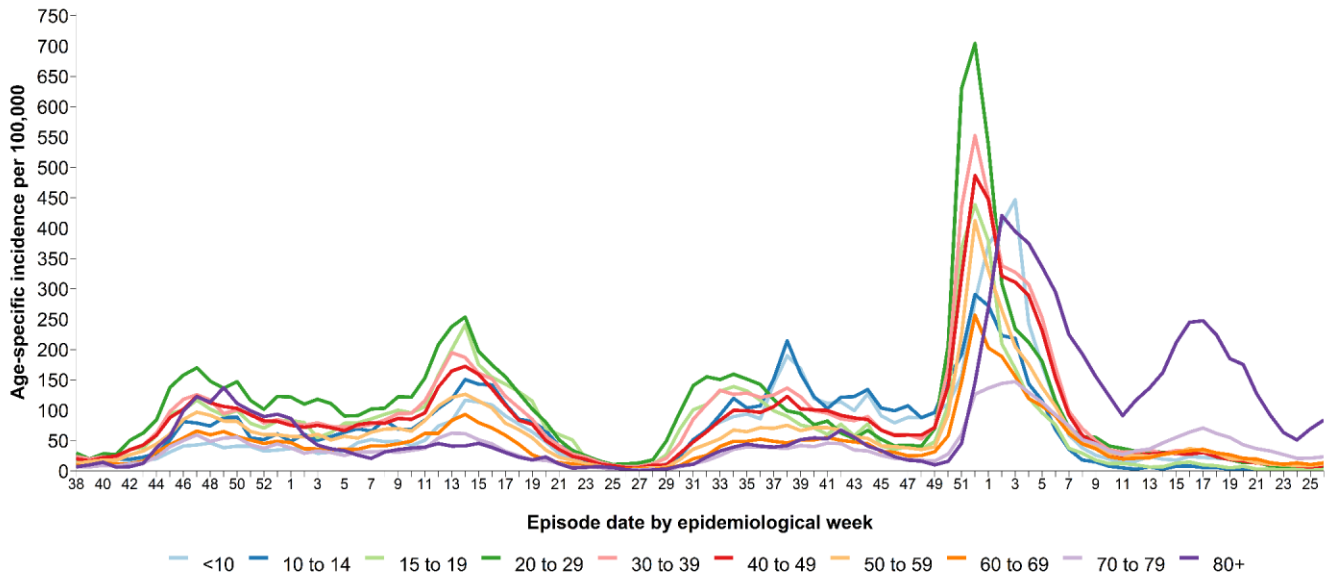
As shown in [Figure 6](#), age-specific incidence rates between week 25 and week 26 increased or remained stable in all age groups. Incidence rates increased the most in the 80+ year-olds from 69 per 100K in week 25 to 84 per 100K in week 26.

Figure 5. Average weekly SARS-CoV-2 MSP testing rates and MSP percent positive by known age group, BC May 28, 2022 (week 21) – Jul 02, 2022 (week 26)



Data source: Laboratory PLOVER data

Figure 6. Weekly age-specific COVID-19 incidence per 100K population by epidemiological week, BC Sept 13, 2020 (week 38) – Jul 02, 2022 (week 26) (N= 367,477)



D. Severe outcome counts and epi-curve

Hospital data include admissions for people who test positive for COVID-19 through hospital screening practices, regardless of the reason for admission. Therefore, reported hospitalizations overestimate the true number of people who are hospitalized specifically due to COVID-19 infection. The number of people in hospital with a positive COVID-19 test decreased from 209 in week 25 to 181 in week 26. In week 26, 60+ year-olds had the highest number of people in hospital with a positive COVID-19 test, with 65 hospitalizations in 60-79 year-olds and 71 hospitalizations in 80+ year-olds.

As of April 2, 2022, death data include people who test positive for COVID-19 and died from any cause (COVID-19 or non-COVID-19) within 30 days of their first positive lab result date. The weekly number of deaths from any cause among people testing positive for COVID-19 decreased from 34 in week 25 to 30 in week 26. Similar to previous weeks, 80+ year-olds had the highest number of deaths from any cause among people testing positive for COVID-19 (18 deaths) in week 26 ([Table 2, Figure 8](#)). Detailed information about outcomes by vaccination status can be accessed at [BCCDC COVID-19 Regional Surveillance Dashboard](#).

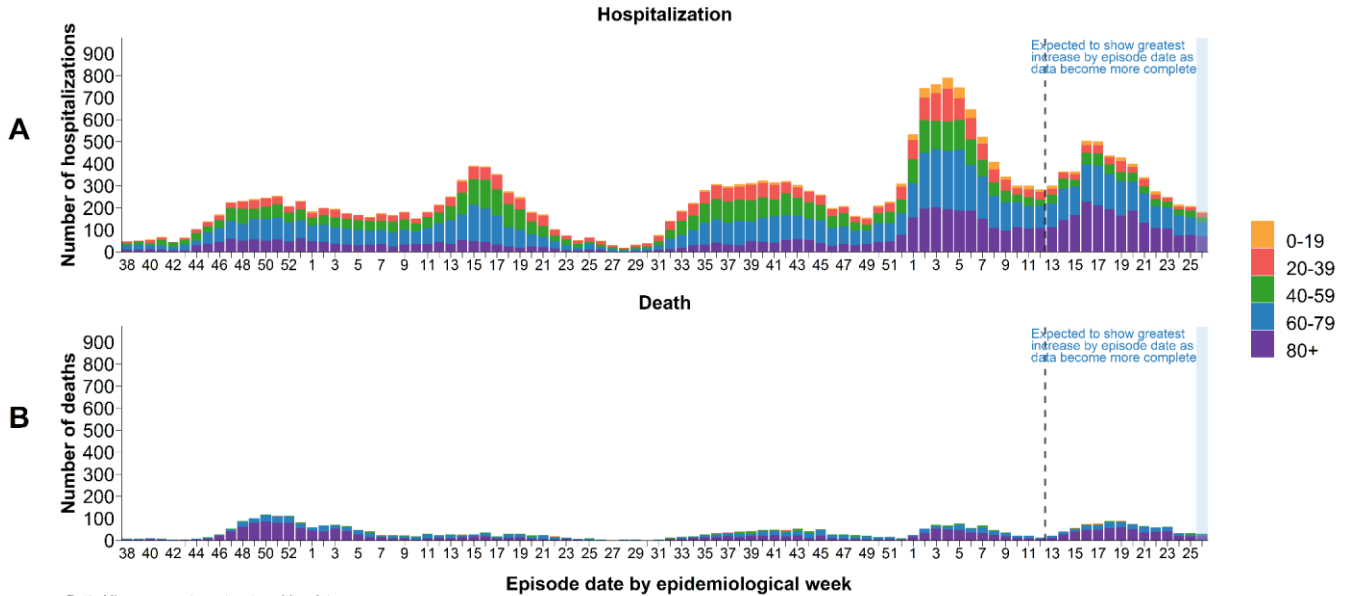
Cumulatively, there have been 32 confirmed cases of [Multi-system Inflammatory Syndrome in children and adolescents \(MIS-C\)](#) in BC since January 1, 2020. There have been no new confirmed cases of MIS-C since the last report. The median age of all cases is 9 years old (range from 4 months old to 16 years old).

**Table 2. COVID-19 severe outcomes by episode date, Health Authority of residence, BC
Jan 15, 2020 (week 3) – Jul 02, 2022 (week 26)**

Severe outcomes by episode date	Health Authority of residence					Residing outside of Canada	Total n/N ^a (%)
	FH	IH	VIHA	NH	VCH		
Week 26, hospitalizations	100	6	29	6	40	0	181
Cumulative hospitalizations	11,410	4,161	2,341	2,055	4,849	17	24,833/375,418 (7)
Week 26, critical care admissions ^b	30	5	7	2	3	0	47
Cumulative critical care admissions^b	2,413	969	406	784	1,076	4	5,652/375,418 (2)
Week 26, deaths	14	6	4	0	6	0	30
Cumulative deaths, pre-transition (case line list)^c	1,348	367	241	330	716	0	3,002/356,556 (1)
Cumulative deaths, post-transition (automated linkage)^c	261	174	151	28	180	0	794/18,862 (4)

- Cases with unknown outcome are included in the denominators (i.e. assumed not to have the specified severe outcome).
- Due to the change in data source for hospitalization data, ICU admissions are no longer available. Critical care admissions are now being provided, which comprises a broader category than ICU admissions (please see Important Notes on Page 2 for more information). Number of critical care admissions should not be compared to number of ICU admissions from previous weeks.
- Pre-transition (case line list) deaths include COVID-19 related deaths reported by Health Authorities up to April 1, 2022. As of April 2, 2022, post-transition (automated linkage) deaths are any COVID-19 lab positive cases who died from any cause recorded in Vital Statistics within 30 days of their first positive lab result date. Deaths reported after the system transition use a broader definition and will overestimate the true number of deaths due to COVID-19 since death registration is recorded before the underlying cause of death is determined. Due to the change in data source for death data, the number of pre-transition deaths should not be compared to the number of post-transition deaths.

Figure 8. Weekly COVID-19 hospital admissions (A) and deaths (B) by age groups, BC, Sept 13, 2020 (week 38) – Jul 02, 2022 (week 26)^a



a. Among those with available age information only.

E. Age profile, severe outcomes

Table 3 displays the distribution of cases and severe outcomes. In week 26, median age of hospital admissions, critical care admissions, pre-transition deaths, and post-transition deaths with underlying cause of death (UCD) as COVID-19 was 66 years, 63 years, 82 years, and 86 years, respectively.

In the past four weeks (from week 23 to week 26), there has been a weekly average of 3 deaths in those <60 years of age, 3 deaths in 60-69 year-olds, 9 deaths in 70-79 year-olds and 25 deaths in the 80+ year-olds (data not shown). The number of deaths may increase over time as data becomes more complete.

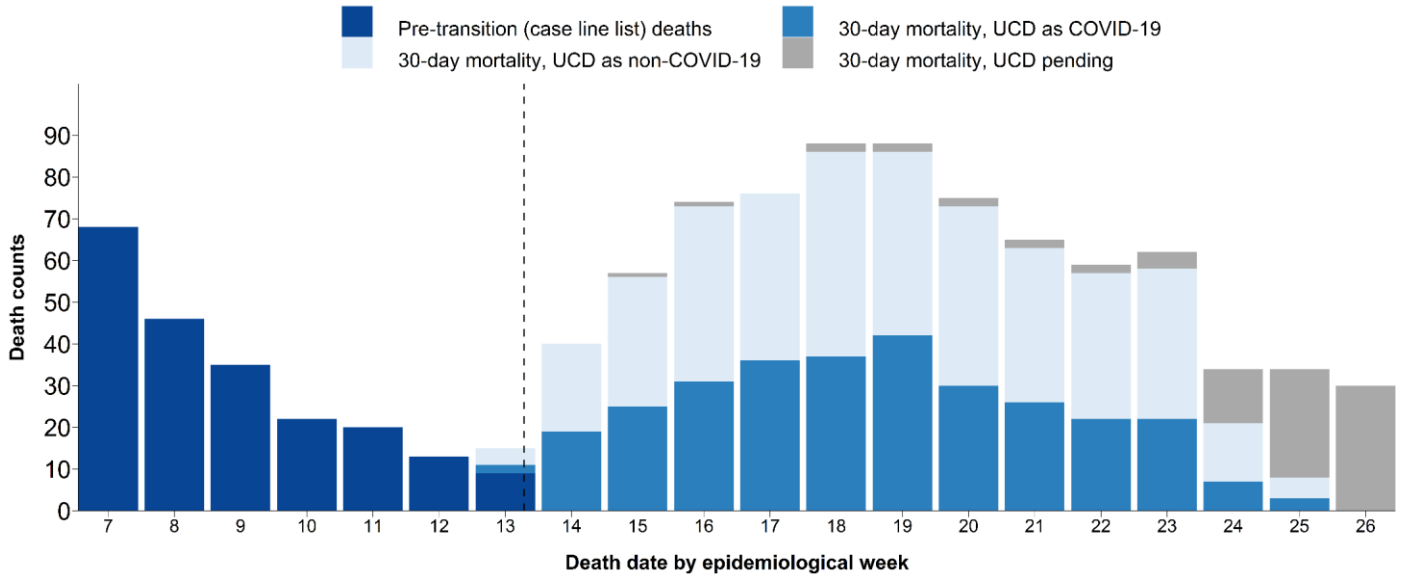
Table 3: COVID-19 cases, hospitalizations, critical care admissions, and deaths by age group, BC, Jan 15, 2020 (week 3) – Jul 02, 2022 (week 26) (N= 375,387)^a

Age group (years)	Cases	Hospitalizations n (%)	Critical care admissions ^b n (%)	Pre-transition (case line list) deaths ^c n (%)	Post-transition (automated linkage) deaths ^c		
					UCD as COVID-19 ^d n (%)	UCD as non-COVID-19 ^d n (%)	UCD pending ^d n (%)
<10	30,591	527 (2)	66 (<1)	2 (<1)	1 (<1)	2 (<1)	0 (<1)
10-19	35,743	342 (1)	48 (<1)	0 (<1)	0 (<1)	1 (<1)	0 (<1)
20-29	73,121	1,333 (2)	198 (<1)	6 (<1)	0 (<1)	5 (<1)	2 (<1)
30-39	69,981	2,273 (3)	416 (1)	31 (<1)	2 (<1)	5 (<1)	0 (<1)
40-49	54,086	2,193 (4)	574 (1)	64 (<1)	1 (<1)	6 (<1)	1 (<1)
50-59	43,920	3,068 (7)	1,037 (2)	166 (<1)	3 (<1)	18 (1)	4 (<1)
60-69	30,286	4,165 (14)	1,397 (5)	353 (1)	22 (1)	38 (2)	8 (<1)
70-79	17,588	4,797 (27)	1,279 (7)	655 (4)	58 (2)	88 (3)	23 (1)
80-89	13,071	4,323 (33)	560 (4)	989 (10)	107 (3)	127 (4)	32 (1)
90+	7,000	1,812 (26)	77 (1)	736 (15)	110 (6)	115 (6)	15 (1)
Total	375,387	24,833	5,652	3,002	304	405	85
Median age	36	66	63	82	85.5	82	80

- Among those with available age information only.
- Due to the change in data source for hospitalization data, ICU admissions are no longer available. Critical care admissions are now being provided, which comprises a broader category than ICU admissions (please see Important Notes on Page 2 for more information). Number of critical care admissions should not be compared to number of ICU admissions from previous weeks.
- Pre-transition (case line list) deaths include COVID-19 related deaths reported by Health Authorities up to April 1, 2022. As of April 2, 2022, post-transition (automated linkage) deaths are any COVID-19 lab positive cases who died from any cause recorded in Vital Statistics within 30 days of their first positive lab result date. Deaths reported after the system transition use a broader definition and will overestimate the true number of deaths due to COVID-19 since death registration is recorded before the underlying cause of death is determined. Due to the change in data source for death data, the number of pre-transition deaths should not be compared to the number of post-transition deaths.
- Since underlying cause of death (UCD) takes approximately 8 weeks to be recorded, all-cause mortality is initially reported and then retrospective evaluations of underlying cause of death are provided here to better understand true COVID-19 mortality. UCD as COVID-19 are deaths that have been determined to be caused by COVID-19 in their Vital Stats record. UCD as non-COVID-19 are deaths that have been determined to be not attributable to COVID-19 in their Vital Stats record that are reported as deaths due to a lab positive COVID-19 test within 30 days of death. UCD pending are all post-transition deaths that do not yet have a recorded UCD.

Figure 9 displays the number of pre-transition deaths and post-transition deaths (i.e. people who test positive for COVID-19 and died from any cause within 30 days of their first positive lab result date) by underlying cause of death as recorded in Vital Statistics from week 7 to week 26 in 2022. From week 14 to week 22 where the UCD has been reported for at least 95% of the post-transition deaths, an average of 44% of these deaths had an UCD as COVID-19. Post-transition deaths with complete UCD are expected to increase over time.

Figure 9: Pre- and post-transition deaths by underlying cause of death, BC, Feb 13, 2022 (week 7) – Jul 02, 2022 (week 26)^{a,b}



Dotted line represents system transition date

- a. Pre-transition (case line list) deaths include COVID-19 related deaths reported by Health Authorities up to April 1, 2022. As of April 2, 2022, post-transition (automated linkage) deaths are any COVID-19 lab positive cases who died from any cause recorded in Vital Statistics within 30 days of their first positive lab result date. Deaths reported after the system transition use a broader definition and will overestimate the true number of deaths due to COVID-19 since death registration is recorded before the underlying cause of death is determined. Due to the change in data source for death data, the number of pre-transition deaths should not be compared to the number of post-transition deaths.
- b. Since underlying cause of death (UCD) takes approximately 8 weeks to be recorded, all-cause mortality is initially reported and then retrospective evaluations of underlying cause of death are provided here to better understand true COVID-19 mortality. UCD as COVID-19 are deaths that have been determined to be caused by COVID-19 in their Vital Stats record. UCD as non-COVID-19 are deaths that have been determined to be not attributable to COVID-19 in their Vital Stats record that are reported as deaths due to a lab positive COVID-19 test within 30 days of death. UCD pending are all post-transition deaths that do not yet have a recorded UCD.

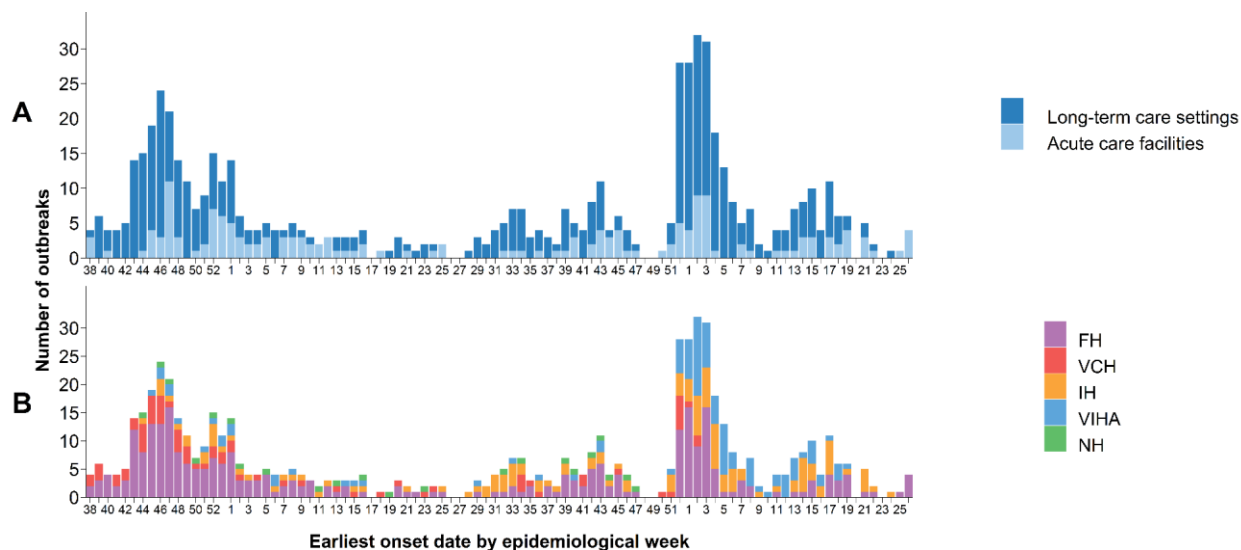
F. Care facility outbreaks

As shown in [Table 4](#) and [Figure 10](#), 680 care facility (acute care and long-term care settings) outbreaks were reported in total in BC to the end of week 26. In week 26, based on earliest symptom onset date (if unavailable, then outbreak declared date is used), 4 new care facility outbreaks were declared in acute care. In the past four weeks (from week 23 to week 26), there has been a weekly average of 2 care facility outbreaks.

Table 4. COVID-19 care facility^a outbreaks by earliest case onset^{b,c}, associated cases and deaths by episode date, BC Jan 15, 2020 (week 3) – Jul 02, 2022 (week 26) (N=680)^{d,e}

Care facility outbreaks and cases by episode date	Outbreaks	Cases			Deaths		
		Residents	Staff/other	Total	Residents	Staff/other	Total
Week 26, Care Facility Outbreaks	4	39	0	39	0	0	0
Cumulative, Care Facility Outbreaks	680	9,610	3,817	13,427	1,453	0	1,453

Figure 10. COVID-19 care facility^a, outbreaks by earliest case onset^{b,c}, facility type (A) and Health Authority (B), BC Sept 13, 2020 (week 38) – Jul 02, 2022 (week 26) (N=612)^{d,e}



- Case and death counts include PCR positive cases only for outbreaks in NHA and VIHA. Vancouver Coastal Health, Fraser Health Authority, and Interior Health Authority outbreaks may also include those diagnosed by rapid antigen tests or considered as suspected reinfection.
- Earliest dates of onset of outbreak cases are subject to change as investigations and data are updated. If unavailable, outbreak declared date is used.
- New outbreaks reported since the last report with an earliest case onset date (if unavailable, outbreak declared date is used) prior to the current reporting week will be included in the cumulative care facility outbreak total.
- Cases with unknown role are included in the case count for Staff/other.
- Data might be incomplete or vary from what was reported previously due to updates by Health Authorities.

G. Wastewater surveillance

The BCCDC and Metro Vancouver measure SARS-CoV-2 in wastewater at five wastewater treatment plants (treating wastewater from 50% of BC’s population). To account for changing wastewater volume due to rainfall or snowmelt, SARS-CoV-2 concentrations are normalized to wastewater flow. Normalized SARS-CoV-2 wastewater levels (measured as viral copies per day) are shown alongside incident COVID-19 cases in each wastewater catchment area in [Figure 10](#) and [Figure 11](#). The BCCDC’s test results are obtained from the liquid fraction of the wastewater sample. Other organizations, such as the National Microbiology Laboratory, test from the solid fraction of wastewater and therefore, their results are not directly comparable.

Key messages with results through to July 9, 2022:

Overall, viral loads of SARS-CoV-2 in Metro Vancouver wastewater continue their recent upwards trend. This is consistent with increased incidence of COVID-19 in Metro Vancouver.

- Over the past four weeks, viral loads at Annacis Island wastewater plant (Fraser North and South) have increased by 70%.
- After increasing for three weeks, viral loads at Northwest Langley (Northwest Langley) have decreased by 25%.
- Over the past three weeks, viral loads at Iona Island (Vancouver) have increased by 92%.
- Over the past week, viral loads at Lulu Island (Richmond) have increased by 62%.
- Over the past two weeks, viral loads at Lions Gate (North Shore) appear to have increased by 300%. This needs to be interpreted with caution as two data points, July 6 and July 9, were omitted from this week’s analysis due to technical issues, resulting in the weekly average being based on a single sample. This upward trend should be considered provisional until confirmed by additional sampling and testing.

Figure 11. Wastewater surveillance, FH

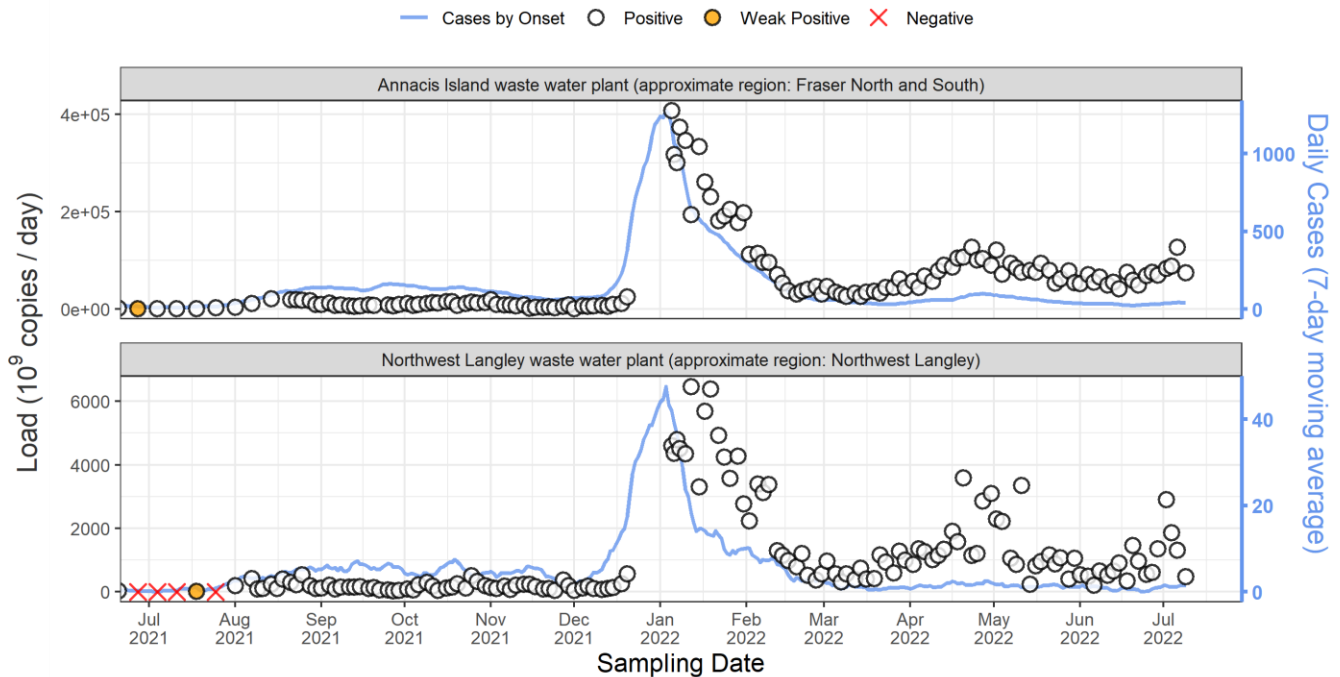
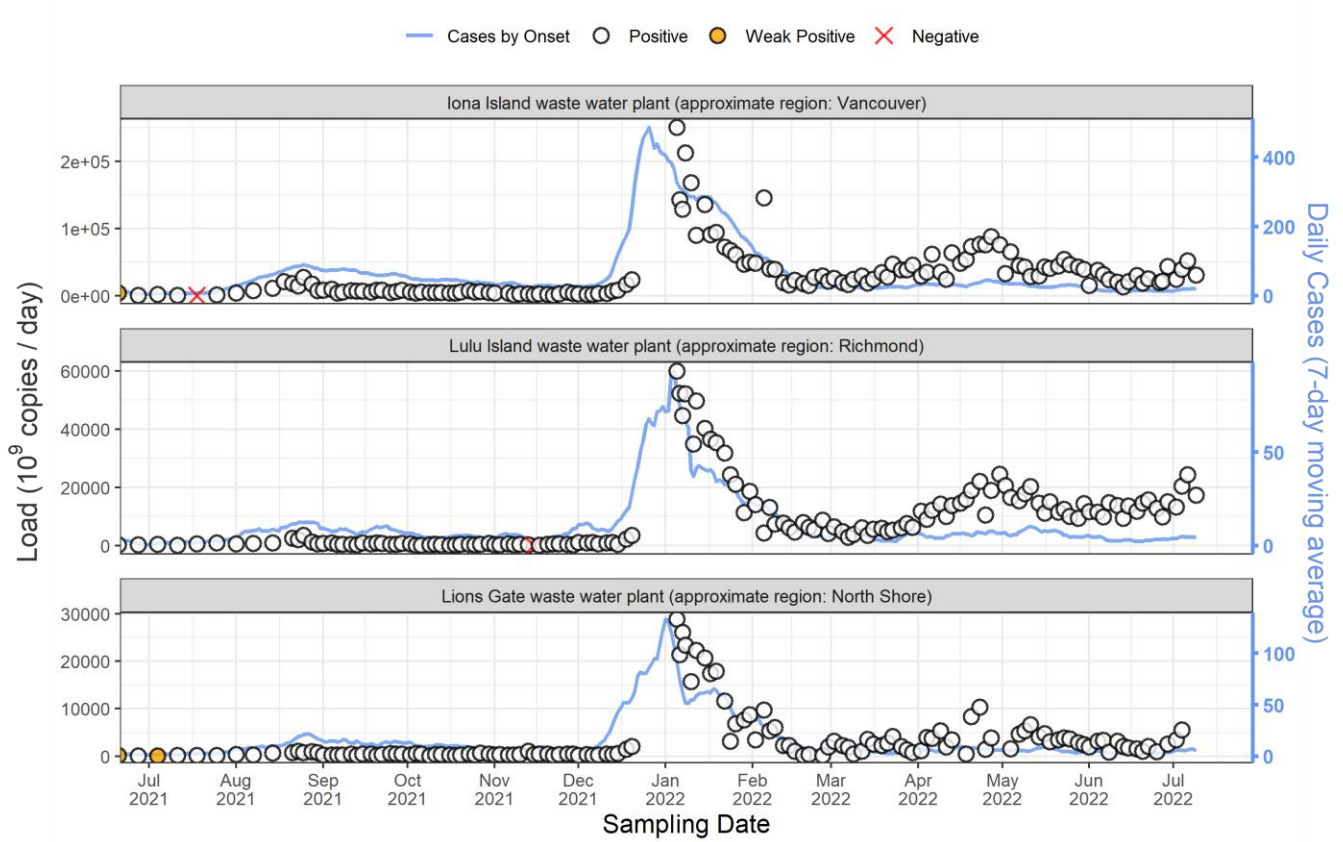


Figure 12. Wastewater surveillance, VCH



H. Additional resources

For maps and geographical distribution of cases and vaccinations, visit the BCCDC COVID-19 Regional Surveillance Dashboard here: <http://www.bccdc.ca/health-professionals/data-reports/covid-19-surveillance-dashboard>

Variant of concern (VOC) findings are available weekly here: <http://www.bccdc.ca/health-info/diseases-conditions/covid-19/data#variants>

For local, national, and global comparisons of BC to other jurisdictions on key epidemiological metrics, visit the BCCDC COVID-19 Epidemiology App here: https://bccdc.shinyapps.io/covid19_global_epi_app/

I. Appendix

[Vaccination phases](#) defined by vaccine eligibility of target populations in BC

Vaccination Phase 1 (December 2020 – February 2021)

Target populations include residents, staff and essential visitors to long-term care settings; individuals assessed and awaiting a long-term care placement; health care workers providing care for COVID-19 patients; and remote and isolated Indigenous communities.

Vaccination Phase 2 (February 2021 – April 2021)

Target populations include seniors, age ≥ 80 ; Indigenous peoples age ≥ 65 and Indigenous Elders; Indigenous communities; hospital staff, community general practitioners and medical specialists; vulnerable populations in select congregate settings; and staff in community home support and nursing services for seniors.

Vaccination Phase 3 (April 2021 – May 2021)

Target populations include people aged 60-79 years, Indigenous peoples aged 18-64 and people aged 16-74 who are clinically extremely vulnerable.

Vaccination Phase 4 (May 2021 – November 2021)

Target populations include everyone 12+ years. In September, third dose is available for people who are clinically extremely vulnerable.

Vaccination Phase 5 (November 2021 – February 2022)

Target populations include everyone 5+. Children aged 5-11 are eligible at the end of November. Everyone 18 and older will be invited to get a booster dose within 6-8 months of their second dose.

Vaccination Phase 6 (February 2022 – April 2022)

Target populations include everyone 5+. Everyone 12 and older will be invited to get a booster dose within 6-8 months of their second dose.

Vaccination Phase 7 (April 2022 – Present)

Target populations include everyone 5+. Everyone 12 and older will be invited to get a booster dose within 6-8 months of their second dose. People in long-term care, assisted living, seniors and Indigenous people can get a second booster 6 months after the date of the first booster.