

International Horizon Scanning and Learning to Inform Wales' COVID-19 Public Health Response and Recovery

Report 21, 17/12/2020



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World Health Organization
Collaborating Centre on
Investment for Health and Well-being



Overview

The International Horizon Scanning and Learning work stream was initiated following and informing the evolving coronavirus (COVID-19) public health response and recovery plans in Wales. It focuses on COVID-19 international evidence, experience, measures, transition and recovery approaches, to understand and explore solutions for addressing the on-going and emerging health, wellbeing, social and economic impacts (potential harms and benefits).

The learning and intelligence is summarised in weekly reports to inform decision-making. These may vary in focus and scope, depending on the evolving COVID-19 situation and public health / policy needs.

This work is aligned with and feeding into the Welsh Government Office for Science and into Public Health Wales Gold Command. It is part of a wider Public Health Wales' systematic approach to intelligence gathering to inform comprehensive, coherent, inclusive and evidence-informed policy action, which supports the Wellbeing of Future Generations (Wales) Act and the Prosperity for All national strategy towards a healthier, more equal, resilient, prosperous and globally responsible Wales.

Disclaimer: The reports provide high-level summary of emerging evidence from country experience and epidemiology; research papers (peer-reviewed/not); and key organisations' guidance / reports, including sources of information to allow further exploration. The reports don't provide detailed or in-depth data/evidence analysis. Due to the novelty of COVID-19 virus/disease, and dynamic change in situation, studies and evidence can be conflicting, inconclusive or depending on country/other context.

In focus this week

- ✚ **Pandemic fatigue and population adherence to COVID-19 measures**
- ✚ **COVID-19 vaccine hesitancy and distribution**
- ✚ **Comparing COVID-19 cumulative rates**
- ✚ **Measures to prevent COVID-19 in long-term care facilities**

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At a glance: summary of international learning on COVID-19

“As we enter the coming celebration season, we will need to combat fatigue by meeting the needs of citizens in new, innovative ways. By balancing science, social and political needs we can develop precautionary measures that are culturally accepted. Every sector and every citizen has a role to play...”

Dr Hans P. Kluge, WHO Regional Director for Europe

Pandemic fatigue and population adherence to COVID-19 measures

- ✚ A **“pandemic fatigue”** to COVID-19 measures, resulting in a demotivation to engage in protective behaviours and to seek information, has been growing across the world
- ✚ A **complex interplay of factors** affects COVID-19 protective behaviours and fatigue, influenced by **cultural, social, economic, structural and legislative context**
- ✚ **Common individual-level barriers** to population adherence include distrust towards the government; and feelings of stress and loneliness during isolation
- ✚ **Factors with impact on adherence** to COVID-19 measures include: age, gender, education, social norms and attitudes, life circumstances, literacy and access to the internet, faith and religious practices, fear of stigma, and politics
- ✚ **Mitigating pandemic fatigue and increasing population adherence** requires **multifactorial action across all levels** of society
- ✚ Strategies to reinvigorate public support must be informed by **societal, cultural, economic and public health** considerations, and must ensure that **no one is left behind**
- ✚ **Key strategies to increasing population adherence** include:
 - 1) Understand people to develop tailored and effective policies, interventions and communication, informed by evidence
 - 2) Engage people as part of the solution, involve communities and individuals
 - 3) Allow people to live their lives, but reduce risk
 - 4) Acknowledge and address the hardship people experience, and the profound impact the pandemic has had on their lives

More information is summarised on **pp. 5-8**

COVID-19 vaccine hesitancy and distribution

- ✚ **Vaccine hesitancy** is a barrier to vaccine uptake and is posing a threat to tackle the COVID-19 pandemic effectively
- ✚ **Multiple underlying factors** play a role in COVID-19 vaccine hesitancy, including: speed of the vaccine development; concerns of side-effects; social norms; costs in terms of time and effort; trust in the health system, government, and decision making bodies
- ✚ A global survey across 19 countries found that **nearly 72% of respondents would be likely to take a vaccine** if it becomes generally available, and proven safe and effective
- ✚ **Higher acceptance rates** are found among older people, women and those with higher levels of education
- ✚ **Addressing vaccination hesitancy** requires:
 - ✓ Understanding the drivers of immunization uptake
 - ✓ Improving and sustaining uptake
 - ✓ Monitoring and evaluation of interventions

- ✚ Many countries have developed **COVID-19 vaccine deployment and prioritisation** plans, focusing predominantly on:
 - ✓ Older people (varying from 60+ to 80+)
 - ✓ Health and social care workers
 - ✓ Adults with comorbidities
 - ✚ European Member States and five other countries have pre-ordered approximately half of the vaccine manufacturing capacity; while **low- and middle-income countries are left with short-term supplies**
 - ✚ Investing in **fair structures, mechanisms and migrant-aware policies** can ensure that vulnerable population groups are not left behind in the COVID-19 vaccination process
- More information is summarised on pp. 9-12*

Comparing COVID-19 cumulative rates

- ✚ **COVID-19 reporting** of incidence (cases) and mortality (deaths) **across countries vary substantially**
- ✚ Country comparisons are difficult and **must always consider population, contextual and methodological factors**
- ✚ Many **factors influence the surveillance and reporting of COVID-19**, including:
 - ✓ How advanced the spread of the disease is
 - ✓ Testing capacities and strategies
 - ✓ Demographic, economic, social and environmental factors, and dynamics
 - ✓ Health and risk profile of the exposed population and patients, and dynamics
 - ✓ Preparedness, availability and quality of the health and social care system
 - ✓ Public health and policy approaches; and methodological issues

More information is summarised on pp. 13-15

Measures to prevent COVID-19 in long-term care facilities (LTCF)

- ✚ Residents in LTCF are at a **higher risk of COVID-19 infection and death**
- ✚ LTCF have been **severely affected by COVID-19 across Europe**, with deaths among residents accounting for 37–66% of all COVID-19-related deaths
- ✚ LTCF have become a **blind spot for priority testing, tracing and monitoring** of COVID-19 in many countries, and mortality rate for care home residents is unavailable
- ✚ **Key measures to prevent COVID-19** transmission in LTCF include: regular and systematic monitoring, testing, isolation, meticulous infection, prevention and control measures, limiting visitors, wearing appropriate PPE, education and training of staff

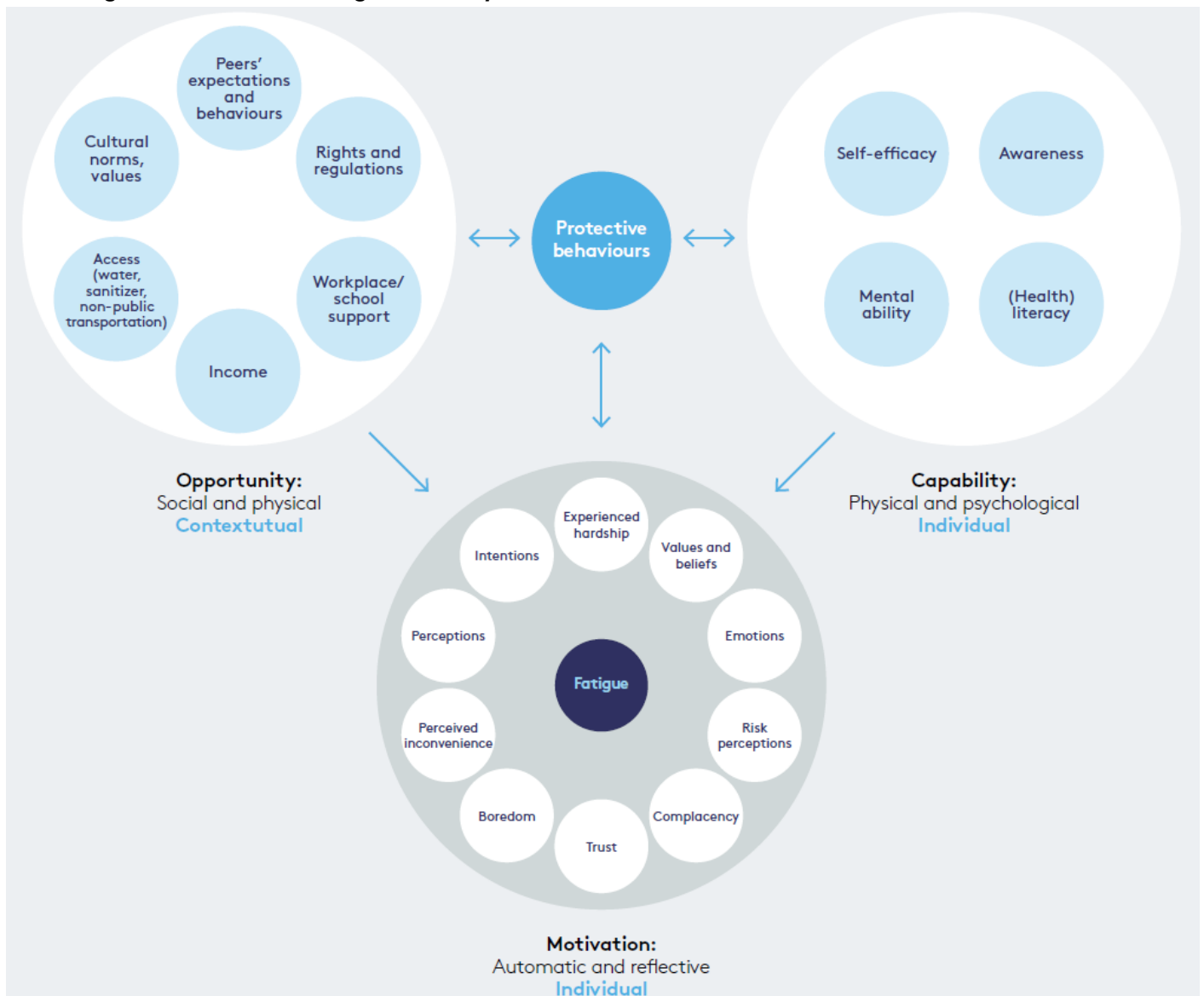
More information is summarised on pp. 16-17

Pandemic fatigue and population adherence to COVID-19 measures

Overview

- Globally, many countries are experiencing a **“second wave”** of COVID-19, responding with a **re-introduction of mass restrictions and public health measures**¹
- Countries across the world are experiencing an increase in **“pandemic fatigue”** or **“response fatigue”** to COVID-19 and related measures²
- **Pandemic fatigue** as a natural expected reaction to sustained and unresolved adversity in people’s lives, resulting in a demotivation to engage in protective behaviours and to seek information, as well as in feelings of complacency, alienation and hopelessness. It evolves gradually over time, affected by cultural, social, structural and legislative context³
- A complex interplay of factors is affecting COVID-19 protective behaviours and fatigue² (Figure 1)

Figure 1. Factors affecting COVID-19 protective behaviours



¹ <https://www.hopkinsmedicine.org/health/conditions-and-diseases/coronavirus/first-and-second-waves-of-coronavirus>

² <https://apps.who.int/iris/bitstream/handle/10665/335820/WHO-EURO-2020-1160-40906-55390-eng.pdf>

³ <https://www.euro.who.int/en/health-topics/health-determinants/behavioural-and-cultural-insights-for-health/news2/news/2020/10/how-to-counter-pandemic-fatigue-and-refresh-public-commitment-to-covid-19-prevention-measures>

Population adherence to COVID-19 measures across countries

Europe and North America⁴

- The most frequently reported individual-level barriers to population adherence include:
 - 1) Distrust towards the government, and
 - 2) Feelings of stress and loneliness during isolation
- Women and older individuals (over 45 years old) are more likely to avoid socialising in person and maintain social distancing than men and younger individuals (18–24 years old)
- Completing a bachelor degree or higher, pro-social attitudes, and motivation for social distancing, have been associated with adherence to working remotely

Eastern Mediterranean, Middle East and North Africa (MENA)⁵

- Reports from across the region describe densely packed public transport, and non-adherence to distancing measures in public spaces, businesses, shops, markets, streets and workplaces
- Social and gender norms and attitudes, faith and religious practices, trust, the threat of stigma, and politics, can affect the level of compliance with physical distancing measures
- The overuse of fear can result in inaction or poor compliance
- Religious institutions have shown flexibility and adaptability in interpreting scriptures in a way that is corresponding to public health requirements
- Women are more likely to wear a face covering in public for religious reasons; whereas men are more likely to wear a face covering for hygienic reasons
- In Egypt, 75% of surveyed people believed that wearing a mask would protect them from infection, but only 35% stated they would be willing to wear one

Considerations for low- and middle-income countries⁶

- Low literacy and limited access to the internet combine to form a structural barrier to information access, including changing guidelines about health behaviours
- Living within close proximity, in informal settlements (such as in South Africa, Nigeria, India) and refugee camps, makes social distancing and isolation difficult

Mitigating pandemic fatigue and increasing population adherence^{7,8}

- Finding effective ways to tackle pandemic fatigue, and reinvigorate public vigilance and adherence to measures, is a growing challenge
- Given the complex nature of pandemic fatigue, a multifactorial action plan is needed, based on the barriers and drivers experienced by people
- Action must be implemented in an integrated way across all levels of society; and must appeal to the public, rather than allocate blame
- Strategies to maintain and reinvigorate public support must be informed by public health, societal, cultural and economic considerations, and must ensure that no one is left behind
- The World Health Organization (WHO) Regional Office for Europe has developed a framework of policy recommendations to support COVID-19 prevention and management

⁴ <https://pubmed.ncbi.nlm.nih.gov/33027281/>

⁵ <https://www.ids.ac.uk/publications/rccce-strategies-to-overcome-covid-19-response-fatigue-in-the-eastern-mediterranean-middle-east-and-north-africa/>

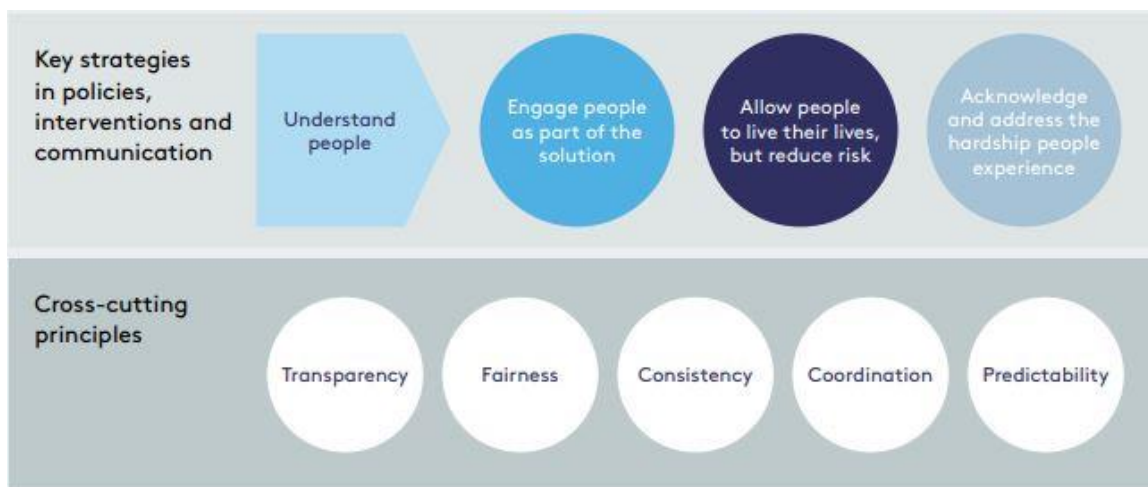
⁶ <https://pubmed.ncbi.nlm.nih.gov/32524893/>

⁷ <https://apps.who.int/iris/bitstream/handle/10665/335820/WHO-EURO-2020-1160-40906-55390-eng.pdf>

⁸ <https://www.who.int/news-room/feature-stories/detail/who-europe-discusses-how-to-deal-with-pandemic-fatigue>

- The WHO framework includes **four key strategies** (Figure 2):
 - 1) **Understand people**: collect and use evidence for targeted, tailored and effective policies, interventions and communication
 - 2) **Engage people as part of the solution**: involve communities and individuals in a meaningful way at every level
 - 3) **Allow people to live their lives, but reduce risk**: wide-ranging restrictions may not be feasible for everyone in the long run
 - 4) **Acknowledge and address the hardship people experience**, and the **profound impact** the pandemic has had on their lives

Figure 2. Strategies to overcome pandemic fatigue



Country insights

Examples of mitigation measures to tackle pandemic fatigue are shown in *Table 1*.

United Kingdom (UK)

- Lower adherence to guidance and rules appears to be related to life circumstances (e.g. socio-economic disadvantage), rather than to motivation⁹
- A recent social study suggests¹⁰ (Figure 3):
 - ✓ Compliance levels have improved slightly, compared to those at the end of August
 - ✓ The percentage of people who followed guidelines completely (“complete” compliance) is 21% higher; and to a large extent (“majority” compliance) - 5% higher
 - ✓ Compliance levels vary between age groups with lowest levels for 18-29 years old
 - ✓ Compliance levels appear **lower** in higher income households, in England, in urban areas, amongst women, amongst people with a physical health condition, and amongst adults living with children (compared to sole adult households)

Turkey¹¹

- Survey findings show that ‘non-fatigued’ participants:
 - ✓ Have more positive attitudes, trusting that COVID-19 will finally be controlled, satisfaction with preventive measures, and reporting suspected cases with symptoms

⁹ <https://www.medrxiv.org/content/10.1101/2020.04.01.20050039v1.full.pdf+html>

¹⁰ https://b6bdc03-332c-4ff9-8b9d-28f9c957493a.filesusr.com/ugd/3d9db5_10010a26414a4f6eafeea8b24fd89936.pdf

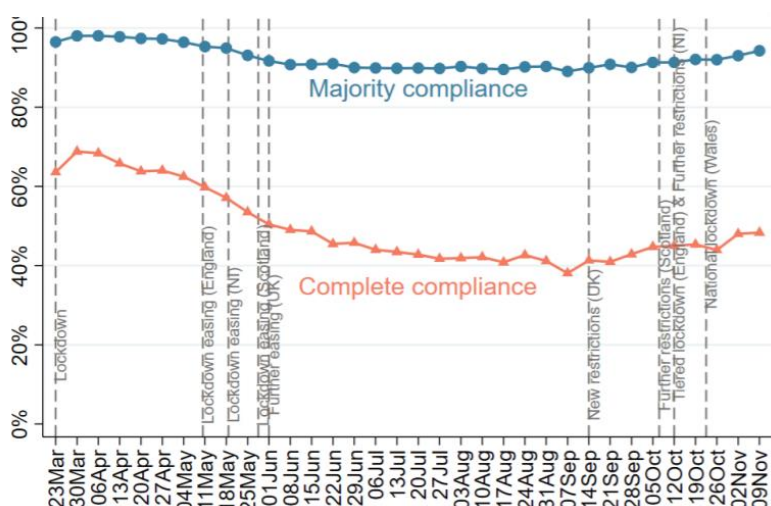
¹¹ https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7355205/pdf/10.1177_0020764020941889.pdf

- ✓ Have better practices for wearing face masks, gloves, washing hands, obeying guidelines and keeping physical distance
- Levels of education and occupational status are significant predictors of fatigue

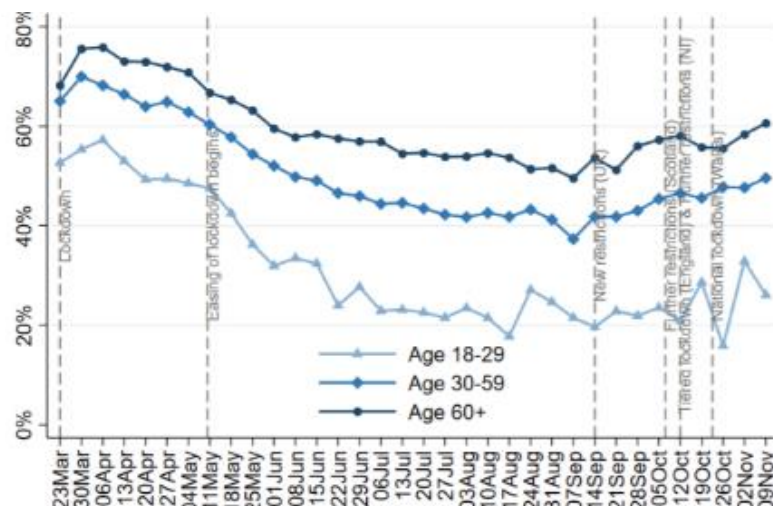
Table 1. Pandemic fatigue mitigation measures across countries

Country/Region	Examples of mitigation measures
France	<ul style="list-style-type: none"> - Ministry of Health researchers documented personal experiences over 16 weeks with 60 participants to provide insight to inform policy - Measures include a free national telephone hotline; and information and referral lines for those experiencing psychological distress
Germany	<ul style="list-style-type: none"> - The Federal Government has engaged philosophers, historians, theologians, health, and behavioural and social scientists, discussing restrictions to balance ethical, cultural and behavioural aspects, while safeguarding public health
The Netherlands	<ul style="list-style-type: none"> - Supporting people to balance high-risk and low-risk activities, rather than issuing all-or-nothing recommendations
Norway	<ul style="list-style-type: none"> - Decision-making processes have been as transparent as possible, recognizing that people are experts of their own environment, enabling local decision-making, ownership and autonomy - Kindergartens took a flexible approach when implementing national strategies to re-open safely
Denmark	<ul style="list-style-type: none"> - The Danish Lung Association created a campaign targeting young people, gathering their ideas how to spend time together in a safe way during the pandemic
Romania	<ul style="list-style-type: none"> - Government used behavioural insights survey to inform a strategy to reopen schools
Latvia	<ul style="list-style-type: none"> - Strategy of openness and honesty (about the unknowns) has been a fundamental political principle, demonstrating transparency - essential to building and maintaining trust among the public and adherence to government guidelines
Ukraine	<ul style="list-style-type: none"> - Behavioural insight surveys used to tailor health messages to target groups to prevent fatigue
Israel	<ul style="list-style-type: none"> - Different ways to support businesses has been a critical element to tackle pandemic fatigue - Local businesses opened a 'floating cinema' to encourage safe social interactions
Turkey	<ul style="list-style-type: none"> - The WHO office in Turkey used social media to engage the public via low-cost activities to help them think about their behaviour and to remind them of the on-going pandemic
West Africa	<ul style="list-style-type: none"> - Community leaders often have a high level of trust and a good understanding of the community norms and values, which can be of great value to decision-makers in policy formulation

Figure 3. Compliance with guidelines in the UK¹² during the pandemic
Overall ("majority" & "complete")



"Complete" compliance by age group



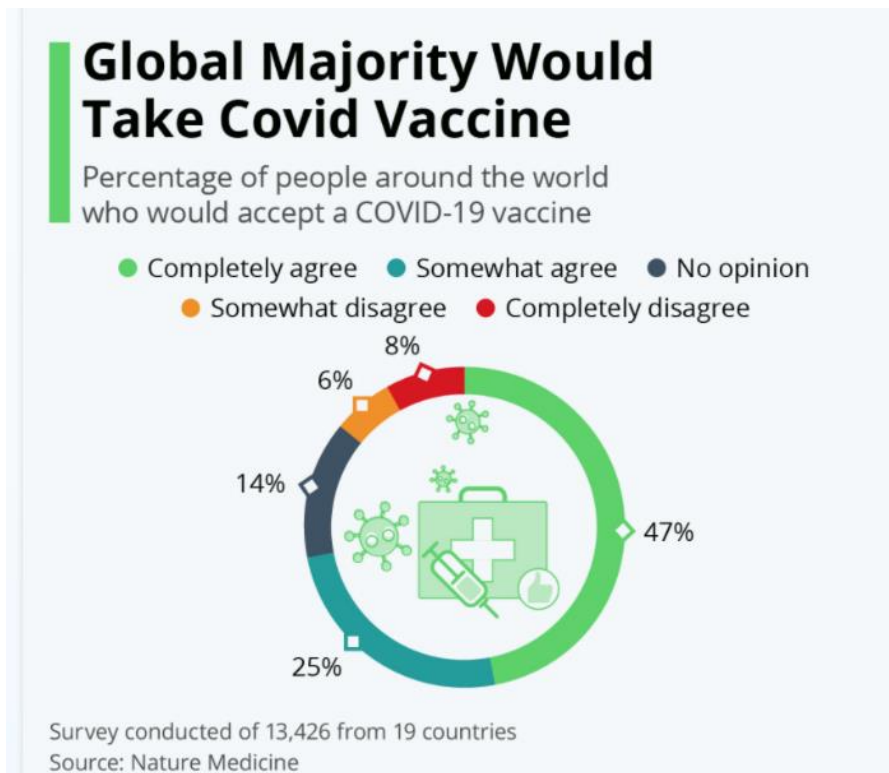
¹² https://b6bdc03-332c-4ff9-8b9d-28f9c957493a.filesusr.com/ugd/3d9db5_10010a26414a4f6eafeea8b24fd89936.pdf

COVID-19 vaccine hesitancy and distribution

COVID-19 vaccine hesitancy and uptake¹³¹⁴

- **Vaccine hesitancy** is a barrier to vaccine uptake and is posing a **threat to tackle the pandemic effectively**
- **Multiple underlying factors** play a role in COVID-19 vaccine hesitancy, including:
 - ✓ speed of the vaccine development (prominent)
 - ✓ concerns of side-effects of the vaccine, including perceived risk of developing disease and long-term effects (prominent)
 - ✓ social norms
 - ✓ costs in terms of time and effort
 - ✓ trust in the health system, government, and decision making bodies
- A **global survey** across 19 countries (13,426 people) reports (Figure 4)¹⁵:
 - ✓ **Nearly 72% of respondents** would be very or somewhat likely **to take a vaccine** if it becomes generally available, and proven safe and effective
 - ✓ **14% of respondents** would be very or somewhat likely to **not take a vaccine**
 - ✓ **Higher acceptance rates** among **older people, women** and those with **higher levels of education**
 - ✓ Highest rate of acceptance reported in China (90%)
 - ✓ Lowest rate of acceptance reported in Russia (55%)
 - ✓ Acceptance rates highest in China, South Korea, Singapore, Brazil, India and South Africa with respondents having the strongest tendency to trust in a potential vaccine

Figure 4. Percentage of people who would accept a COVID-19 vaccine¹⁶



¹³ <https://blogs.worldbank.org/developmenttalk/covid-19-can-behavior-insights-address-vaccine-hesitancy-and-increase-take>

¹⁴ <https://www.oecd-forum.org/posts/uniquely-uncertain-the-impact-of-covid-19-on-vaccine-hesitancy>

¹⁵ <https://www.nature.com/articles/s41591-020-1124-9>

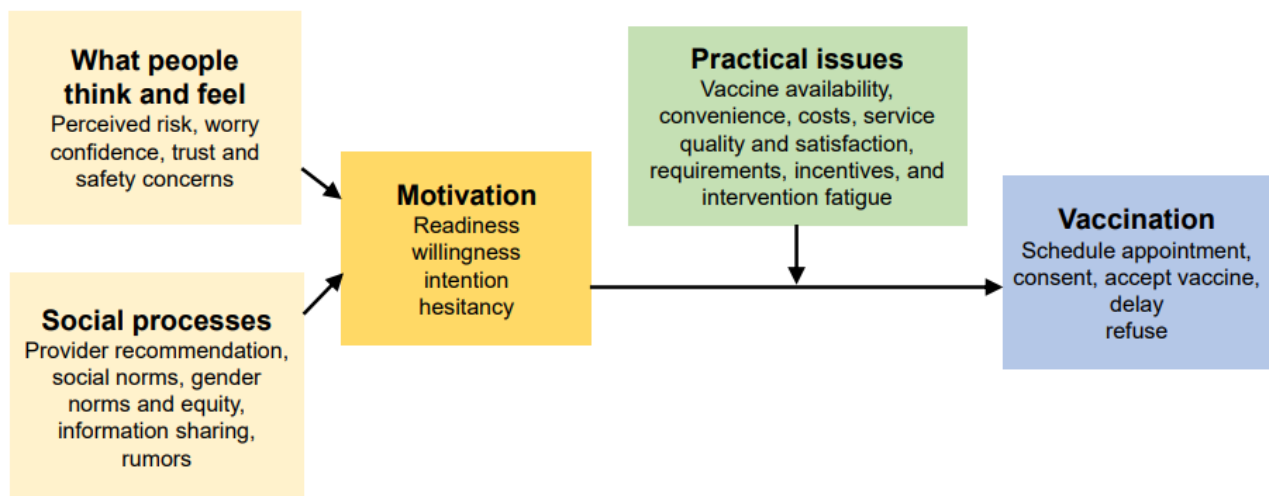
¹⁶ <https://www.statista.com/chart/23306/global-acceptance-for-covid-vaccine/>

Improving vaccination demand and addressing hesitancy¹⁷

“Increasing Vaccination Model” to address vaccination hesitancy requires (Figure 5):

- 1) **Understanding the drivers** of immunization uptake
- 2) **Improving and sustaining uptake**, including:
 - ✓ Tailoring Immunization Programmes
 - ✓ Addressing missed opportunities for vaccination
 - ✓ Addressing hesitancy
 - ✓ Supporting health workers;
 - ✓ Engaging with communities
- 3) **Monitoring and evaluating** interventions

Figure 5. Increasing Vaccination Model¹⁸



COVID-19 vaccine plans and prioritisation in Europe¹⁹

- All European Union and European Economic Area (EU/EEA) countries and the UK have developed vaccine deployment plans
- Nine countries have published interim recommendations for prioritisation (Table 2)
- Main priority groups across most EU/EEA countries and the UK include:
 - ✓ Older people (varying from 60+ to 80+)
 - ✓ Health and social care workers
 - ✓ Adults with comorbidities

COVID-19 vaccine distribution across countries²⁰

- **COVAX** is the vaccines pillar of the **Access to COVID-19 Tools (ACT) Accelerator**²¹
 - ✓ The ACT Accelerator is a global collaboration to accelerate the development, production, and equitable access to COVID-19 tests, treatments, and vaccines
 - ✓ COVAX is a joint fund, co-led by Gavi, the Coalition for Epidemic Preparedness Innovations (CEPI) and WHO, aiming to accelerate the development and manufacture of COVID-19 vaccines, and to guarantee fair and equitable access for every country in the world²²

¹⁷ http://awareness.who.int/immunization/programmes_systems/vaccine_hesitancy/en/

¹⁸ https://www.who.int/immunization/programmes_systems/Increasing_Vaccination_Model-WHO.PDF?ua=1

¹⁹ https://www.ecdc.europa.eu/sites/default/files/documents/Overview-of-EU_EEA-UK-vaccination-deployment-plans.pdf

²⁰ <https://www.npr.org/sections/goatsandsoda/2020/12/03/942303736/how-rich-countries-are-hoarding-the-worlds-vaccines-in-charts>

²¹ <https://www.who.int/initiatives/act-accelerator>

²² <https://www.gavi.org/covax-facility>

- **EU Member States and five other countries**, accounting for an estimated 13% of the global population, have pre-ordered approximately half of the vaccine manufacturing capacity (*Figure 6*)
- Canada has ordered the highest amount of COVID-19 vaccines per person²³
- **Low- and middle-income countries** are left with short-term supplies and would rely mostly on contributions from COVAX
- Some countries have started making agreements with pharmaceutical companies to purchase experimental COVID-19 vaccines, even before clinical trials have finished
- Evidence shows the **vulnerabilities of migrants, refugees and asylum seekers** have exacerbated during the COVID-19 pandemic and suggests that COVAX should explicitly include asylum seekers and refugees in their **'at risk populations'**²⁴
- Investment in fair structures, mechanisms and migrant-aware policies can ensure that vulnerable population groups are not left behind in the COVID-19 vaccination process

Table 2. Priority groups for COVID-19 vaccination - interim recommendations in nine countries, as of 30th November 2020²⁵

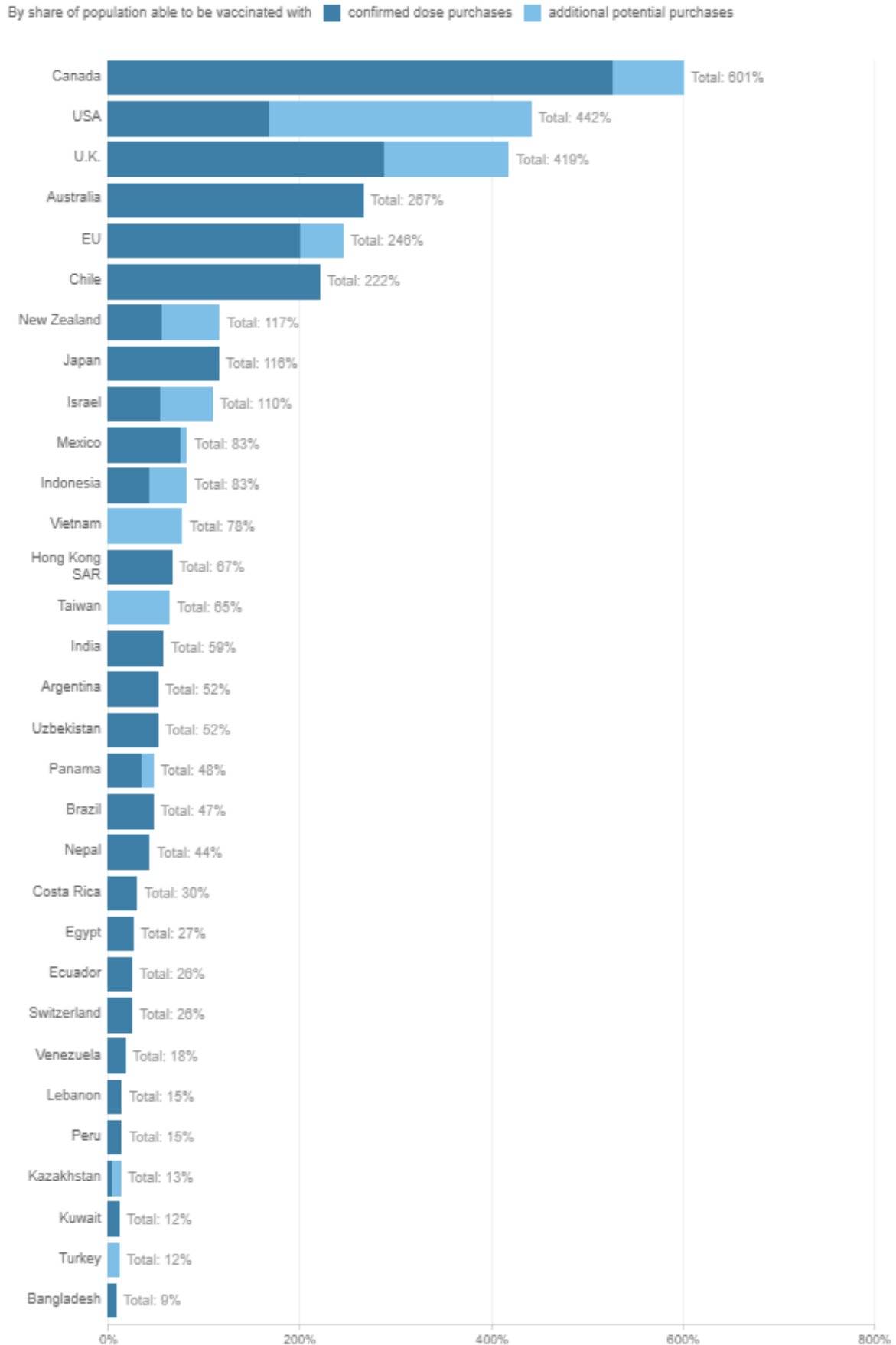
Country	Priority groups
Austria (As of November 2020)	<ul style="list-style-type: none"> - People 65+ living in long-term care facilities - Adults with comorbidities - Healthcare workers
Belgium (As of July 2020)	<ul style="list-style-type: none"> - Healthcare workers - People 65+ - People aged 45-65 with comorbidities
France (As of November 2020)	Those in in long-term care facilities, including residents and healthcare workers
Spain	A staged approach: <ul style="list-style-type: none"> - Stage 1. Residents and health and social care personnel in care homes for the elderly and the disabled - Stage 2. Front-line health personnel - Stage 3. Other health and social health personnel - Stage 4. Dependent people with disabilities who require intensive support measures
Sweden	<ul style="list-style-type: none"> - People 70+ - Healthcare workers - Risk groups for severe COVID-19 disease
The Netherlands	<ul style="list-style-type: none"> - People 60+ - Adults with co-morbidities - Healthcare workers
Luxembourg	<ul style="list-style-type: none"> - People 65+ - Vulnerable individuals, according to national definition for COVID-19 vulnerability
Czech Republic (As of September 2020)	<ul style="list-style-type: none"> - Chronically ill people - People 65+ - Healthcare workers, public health staff, and social workers
UK	<ul style="list-style-type: none"> - Those aged 80+ - Adults with co-morbidities over 65 years - Healthcare and social care workers

²³ <https://www.nature.com/articles/d41586-020-03370-6>

²⁴ <https://gh.bmi.com/content/bmigh/5/11/e004085.full.pdf>

²⁵ <https://www.npr.org/sections/qaatsandsoda/2020/12/03/942303736/how-rich-countries-are-hoarding-the-worlds-vaccines-in-charts>

Figure 6. Percentage of confirmed COVID-19 dose purchases across countries²⁶



²⁶ <https://www.npr.org/sections/goatsandsoda/2020/12/03/942303736/how-rich-countries-are-hoarding-the-worlds-vaccines-in-charts>

Comparing COVID-19 cumulative rates

This section focuses on the complexity of reporting and comparing COVID-19 cumulative incidence (new cases) and mortality (death) rates. Additional information is available in *International Horizon Scanning reports* [5](#) and [15](#).

Factors influencing reporting of COVID-19 incidence and mortality²⁷

- COVID-19 **data reporting across countries vary** substantially
- **Country comparisons should be done with caution**, always considering population, contextual and methodological factors
- Many **factors can interplay and influence** the surveillance and reporting of COVID-19, including but not be limited to:
 - ✓ How advanced the spread of the disease is
 - ✓ Testing capacities and strategies
 - ✓ Demographic, economic, social and environmental factors and dynamics
 - ✓ Health and risk profile of exposed population and patients
 - ✓ Dynamic changes in the exposed population, for example age profile
 - ✓ Preparedness, availability and quality of the health and social care system, including continuous learning, evolving treatments, and hospital capacity
 - ✓ Public health and policy approaches
 - ✓ Methodological issues, such as case and death definitions

Comparing mortality rates^{28,29,30}

- **WHO has recommended a definition** for COVID-19 deaths reporting:

“A COVID-19 death is defined for surveillance purposes as a death resulting from a clinically compatible illness in a probable or confirmed COVID-19 case, unless there is a clear alternative cause of death that cannot be related to COVID disease (e.g., trauma). There should be no period of complete recovery between the illness and death.”
- There is **no common standardised method for attributing and recording deaths** associated with COVID-19
- There is **no international consensus on methods for reporting daily death figures**
- Countries can include different settings in the COVID-19 deaths statistics, such as **hospitals, care/nursing homes and the wider community**
- Mortality reporting is particularly challenging, as clinicians need to determine if **COVID-19 is a contributing or an underlying cause of death**; and countries differ in the way they issue death certificates
- Further investigation into the death of individuals pose **additional risk for staff**, as deceased patients are still infectious
- A **UK four nations agreement** has proposed two new measures to standardise reporting:
 - 1) The number of deaths in people with COVID-19 that occur within 28 days of a first positive laboratory-confirmed test
 - 2) The number of deaths that occur within 60 days of a first positive test

²⁷ https://ihcc.publichealthnetwork.cymru/files/6216/0086/0976/PHW_COVID19_IntHorizonScan_Report_15_22Sept2020.pdf

²⁸ <https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200411-sitrep-82-covid-19.pdf>

²⁹ <https://publichealthmatters.blog.gov.uk/2020/08/12/behind-the-headlines-counting-covid-19-deaths/>

³⁰ https://ihcc.publichealthnetwork.cymru/files/3415/9007/6301/PHW_COVID19_IntHorizonScan_Report_5_21May2020.pdf

Reporting COVID-19 cases, deaths and testing across selected countries

- The five selected countries were among the first to report COVID-19 cases
- Death rates vary relatively less (between 752 and 955 per 1,000,000), while incidence rates vary relatively more (between 2,365 and 4,843 per 100,000) (*Figure 7*)
- Testing rates vary considerably with testing capacity generally increasing over the course of the pandemic (*Figure 8*)
- The UK testing rate is considerably higher than in other countries
- More extensive testing inevitably leads to the identification of more cases

Figure 7. Cumulative COVID-19 incidence rate (per 100,000) and death rate (per 1,000,000), selected European countries, 3 January to 29 November 2020³¹

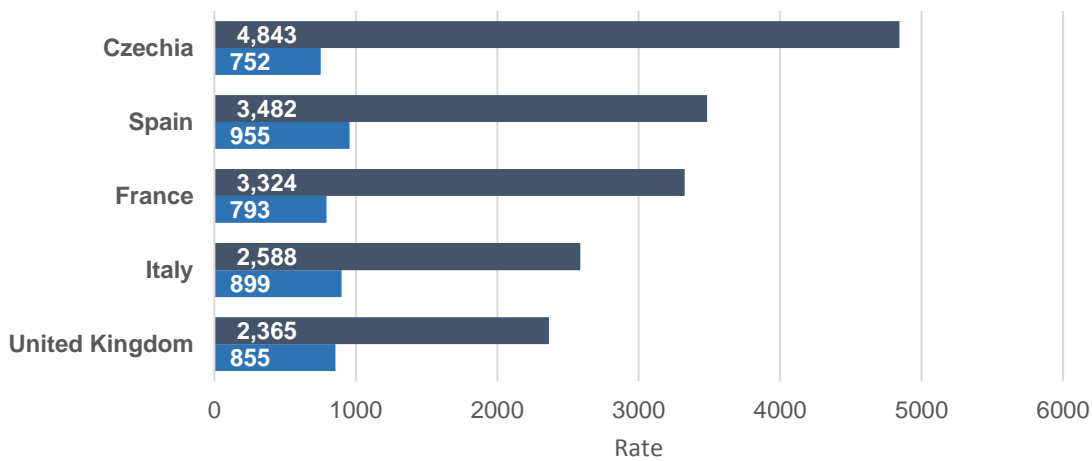
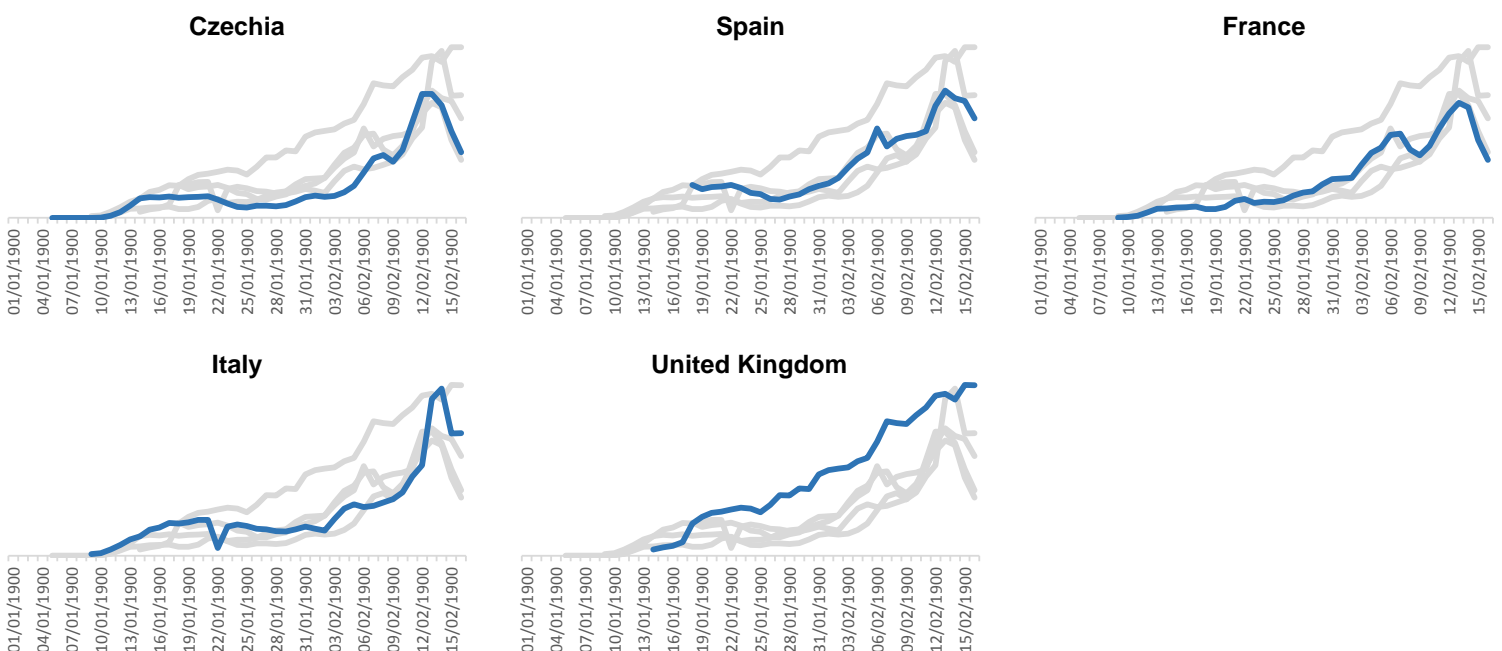


Figure 8. COVID-19 testing rate per 100,000 population, selected European countries, 2020³²



³¹ <https://covid19.who.int/>

³² <https://www.ecdc.europa.eu/en/publications-data/covid-19-testing>

Population health profile and risk of dying from COVID-19³³

- Becoming seriously ill from COVID-19 increases the risk of dying
- COVID-19 can make anyone seriously ill, but the risk is higher for some, depending on their **age and health**, including having **underlying conditions and/or risk behaviours**
- **Population demographics and health profile** (e.g. proportion of people classified at high or moderate risk) varies between countries, which, in turn, **influences COVID-19 outcomes**, including serious illness and deaths
- The differences in health profile / risk factors for becoming seriously ill (and dying) from COVID-19 are highlighted in the five selected countries (highlighted in red):
 - ✓ The prevalence of diabetes (type 1 & 2) is highest in Spain (7.2%); and lowest in the UK (4.2%) (*Figure 9*)
 - ✓ Cancer incidence, which, in this case is being used as a proxy for cancer treatments (such as chemotherapy, antibody treatment, immunotherapy) is highest in France (630 per 100,000 population); and lowest in Spain (515 per 100,000 population) (*Figure 10*)

Figure 9. Age-standardised prevalence of the population aged 18-99 with Type 1 or Type 2 diagnosed diabetes, 2017³⁴

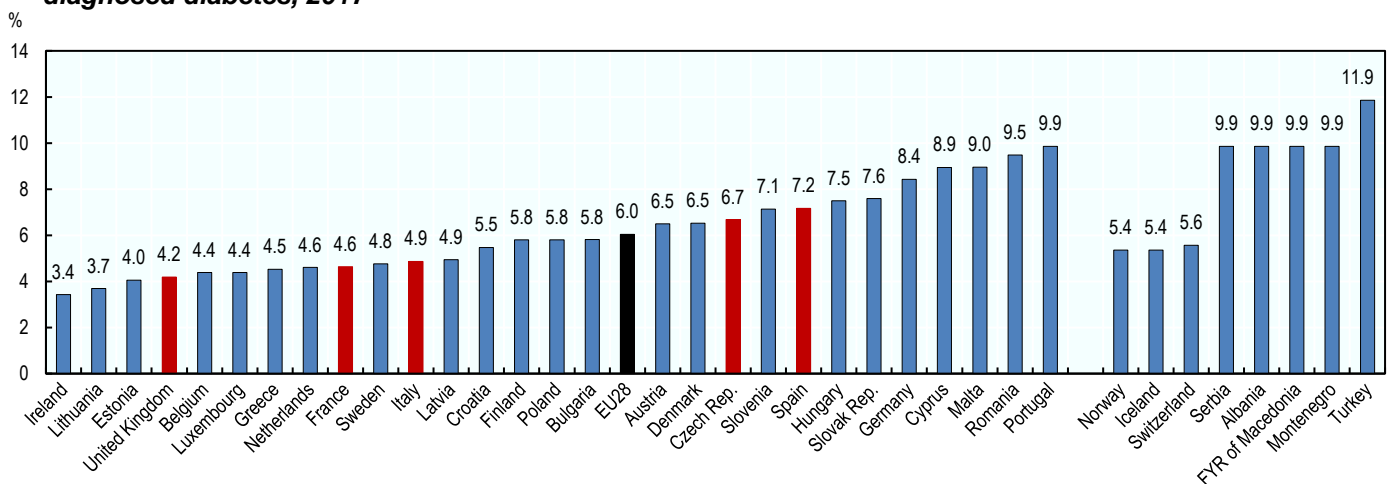
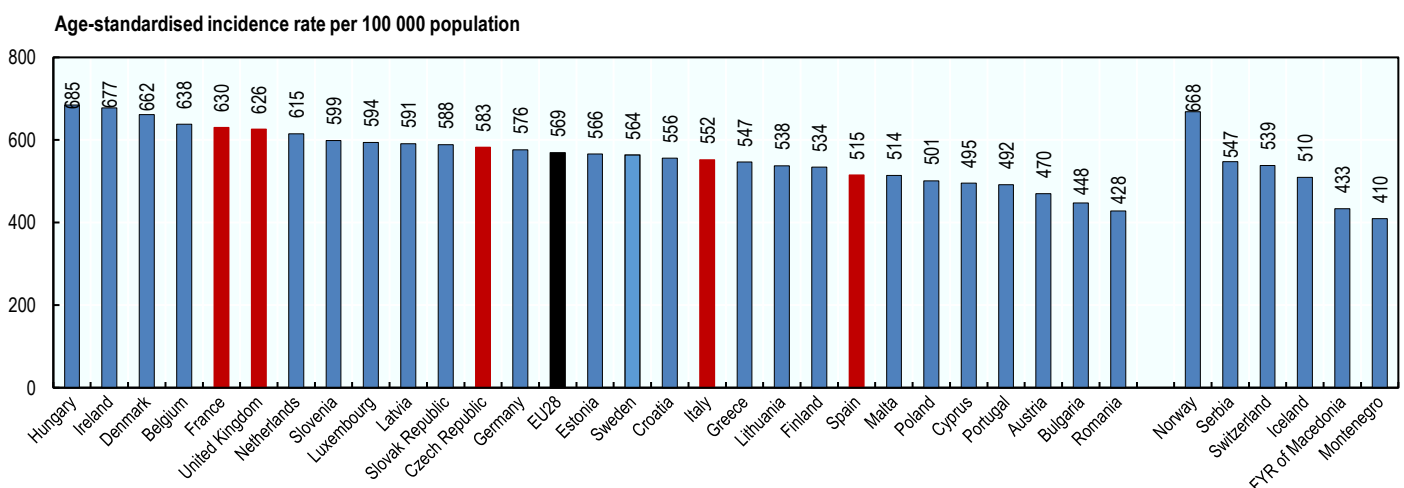


Figure 10. Age-standardised incidence rate for all cancers, as a proxy for cancer treatments, 2018⁶



³³ <https://www.nhs.uk/conditions/coronavirus-covid-19/people-at-higher-risk/whos-at-higher-risk-from-coronavirus/>
³⁴ https://ec.europa.eu/health/sites/health/files/state/docs/2018_healthatglance_rep_en.pdf

Measures to prevent COVID-19 in long-term care facilities

Overview³⁵³⁶³⁷

- Residents in long-term care facilities (LTCF)* are at a higher risk of COVID-19 infection and death, as they often belong to older age groups
- LTCF have been severely affected by COVID-19 across the EU/EEA countries, with deaths among residents accounting for 37–66% of all COVID-19-related deaths
- LTCF have become a blind spot for priority testing, tracing and monitoring of COVID-19 in many countries, and mortality rate for care home residents is unavailable
- International comparisons are difficult due to variation in testing capacities, public health approaches, and differing definitions of what constitutes a “care home”

Measures to prevent COVID-19 transmission in LTCF³⁸³⁹⁴⁰⁴¹⁴²⁴³⁴⁴

- Daily screening and systematic monitoring for COVID-19 symptoms in residents / staff
- Wearing appropriate Personal Protective Equipment (PPE), hand hygiene and social distancing where possible
- Meticulous infection, prevention and control (IPC) measures
- Isolate possible/confirmed COVID-19 cases for 14 days or until they have two negative tests (taken 24 hours apart) after the resident’s symptoms have resolved
- Regular testing of all staff - weekly or bi-weekly in areas with high community transmission
- Comprehensive testing of all residents and staff is recommended, including testing of those without symptoms, when a first case is confirmed in a resident or staff member
- Systematic testing of new and returning residents, between 24 and 72 hours before admission, and daily monitoring for COVID-19 symptoms
- New residents and those leaving the LTCF need to be isolated for 14 days
- Limiting the number of visitors, with due consideration that the isolation of residents may have a negative effect on their mental wellbeing and physical health status
- Pre-screening of all visitors
- Maintaining a registry with the contact details of all professionals and visitors to facilitate testing and contact tracing
- Administrative records updated daily
- Renovation of ventilation systems to prevent re-circulating of air into the wards
- Staff training and education identified as a strong factor in preventing transmission⁴⁵⁴⁶⁴⁷
- Testing strategies need to distinguish between “affected local areas” and “unaffected local areas”

³⁵ <https://tccovid.org/wp-content/uploads/2020/10/Mortality-associated-with-COVID-among-people-living-in-care-homes-14-October-2020-3.pdf>

*Long-term care facilities may vary by country. Nursing homes, skilled nursing facilities, assisted living facilities, residential facilities and residential long-term care facilities are collectively known as long-term care facilities

³⁶ <https://pubmed.ncbi.nlm.nih.gov/32524949/>

³⁷ https://www.who.int/publications/i/item/WHO-2019-nCoV-Policy_Brief-Long-term_Care-2020.1

³⁸ <https://link.springer.com/article/10.1007/s41999-020-00405-z>

³⁹ https://apps.who.int/iris/bitstream/handle/10665/331508/WHO-2019-nCoV-IPC_long_term_care-2020.1-eng.pdf

⁴⁰ https://www.ecdc.europa.eu/sites/default/files/documents/TestingStrategy_Objective-Sept-2020.pdf

⁴¹ <https://www.ejgms.de/static/en/journals/dqkh/2020-15/dqkh000361.shtml>

⁴² <https://onlinelibrary.wiley.com/doi/pdfdirect/10.1111/jgs.16447>

⁴³ <https://onlinelibrary.wiley.com/doi/pdfdirect/10.1111/jgs.16447>

⁴⁴ <https://academic.oup.com/cid/advance-article/doi/10.1093/cid/ciaa1270/5898577>

⁴⁵ https://www.cdc.gov/mmwr/volumes/69/wr/mm6937a5.htm?s_cid=mm6937a5_w

⁴⁶ <https://onlinelibrary.wiley.com/doi/10.1111/jgs.16689>

⁴⁷ <https://pubmed.ncbi.nlm.nih.gov/32674817/>

National surveillance systems to monitor and manage infectious disease outbreaks in LTCF⁴⁸

- **Belgium** has set up a specific surveillance system to monitor COVID-19 in LTCF
- In **France**, a surveillance system for outbreaks of acute respiratory infections in LTCF has been in place for over 10 years. Its primary objective is to allow early optimal management by the Regional Health Agencies, as well as by the National Public Health Agency (Santé Publique France) to assess in real time the impact of epidemics (e.g. influenza) on older people
- In **Germany**, a local syndromic surveillance on a daily basis (residents and staff) in LTCFs has been recommended by the Robert Koch Institute
- In **Ireland**, a national surveillance system for monitoring all infectious disease outbreaks has been in place for over 15 years
- In **Norway**, there is mandatory reporting of all outbreaks in LTCFs to the National Institute of Public Health

⁴⁸ <https://www.ecdc.europa.eu/sites/default/files/documents/covid-19-long-term-care-facilities-surveillance-guidance.pdf>

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