



- **Adviesaanvraag**

Vraagsteller	Regeringscommissariaat Corona
Datum van adviesaanvraag	
Onderwerp	OCC 19/11/2021
Vraag	

- **Adviesverstrekking t.a.v. het Overlegcomité**

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### 1. Some epidemiologic 'landmark' facts

- National 14 d-incidence of cases/100,000 now
  - Belgium 1054
  - Flanders 1114 (Flanders has 30th highest incidence among 211 ECDC regions in Week 2021/44)
  - Wallonia 999 (35th in ECDC ranking)
  - Brussels 799 (56th in ECDC ranking)
  - Ostbelgien 1486
  - Provincial incidences between 743 (Hainaut) and 1363 (West-Vlaanderen)
- Hospital occupancy is now > 2000 beds
- ICU occupancy likely crossing 500 beds-line around November 15, 2021 and 600 one week later. It is not unlikely that 700 will be reached. Note that 500 used to be the red line under which it was considered safe to relax measures, hence it is logical to strengthen measures again when crossing it again.
- Short term predictions (Christel Faes): fast increase in ICU-beds, probably > 600-700 occupancy before the end of the month November

### 2. International benchmarking: see Annex 1

When compared within a group of 17 'EU-14+'-countries, Belgium ranks second highest in terms of daily hospitalizations per million inhabitants, (no data for Austria, Finland, Sweden), with only Greece doing worse, and considerably so.

In terms of daily deaths per million, Belgium ranks third highest, just before Austria. Only Greece has considerably worse performance in this regard.

### 3. General strategy to contain the situation, now and throughout winter

- 'Re'-implement a set of enforceable measures, in all sectors and layers of society (work, leisure, home, public transport, schools,...), with mitigation measures where applicable to make this feasible for everybody (see below)
- Which can be maintained throughout winter and adapted in function of the epidemiology
- Aim = allow going back to nationwide alarm level 1 or 2 (instead of current 4-5)
- Ambitious package as an investment for the next months in which all sectors should be involved and which should be clearly communicated by the authorities to strengthen adherence:
  - Aim to keep schools open on site throughout winter
  - Ensure continuity of activities in enterprises
  - Temporarily suspend the most high risk activities (= where masks/distance cannot be kept e.g. nightlife), in order to protect the more basic societal activities (e.g. schools)
- Authorities have to issue clear lines/rules (what's allowed (and not) /'what must or should be done')
- Clear communication on the strategy to promote motivation for and adherence to individual risk reduction behaviours as well as enforcement are essential for long lasting improvement of the situation. Motivating communication with clear targets should be systematically supported by visuals. A more specific set of recommendations for motivating communication is provided in Annex 2.

### 4. Basic package:

- Strive to maximise the vaccination coverage among the general population (1st, second and third doses for all eligible persons). Speeding up the application of a third dose to all 65+ and vulnerable persons implies the need to guarantee sufficient capacity in vaccination centres, which is actually jeopardized due to end of application of the 'Noodwet'



- Mask wearing from age 9 onwards for indoor and in very crowded outdoor activities (=people within personal distance zone defined as the **area 0.5 to 1.5 m**). For specific considerations regarding mask wearing in children see below.
- Distance 1.5 m at all times, avoid hugging & kissing of people not belonging to your household
- Adequate ventilation in workplaces, schools, horeca and all other places where large numbers of people come together should be systematically monitored and controlled according to the recommendations of the Superior Health Council. This implies the assesment of CO2-levels as a proxy in all places where people convene (including all workplaces, classes, sports and leisure infrastructure) as well as effective action to reduce CO2-levels or interrupting activities where applicable.
- Reduce number of contacts in private and public activities, especially close unprotected contacts. Recommend the use of masks/distance/ventilation/preferential outdoor setting for contacts in private life.
- Everyone feeling ill should remain at home and get tested, respect quarantine and isolation. In addition, the use of self-tests to reduce risks in private gatherings should be further promoted (see below).
- Additional attention should be given to infection prevention measures in the physically fragile, immunosuppressed people, especially those who did not get yet the 3d dose and their households/the persons surrounding them need to have

#### 5. What it means for the workplace

- Telework should be made mandatory (exceptions for specific activities based on local and documented risk assessment may apply) until the Christmas holiday. This measure could also decrease pressure on public transport
- For those who are physically not in the possibility to telework:
  - masks/ventilation/distance 1.5 m should be guaranteed maximally at all workplaces
  - monitoring and adequate management of ventilation at the workplace through systematic assesment of CO2-levels.
  - employers should at all times allow their employees to respect quarantine and isolation rules. The GEMS would like to remind that there remain important inequalities to that respect, for those people who cannot work from home and whose absence is not financially compensated
  - extra preventive measures for lunch breaks (including ventilation, maximal occupancy and distance)
  - work related events: while it is highly recommended to postpone any work parties and receptions, these should only take place if they can be organised at a venue with standard protocol (CST+, ventilation, masks) in line with the current rules (see other advice) given the circumstances and number of attendants, until pressure on our health care system subsides.
  - even if at work, apply online meetings - if the use of meeting rooms cannot be avoided: distance, masks, ventilation
  - if presence is required at the workplace, split workforce in different groups that do not mix, thus avoiding that people come all to the office/workplace the same day
  - additional capacity in public transport is needed; medically vulnerable persons may need to wear FFP2-masks for additional protection (subject of RAG-discussion)
- Several high-incidence sectors are in the public rather than private sector. Government at all levels as employer (federal, regional, provincial, local) should take their responsibility and allow/stimulate telework again

#### 6. What it means for events/culture/sports



- Static activities (e.g. cinema, concert, theatre play): can continue with CST + masks/ventilation/distance.
- Activities where masks and/or distance and/or ventilation cannot be used or guaranteed:
  - indoor, publicly organized (e.g. nightlife, dancing events, indoor high contact sports, student leisure activities): suspend these activities on hold x 3-4 weeks, then try to resume with vaccination/recovery proof (= G2) + negative test (this requires sufficient test capacity, may need time to build up) + ventilation. Alternatively, the test could be a selftest for vaccinated/recovered persons or a PCR for unvaccinated persons.
  - indoor, private parties (e.g. weddings): allow, provided small scale (max 50 p) and CST + negative self test + maximal attention for ventilation. See recommendations for private life. This would require making selftests available at low financial thresholds through CPAS, youth centres, students centres etc...
- Outdoor, large scale (e.g. Kerstmarkt, carnival, audience at large sports events): CST + mask + distance (in very crowded circumstances). This will imply capacity reduction/occupancy monitoring, strict enforcement and additional attention when also eating and drinking;

Note: How to make the best use of CST?

Vaccination provides a personal protection against severe disease, the actual situation and scientific research shows us that it is less protective for acquiring infection and becoming contagious or mildly ill.

Better communication is needed to make sure that people do not perceive the CST as completely proof for all activities and that other preventive measures (e.g. masks) remain important.

In addition, in high risk activities, adding a negative test (= person is probably not contagious) to a vaccinated person (= protected against severe disease) is meaningful to reduce the risk for superspreading events. Obviously, it is essential that the overall test capacity is sufficient and affordable.

**7. What it means for horeca**

- only seated places
- masks worn by all staff
- masks worn by all customers except when seated/eating/drinking
- following the existing measures: ventilation, CST, mask for staff; should be followed meticulously + enforced.
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**8. What it means for the education system (including primary, secondary and higher education)**

- masks for all teachers and pupils from 9 y old i.e. from 4th primary onwards (see note below).
- availability of masks for children at school (for equity and hygienic reasons)
- CO2 meters in all classrooms and incorporate awareness and application of the existing ventilation guidelines as issued by the Superior Health Council in daily classes. This should include the introduction of systematic ventilation breaks (e.g; 10 minutes after each hour)
- reinstall Q for the (unvaccinated) HRC. Masks will turn many HRC into LRC, which is beneficial on all fronts
- explore alternative long term options for testing e.g. saliva testing 1-2 x/week
- avoid mixing different class group
- until Christmas suspend high risk activities which involve mixing generations and households (e.g. school dinners, parties,...)

Note on masks for children:

It is important to carefully weigh the arguments pro and contra:



- Mask wearing is unpleasant for children and makes it harder for children to correctly identify the expression of basic emotions (Roberson, 2012), yet the long term effects on children's emotional and social development, acquisition of language and learning are not well known and to be followed up closely (Freiberg et al., 2021). Also, the negative side effects of mask wearing may be more limited compared to more intrusive measures (e.g., closing indoor, extra-curricular activities). Yet, to avoid potential negative side effects on children's development, a number of mitigating measures need to be taken, such as:
  - investing in child-friendly communication such that children understand the added value and importance of this measure (e.g., through TV programs like Karrewiet), while highlighting that this measure is part of a broader package involving an effort from diverse sectors
  - allowing two morning breaks outside during which mouth mask wearing is not required
  - clarifying the conditional nature of the measure, implying that mask wearing can again be abandoned when predefined targets are reached (or when the 5-11 age group can be vaccinated)
  - considering exceptions for mask wearing among children with specific needs where applicable
  - make well-fitting, child-friendly masks easily available to avoid increases in inequalities among pupils.
- A recent Sciensano report 29/10 mentioned the evidence on the added value of masks in children < 12 y old to be unclear and makes the recommendation to be very careful with application of masks among children but this report does not include evidence with Delta.
- ECDC does not recommend the application of masks in ages < 12.

On the other hand:

- The actual epidemiological data show that there is a linear increase of infections among pupils attending primary schools. With the emergence of delta, the role of schools and children ages 6-11 y in the actual epidemic has evolved. Data from school infections in Flanders show that the incidence in primary school children is about 4 x the incidence of secondary schools and 2 x the national average incidence. The most recent RAG report confirms that the incidence is highest in 7-12 years old nationwide. In addition, keeping distance and adequate ventilation are challenging in the actual school system. Also, recent changes in testing/quarantine rules in primary schools have
- Masks from ages 6+ have been implemented in Italy, France, Spain as part of a package with other strong measures)
- CDC recommends universal masking from ages 2+
- WHO advice: in the absence of conclusive evidence on tangible benefits, mask wearing mandates for 8+ children fall under the precautionary principle, which should be observed in times of rapidly deteriorating epidemiology.
- Agentschap Zorg & Gezondheid and AVIQ recommend the use of masks for children < 12 y old can be applied if the setting or epidemiological situation require this.
- Wearing masks can help to reduce the number of HRC in schools, since these turn into LRC, which is beneficial on all fronts to avoid closure of classes and schools
- In his critical evaluation of the strategy adopted during 2020-2021, the Spanish association of paediatricians concluded that the measures implemented (included mask face >six, ventilation, hand hygiene, etc.) were followed by children and families in an exemplary way, the mask was remarkable well tolerated in particular by the youngest. Super contaminator events were extraordinarily rare. The percentage of infected children was about 0.5% during the entire period. The R0 was 0.3 in primary school and 0.6 in secondary school. Spain was in the top 10 countries



(out of 30 OECD countries) in terms of the number of school days lost, and achieved to maintain school without any closure for 8 million children.

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In conclusion:

- The actual rapidly worsening situation warrants broad societal application of mask wearing, also in primary schools where children are not yet vaccinated, and ventilation and distance keeping are challenging.
- However applying masks in children should be part of a complete societal package, this can only be introduced under the condition of equal measures in all other sectors and ages
- mitigating measures for the most vulnerable children (socially, financially, medically) need to be taken into account
- creativity on masks 'breaks'
- when epidemiological situation improves (e.g; when alarm levels improve significantly), this measure should be the first to be re-evaluated
- this would imply also to wear masks indoor also with leisure and low intensity sports activities

#### 9. What it means for the private life

- No formal 'bubble', but clear set of recommendations to reduce number of contacts and having safer contacts:
  - 'Veilig de winter door' (with section on safe ways for gatherings with families and friend)
  - Consider reducing number of close contacts to less than e.g. 5 per day (tentative value)
  - Attention for adequate ventilation in private settings
  - Outdoor versus indoor, keeping safe distance
  - Specific attention for vulnerable and the people around them in risk communication (e.g. importance of vaccination (consider providing FFP2 masks at low cost)
  - Broad use of self test prior to family and friends' gatherings
  - Mask wearing in public transport remind highly important

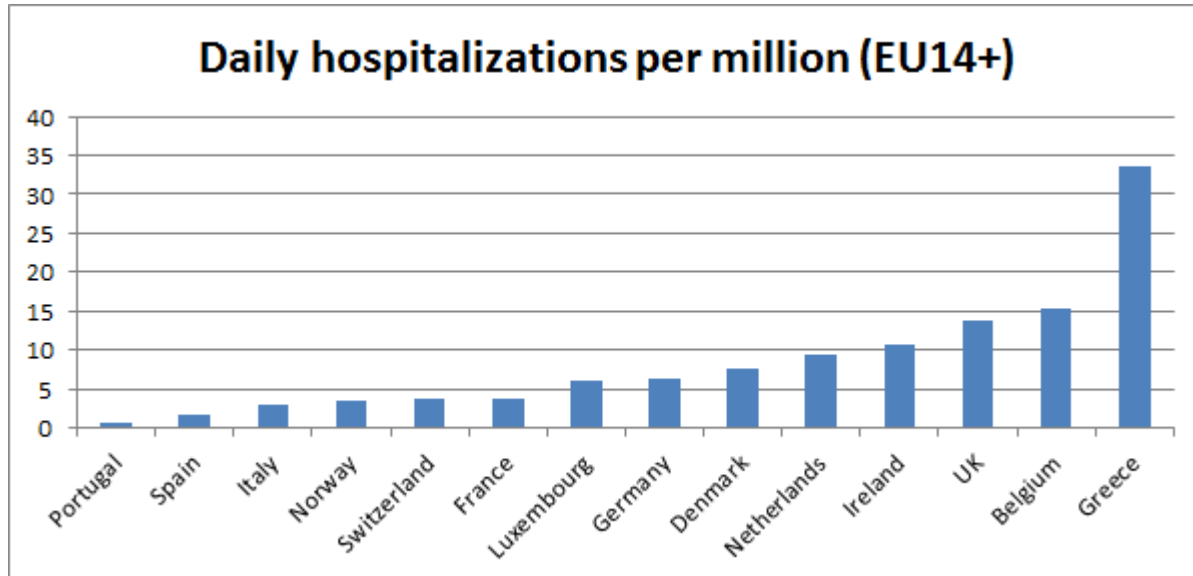


## ANNEX 1: International benchmarking

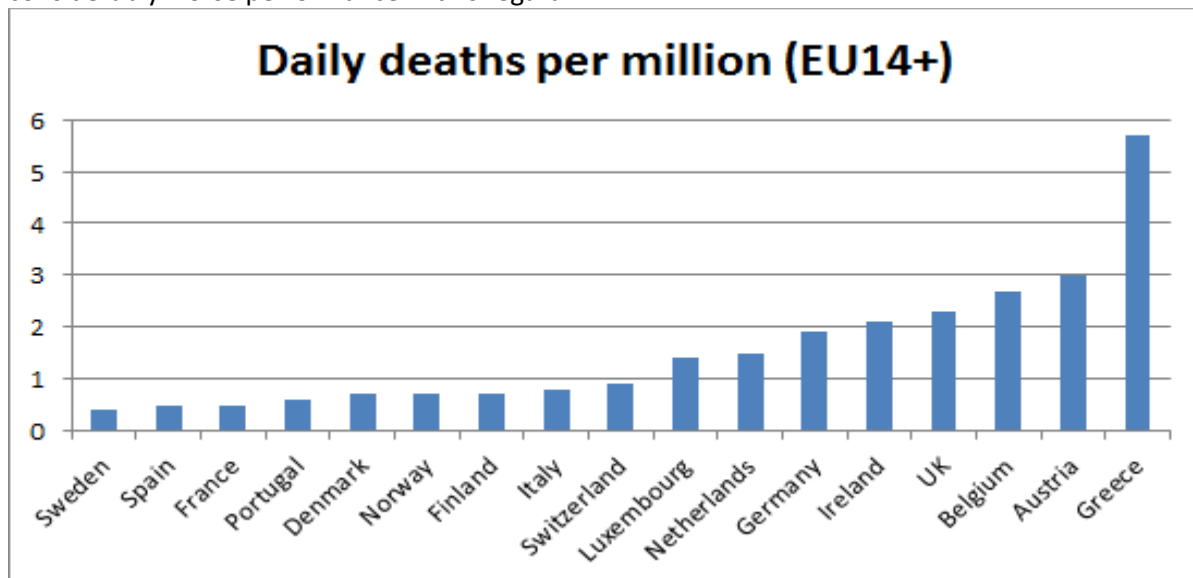
### The EU14+countries

As a set of peer countries for Belgium, consider the 17 countries consisting of the EU-14 countries, supplemented with the United Kingdom, Norway, and Switzerland. The data pertain to 13 November 2021.

In terms of daily hospitalizations per million inhabitants, Belgium ranks second highest (no data for Austria, Finland, Sweden), with only Greece doing worse, and considerably so.



In terms of daily deaths per million, Belgium ranks third highest, just before Austria. Only Greece has considerably worse performance in this regard.



Descriptive modeling shows that 90% in the country-to-country variability in both hospitalizations and mortality is explained by:

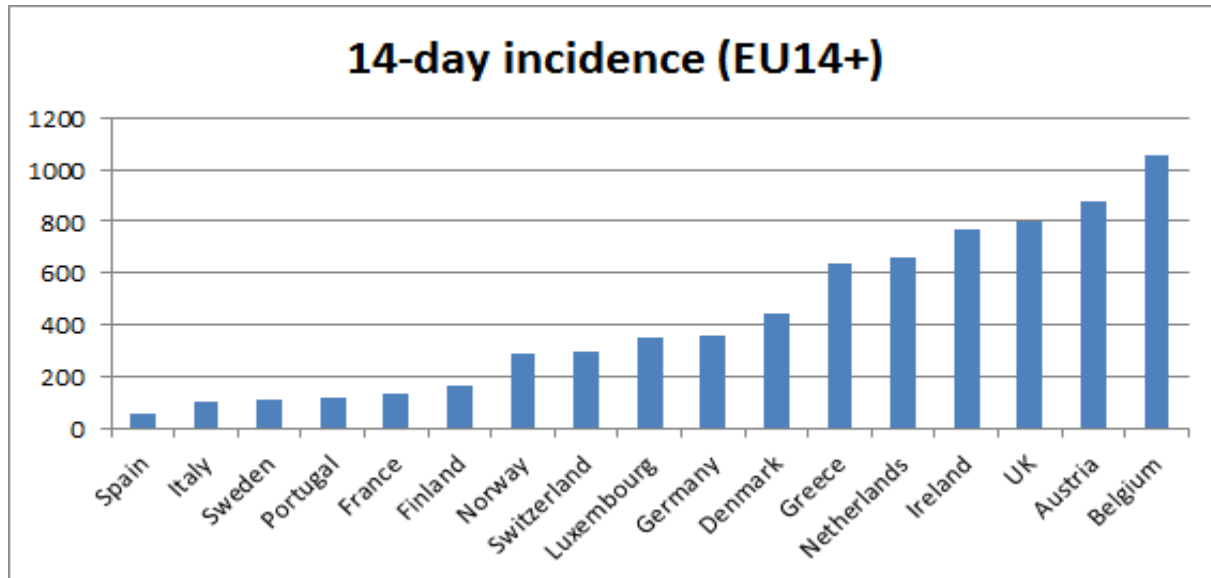
- incidence, i.e., viral circulation



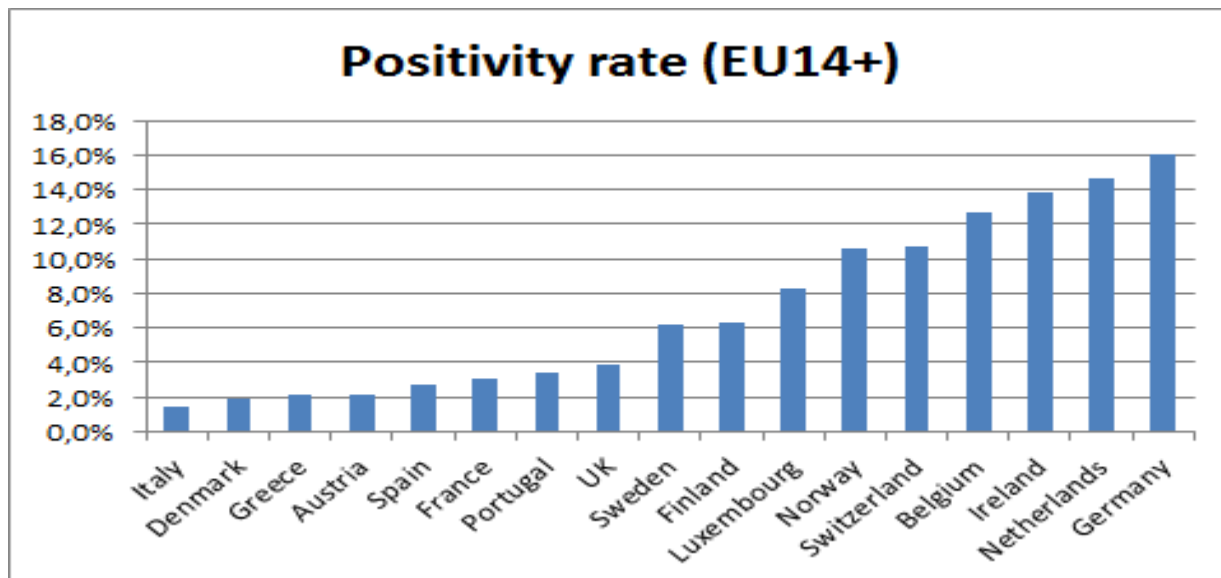
- vaccination rate
- stringency

Consider each of these in turn.

Belgium has the highest incidence in this group.

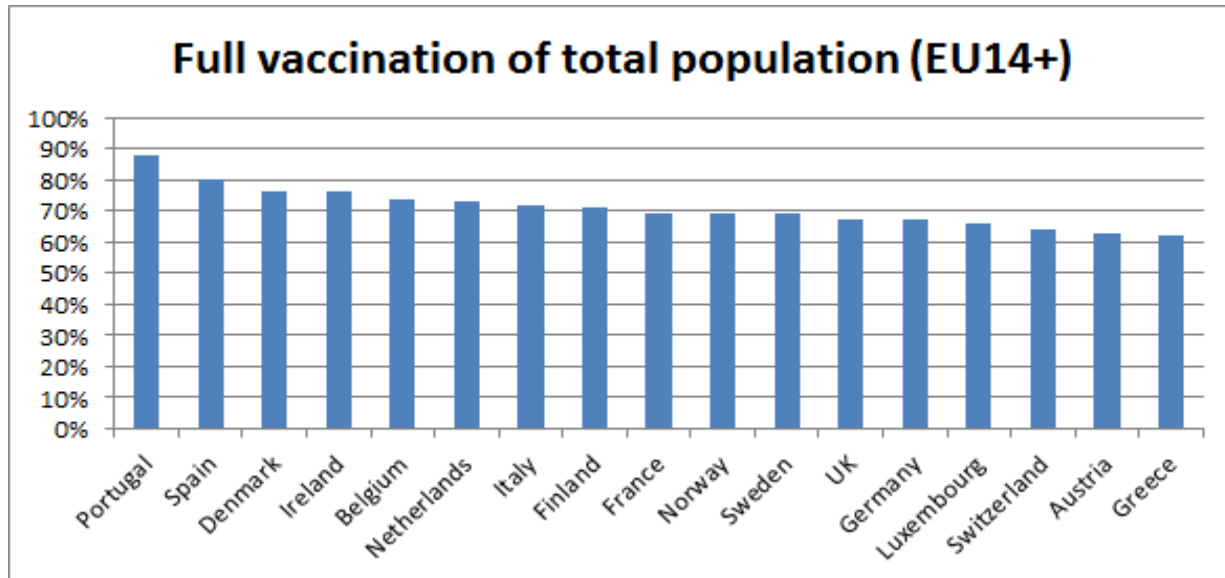


Incidence is best interpreted against the background of positivity rate, as testing policies vary between countries. Also in terms of positivity, Belgium has a relatively poor performance.

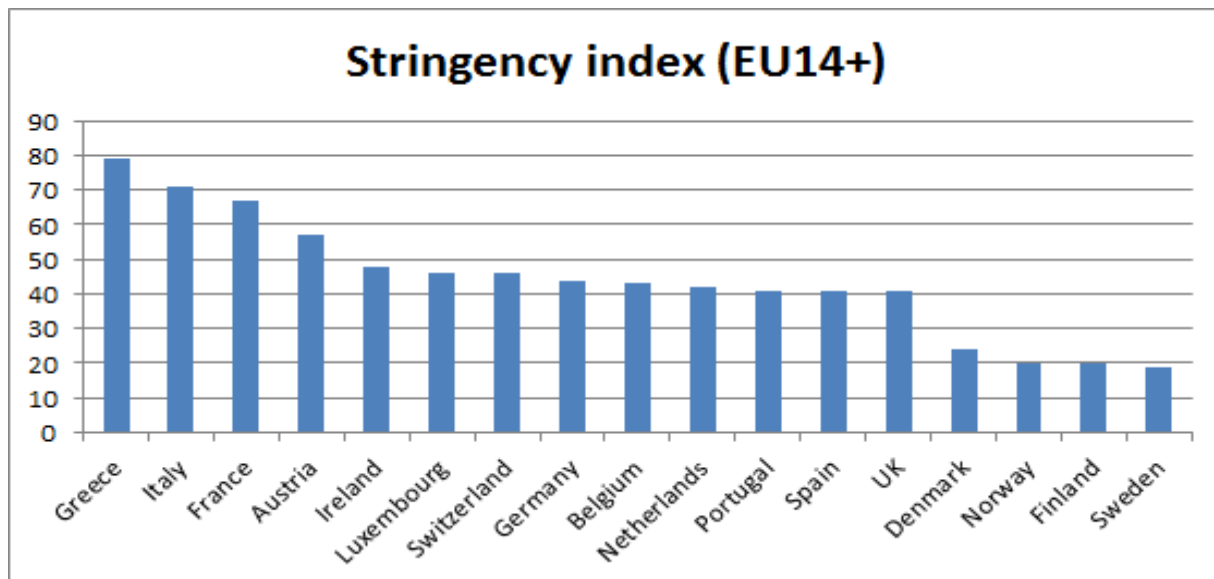


In terms of full vaccination of the total population, Belgium scores well, with only four countries scoring higher: Portugal, Spain, Denmark, and Ireland.



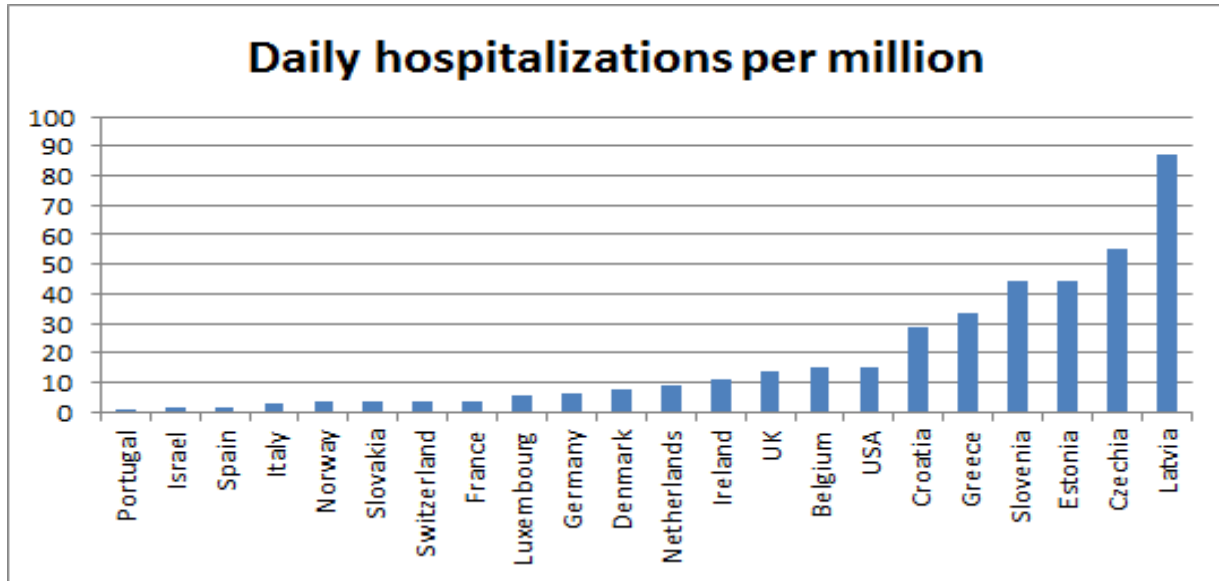


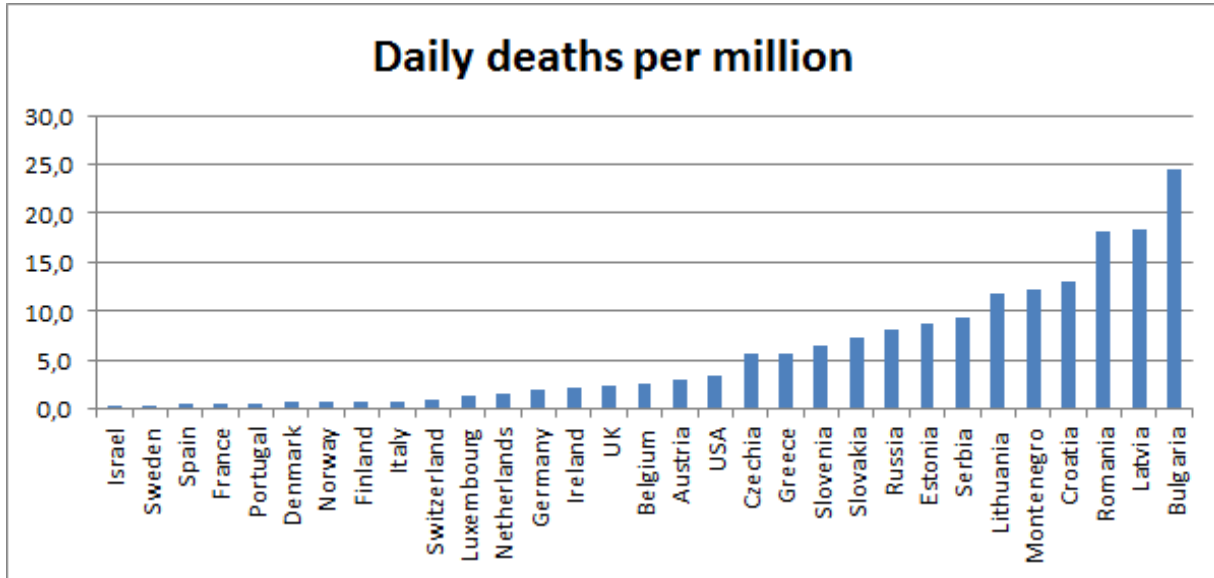
For stringency, Belgium is located in the middle of the E14+ group. It is noteworthy that Greece has the highest stringency, even though the country has the worst performance in terms of hospitalization and mortality. It is safe to assume that compliance is not so good in Greece. On the other hand, it is important to note that Italy and France are maintaining relatively high levels of stringency, even though they have high vaccination levels (Italy) and/or relatively low incidence (Italy and France).



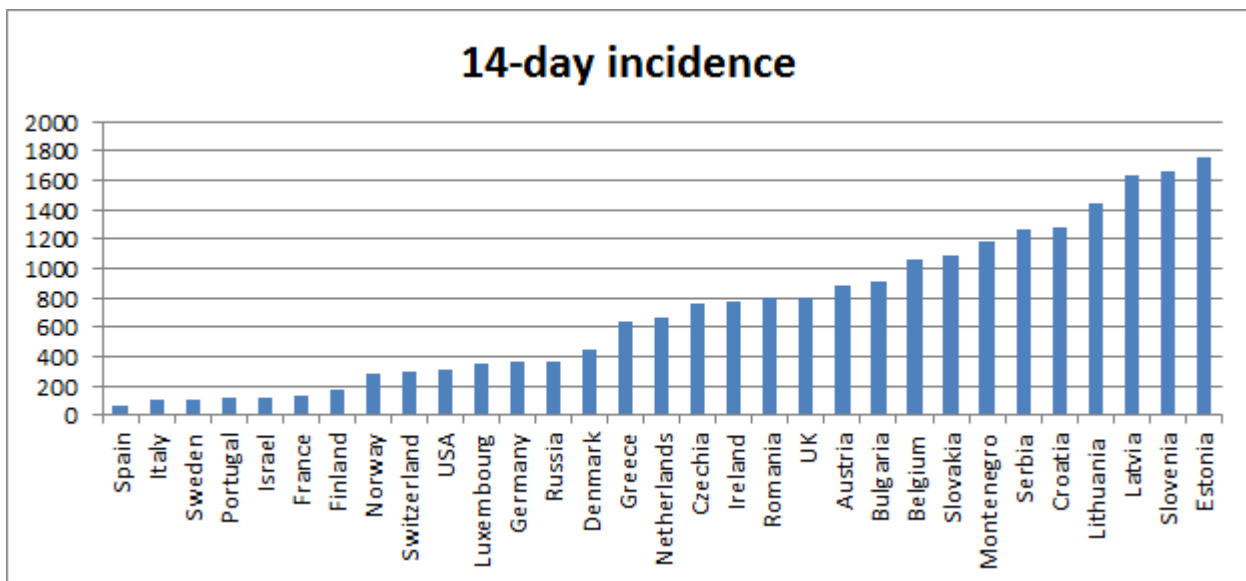
## 2.2 A wider selection of countries

Considering a wider selection of countries, including newer member states of the EU as well as some non-EU countries (Israel, USA), it is clear that in many of these the performance in terms of hospitalizations and mortality is considerably worse.

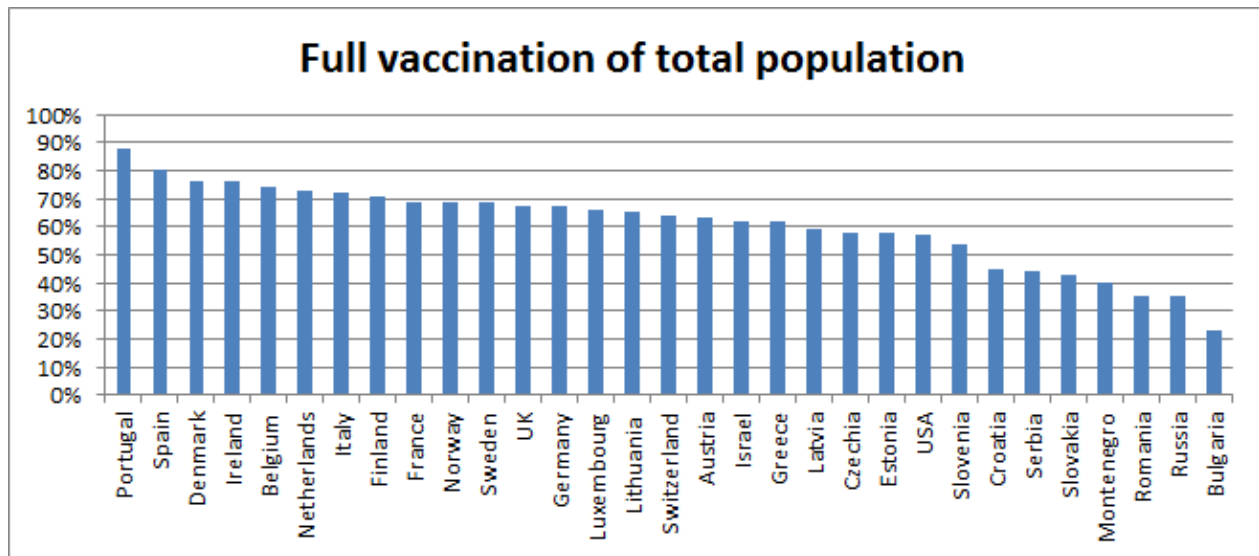
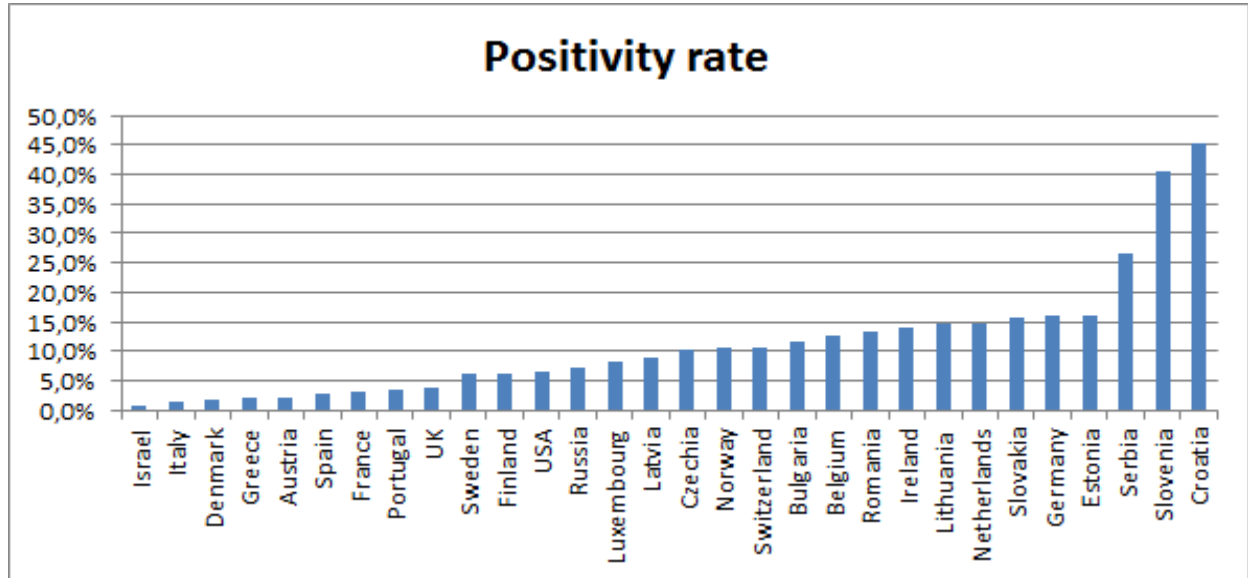




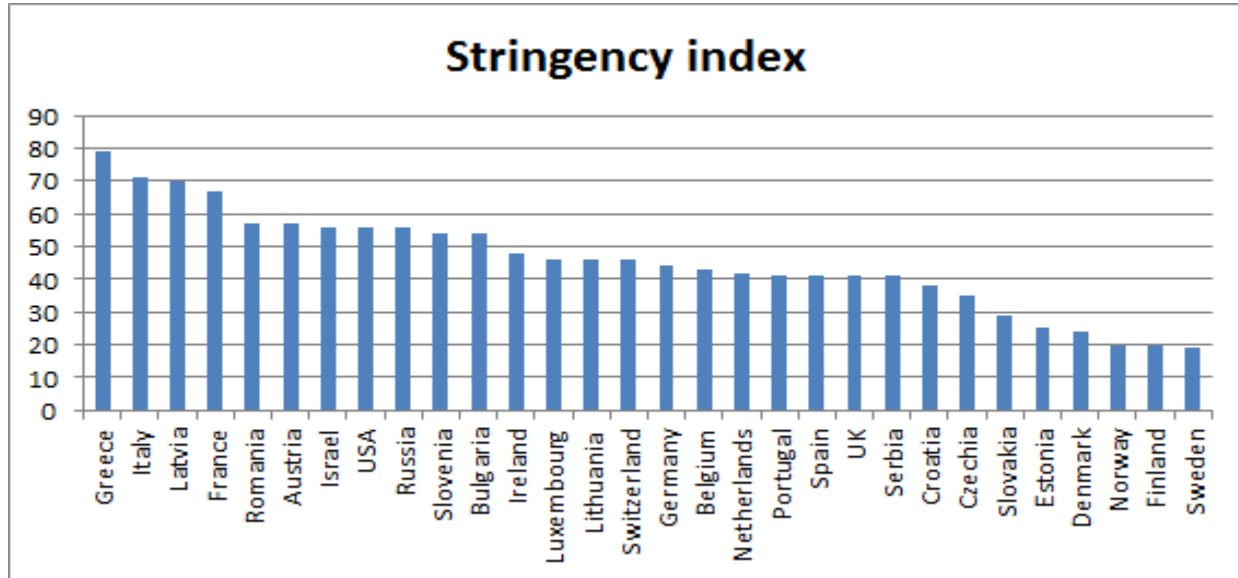
It is useful to also consider incidence, positivity, vaccination, and stringency.



Clearly, Belgium's position is situated among the higher incidences. Likewise, Belgium's positivity is relatively high, while the values in Serbia, Slovenia, and Croatia are dramatic.



With Belgium being on the higher end, we observe that in some, predominantly Eastern countries, whether EU members or not, the vaccination rates are very low.



Belgium is located in the middle based on stringency, which in view of its performance may point to the need for an increase. It is noteworthy that some countries with good performance (Italy and France) have a relatively high stringency, while countries with a deeply problematic epidemiological situation (Estonia, Slovakia, Czechia, Croatia, Serbia) have a very low stringency.



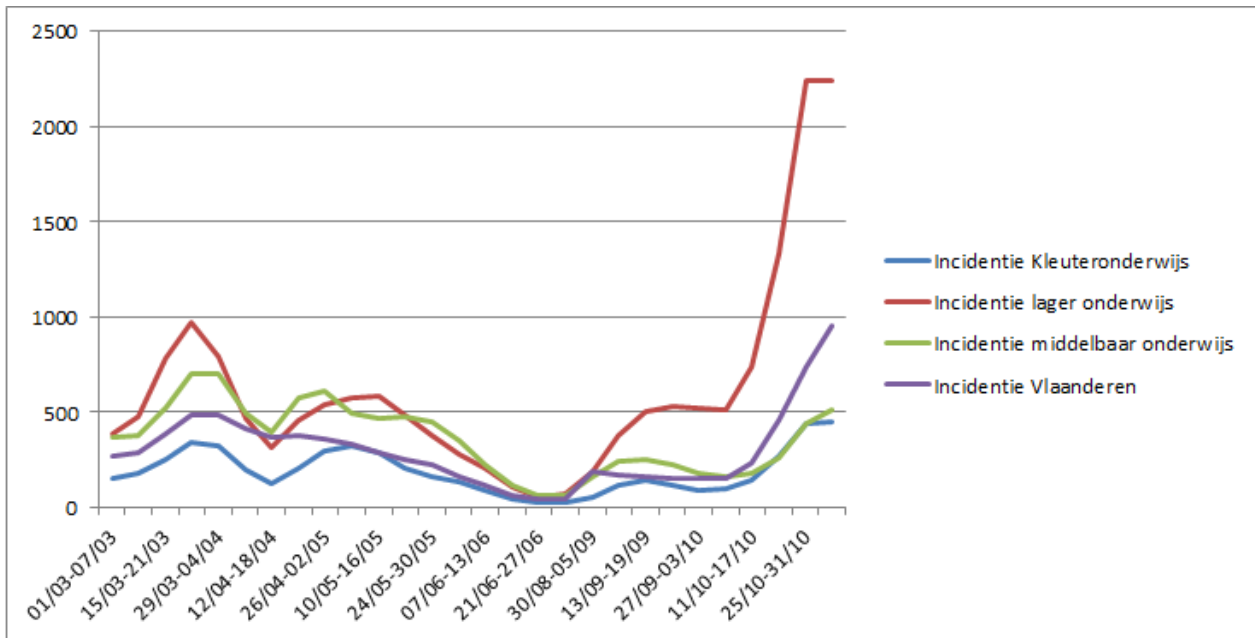
## ANNEX 2. Recommendations for motivational communication

1. Invest in **visual communication** that provides a concrete insight in the beneficial impact of one's own behavior (e.g., keeping distance, wearing masks). This requires sustained efforts so that people develop a realistic insight in how quickly the virus circulates in a given situation (e.g., at work) and what the risk is to be seriously infected under these circumstances.
2. Develop and communicate a **clear, coherent, and long-term winter plan**:
  - ❖ Create a sense of predictability: indicate the critical thresholds for proceeding to a new phase of strengthening the measures.
  - ❖ Emphasize that only a combination of various safety measures allow for a safe situation. It is not about an either-or story, but about an and-and story. Communicate the 'why': indicate concretely (with figures, visuals) what the added value of mouth masks and keeping a distance is when attending an event with a Covid Pass.
  - ❖ Make clear when the roll out of a booster vaccine can be expected and why it is of added value.
  - ❖ Highlight that a significant effort is again required from all subgroups and sectors in the population to avoid polarization.
3. **Learn the population to think in terms of probabilities rather than in binary terms.** The probability of infection after vaccination, after a booster vaccine or after entering with a Covid Pass is reduced, but not reduced to zero. Expressions like 'everything is over' or 'we are back to normal life' create the wrong impression that safety measures are no longer required.
4. **Abolish the term 'Covid Safe Ticket'**. It creates the false impression that a 'Covid Safe Ticket' allows one to have close contacts, hug each other and shake hands. Systematically use the term Covid pass instead.
5. **Communicate ongoingly and explicitly about the effectiveness of vaccination.** Indicate in daily covid figures the probability of being hospitalized or ending up intensive care under conditions of vaccination vs. lack thereof. In this way, the trust in the added value of the vaccine grows and risk awareness may increase among the unvaccinated, which fosters their willingness to accept a vaccine.
6. Show **projections** of what the current situation may look like in intensive care without large-scale vaccination or what it might look like in the future if the population refuses a booster vaccine. This reinforces the belief in the effectiveness of the vaccine.
7. **Share testimonials** from vaccine-critical individuals who decided after being hospitalized to accept the vaccine anyway. The motivating impact of like-minded people is greater to convince non-vaccinated persons to get vaccinated.
8. Make it concretely (graphically) clear that **vaccination remains of added value even if one was previously infected**. This information is crucial to encourage previously infected but unvaccinated individuals to accept a vaccine.

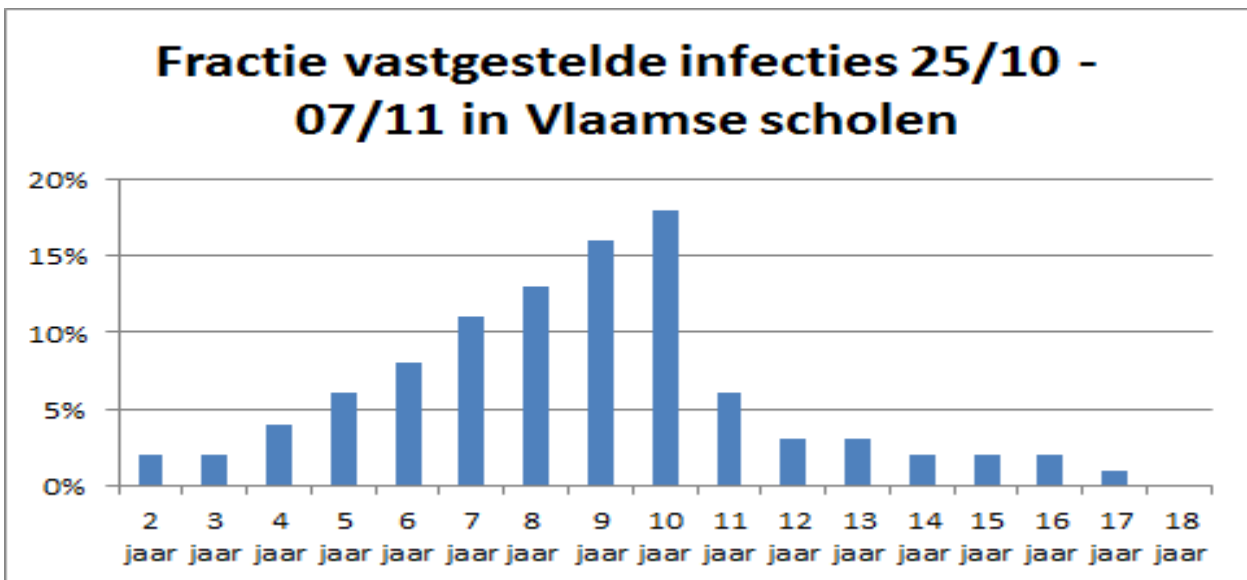


### ANNEX 3. Epidemiological facts about the Flemish school system

The incidence in the Flemish school system is depicted in the next figure. It is split over kindergarten, primary school, and secondary school. Also the Flemish general population incidence is shown. It is clear that kindergarten and secondary school have increased, but at a level lower than the general population. This is the opposite in the primary school system.



Over the most recent 14-day period, the infections in Flemish schools are shown in the next figure:



We see a gradual, almost linear increase of the fraction of infections from 3 to 10 years of age, after which it drops dramatically, thanks to vaccination.