Adviesaanvraag

Vraagsteller	OCC
Datum van adviesaanvraag	30/12/2020
Onderwerp	Beheerstrategie
Vraag	- Kan een update gegeven worden over de adviezen m.b.t. de beheerstrategie?
Reden	

Adviesverstrekking t.a.v. het Overlegcomité

Datum van adviesverstrekking	05/01/2021
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GEMS ADVICE – UPDATE ON THE MANAGEMENT STRATEGY (05/01/2021)

1. Epidemiological update

A full overview on the evolution of the epidemic in Belgium and abroad is described in the weekly RAG-report and elsewhere in the report of the Commissariat.
We would like to draw the attention to the following points:

- The current evolution in Belgium appears positive so far, with a decreasing trend in the number of cases. Nevertheless, we observe this less convincingly in the number of hospitalisations and a slight increase in some provinces as well as in the positivity ratio which is still fairly high at 7.4 %. Recently, several outbreaks have been observed in health care and nursing home settings. These have not yet been attributed to novel variants; investigations are still ongoing. Possibly seasonal effects play a role here.
- It is too early to assess the possible impact of returning travellers and/or social gatherings around the Christmas/New Year season. This should become clearer over the upcoming 1-2 weeks.
- There is a very worrisome evolution in several of our neighbouring countries, as well as in some other European countries, leading to healthcare services being overwhelmed with the need for further tightening of measures or even strict lockdowns (i.e. UK, especially England and Scotland, Ireland, the Netherlands, France, Germany, the Czech Republic,…). Part of the explanation is in the emergence and fast spread of the new variant (B.1.1.7), in combination with seasonal effects (cold and dry weather) and less or different measures taken over the last weeks. Given the intensity of the epidemic in several countries very close to Belgium, we should realistically be prepared for spill-over effects, e.g. via incoming travellers.

2. Motivational update

A more extensive update on our population's motivation and detailed recommendations can be found in Annex 1.
We would like to draw the attention to the following points and recommendations:

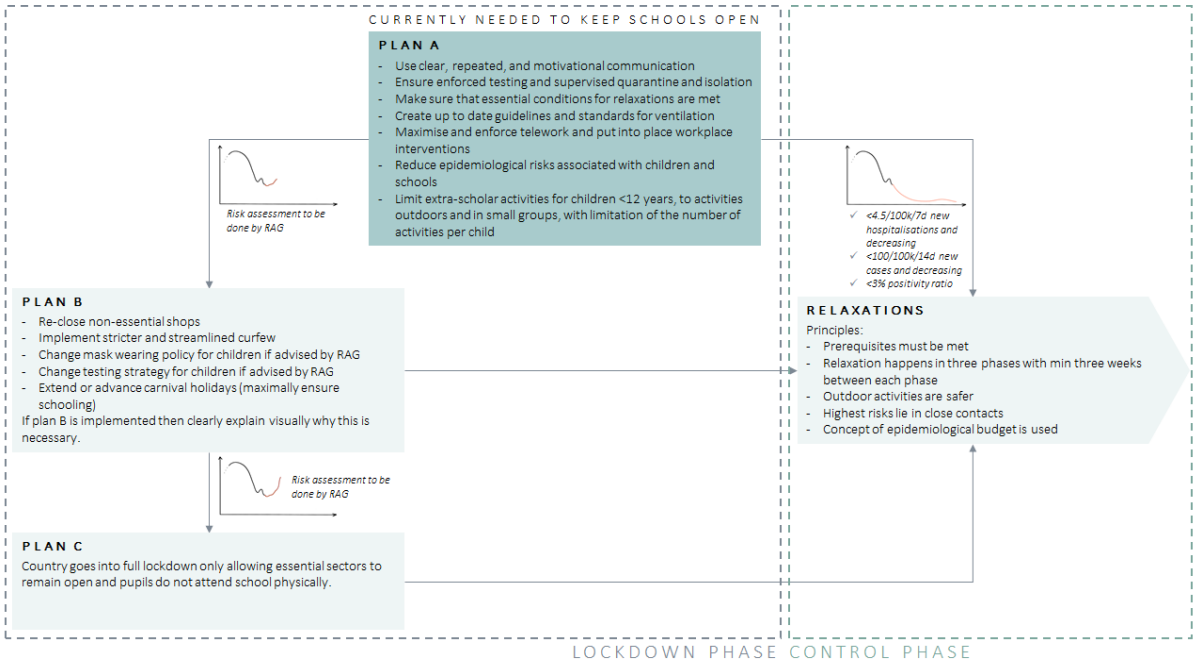
- While reaching the actual epidemiological 'control phase', people are confronted with a difficult equilibrium between hope (possibly gradual relaxation of the behavioural restrictions) and disappointment (depending on spreading of new virus mutants) within a context of steady increase in vaccine administration which may contribute to an illusory sense of safety (see RAG advice on use of mask and other measures during the roll-out of vaccination). This brings along important behavioural challenges.
- We observe a partial shift from intrinsic motivation towards 'must'ivation and amotivation. Even though the latter has helped to maintain good adherence to the current measures, this is not a sustainable situation in the long run.
- Also motivation to be vaccinated is increasing, but this is often associated with perceived immediate benefits instead of the collective goals.
- In order to manage the situation, a collective mission needs to be reinforced: the motivational, psychosocial, and behavioural challenges require (a) the need for sustained risk awareness, (b) a clear perspective, and (c) a socially connecting, positive, and motivating climate.

3. Management strategy in two directions

Given the uncertainties around the epidemiological evolution, we have organised our work and preparations in two large workstreams:

a. 'When the epidemiological situation evolves negatively': essential and urgent preparations to be done for a worsening epidemiological situation. Even though we are actually still in 'lockdown light' as of November 2nd 2020, we listed still several actions which should be taken either:
   i. Immediately (= **Plan A**: either new or strengthening already existing activities, to maintain the further decreasing trend).
   ii. In case of worrisome stabilisation or minor flare-up (= **Plan B**: urgent supplementary actions to prevent a slightly worse situation from further worsening).
   iii. When the epidemic evolves out of control (= **Plan C**: urgent actions to regain control of the epidemiological situation in order to protect the health care system and the public health at large).

b. 'When the epidemiological situation evolves positively': outline of possible relaxations + definition of smart lockdown-package in case of roll-back scenario.



4. Plan A: actions to be taken or strengthened now

In order to maintain the current decreasing epidemiological trend, we recommend the following measures, to be reinforced if they are already in place or to be implemented as soon as possible.
We consider this list as 'essential', hence the elements in what follows are not optional but to be taken into account in unison: interventions at all levels and in all sectors are essential to keep the virus effectively under control.

a. Organise clear, repeated and motivational communication
   i. Need for inducing risk awareness without inducing fear or worry, offer perspective and create a socially connecting, positive and motivating climate In Annex 1, several

concrete examples are listed, both on how to maintain risk perception without inducing fear and keeping a common goal.

ii. Increasing risk awareness without inducing fear or worry should always be accompanied by **clear action plans**.

iii. **Visual communication** is essential to describe the risks but also the common goals and the trajectory (e.g. visualisation of barometer 2.0, thresholds for relaxation to be shown repeatedly e.g. in media,...).

iv. Investment in social support is needed to keep motivation going and to buffer also against the well-being costs associated with limited social contact.

v. Communication should be targeted and inclusive for several at risk groups.

b. Ensure enforced testing and supervised quarantine and isolation

i. Within existing test indications, individuals should be more motivated to have tests carried out. Communication towards frontline healthcare workers (e.g. GPs) to encourage testing is also very important. Additional schemes or modalities for the rational use of the available testing capacity may need to be explored.

ii. Isolation of positive persons or to-be-quarantined persons should be made possible, e.g. through financial and logistic support where needed.

iii. Quarantine and isolation are important public health measures in an epidemic context and should be ensured, supervised (e.g; corona-coaches), controlled, enforced.

iv. Maintain strict rules for returning travellers; continue to discourage non-essential international travel (or, if the situation is dire, consider prohibiting international travel).

c. Make sure that the essential conditions for societal relaxations are met ('randvoorwaarden'), see suggested KPIs and dashboard in nota of the Commissariaat.

d. Create up to date guidelines and standards for ventilation, which can be translated in formal and controllable certificates. This will be essential to improve infrastructural safety in already active sectors (e.g. schools, workplace, nursing homes and health care,…) Given the importance of transmission through aerosols, this will be an essential component of e.g. reopening sport clubs, horeca and other places where large groups gather.

e. Maximally avoid viral transmission at the workplace

i. Maximise and enforce **telework**, which also means discouraging (international) travel for face-to-face meetings.

ii. Install transparent shields or other **physical barriers** where possible to separate employees and visitors where social distancing is not an option.

iii. Organise **universal use of masks at the workplace and (hand) hygiene measures,** and keep **working conditions maximally safe,** also during lunch breaks, avoiding parties and reception…

f. Reduce epidemiological risks associated with children and schools

i. We support the continuation of school activities; the political decision has already been taken to maintain the measures in the educational system as of November 16th. until February 15th. In order to make this possible in the current epidemiological context, the above mentioned broad societal interventions will be needed to protect primary and secondary schools.

ii. Clear and repeated communication to all stakeholders, especially parents but also teachers and schools staff, to engage them in the conversation and explain the role of children in the spread of SARS-CoV-2 and convince them of the importance of quarantine (after return from international travel and in case of illness within the household). Draw up a visual communication package for principals, teachers and parents, involving the following components (see Annex 2 for details).
    1. Clear instructions how to react to children/teachers in need for testing and or placed in quarantine.
    2. Explanation of the reasons underlying these measures: need for testing even for small children and especially if there are several children in the same class with symptoms.
    3. Offering a set of guidelines on how to spend the quarantine period safely.
iii. Strengthen compliance with quarantine of children and families
    1. When a household member is a possible case of COVID-19 (even before or when awaiting test results).
    2. After international travel.
iv. Further strengthen contact tracing and testing of high risk contacts at schools. In case of outbreaks, unexplained, large clusters should be sequenced as part of the larger genomic surveillance plan that is being set up. We suggest to request the RAG to assess the feasibility and potential benefits of systematic screening of teachers and potentially pupils, and to reassess the actual risk classification of high and low risk contact for primary school pupils in the light of the current epidemiological situation (in particular emergence of B.1.1.7).
v. Pay particular attention to school children commuting in and out of our neighbouring countries when the epidemiological situation is less favourable in these countries. Awareness of children, school personnel, and parents should be raised to maximally exhibit safe behaviour, at school, in transportation, and at home.
vi. Consider reducing the age for children to wear masks to 10 y (We suggest to request the RAG to revisit its earlier advice in the light of the emergence of the new variant B 1.1.7).

g. Limit extra-scholar activities for children <12 years, to activities outdoors and in small groups (e.g. 4-8 children), with limitation of the number of activities per child (max. 1 type of activity to limit group mixing). It is critical to provide a set of criteria to assist parents in choosing the activities with the lowest risk. Further modalities to be defined with departments of Youth, Sports, Culture, and always in a sense to protect the most vulnerable in society.

5. Plan B: what to do when epidemiological situation slightly worsens

If the incidence would increase again, there should be a swift reaction to avoid having to go into full lockdown. The decision will have to be taken based on a quantitative and qualitative review of the epidemiological data by the RAG, which includes the evolution (both absolute value and speed of change) of the R-value, incidences of cases and hospitalisations, outbreaks, emergence of the B.1.1.7-strain, etc…

It is important that the possibility of this 'plan B' is known, prepared and communicated early enough. This will help to increase predictability and allows all parties to get properly organised. In case of

worrisome epidemiological evolution, the following measures should be implemented as soon as possible:

a. Close non-essential shops, at least in border regions (if shops are closed in the neighbouring country), but preferably everywhere to avoid spill-over effects within the country, to avoid import of new cases from abroad (with or without new variant).
b. Implement stricter and streamlined curfew.
c. Mask-wearing from age 10 y in all contexts (depending on advice RAG, see above).
d. Extend (with online schooling) or advance carnival holidays

6. Plan C: what to do when epidemic gets out of control

If the measures suggested in plan A and B are not sufficient to keep the numbers down, the country will require a new full lockdown to avoid a collapse of the healthcare system. That a chance for this happening is real, is clearly demonstrated in the rapid and unfavourable evolution in the United Kingdom and Ireland (see Appendix B).

As there is a general consensus that closing schools has a negative physical, mental, and educational impact on children, this should be added only as a last resort, i.e., in the case where even a full lockdown is not sufficient to bring the numbers down. School closure implies that teaching takes place at 100% on distance for this period.

The measures of plan A and, if needed, plan B, should be implemented meticulously and early enough, to avoid this final step at all cost.

7. Outline of relaxations (in preparation)

In case of further positive evolution of the epidemiology, preparations can be made for relaxations under the following conditions:

1. Timing:
    a. Relaxations can only start when the epidemiological situation reaches the earlier set 'safe haven' (i.e. < 75 hospitalisations/d, < 100/100.000/14 d cases and < 3% positivity ratio) and this with a stability for at least 3 weeks. It is important to respect this timing, given too early relaxations, in a context of high viral transmission and without sufficient background immunity, can ignite quickly a subsequent wave.
    b. At least 3 phases/packages of relaxations are foreseen, with at least 3 weeks in between.

2. Essential conditions:
    a. All earlier essential conditions ('Randvoorwaarden') and elements from plan A should be met and constantly be strengthened, the suggested KPI should be approved and monitored.
    b. Additional conditions to take into account, as mentioned in plan A: ventilation, communication, testing.
    c. Role of vaccination: even though the actual vaccination campaign has just started, it will take several months before sufficient herd immunity has been reached to allow major loosening of the measures hence before the vaccination status can influence our relaxation policy. Nevertheless, specific relaxations in confined communities (e.g. nursing homes) need to be discussed in due time.

3. Epidemiological budget:
    As can be seen from the 'long term predictions' as analysed for several scenarios by Niel Hens and Steven Abrams (see Nota Commissariaat), the potential impact of increasing social contacts through private, leisure or work-related activities remains significant in igniting a third (or fourth) wave. This still significant risk will have to be taken into account when considering future relaxations. A consequence is that possible future relaxations will need to be very gradual, without restarting too many activities altogether. This is called the 'epidemiological budget': a budget can be spent only once…

4. Equity:
    Specific considerations are to be made with regards to justice and equity, balancing the epidemiological budget and pragmatism with meeting the needs of all (and in particular the most vulnerable).

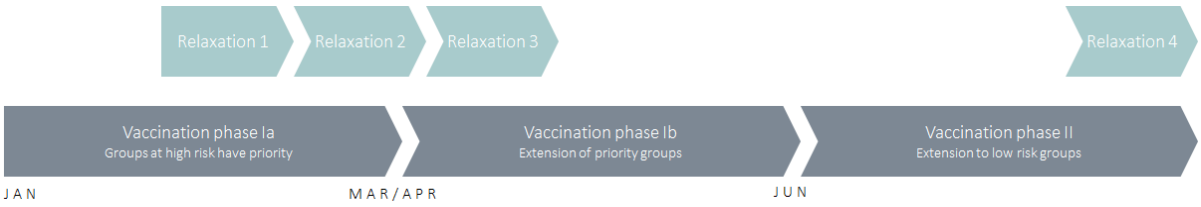
5. Private life:
    a. We propose to build further on the concept of 'close contact as individual right'
    b. We suggest to distinguish between indoor and outdoor provide contacts, to provide longer term stability in the allowed contacts (slowly progressing, leaving room for other sectors too in the epidemiological budget), and to distinguish contact rules for individual and collective living types.

6. Sectors:

Relaxations are being discussed for the private life, but also for commercial and non-commercial sectors (see list below).
Wherever possible, relaxations will be discussed together with the affected sectors through the respective cabinets and administrations, and in close collaboration with the working group on Protocols (lead: Piet Van Themsche, Commissariaat). Sectors are preferably discussed as a whole, in joint discussions with the different federated entities, to enable maximal harmonisation between the regions and within the sectors. Protocols remain at all times the responsibility of the respective ministers, while the GEMS and Commissariaat offer their expertise to solve specific issues.

a. Education (primary, secondary, higher, adult, arts,…)
b. Culture/events, sports, youth, religion
c. Contact professions, horeca, tourism
d. Mobility & international travel

The following figure shows an estimated high level timeline of relaxations (mapped on foreseen vaccination plan). Both of these timings are of course subject to change.



8. Follow up note on contact professions:

Given the uncertain epidemiological situation, and the not-yet-reached safe haven, we believe this is not yet the correct moment to discuss the re-opening of contact professions. We refer also to our risk assessment dd. 15/12/2020.
However, as mentioned in our earlier recommendation, we suggest to open a dialogue with this sector in order to prepare their members better to safer working conditions, and to investigate specific conditions which may improve safety at their restart (e.g. better use of masks, improved ventilation, shorter contact times,…) in Phase 1 of relaxations.

Annex 1: Motivational challenges

Due to the persistent efforts of the population, we were able to collaboratively and steadily move over the past few weeks from the 2nd wave peak towards a substantial reduction of the virus circulation. Reaching the control phase with a difficult equilibrium between hope (possibly gradual relaxation of the behavioural restrictions) and disappointment (depending on spreading of new virus mutants) within a context of steady increase in vaccine administration which may contribute to an illusory sense of safety, there are important behavioural challenges ahead. In order to manage the situation, a collective mission needs to be reinforced. This requires a shared understanding of the precarious nature of the current situation together with a precise view of the distant goals and the trajectory leading towards these goals. The motivational, psychosocial, and behavioural challenges require: (a) the need for sustained risk awareness, (b) a clear perspective, and (c) a socially connecting, positive, and motivating climate.

1. Some recent findings

What is the effect of increasing hospitalisations? To motivate citizens to adhere to the measures, experts and politicians often refer to the increasing infections and hospitalisation. Yet, an increasing number of hospitalisations is a double-edged sword from a motivational perspective. To the extent that increasing numbers are presented in a factual and informational way, thereby highlighting the long-term consequences, they elicit risk awareness. Yet, the increasing numbers could also be used to alarm the population, thereby eliciting worry and even panic and anxiety. Analysing the data collected over the first 250 days of the crisis, we were able to show that on days that hospitalisations were peaking, people report both more risk awareness and worry (see figure 1). Yet, *only risk awareness instigates voluntary motivation which then strongly predicts adherence* to the measures on these days. Worry on the other hand does not yield any significant contribution at all. For experts and politicians, it is a thin line to use the increasing hospitalisations as an argument to induce motivation through fostering risk awareness but avoiding anxiety induction. Raising risk awareness without inducing worry implies the communication of the risk together with a clear and convincing action plan that fosters a sense of (self-)efficacy. *In sum, communication heightening risk awareness should always be accompanied by clear action plans*.

Motivational shifts. Figure 2 presents the shifts in motivation over the past few weeks. Voluntary motivation, which is the best predictor of sustained adherence and fuelled by risk-awareness, remains fairly stable in December, with around 50% of respondents being highly committed to adhere to the measures. The two other indicators, controlled motivation (or 'must'-ivation) and amotivation have increased on different moments during the lockdown. The announcement at the end of November that the measures would not be relaxed during the Christmas break came along with an increase in discouragement and indifference. Since then, scores for discouragement have stabilised. An increase in controlled motivation was noticed right before the Christmas break. At that point, many sanctioning messages were voiced: zero tolerance, drones, threats, and anxiety induction were key terms. Contrary to what is often expected, sanctioning policy and communication may backfire, thereby eliciting opposition among those that are already demotivated (see also report 9 in the motivation barometer). In addition, data suggest that emphasising control and sanctions contributes to the authorities being perceived as losing control over the situation. The specification that children under 12 were also considered close contacts, which came as a surprise to many citizens, may also explain the increase in controlled motivation. When contrasting the motivational differences between November and December the overall trend is clearly

negative: autonomous motivation is lower whereas controlled motivation and amotivation are higher (all ps <.001). *These motivational shifts signal that the motivational support is gradually eroding and indicate the pitfalls of a lack of coordination and visualisation of key motivational messages*.

Social restrictions. When examining the motivational dynamics underlying the different measures, it is clear that the social restrictions are the hardest to stick to for the population. People's self-efficacy to stick to the measures has been gradually going down during the 2nd (semi-)lockdown, with a mean significant difference being observed between the first month (*M* = 3.56; *SD* = 1.20) and second month (*M* = 3.46; *SD* = 1.17) of the lockdown. Paralleling these differences, people's self-reported adherence to the social restrictions also was significantly lower during the second (*M* = 4.17; *SD* = 1.10), compared to the first month (*M* = 4.09; *SD* = 1.07) of the lockdown (see Figure 3 for a shift over time). At the same time, it should be noted that up to 84% of the respondents indicated that they adhered to the measures during Christmas eve and day. This percentage is much higher than what people had indicated they would do at the end of November (i.e., 63%). Overall, we adhered to the measures because we were convinced that it was needed, but it was done reluctantly. This seems like an extra effort that people were temporarily willing to pay for during a short time at the expense of social connectedness. *The overall picture is, however, that people are suffering from lacking contacts, suggesting that investment in social support is needed to keep motivation going and to buffer also against the well-being costs associated with limited social contact.*

2. Motivational challenges

Fostering sustained collective risk awareness and motivation. In the ideal world, people's motivation and adherence would play a preventive role, thereby keeping the number of hospitalisations under control. Yet, at this moment, increasing motivation seems more a side-effect of increasing hospitalisations implying that our behavioural efforts come too late. In fact, this relationship should be reversed: risk perception should precede and help prevent hospitalisations from rising. This requires people to (learn how to) think anticipatorily about the effects of their behaviour. Put differently, potential long-term consequences of present behaviour need to be brought to awareness, thereby fostering risk perception and associated voluntary commitment to the measures. In order to learn to think anticipatorily, infographics and visuals are badly needed and need to be intensely and repeatedly implemented in media messages.

A clear perspective. A second challenge involves providing a clear perspective for the population. The psychological distance to relaxations is still very far and discouraging at this point. If we collectively strive for a common goal and set intermediate goals to attain, we can build a collective sense of efficacy, which supports motivation. These intermediate goals offer a sense of control and predictability and help to materialise our common mission. At the same time, it is critical within a shared mental model of the situation, that the population has an idea of the basic logic that is used to install relaxations and of the sequence of relaxations within the control phase. Through these insights, the population will be capable to more proactively engage themselves in this shared project.

Fostering social cohesion. A third challenge is to develop a more socially shared positive climate, such that people feel truly supported in the current situation. As social beings, we have a basic psychological need for relatedness, which is threatened in the given circumstances. Yet, by stimulating social support and investing in socially mobilising projects, social needs could be better satisfied, thereby fostering people's well-being and motivation.

3. Recommendations

To address these challenges, a **clear "conceptual framework"** (e.g., switch system, barometer) could be installed in the population to serve as a shared mental model. Such a shared mental model would help to create more motivating conditions as it would promote greater risk awareness, encourage people to monitor the evolution (eventually to think ahead and appreciate exponential dynamics), to take responsibility for themselves and others, offer them shared targets to strive for, create perspective, enhance a sense of predictability and control and allow us to communicate in more visually attractive ways (see opinion piece). In the absence of such a coherent framework, different 'decontextualised' recommendations are presented.

1. INVEST IN COMMUNICATION USING DIFFERENT MEANS AND CONTENT: Since the beginning of the crisis is the vast majority of the communication conveyed in a verbal manner and focused on virologically relevant information. Yet, **clear infographics, a visualised phased system** (cfr. barometer) are more powerful as messages can be more easily spread and repeated, while a focus on psychosocial aspects of the crisis and how to deal with them is largely lacking. This is unfortunate.

Challenge 1: Fostering sustained collective risk awareness and motivation

2. PROMOTE RISK AWARENESS AND BUILD TRUST IN THE MEASURES

   ⇨ Show **if-then** scenarios: visualise how the curve of infections/hospitalisation would evolve if we would allow relaxations at this point?

      - How many weeks would get lost before we move to the control phase?
      - To what extent would the health care system again be put under pressure?
      - Indicate how our consistent adherence to the social restrictions in the first month of the second semi-lockdown have proven a key factor

   ⇨ Share the **stories of health care workers** in an informational (but not guilt-inducing) way such that people better understand the fragile character of the situation in hospitals and better appreciate the work being done by them.

   ⇨ Refer to **concrete situations** during which the virus began circulating very quickly to provide an insight in what an exponential curve implies, e.g. Sint Nicolaas example

3. PROVIDE A SOLID JUSTIFICATION FOR NEW, RISK-REDUCING MEASURES

ð If new, more stringent measures are needed, it will be critical to provide a solid justification such that people endorse the changes being made (e.g. restricting extra-curricular activities among children)

ð Explain the **'why' of this measure**: Highlight …

- … how not introducing these measures may lead to a rapid increase in virus circulation (e.g., through a graph)
- … the effectiveness of these new measures to prevent such increases
- … how this more strict measures helps us to stay on track towards our more distant goals

4. PERSONALISE KEY VALUES: Keep emphasising the key values we want to preserve and attain.

⇒ **Repeat** ongoingly the importance of protecting our economy, education, healthcare sector and our mental health

⇒ **Make it very concrete** through real-life stories of people, who indicate for which persons specifically they adhere to the measures (e.g., I adhere to the measures such that my children can go back to the youth movement).

⇒ Refer to the **vulnerable people** and persons for whom **non-COVID care got delayed** (e.g., I adhere to the measures because a friend's fertilisation trajectory is no longer delayed).

⇒ Ask **politicians** to disclose their own personal stories

Challenge 2: Offer perspective

5. PROVIDE DIRECTION: Highlight a **shared common goal**

⇒ Define and repeat what the control phase involves: which parameters indicate low virus circulation

⇒ Highlight the **added value** of a control situation, which …

- … offers more freedom, which supports our mental health, social harmony, and economy
- … implies low virus circulation such that the crisis is easier to control (cf. test & trace, quarantine, vaccination).
- …allows one to more swiftly and efficiently intervene to avoid an exponential increase of the curve

6. PROVIDE A TRAJECTORY: Estimate a trajectory with a **time frame** and **intermediate goals**, which serve as critical virological and psychological milestones

⇒ Provide estimates (through infographics) about the timing to reach the safe haven when we maintain, intensify or reduce our efforts

⇒ Putting forward **intermediate goals** does not imply a relaxation of measures. Just as cyclists do not face the top of a mountain halfway but focus on the next upcoming curve, it is critical to engage the population to move steadily forward, thereby breaking down the long trajectory in steps.

7. INVEST IN SYSTEMATIC FEEDBACK

⇒ Indicate how the curve currently evolves relative to the predicted curve and whether we are on track

⇒ Provide **systematic feedback** about the effect of our efforts, thereby highlighting the collective efforts of the population instead of attributing success to the measures.

⇒ Positive feedback without a clear view on the still present risks and anticipated evolutions may create a sense of unjustified optimism.

Challenge 3: Create a socially connecting, positive and motivating climate

8. CO-CREATE SOCIAL INSPIRATION GUIDE: Develop together with the population in an interactive and participative way an inspiration guide with creative, social alternatives such that people don't have to come up with these alternatives themselves. This helps to build their efficacy to deal with the social constraints. **Customise** these examples in three different ways.

⇒ **Event-dependent:** provide examples for Christmas, New Year Night, the Christmas Holidays, and the remaining winter months

⇒ **Target group-dependent**: youngsters, students, elderly.

⇒ **Weather-dependent**

9. CREATE PLATFORM TO SHARE INSPIRING EXAMPLES OF SOLIDARITY AND MUTUAL CARE

⇒ Many excellent local initiatives by different organisations have been developed

⇒ These initiatives could be shared to inspire and help each other

10. MOBILISE SOCIALE PROJECTS

⇒ Financially support the development of socially mobilising projects with playful and humoristic elements (cf. the warmest week should be turned into the warmest winter). The **cultural and event sectors** could play a critical creative role herein.

⇒ Ask governors and politicians to place such socially unifying initiatives in the **spotlights.**

Figure 1

Integrative Structural Model Delineating the Motivational Sequence between Hospitalisations and Adherence

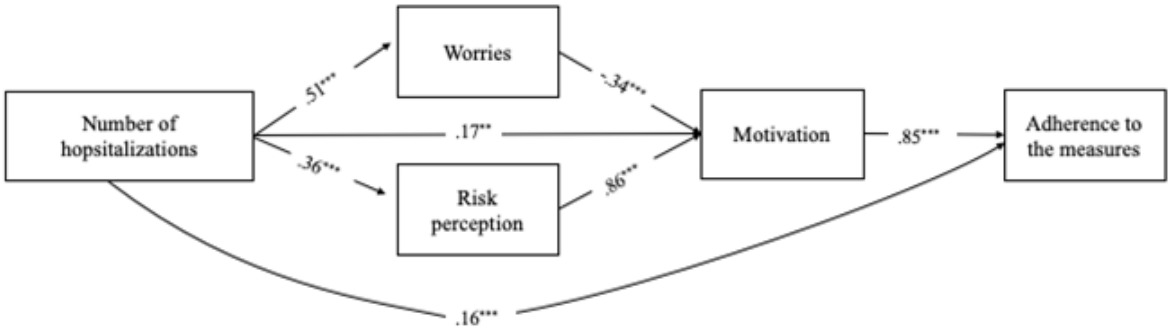


Figure 2

Mean Level Differences in Motivational Orientation Across the Epidemic

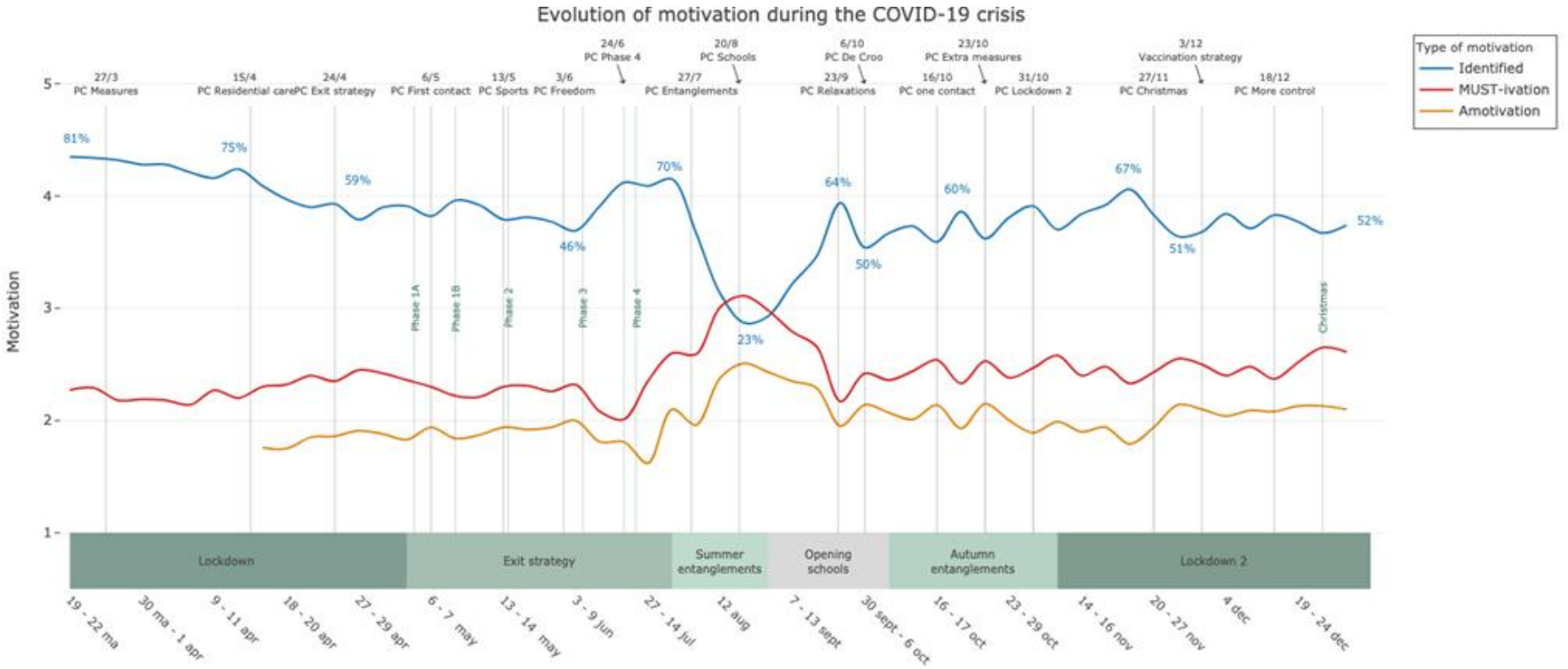
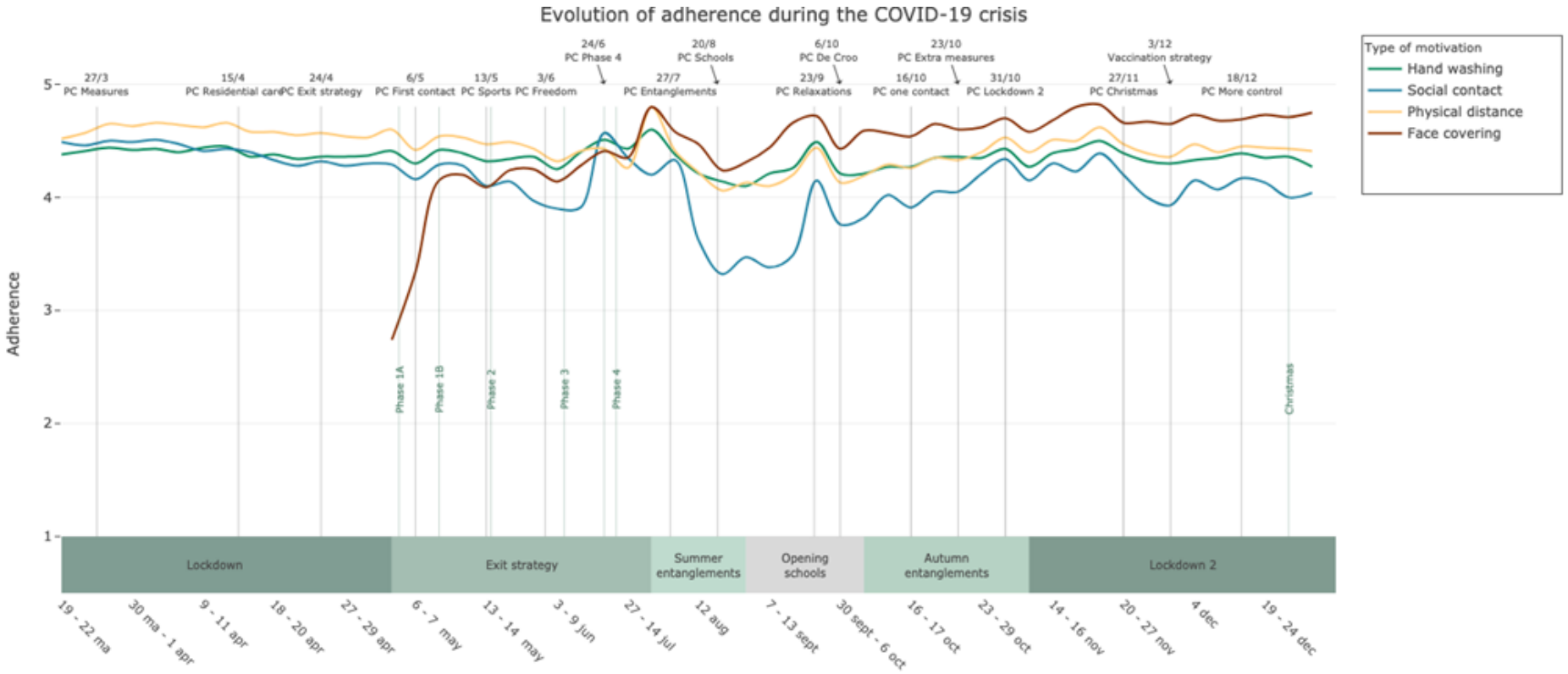


Figure 3


Evolution of adherence during the COVID-19 crisis
Adherence
5
4
3
2
1
27/3 PC Measures
15/4 PC Residential care
24/4 PC Exit strategy
6/5 PC First contact
13/5 PC Sports
3/6 PC Freedom
24/6 PC Phase 4
27/7 PC Entanglements
20/8 PC Schools
23/9 PC Relaxations
6/10 PC De Croo
16/10 PC one contact
23/10 PC Extra measures
31/10 PC Lockdown 2
27/11 PC Christmas
3/12 Vaccination strategy
18/12 PC More control
Phase 1A
Phase 1B
Phase 2
Phase 3
Phase 4
Christmas
Lockdown
Exit strategy
Summer entanglements
Opening schools
Autumn entanglements
Lockdown 2
19 - 22 ma
30 ma - 1 apr
9 - 11 apr
18 - 20 apr
27 - 29 apr
6 - 7 may
13 - 14 may
3 - 9 jun
27 - 14 jul
12 aug
7 - 13 sept
30 sept - 6 oct
16 - 17 oct
23 - 29 oct
14 - 16 nov
20 - 27 nov
4 dec
19 - 24 dec
Type of motivation
Hand washing
Social contact
Physical distance
Face covering

Annex 2. Elements for clear communication on children, parents and families in the COVID-19 epidemic

This chapter describes a compilation of the most relevant and up-to-date insights on the role of children, families and schools in the covid-10-epidemic, and the implications of these insights for current recommendations.

NB: *The following statements **do not consider the epidemiology of COVID-19 in relation to new variants of SARS-CoV-2** (e.g. the one first identified in the UK), for which robust evidence on the potential impact in school settings is not yet available.*

1.1. Epidemiological update

1.1.1. Insights in the role of children in this epidemic

Children of all ages can transmit SARS-CoV-2. When younger children are infected, onward transmission appears to occur less often than in older children and adults.[1] The upsurge in cases observed in many EU Member States in October 2020 do not appear to be driven by the reopening of schools.[1] The epidemiological curve in schools **follows** the evolution of the epidemic in the general population. Apart from having a lower incidence, the number of cases in children younger than 16 rises only after the number of cases in the general population increases.[2] On the contrary, adolescents (16-18 years old) and young adults (19-25 years old) are thought to play as important a role as adults in the transmission of SARS-CoV-2, as the beginning of the second wave shows.[2]

Furthermore, educational staff and adults within the school setting are generally not seen to be at a higher risk of infection than other occupations, although educational roles that put one in contact with older children and/or many adults may be associated with a higher risk.[1]

1.1.2. Impact of epidemic on children's health

Children of all ages are susceptible to SARS-CoV-2. Younger children appear to be less susceptible to infections than older children and adults. In surveillance data, among childhood COVID-19 cases, children between 1-18 years of age have lower rates of hospitalisation, severe hospitalisation and death than do all other age groups.

1.1.3. Insights on variant B.1.1.7

The new variant B.1.1.7 seems to have a much higher viral load (3-10-fold) and has a 56 % higher transmissibility. A back-of-the-envelope calculation relying on this higher transmissibility as based on the available data from the UK and on the trend observed with restarting schools after autumn holidays in Belgium; up to 24% increase in Rt; would imply that **with the current measures in place** an **Rt of minimum 1.25 would be reached if the new variant B.1.1.7 would be widely circulating**.

[1] ECDC

[2] Contact tracing analysis by Sciensano

Furthermore, there is some anecdotal evidence of more disease in 0-9 year olds (based on a large cluster in the Netherlands), although there is no systematic evidence yet. The differences between children and adults seem to remain largely the same.[3]

1.2. Implications for children

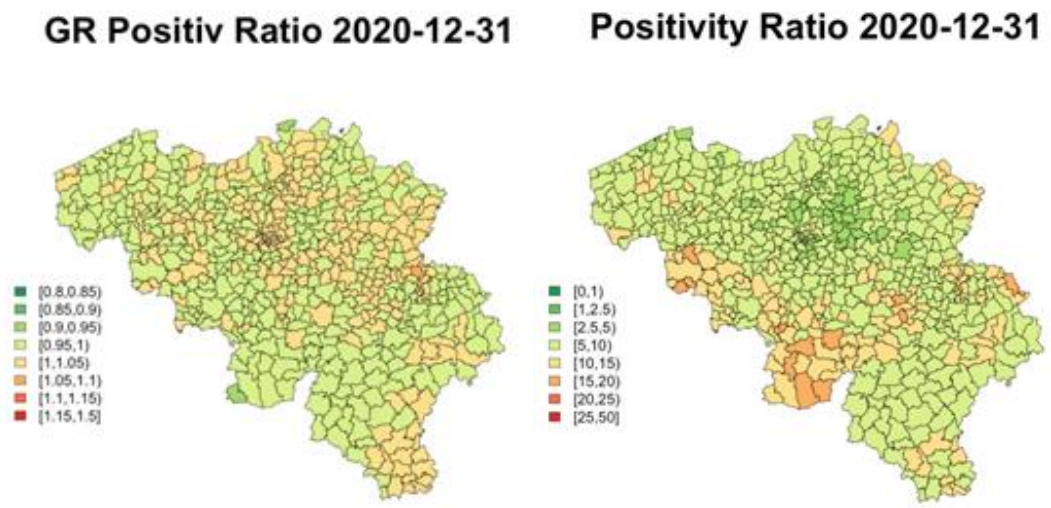
1. We should try to keep schools open as long as possible, which might mean that there will need to be extra safety measures to make schools as safe as possible.
2. Extra-scholarly activities should be suspended (or significantly restricted) for all ages for now, at least until we have a clearer view on the implications of variant B.1.1.7 on children and its circulation in Belgium. Specific measures might be required to address specific needs of children in vulnerable situations.
3. The influence of children's private life should not be underestimated and should not stand in the way of guaranteeing proper education for children in general. It is therefore very important that if a child lives in a household where someone is infected with COVID-19, that they should stay in quarantine as well, which means not attending school physically. The same rule applies when children return from a red zone. If the isolation of a sick parent or household-member is not possible/feasible then the exposed child should start his quarantine at day 7.

[3] Volz et al. (2020) Transmission of SARS-CoV-2 Lineage B.1.1.7 in England: Insights from linking epidemiological and genetic data. https://virological.org/t/transmission-of-sars-cov-2-lineage-b-1-1-7-in-england-insights-from-linking-epidemiological-and-genetic-data/576

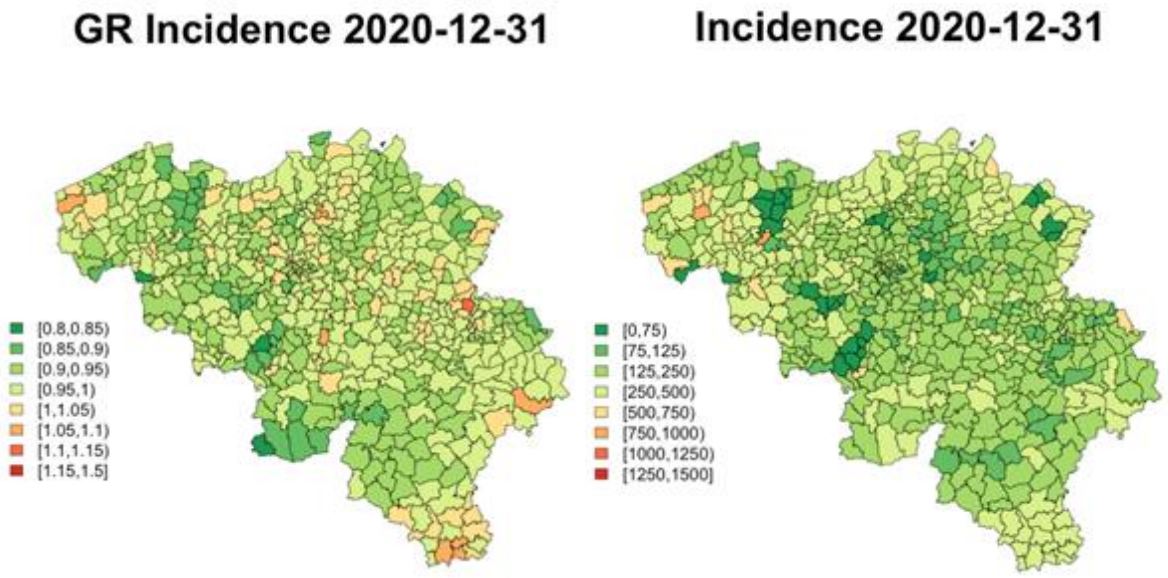
Annex 3. Spatial distribution of positivity and incidence growth rates and levels

1. Growth rates of positivity and incidences at town level

Positivity grows in the border regions of Province Antwerp, Limburg, and Luxembourg. Positivity levels are high in the border regions of Hainaut and Namur still, but not typically growing.



The growth of incidence shows a more diffuse picture, with a tendency to be higher in Luxembourg. The levels of incidence tend to be high, generally speaking, in border regions.



Annex 4. International Situation (in addition to RAG report)

1. Transnational situation: 14day incidences in selected contiguous provinces and regions

Province	**14day incidence (8/12 → 15/12 → 20/12 → 28/12 → 5/1)**	**Neighbouring province/region**	**14 day incidence (8/12 → 15/12 → 22/12 → 29/12 → 5/1)**
Oost-Vlaanderen	303 → 346 → 313 → 349 → 250	Zeeland (NL)	268 → 354 → 510 → 542 → 629
West-Vlaanderen	319 → 398 → 353 → 394 → 276		
Antwerpen	248 → 266 → 298 → 309 → 217	Noord-Brabant (NL)	474 → 605 → 823 → 838 → 861
Limburg	228 → 234 → 254 → 266 → 218	Limburg (NL)	422 → 655 → 988 → 1024 → 1143
Luxembourg	400 → 392 → 369 → 311 → 231	Luxembourg (LUX)	1182 → 1197 → 1206 → 1037 → 643
Namur	291 → 268 → 305 → 316 → 205	Dept. des Ardennes (FR)	419 → 527 → 639 → 669 → 572

The foreign incidences are coming from the Working Group on color codes (Tuesday, December 8, 15, 22, and 29, 2020). The Belgian incidences come from four Sciensano daily reports, on December 8, 15, 20, and 28, 2020, and January 5, 2021.

In the Dutch provinces of Noord-Brabant (NL) and Limburg (NL), the incidences have been increasing rapidly and are well above the Belgian level: 4 times for North Brabant, and 5 times for Dutch Limburg. In Zeeland, the increase is also rapid, and is at 2.5 times the level of Oost- and West-Vlaanderen.

2. International situation: 14day incidences, measures taken, and considerations

Belgium

Date	**21/12/20**	**28/12/20**	**04/01/21**
14day incidence	**296**	**263**	**207**

Luxembourg (746/100k/14d):

Date	21/12/20	28/12/20	04/01/21
14day incidence	975	631	384

Christmas break is extended by one week, which means that the week starting 04/01 will be “home schooling”.

For the first time in long, the Luxembourg incidence seems to be decreasing. A word of caution is needed, as there seems to be a reporting delay due to the succession of weekends and holidays over the festive season.

Sweden

Date	21/12/20	28/12/20	04/01/21
14day incidence	840	825	?

Secondary schools and higher education operate online until January 24.

The Netherlands

Date	21/12/20	28/12/20	04/01/21
14day incidence	804	872	746

There is a strict lockdown in the Netherlands, currently planned and in execution from 15/12/20 to 19/01/21. The measures in the Netherlands take the following form:

- Binnen en buiten: groep van max. 2 personen of 1 huishouden (Uitzondering: 24, 25 & 26 december mogen er 3 personen op bezoek komen).
- Volgende locaties sluiten:
    - Winkels (behalve voor essentiële zaken zoals levensmiddelen, zie uitzonderingen onder)
    - Locaties van contactberoepen zoals kappers, nagelstudio’s, seksinrichtingen.
    - Theaters, concertzalen, bioscopen, casino’s, etc.
    - Dierenparken, pretparken, etc.
    - Binnensportlocaties zoals sportscholen, zwembaden, sauna’s, wellness, etc.
    - Restaurants en café’s.
    - Hotels zijn open, maar restaurants en roomservice in een hotel zijn gesloten.
    - Uitgezonderde winkels die open mogen blijven:
        - Winkels die voornamelijk levensmiddelen verkopen, drogisterijen, apotheken, opticiens, audiciens, winkels voor reparatie en onderhoud mogen openblijven.
        - Doe-het-zelfzaken mogen een afhaalfunctie inrichten.

    - Servicepunten voor het ontvangen en versturen van pakketten mogen open blijven.
    - Locaties voor zakelijke dienstverlening (banken, hypotheekverstrekking, makelaars) blijven open. Het loket van de gemeente, de rechtbank en andere overheidslocaties blijven ook open.
    - Boeken afhalen bij bibliotheken blijft mogelijk.
- Verbod op bezit (in de openbare ruimte) en verkoop van alcohol na 20u00.
- Dringend advies om thuis te werken.
- Sporten maximaal met 2 personen op 1,5 m afstand, en alleen buiten. Uitzondering: Kinderen t.e.m. 17 jaar mogen buiten sporten in teamverband, topsporters mogen trainen en wedstrijden spelen.
- Het openbaar vervoer is (bij dringend advies) alleen voor noodzakelijke reizen.
- Nederland verlengt het advies om niet te reizen naar het buitenland tot medio maart.
- (para)Medische contactberoepen zijn toegestaan.
- Vanaf 16 december geldt afstandsonderwijs als de regel. In het voortgezet onderwijs kunnen examens, praktijklessen en lessen voor examenleerlingen wel op locatie doorgaan.

Czech Republic

Date	**21/12/20**	**28/12/20**	**04/01/21**
14day incidence	**753**	**871**	**1113**

Schools reopen on January 4, with first, second, and last year fully physical, while all other years will be in 50/50 hybrid-form. The rapidly increasing figures come on top of an already strained situation, with stretched capacity in the hospital system.

Denmark

Date	**21/12/20**	**28/12/20**	**04/01/21**
14day incidence	**777**	**739**	**574**

Schools operate online until January 17.

Germany

Date	**21/12/20**	**28/12/20**	**04/01/21**
14day incidence	**399**	**376**	**313**

Schools are closed until mid-January, as part of the lockdown. It is very likely that the lockdown will be extended until 31/01. The German authorities indicate that the figures are going down thanks to the severe measures taken.

Italy

Date	21/12/20	28/12/20	04/01/21
14day incidence	366	332	334

De periode van 24/12 tot 6/1 tijdens dewelke heel Italië als rode zone werd beschouwd, loopt op zijn einde maar de regering overweegt de maatregelen te verlengen, mede uit bezorgdheid over de "Engelse variant":

Waarschijnlijk wordt het weekend van 9-10/1 opnieuw rode zone voor heel Italië (uitgaansverbod, winkels gesloten, verboden de gemeente te verlaten).

De scholen worden normaal gezien heropend op 7/1 maar de regio's vragen de minister van onderwijs deze heropening uit te stellen. In Veneto en Friuli Venezia Giulia overwegen de Presidenten alvast zelf de heropening (gedeeltelijk) uit te stellen tot 31/1.

Op vraag van de Regio's heeft de Minister van Gezondheid op 2/1 een verordening ondertekend waarmee de opening van de skigebieden, die had kunnen plaatsvinden op 7/1, wordt uitgesteld tot 18/1.

France

Date	21/12/20	28/12/20	04/01/21
14day incidence	283	282	278

Two voluntary days off prior to Christmas. Stricter measures in a set of regions with high incidences, including a very early curfew at 18:00.

Ireland

Date	21/12/20	28/12/20	04/01/21
14day incidence	117	212	562

Ireland has had the epidemic under control since having placed the country in 'Level 5' (highest level of measures; lockdown) in October. Level 5 is a strict lockdown, including a perimeter of 5 km, but with schools open. For months, the incidence was among the lowest in Europe, with the country most of the time in the top 3 (out of 31 ECDC ranked countries). Since three weeks, the incidence has gone up at an alarming rate, and Ireland is propelled to the middle of the pack in Europe. The country is placed in Level 5+, which implies Level 5 but with further restrictions on private contacts: households cannot receive visitors, neither inside nor outside.

The doubling time of the incidence is shorter than one week, and considerably shorter for hospitalizations and ICU admissions.

Non-essential surgical interventions are being canceled. The testing capacity is strained and therefore restricted to the most vulnerable.

Schools were scheduled to reopen on January 11, one week later than planned. This will be postponed further.

United Kingdom

Date	**21/12/20**	**28/12/20**	**04/01/21**
14day incidence	**497**	**680**	**946**

The characteristics and spread of B.1.1.7 have been documented by various sources. It is now dominant in London, East of England, and South East. The stark increase of the incidences at national level is even more spectacular across these regions. Consider the 14day incidences across the five parts of London:

Part of London	**29/12/20**	**05/01/21**
Inner London – West	**1777**	**2262**
Inner London – East	**2445**	**3242**
Outer London – East and North East	**3211**	**4011**
Outer London - South	**2341**	**3280**
Outer London – West and North West	**2044**	**3029**

Scotland and England have been placed in a strict lockdown on 5 January 2021, which effectively means that the UK is in strict lockdown.

Norway

Date	**21/12/20**	**28/12/20**	**04/01/21**
14day incidence	**104**	**115**	**127**

The situation is deemed unstable, because of the effects of the festive season and B.1.1.7. Stricter measures are in place until January 17, 2021.

- **Internationale reizen:** de maatregelen die voordien enkel golden voor reizigers uit UK worden nu veralgemeend inzake testen en registratie. Een test bij binnenkomst van het land is voortaan vereist aan de grens (of indien dit onmogelijk is binnen de 24u). NO zal ook verschillende kleinere grensovergangen sluiten om een betere controle toe te laten. De lijst is voorlopig nog niet bekendgemaakt. Deze maatregelen zullen na 4 weken opnieuw geëvalueerd worden. Een verplichte registratie van alle reizigers verloopt voortaan ook digitaal en kan niet vroeger dan 72u voor vertrek gebeuren. Een aangepast voorstel voor het reisadvies met deze nieuwe bepalingen gaat in bijlage.
- **Binnenlandse reizen** worden sterk afgeraden.
- Alle **scholen** in het secundair onderwijs naar het rode niveau, wat een mix tussen fysieke en online leermethodes impliceert. Voor lagere scholen en kinderdagverblijven zal dit op lokaal niveau bepaald worden. In het hoger onderwijs zal alvast geen fysiek onderwijs plaatsvinden tot 18 januari.
- **Bezoekers thuis:** individuele bezoeken worden volledig afgeraden met uitzondering van palliatieve zorg, alleenstaanden (maximaal 2 bezoekers) of kinderen jonger dan 12 die kinderen uit de klas ontvangen.
- Private **evenemente**n worden beperkt tot 5 personen buitenshuis, publieke evenementen kunnen tot maximaal 10 personen. Voor begrafenissen geldt een maximum van 50 personen. Waar stoelen vastgemaakt zijn aan de grond kunnen evenementen tot 200 personen nog steeds indien de sociale afstandsregels gerespecteerd worden.
- Winkels blijven open, maar worden aangeraden om maximale aantallen klanten vast te leggen.
- Georganiseerde indoor **vrijetijdsactiviteite**n worden verboden.
- Het schenken van **alcoholische dranken** wordt verboden op evenementen en in restaurants.
- **Telewerken** blijft de norm.

For reference, some more countries:

Spain

Date	**21/12/20**	**28/12/20**	**04/01/21**
14day incidence	**250**	**273**	**299**

Portugal

Date	**21/12/20**	**28/12/20**	**04/01/21**
14day incidence	**502**	**448**	**543**

Switzerland

Date	21/12/20	28/12/20	04/01/21
14day incidence	690	621	554

Turkey

Date	21/12/20	28/12/20	04/01/21
14day incidence	427	351	251