



Northern Periphery and Arctic Programme
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COVIDWATCHEU-NPA PROJECT #411 FINAL REPORT 4 - March, 2021

4. Territories & Key Statistics (ranked by COVID-19 mortality, data to 28-02-2021)

The following section provides key details for each country/territory of the NPA individually (key statistics as of the 28th of February, 2021). Large variations are seen between infection rates (more accurately, case detection rates) and mortality rates.

The case fatality proportion (CFP) is again included, which is simply calculated by dividing number of deaths by number of cases and expressing it as a percentage. Early in the pandemic, all countries that experienced significant outbreaks presented data with relatively high CFP rates due to limited testing capacity where testing of the sickest patients only was carried out. While other countries have seen their CFP decline as more people are tested, and thus less severe infections are documented, Scotland's CFP has remained relatively high (see Figure 4). This could relate to lower accessibility to testing or potentially highlights a population or health system at greater risk from COVID-19.

4.1 Greenland



- popn. 57k

COVID-19 cases	30	(rate/100,000	53)	case fatality
COVID-19 deaths	0	(rate/100,000	0.0)	proportion
					0

Greenland, an autonomous territory of Denmark, confirmed its first case of COVID-19 on the 16th of March 2020. The first infected patient lived in the capital, Nuuk, and was placed in home isolation. Eleven cases were detected in the following 30 days, all in Nuuk. These cases were all isolated at home, and all survived. Flights into and out of the country, in addition to domestic flights for citizens, were discouraged. The only flights that remain operational are those to Copenhagen, Denmark.

On the 28th of March 2020, the government prohibited the sale of alcoholic drinks until the 15th of April. In step with Denmark, Greenland quickly closed its borders to tourists. On the 24th of May, SARS-CoV-2 was again detected in Greenland in a traveler returning from Denmark, who had recently recovered from COVID-19 whilst in Denmark. While not anticipated to be an infectious risk, as a precaution they were placed in quarantine. This scenario again arose in early June, and again the person was placed in quarantine.

Greenland has imported only a handful of cases over the past 7 months, with a spike seen at the end of December, where 6 people tested positive in quick succession in the settlement of Ilulissat. The 6 people came from 3 unrelated households, and all cases were detected on testing performed 5 days after arrival as part of follow-up testing designed to allow people to cut short their 14-day isolation period following arrival. Of note all 6 had arrived in Greenland with recent negative tests, as dictated by travel restrictions currently in place. Greenland has had no deaths due to COVID-19 thus far.

4.2 The Faroe Islands



• popn. 52k				
COVID-19 cases	646	(rate/100,000	1262) case fatality
COVID-19 deaths	1	(rate/100,000	1.9) proportion
				0.2%

The Faroe Islands, a self-governing archipelago in the North Atlantic (in the kingdom of Denmark), reported its first case COVID-19 on the 3th March 2020 in a citizen returning from France. Lockdown measures were introduced on March 12th to contain the spread of the Covid-19 coronavirus in the Faroe Islands. Widespread societal restrictions were advised by the Faroese government, including encouragement to work from home if possible, to restrict travel to essential trips only. Schools and colleges were closed and the government appealed to all bars, cafes and restaurants to close by 22:00 daily. Temporary border control on entry to the Faroe Islands from abroad was introduced on the 17th of March. Lockdown was

gradually lifted starting the 9th of April and the last positive test during the first wave of COVID-19 was registered on the 22nd of April³².

After 104 days without any known cases of COVID-19, one was confirmed on the 4th of July in a returning traveller. So far, there have been four waves of COVID-19 cases in the Faroe Islands. The first was in March–April, the second wave of COVID-19 began in August, the third in September and the fourth in December 2020. The Faroese strategy in handling the COVID-19 epidemic complied with the official recommendations of the WHO by applying an active suppression strategy with liberal testing and rapid isolation of cases and their close contacts. The rapid resurgence of a second wave of COVID-19 in the Faroes was attributable to loosened border restrictions where, on June 15, regulations were changed from a 14 day quarantine for travelers to a single negative test at the border. This did not immediately lead to a rise in identified cases.

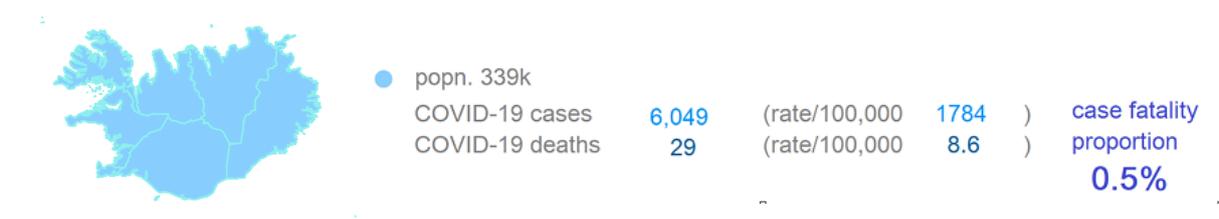
However, following large gatherings [e.g. private parties, and the national festival (July 28/29)], a large outbreak of COVID-19 occurred presumably because infected individuals who had tested negative at the border had participated. The third wave consisted of positive cases with a number of chain of infections. The fourth wave in December was as a consequence of the many Faroese abroad traveling back for the holidays from areas with very high number of positive cases, e.g. Denmark. Since then, only a few cases have occurred sporadically. Currently, 9.4% of the population has had the first vaccination and 7.5% have been fully vaccinated (<https://corona.fo/>).

In short, the preventive measures in the Faroes now are: recommended test up to 3 days before traveling to the Faroes, mandatory testing at arrival for at the border, recommended quarantine for 6 days followed by a new test. Social gatherings up to 200 persons keeping 2-meter distance are accepted (March 5th).

Important elements of the response in the Faroes include³³:

1. Strong testing system: Ensuring abundance of test capacity and easy and free access to it. The test capacity was provided by a public and private partnership, making it possible to avoid waiting lists and to achieve test reporting within 24 hours.
2. Strong quarantine measures: All infected persons were put in quarantine for two weeks and all their close contacts were traced and quarantined also.
3. Strong border control: Compulsory testing of all travellers to the Faroe Islands, followed by a recommended test on the 6th day after arrival.
4. Strong communication strategy: Finally, good and plentiful communication both on personal and community level has been crucial since the preventive effort has been almost entirely voluntary and not based on legislation.

4.3 Iceland



The first case of COVID-19 was confirmed in Iceland on February 28th. The Icelandic Civil Protection Department declared a 'danger alert level' on the same day. The response of the Icelandic authorities and the objectives of the COVID-19 measures taken have been clear from the outset. The focus has been on ensuring that Iceland's essential infrastructure, particularly the healthcare system, can handle the workload inevitably generated by the disease. The main measures taken included early identification of risk areas and quarantine and/or testing of travellers arriving from these areas.

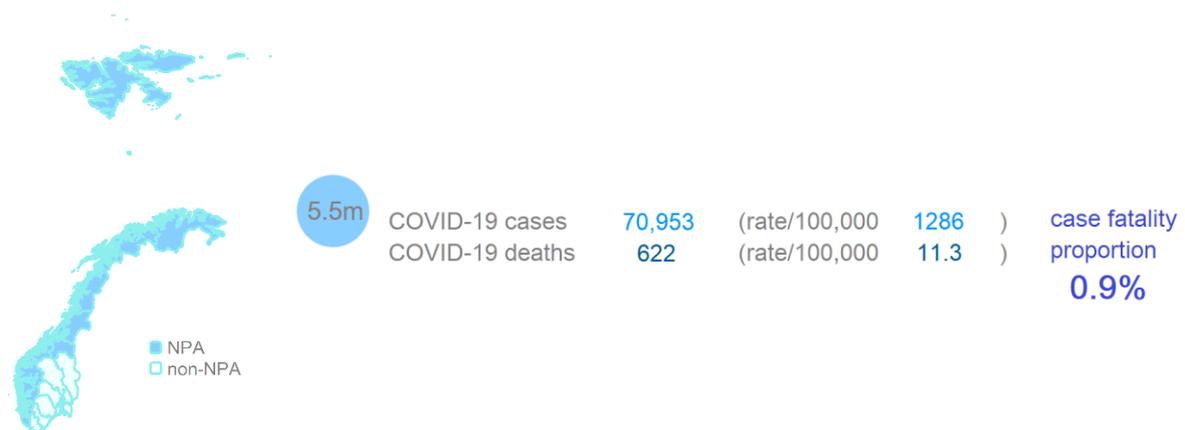
From the outset there has been a strong focus on testing as many people as possible and fully tracing all infections possible. Along with the Faroes, Iceland has one of the highest testing rates per capita in the world (see Table 4). Everybody who has had contact with infected people is ordered to quarantine. There are also restrictions on gatherings, while secondary schools and universities use distance learning. There is limited running of nursery schools and primary schools.

Finally, there is a strong focus on continuously educating the public and providing information. Information is published on the covid.is website in 11 languages. Regular press conferences with the Chief Epidemiologist and the Civil Protection Department are broadcast live by Iceland's major media outlets. Despite initial subsidence of the first wave of COVID-19 in Iceland in May, there was a resurgence in August 2020, as seen in other European countries.

This second wave was relatively short-lived but soon after - in the middle of September - a third wave started with rapidly increasing daily new cases. This third wave reached the maximum point in the middle of October, but it took longer to subside than the first wave. Also, at the peak a group infection in an elderly ward at Iceland largest hospital caused the death rate to rise. More restrictions domestically and at the borders were applied and are still to large extent in place at time of writing.

Vaccination was started in Iceland during the last week of 2020 and the emphasis was on frontline health care workers and the older age groups. Welfare care workers were also in the first groups. To date about 10% of the population have started their vaccination schedule and a third are fully vaccinated.

4.4 Norway



Norway recorded its first confirmed case of COVID-19 on the 26th February 2020 in an individual who came back from China. On the 12th of March, Norway was 'closed down' by the Government. Due to lack of testing systems and equipment, vulnerable healthcare staff and difficult geographic and weather-related circumstances, many Norwegian rural communities adopted stricter local quarantine rules. The initial rise in COVID-19 cases in March and April were mostly due to Norwegians coming home from skiing holidays on the European mainland. Most initial deaths were among older age groups, chiefly in nursing home settings.

The public health system in Norway is different from most other countries in that it is very decentralised. Each individual municipality has a chief medical officer and local public health team who set public health and disease prevention strategies for each municipality. At a national level the pandemic is handled collaboratively between institutions such as the Norwegian Institute of Public Health, the Directorate of Healthcare, and the Ministry of Health and Care Services.

Autonomy of municipalities is strong in Norway. Local democracy is rooted and regulated in the Constitution. The Local Government Act and the Infection Protection Act provide individual municipalities with the authority to adopt local measures of intervention. This decentralised system of public health has been a key element in the fight against the COVID-19 pandemic. There are 355 municipalities in Norway and each of these has their own chief medical officer who normally also is the local head of public health. In rural municipalities, the position is often part time in combination with being clinically active in general practice. In larger cities, there are often several medical officers.

The law regulating the response to communicable diseases allows the local public health officer to pass temporary local decisions of intervention. This opportunity was used by many local public health officers at the beginning of the COVID-19 pandemic in order to buy time to establish equipment, personnel and routines, and is now used in local outbreaks. Through the so-called Corona Act, the Norwegian Government was granted a time-limited extended

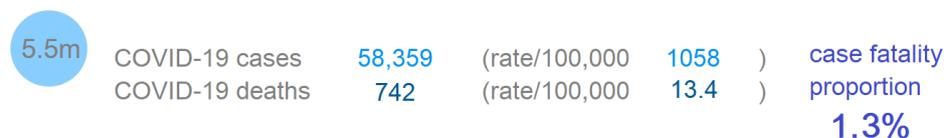
power of attorney to complement, supplement or deviate from the Local Government Act, but not to the extent that local self-government lost its importance. Most of the national and local restrictions are recommendations, and the majority of the people are compliant with the advice from the authorities. In serious situations some restrictions are mandated by legislation.

One of the most effective actions in Norway has been the TISK-strategy (Norwegian acronym meaning Test – Isolate – Track – Quarantine) performed by local outbreak detection teams. Covid-19 positive persons are isolated, and the teams track down and quarantine all close contacts. Another effective action is the targeted, temporary local restrictions made by the municipal council and the public health officer in municipalities with outbreaks.

Norway’s COVID-19 vaccination programme started 27th December 2020. Due to limited availability, there was an initial prioritisation. The government determines this priority on the advice of the Norwegian Institute of Public Health, with vulnerable and older adults receiving the first tranche of vaccinations. All eligible persons living in nursing homes and care homes were fully vaccinated by February 2021. In January 2021 health personnel were added to the prioritising list. The first vaccine to be approved was Pfizer BioNTech, followed by Moderna and AstraZeneca, the latter only for persons under 65 years. The municipalities are responsible for offering coronavirus vaccination to people in recommended groups. A fair geographical distribution of vaccine doses across the country has been chosen. The coronavirus vaccine is mainly distributed according to how many people there are in the relevant risk groups in each municipality, with a dynamic order of priority. The order will be adjusted according to the infection situation and decisions by the Government.

An important lesson learned in Norway is that local anchoring of information and measurements creates trust and loyalty among people. The decentralized organization of public health work in Norway has been one of the success factors of the Norwegian handling of the pandemic. Understandable and transparent national decisions must be combined with community adjustment based on local knowledge in open, respectful dialogue between local and national authorities.

4.5 Finland



On January 29th 2020 the first SARS-CoV-2 case in Finland was identified as a Chinese tourist visiting Rovaniemi who had suffered from COVID-19. Finland recorded its first new confirmed case of COVID-19 on the 26th Feb 2020 in a Finnish citizen returning from Northern Italy. Before that, adequate testing systems took some time to be established. Infection rates in older age groups and in nursing homes/residential settings in the period March to May 2020 were linked to the majority of COVID-19 deaths. However, surge capacity in state-run and private hospitals was not overwhelmed by the first wave. Widespread societal restrictions, including restriction of movement and closure of schools and universities, were gradually loosened over the summer of 2020 as COVID-19 cases and deaths remained low.

New restrictions were introduced at the end of September 2020 to control the spread of SARS-CoV-2 in a second wave. These restrictions, in addition to a more expansive and robust testing strategy, accompanied by better shielding of older age groups allowed health authorities to quickly regain control and the country experienced relatively few deaths during this wave in October-December. Most cases were in the metropolitan area Helsinki-Uusimaa but gradually spread to some specific areas around the country. The government supported the implementation of stronger restrictions during the Christmas period specifically to reduce the amount of internal travel occurring.

Finland reported their first case of a new variant of SARS-CoV-2 on 28th December, 2020 from the United Kingdom, after a person who travelled from Western Europe tested positive for COVID-19. On the same day, a separate, second variant from South Africa was also reported in Finland, after two people tested positive for COVID-19. Restrictions on entry to Finland were activated in December and gradually in January 2021 those were extended till 22nd February 2021. The SARS-CoV-2 vaccination programme, using Pfizer BioNTech and AstraZeneca vaccines, began with older citizens but also prioritised frontline health professionals and patients at higher risk of severe disease. The roll-out has been slow due to supply problems, especially in rural areas.

4.6 Ireland



Ireland recorded its first confirmed case of COVID-19 on the 29th Feb 2020 in a citizen returning from Northern Italy. Adequate testing systems took some time to be established. High rates of infection in older age groups and in nursing homes/residential settings in March

and April led to relatively high numbers of COVID-19 deaths. However, surge capacity in state-run and private hospitals was not overwhelmed by the first wave. Widespread societal restrictions, including restriction of movement and closure of schools, were gradually relaxed over the summer of 2020 as COVID-19 cases and deaths remained relatively low.

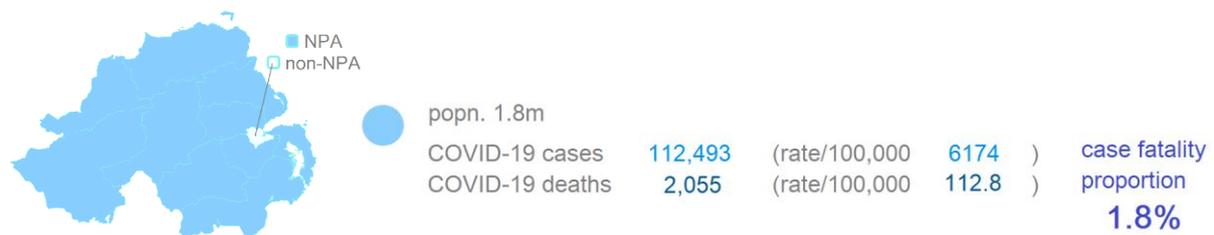
Nationwide “Level 5” (the most restrictive level) lockdown was re-introduced on the 21st October 2020 to control spread of SARS-CoV-2 in a second wave. These restrictions, in addition to a more expansive and robust testing strategy, accompanied by better shielding of older age groups allowed health authorities to quickly regain control and the country experienced relatively few deaths during this wave in October and November.

However, it seems that by not fully suppressing this second wave, followed by relaxation of widespread societal restrictions over the Christmas period, the third and most significant wave of SARS-CoV-2 infections was triggered. This saw a dramatic rise in cases in the first weeks of 2021 with Ireland having the highest rates of infection in the world in January 2021. Due to the maturation of the SARS-CoV-2 testing system as the pandemic has unfolded, Ireland’s case numbers undoubtedly better reflect disease burden in communities during this third wave, and it has been striking how quickly the situation has deteriorated.

The huge rise in cases, in a very short period of time, has seen hospitalisations and ICU beds quickly become saturated with patients with severe COVID-19 illness. This has seen cancellation of elective work and planned operations in hospitals, and mortality has again begun to rise. This ominous start to the new year reminds us that COVID-19, left unchecked, can rapidly become a huge problem for a healthcare system.

Ireland’s COVID-19 vaccination programme is underway, with vulnerable and older adults receiving the first tranche of vaccinations. Healthcare workers and older patients in the community are now being vaccinated, although supply issues are a limiting factor.

4.7 Northern Ireland



The first COVID-19 case in Northern Ireland was recorded on the 27th February 2020 by a citizen who had returned from Northern Italy, and was the first case recorded on the island of Ireland. By the 9th March it was decided to cancel the annual Saint Patrick’s day festivities when cases in NI had reached 52, and on the 19th March 2020 the first death was recorded.

Restrictions to contain the spread of the virus were enacted from the 20th of March 2020. These restrictions included the closing of social venues such as bars, restaurants, and gyms. On the same day, the government job retention scheme was announced which would provide grants to companies to cover 80% of an employee's salary up to £2,500 per month if they kept them on their payroll for the following three months. Restrictions were strengthened further on the 28th of March 2020 to include a stay-at-home requirement, a mandate for working from home where possible and the closing of non-essential retail. These restrictions were enforced through fines of up to £5,000. COVID-19 testing in Northern Ireland began on the 4th of April 2020 with a testing centre set-up in the SSE Arena in Belfast for healthcare personnel only. Restrictions began to be eased on 12th June 2020 with the reopening of non-essential retail, and by July restaurants, bars, and salons were allowed to reopen with some restrictions.

However, due to increases in infection rates in September, a "circuit breaker" lockdown was initiated from 16th October 2020, which was originally due to last four weeks. However, as the number of cases continued to rise it was decided to extend the "circuit breaker" as well as introduce additional lockdown measures first for a further three weeks then for an additional week. Businesses were permitted to reopen on the 11th December for 2 weeks to facilitate Christmas shopping.

On the 16th December however, it was reported that hospital capacity across the region stood at 104% with some patients waiting up to 28 hours to be admitted. This resulted in patients being treated in ambulances in hospital carparks across all 11 emergency departments in NI. With the sharp increase in cases and obvious strain on the health system, a third full lockdown was initiated which began on the 26th of December and is still on-going pending a monthly review. An 8pm curfew was introduced from 26th December for 1 week to ensure gatherings for new year's celebrations were avoided. On 8th January new powers were granted to the police with £200 fines now being given to anyone breaking the lockdown rules. As of 28th February, a full lockdown remains in place in NI.

The Pfizer/BioNTech vaccine was approved for use in Northern Ireland on the 2nd of December 2020 and the first dose was administered on the 8th of December 2020. The new variant of SARS-CoV-2 was detected on 23rd December. When compared to the rest of the United Kingdom, Northern Ireland currently has the lowest death rate of all UK regions. As of 3rd March 2021, 582,881 vaccines have been administered. Of these, 545,019 have been first doses and 37,862 second doses. First doses have been received by 96% of over 80-year-olds (69,146 people); 91% of 75-79 age group (56,474 people); 86% of 70-74 age group (70,098) people; 72% of 65-69 age group (64,643 people); 45% of Clinically Extremely Vulnerable patients (42,832 people). Many other CEV people are in the 65 plus age group, so are being covered in that section of the vaccination programme.

4.8 Sweden

■ NPA
□ non-NPA



10.2m

COVID-19 cases	680,130	(rate/100,000	6648)	case fatality
COVID-19 deaths	12,826	(rate/100,000	125.4)	proportion
					1.9%

SARS-CoV-2 was confirmed to have reached Sweden on 31st of January 2020, when a woman returning from Wuhan in China tested positive. On 26th of February, multiple travel-related clusters appeared in Sweden. Community transmission was confirmed on the 9th of March in the Stockholm region.

Sweden has attracted attention internationally for having less stringent restrictions than neighbouring countries. In short, the approach has been to slow down the spread rather than eliminating the virus³⁴.

For Swedish citizens and visitors from the EU, it is recommended that those who are feeling unwell should stay at home, people should stay at least an arm's length away from other people in public and that everyone should wash their hands frequently with soap and water. Access to PCR testing for people in Sweden can be organised by calling 1177.

Some additional public health measures have also been advised since the start of the pandemic, including advice to work from home where possible, to avoid public transport, to avoid unnecessary travel and to limit numbers allowed into shops. Primary schools did not close early on in the pandemic, and reopened as normal after the usual summer break. Public events were initially restricted to 500 (11th March 2020), and then to 50 just over 2 weeks later. This limit has remained in place since.

Travel restrictions were relaxed leading up to the summer, but everything else stayed in place. Case numbers fell significantly during the summer months and schools and universities reopened as normal in August/September 2020. Case numbers increased steadily during October and November, leading to increased restrictions leading up to Christmas. All sports activities were cancelled, remote learning for school-going children aged 13yrs+ was introduced and citizens were advised to limit or eliminate visits to other households.

Other additional measures have also been put in place in the past few months, including closing universities, a requirement for masks on public transport and further restrictions on opening times and patron-limits in restaurants. The rules are being adapted quite frequently,

and there is very little that is mandatory for individuals. However, it is mandatory for restaurant operators and other businesses to comply with guidelines.

There have been 3 peaks/waves in case numbers - the initial peak in March/April 2020, then the pre-Christmas surge, and then the current one, which is ongoing at time of writing.

The initial peak brought in the basic restrictions. The November one shut down universities and restricted pubs/restaurants. The post-Christmas surge has seen the introduction of facemasks, more restrictions on restaurants and new cross-border travel restrictions, where a COVID-19 negative test is required to transit through airports.

To summarise, the Swedish authorities ramp up restrictions in response to case numbers, and while individuals are not obliged to comply with restrictions, there have been significant changes to normal daily life in Sweden. While the government has passed laws which would let it take more drastic steps (i.e. full lockdown), these laws have not yet been brought into force.

4.9 Scotland



Scotland's first case of COVID-19 was confirmed on 1st March 2020, in a Scottish resident returning from Northern Italy. The first COVID-19 death was confirmed on the 13th March. On the 15th March, the Scottish government announced people should avoid non-essential travel and meetings, and work from home if possible. Five days later, schools and pubs were closed. On the 23rd March, a "stay at home" order was issued.

Initial poor testing capacity, very stringent testing criteria and a limited definition of a death from COVID-19 meant that the true burden of disease in Scotland was difficult to assess early on in the pandemic. An older population and high obesity rates (see Table 1) may indicate a population at more risk from COVID-19, when compared to the other countries featured in

this report. However, as in other countries, a large determinant of mortality from COVID-19 is if large numbers of older patients contract the disease. COVID-19 found its way into Scottish care homes early in the pandemic³⁵ with a high excess mortality as a result (see Section 3).

Scotland, much like the rest of the UK, experienced a large spike in cases and consequent deaths after the Christmas period, leading to prolongation of restrictions.

Vaccinations have been swiftly delivered to Scottish citizens, and as of the end of February 2021, 36% of the population had received their first dose of a COVID-19 vaccination³⁶.

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