



Autumn upswing of the COVID-19 pandemic

Daily COVID-19 cases started rising again at the end of July after consistently low rates since early May. Twelve new cases were diagnosed on 29 July, the highest number since 16 April. The rate peaked on 6 August, with 17 new cases, after which the rates went down again until 15 September. This marks the start of the so called third wave of the COVID-19 pandemic in Iceland, when rates quickly increased. Figure 1 shows the daily number of new cases from 1

July to 31 October, calculated as the moving average of the past five days, in order to reduce daily fluctuations. The timings of the main public measures against the epidemic are also shown. A summary of the measures is listed on p. 2.

A total of 317 COVID-19 cases were diagnosed in Iceland between 29 July and 14 September, 70% of which were domestic. 2,720 cases were diagnosed

from 15 September to the end of October, 93% domestic. Many of these cases were traced to outbreaks in clubs, bars and gyms. A severe outbreak also occurred at Landakot, a geriatric ward of Landspítali National Hospital. This spread to other health care institutions and into the community. Rates of COVID-19 infections diagnosed at the border also rose considerably in the autumn, in line with increased spread of the virus across Europe.

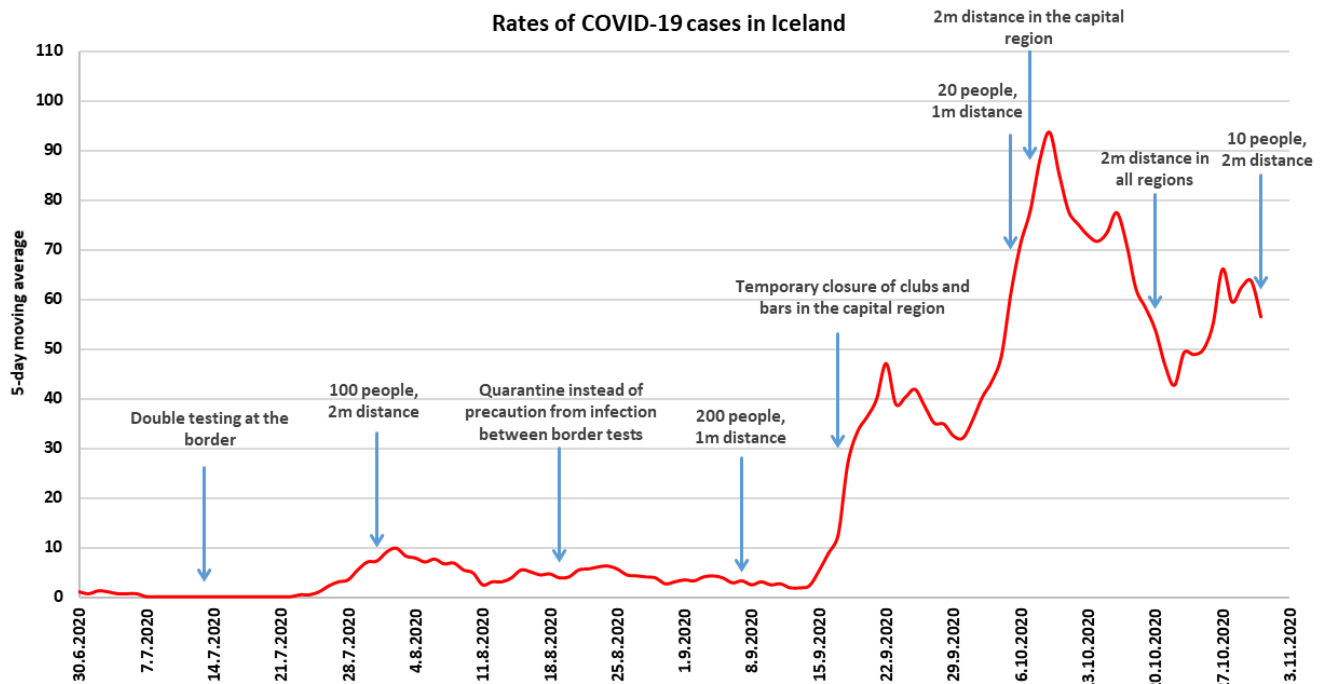


Figure 1

Source: Directorate of Health

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Public measures against COVID-19

The [last issue of EPI-ICE](#) summarised public measures against COVID-19 in Iceland until mid-June. At that point, restrictions on public gatherings had been eased to 500 people and the 2-meter social distancing rule was optional. Passengers arriving at the border could choose between 14-day quarantine or have a test for COVID-19. All countries apart from the Faroe Islands and Greenland were defined as high-risk areas.

An updated summary of public measures until the end of October is below. Only the main measures are outlined, whereas specific rules and guidelines for particular activities such as shops and other businesses, health and social care, sport, culture and education are not listed. Further information can be found on covid.is. All regulations are published in the [State Gazette](#) (only available in Icelandic).

13 July. Double testing at the border is initiated. When arriving in the country, Icelandic citizens and those residing in Iceland can choose between 14-day quarantine or two tests with a 5-day precaution from infection between tests.

16 July. Denmark, Finland, Norway and Germany are no longer defined as high-risk areas.

30 July. Everyone arriving at the border can choose between 14-day quarantine or two tests with a 5-day precaution from infection between tests.

31 July. Gatherings are restricted to 100 people. A 2-meter social distancing rule is initiated for all activities. Face masks to be used during activities where a 2-meter distance between people cannot be secured.

3 August. Swimming pools can only allow entry of up to half of their capacity.

19 August. Everyone arriving at the border can choose between 14-day quarantine or two tests with 5-day quarantine between tests. All countries are defined as high-risk areas.

7 September. Gatherings are restricted to 200 people. 1-meter social distancing rule initiated. Face masks to be used during activities where a 1-meter distance between people cannot be secured. Swimming pools can only allow entry of up to 75% of their capacity.

14 September. Those who are subject to 14 days of quarantine because of proximity to an infected person are offered the option of having a test for COVID-19 after 7 days of quarantine and being released from quarantine if the test result proves negative.

17 September. Clubs and bars in the capital region are closed 18 – 27 September.

5 October. Gatherings are restricted to 20 people. 1-meter social distancing rule remains. Face masks to be used during activities where a 1-meter distance between people cannot be secured. Clubs, bars and arcades are closed and restaurants must close no later than 11pm. Fitness centres are closed to the public. Swimming pools can only allow entry of up to half of their capacity.

7 October. Additional measures for the capital region. 2-meter social distancing. Face masks to be used during activities where a 2-meter distance between people cannot be secured. Sport and fitness activities, where there is increased risk of close proximity, touching or communal contact areas, are prohibited indoors. Restaurants must close no later than 9pm. Swimming pools are closed. Activities which require touching or close proximity are prohibited.

20 October. 2-meter social distancing rule initiated in all regions. Face masks to be used during activities where a 2-meter distance between people cannot be secured. Clubs, bars and arcades are closed and restaurants must close no later than 11pm. Swimming pools can only allow entry of up to half of their capacity.

31 October. Gatherings restricted to 10 people in all regions. 2-meter social distancing rule. Face masks to be used on public transport, in shops and other busi-

nesses. Activities which require touching or close proximity are prohibited. Clubs, bars and arcades closed and restaurants must close no later than 9pm. Swimming pools and gyms closed. In- and outdoor sports, other than those practiced individually, are prohibited. Stage arts are prohibited.

The same factors were emphasised in public measures as earlier in the year. The data show that restricting the number of people per gathering, increasing distance between individuals, contact tracing and placing those who were in contact with an infected person in quarantine have been effective in reducing the spread of the virus.

The Chief Epidemiologist has led a consultation group around creating and disseminating [guidance on preventing infections in the workplace](#) and how to react if cases are diagnosed within organisations and places of business. Weekly meetings have been held since August, in which the situation of the pandemic is discussed as well as current measures and updated guidance.

In October, a remote team of health care workers was established to support the health and social care sector in the event of a COVID-19 infection or outbreak. The goal of the team is to react quickly (within 4–8 hours) to a call from, for example, a nursing home or residential care home, regarding a new case of COVID-19. The concerned institution and the regional epidemiologist request support from the Department of Civil Protection and Emergency Department who contacts the lead of the response team.

Testing for COVID-19

COVID-19 tests at the Icelandic border resulted in 310 confirmed active cases in the period since border testing started on 15 June until 31 October. Around 80% of those were diagnosed in the first test and 20% in the second, five days later. This shows how important this double testing has been in preventing a large number of active infections spreading to the local population.

Sequencing carried out by deCODE Genetics has shown that 230 strains of the virus were detected at the border from mid-June to end of October. However, only 9 strains had been detected in domestic infections during the same period, which shows that the spread of the pandemic could have been much more severe if these measures at the border had not been in place.

The testing capacity in Iceland increased as the pandemic progressed. At present, citizens who experience symptoms of COVID-19 can book a test through the website heilsuvera.is. Screening has also been conducted in response to certain outbreaks, where those who have been at a specific location at a specific time have been offered a test for COVID-19.

Comparison with other Nordic countries

Figure 2 shows the number of domestic tests per 100,000 inhabitants in Iceland compared to the other Nordic countries, from the start of the epidemic until mid-October. This shows that Iceland and Denmark carried out the relatively highest number of test for COVID-19 during this period. Figure 3 shows the 14-day incidence of domestic cases per 100,000 inhabitants over the same period.

The death rate due to COVID-19 was lower in Iceland compared to the other Nordic countries. The rate was highest in Sweden. Table 1 shows the rate of deaths due to COVID-19, from the start of the epidemic until the end of October.

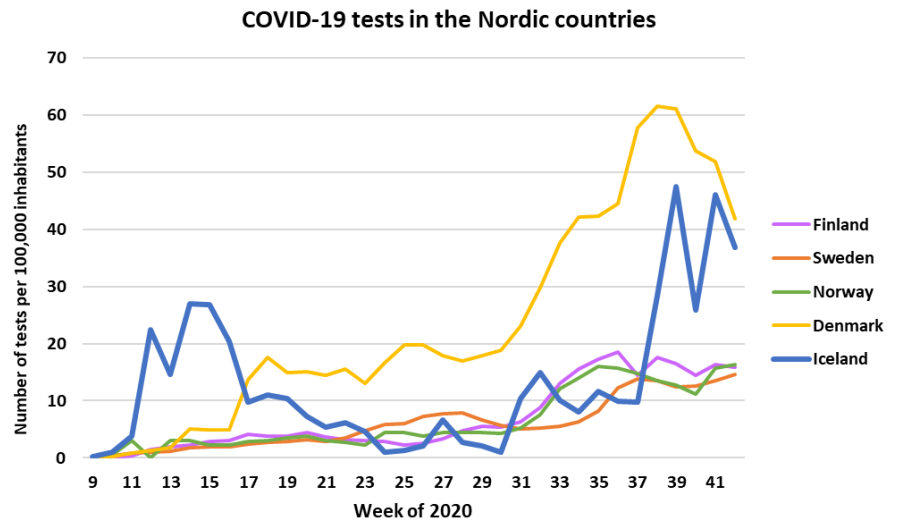


Figure 2

Source: Public databases in [Finland](#), [Sweden](#), [Norway](#), [Denmark](#) og [Iceland](#).

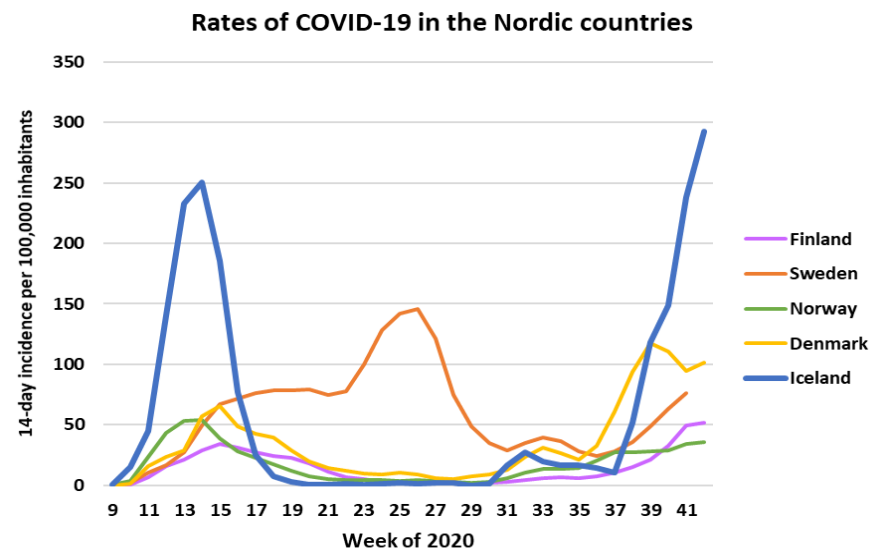


Figure 3

Source: Public databases in [Finland](#), [Sweden](#), [Norway](#), [Denmark](#) og [Iceland](#).

Table 1

Country	Deaths per 100,000
Finland	6.3
Sweden	57.1
Norway	5.2
Denmark	11.7
Iceland	3.5

Source: [ECDC](#) and the Directorate of Health.

The situation at the end of October

On the last day of October, 979 people were in isolation due an active COVID-19 infection in Iceland. 1,862 were in quarantine because of proximity to an infected person and 1,294 were in quarantine due to a recent arrival in the country. 64 were hospitalised due to illness related to COVID-19 and of those, 4 were in intensive care.

cont. p.4

From the start of the pandemic to the end of October, a total of 4,865 people had been diagnosed with COVID-19 in Iceland, 256 had been admitted to hospital and of those, 40 had been in intensive care and 13 people had died. Over 40,000 people had been subject to quarantine. [Researchers at the University of Iceland, the Directorate of Health and Landspítali National Hospital](#) estimated the reproduction rate (R) to be 2.1 outside of quarantine. This means that individuals who were diagnosed with COVID-19, and were not in quarantine at the time of diagnosis, infected 2.1 others, on average. The reproduction rate for those in quarantine was estimated to be 0.6, which demonstrates the effectiveness of quarantine in preventing the virus from spreading. The website covid.hi.is shows a figure similar to Figure 1 of this issue, where the reproduction rate is shown over time in relation to public measures against COVID-19.

The situation in Landspítali was critical at the end of October and the hospital declared a state of emergency on 25 October. On 26 October, [the Minister of Health confirmed the advice of the Director of Health](#) to delay elective surgeries and other not urgent invasive procedures in order to adequately provide necessary health care alongside treating COVID-19 patients. The situation in Landakot was particularly critical as a severe outbreak had occurred among patients in high-risk groups. Another outbreak occurred in a residential care home in Eyrarbakki, on the South Coast of Iceland, which was traced to the outbreak in Landakot. The situation in other health care institutions was better.

Pandemic fatigue

The World Health Organisation Regional Office for Europe published a [report on pandemic fatigue](#) in September. The report defined pandemic fatigue as

demotivation to follow recommended protective behaviours. Four key strategies were proposed in response to the fatigue:

1. Understand people by collecting and using evidence for targeted and tailored policies, interventions and communication.
2. Engage individuals and communities to be part of the solution.
3. Allow people to live their lives while reducing risk.
4. Acknowledge and address the hardship people experience and the impact the pandemic has had on their lives.

The organisation further emphasised transparency in decision making, being consistent in messaging and actions, striving for predictability and fairness, and avoiding mixed messages.

Other respiratory infections

The rates of respiratory infections other than COVID-19 were lower from April of this year until end of October, compared to the same period in past years. Figure 4 shows rates of diagnosed cases of respiratory diseases, such as tracheitis, nasopharyngitis and Influenza-like symptoms, among those of age 67 and older in Iceland this year compared to the average rates in the years 2015–2019.

It may be that public measures against COVID-19 played a part in the observed lower rates this year, in particular among the older population, as an emphasis was placed on protecting older people from the virus. Hope remains that public measures against COVID-19 will also result in lower rates of annual Influenza this winter. The demand for vaccines against Influenza was high this year and [70,000 doses of the vaccine Vaxigrip Tetra](#) were provided by the Chief Epidemiologist.

**Rates of diagnosed respiratory infections
67 years and older**

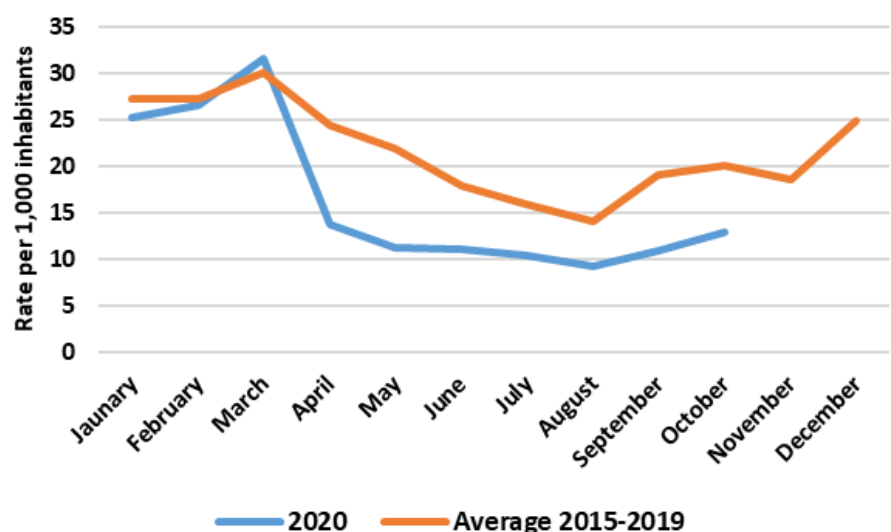


Figure 4

Source: Directorate of Health