

CHS and O'Brien Institute Seminar Series

The Department of Community Health Sciences and the O'Brien Institute for Public Health presents:

Event: Changing behaviours to reduce COVID-19 transmission: Attitudes, current behaviours and barriers to public health measures that inform targeted messaging

Date: Friday, April 30, 2021

Time: 12 – 1 p.m.

Location: Online via Zoom

Question	Answer(s)
<p>Many are encouraging children to attend daycare and school. The suggestion is that interactions with other children and educational impact are a higher priority than the risk of infection and the impact on community spread. The Cumming School Covid Tracker shows a significant number of daycare outbreaks with more occurring recently than early in the pandemic. The tracker also shows an even greater number of outbreaks in schools. (both “schools” and “Junior high schools” as defined in the tracker).</p> <p>Alberta Pediatricians are indicating Alberta needs to lock down to protect children. Their recommendations focus on locking down adults to reduce the spread to children. It is not clear from information in the news whether the pediatricians are suggesting that children should be kept home – when possible.</p> <p>Please advise if your personal recommendation would be to restrict interactions between children. That is to limit daycare and school “in-person” attendance to only those children whose parents are essential workers.</p>	<p>Response: <i>this depends on burden of COVID-19 in the community – right now schools are closed due to very high case counts (and associated risk of COVID-19); in deciding how to approach this, we have to balance the benefits and risks of going vs not going to school / daycare e.g., there are mental health and educational implications for kids and families to not going to school</i></p>

<p>4. These campaigns seem to provide superficial information – extremely short advertisements. Sound bites that we also see in the news. Does this address the suggestion from the focus group that Scientific background information and the long term consequences of the actions are needed to change actions. As an example my observation is the Ontario Science Table and BC Bonnie Henry provide much better detailed information than Alberta, that is scientific detail supporting the recommendations. Is it possible to study the impact of the different provincial approaches to distributing the information.</p>	<p><i>Response: This is a great comment and excellent consideration. The short advertisements are designed to increase concern among those who are not concerned about COVID-19. As these individuals are not concerned about COVID-19, they are less likely to be tuning into press briefings by the Ontario Science Table and Dr. Henry. For individuals with higher levels of concern about COVID-19 who take the time to seek out resources including listening to these experts in public health, detailed explanations about scientific rationale and long-term consequences would likely be beneficial in promoting behaviour change. We have the ability to do regular surveys across Canada and can segment by province. Therefore, it would be possible to frame our questions regarding the approach of each provincial public health department and if this has made impact on persons attitudes and behaviours regarding COVID-19 public health behaviours and vaccination. Thank you.</i></p>
<p>As an example my observation is the Ontario Science Table and BC Bonnie Henry provide much better detailed information than Alberta, that is scientific detail supporting the recommendations. Is it possible to study the impact of the different provincial approaches to distributing the information. The Donald Trump example it seems to me is not the correct approach to health care communication – it was great in motivating angry males. Not so good at changing behavior – the population is now polarized – no change is likely.</p>	<p><i>Response: Same question as above. However, we agree, that the Donald Trump example is not one to emulate.</i></p>

<p>especially WHICH theories comprise your mish mash</p>	<p><i>Response: Thank you for your question. Our overall work is being guided by the Theoretical Domains Framework and the Behaviour Change Wheel. For work related to vaccine hesitancy, we are also using two frameworks specifically developed for assessing and addressing vaccine hesitancy: the 5C Scale and the Vaccine Confidence Index.</i></p>
<p>Have any social marketing (behavior change) experts/practitioners been involved in the work you are doing?</p>	<p><i>Yes, we have a large team that contributes to this work including individuals with prior experience in behaviour change work and implementation science as well as a marketing team that has previously done work in behaviour change in the health system. We also have sought input and advice from some very successful individuals who have led behavior change campaigns in the past including the smoking Truth campaign.</i></p>

How many individuals who have received one dose of the vaccine have contracted Covid? 12.8 million doses have been administered and 1 million people are fully vaccinated (2 doses). About 11 million people have received one dose across Canada over the past 4 months. a. How many of the new covid patients have reported having received one does of vaccine? b. How long after receiving the vaccine did they become infected? (That is the efficacy seems to increase over time, is this starting to show in the data? c. Is the data starting to show the vaccine has a lower efficacy after several months?d. How many have contracted covid after receiving two doses of vaccine?

This is a great question, there is more and more evidence coming out about COVID-19 infections following vaccination. Please see a recent article by Menni et al. that was published in Lancet ID April 27, 2021 out of the UK. 3106 of 103 622 vaccinated individuals and 50 340 of 464 356 unvaccinated controls tested positive for SARS-CoV-2 infection. Significant reductions in infection risk were seen starting at 12 days after the first dose, reaching 60% (95% CI 49–68) for Aztrazeneca and 69% (66–72) for Pfizer at 21–44 days and 72% (63–79) for pfizer after 45–59 days. -Observed that 5–11 days after vaccination, the infection rates in the vaccinated group were only slightly below those of the unvaccinated group whereas 12–20 days after vaccination, infection risk in the vaccinated group was significantly lower than in the unvaccinated group (RR for BNT162b2 –58% [95% CI –62 to –54]; RR for ChAdOx1 nCoV-19 –39% [95% CI –53 to –21]). Observed a further reduction in infection risk after one dose of the BNT162b2 vaccine when compared with unvaccinated controls at 21–44 days after vaccination (RR –69% [95% CI –72 to –66]) and at 45–59 days after vaccination (–72% [–79 to –63]. The RR after one dose of ChAdOx1 nCoV-19 compared with unvaccinated controls was –60% (95% CI –68 to –49) at 21–44 days after vaccination.