Analysis of the COVID-19 pandemic in Navarra

Lessons to be learned

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Gobierno de Navarra
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ANALES
DEL SISTEMA SANITARIO DE NAVARRA

Lessons to be learned

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138. *"… in a pandemic whose course is unknown some decisions will turn to have been wrong, something that was impossible to know at the time."* House of Commons. Health and Social care, and Science and technology Committees. Coronavirus lessons learned to date. 2021.

"At the time, physicians and health officers fought against an enemy that had not been identified and whose mode of action they did not comprehend. In their impossible battle, they were guided by some correct observations, but were also misdirected by erroneous theories. Thus, they were bogged down by innumerable things tha,t in their ignorance, they felt they had to do while they did not do the few things that they should have done. Under such conditions determination and goodwill largely served to expand the gap between costs and benefits" (C.M. Cipolla (1981) Fighting the Plague in Seventeenth-Century Italy. The University of Wisconsin Press, 18)

The world has not yet had time to fully elucidate the lessons of COVID-19 and apply them to preparations for future emergencies. But policymakers should heed the lessons of the pandemic by appreciating the ethical, not just the technical, dimensions of all challenges faced during emergencies; by starting from existing knowledge about the right value and principles to guide policy; and by ensuring that ethics expertise is present before an emergency response is conceived and is effectively integrated into decision making. (Emanuel EJ, Upshur REG, Smith MJ. What COVID has taught the world about ethics. N Engl J Med 2022; 387(17): 1542-1545. https://doi.org/10.1056/NEJMp2210173. Epub 2022 Oct 22. PMID: 36301580.73)

BEGINNING TO CONCLUDE

To end this report I will offer some preliminary thoughts on what has been learned from the lived experiences over the past three years of the pandemic. There is the possibility that our adaptive capacity as the human species will lead us to *forget* the hardest and more complex times of the crisis. This is a type of *resiliency*, in any of the two meanings in the dictionary

of the *Real Academia Española*, RAE (the Spanish Academy): "*capacidad de adaptación de un ser vivo frente a un agente perturbador o un estado o situación adversos" (the capacity of a living being to adapt to a disturbing agent or an adverse state or situation) or "la capacidad de un material, mecanismo o sistema para recuperar su estado inicial cuando ha cesado la perturbación a la que había estado sometido*" (the ability of a material, mechanism, or system to regain its initial state when the disturbance to which it had been subjected has ceased).

In this monograph, David Escors points out that we knew that the occurrence of this type pandemic was possible (refer to Chapter 8), which was also suggested by David Quammen in his book *Spillover: Animal Infections and the Next Human Pandemic*, published in 2012[1]. At the time, Quammen predicted that a new coronavirus may be "*Next Big One"*. This knowledge did not come from the imagination, but from paying attention to the messages sent by well-known scientists. Director Stephen Soderbergh in his 2011 film Contagion also anticipated it. If we already knew that this was a possible scenario, we should ask ourselves why were we unprepared. In fact, at some point we will have to confront different types of public health risks, whether it be in the form of infectious disease pandemics or the effects of climate emergency.

Daniel Innerarity poses the question of whether "a new way of thinking about reality" is possible (refer to the Editorial). He claims that "we must think in terms of **systemic complexity** and change our institutions to govern complex systems and their dynamics, particularly when facing interrelated risks, i.e., when multiple things can go wrong simultaneously. At this point, it is clear that the crisis was not been addressed in many of its stages considering this perspective. This is a key lesson we should learn and remember for any of the phases of a pandemic or peri-pandemic."

"Due to this oversight, at the beginning of the crisis many political actors and analysts thought of it as a seasonal flu in a region of a distant country, and warned us that the only thing we should be worried about was overacting in response to panic reactions. It was envisaged that the number of infected people and deaths would be limited, without realizing that the numbers barely allow calculating the risk in complex systems. These figures must be understood within the context of a general system, taking into account the way a pandemic affects health infrastructures and the consequences of these impacts. If we do not think in systemic terms, data are

1 The Spanish version titled *Contagio: la evolución de las pandemias* was published in 2021 by the publishing house Debate, with an updated final chapter.

analysed in isolation and the infection rates and mortality seen unalarming. When we view things from a systemic perspective, even small figures may announce a potential disaster, as globalization cannot be stopped and even more difficult to delimit" (Daniel Innerarity, Editorial).

It is probably too early to evaluate how the international health crisis and emergency were managed, and all that has been done and learned, lived as an exceptional event. Distance and time, besides freshness, will allow making a rigorous and critical assessment. It is necessary to learn from successes and mistakes, while our memory is fresh and be at our best to deal with future similar emergencies, which, without any doubt we will have to confront. Some other aspects that must be also considered is the globalized and uneven world we live in, the climate and environmental crisis with their impact on potential future epidemics and pandemics.

Thus, **anticipation and preparation** to respond better and ensure that no one is relegated. To begin with, we were unprepared for the COVID-19 global health crisis, which remains active, but fortunately under greater control. Prior crises, more or less global (SARS 2003, Bird Flu 2005, influenza A 2009, and more recently Ebola Virus Disease 2014 and Zika 2015), did not get enough of our attention, and contingency and preparation protocols were not established. As everywhere else, in Navarre we were unprepared to deal with such an explosive crisis with its devastating effects on health, social life, and economy, among other aspects.

Thinking ahead, we have to be better prepared to be able to respond, **before and after**, to future exceptional situations. In this section, we present the lessons learned in the different sections of this monograph: governance, need of strengthening public health, role of information technology for decision-making, communication, and health and social systems.

GOVERNANCE IN THE TIMES OF PANDEMIC

Governance between the Spanish Ministry of Health and the autonomic communities (*CCAA*) has had different moments, some with clear strengths, while others require improvement. During the first weeks of the COVID-19 pandemic, regulations were established in the central government and the *CCAA* responded to the extent possible based on the exponential increase of infected individuals and their needs in primary care and hospitals, particularly in the ICUs. In a second stage of the pandemic, while in transition, the *CCAA* began making the regulations. Governance between the Ministry of Health and the *CCAA* was established and is currently exercised through Presentation of Alerts (*Ponencia de Alertas*), the

Commission of Public Health, and the Interterritorial Council of the Health National System (*CISNS*), presided by the designated person at the Health Ministry and the corresponding department of the 17 *CCAA* and autonomous cities.

The advisory, management, and decision-making bodies created in our Autonomous Community to deal with global health crises, responded with the available tools they had for the purpose they had been created for, considering the circumstances in which they have developed. Without doubt, in an uneven manner. Surely, there has been high human and personal costs, as well as high opportunity cost (difficult to assess). There is probably substantial margin for improving efficiency, understood as doing things in the shortest possible time, energy, and resources. Among the lessons learned for the future, a careful and critical review and evaluation of the created committees should be done. Moreover, protocols should be prepared in advance to provide a better response to potential similar future situations (refer to Chapter 1.1).

In terms of social innovation in our region, we would like to highlight the creation of the Commission for the Transition, as well as the clinical usefulness of the Advisory Committee on ethical decisions regarding the care of coronavirus patients, as recognized by the involved professionals. As for the day-to-day management of the crisis, a time- and energy-consuming process, the COVID-19 follow-up commission has been key for sharing the analysis of the situation (as well as for the management of certain emotions and development of support) and to help come to agreements and align decisions and actions. The communication with local entities and the Navarre Federation of Municipalities and Councils (*FNMC*) (its mayors), has been one of the richest experiences of the process, as described in Chapter 1.3. Regular communication and meetings with the most affected economic and social sectors (catering, tourism, culture, sports, and trade) have proven to be valuable, despite the novelty and complexity.

The Transition Commission has been a very valuable innovative experience, according to the people who attended the farewell meeting of the group. In our opinion, not only because of the specific contributions and management of transitions between the various stages of the pandemic, but also because there was an input of ideas and critics from people who represented different sectors and actors in our community, such as local entities, our two universities , non-governmental organizations, business and social economy sector people, health professionals, philosophers, politicians, sociologists, experts in emotional mourning, among others. Moreover, the commission was empathetic with the global situation, had some complicity, and gave support to the people directly responsible of the management

during the extended health emergency (Health Department) at particularly complicated times, with the emotional and institutional reinforcement this involves.

As for the Technical Advisory Committee, and in the face of future health crises, it would have been better to create it slightly before and shape its tasks and internal functioning more explicitly. Surely, primary care and health intelligence professionals should have had greater weight, rather than the hospital sector.

Overall, the Interdepartmental Committee did not act as a shared management body of the crisis. It was however useful during the first days and weeks for rapid exchange - up-to-the-minute - of information. As for the most acute stage of the general confinement, the different governmental general directorates, particularly those with the most relevant competencies, demanded to resume their corresponding competencies and leadership. In the face of future contingency scenarios, the Interdepartmental Committee should be formalized and establish clear functions and more explicit capacity for action. If adequately structured and protocolized, this committee may be a valuable governance tool even outside emergencies (sustainable development and the 2030 agenda, climate crisis, depopulation, active and healthy aging…), in line with the approach "***Health for all policies***".

Finally, as for the highest level of decision-making - led by the President of Navarre in a coalition government -, we believe from our experience at the Health Department, it has been key in processes that required relevant decision-making. In potential future crisis, it should be created earlier.

Navarre's highest decision-making body, described above, was formed by the President, two vice-presidents, the health representatives (the Advisor and the General Director and Manager of the SNS-O), and the DG de Presidencia for legal matters.

A recurrent ethical topic in the pandemic has been the debate regarding the rights and fundamental freedoms, and the implementing rules. The restrictions of rights and freedoms, although was aimed for collective health protection, is a matter of great relevance. Despite of the fact that the debates on the potential paternalism of public health are almost as old as the discipline, never has there been such centrality in public debate. After the first phase of the pandemic, as of May 2020, the Central State Administration transferred a large part of the pandemic management responsibility to the *CCAA*. The *CCAA* legislated with the available legal tools and the interpretation of the regulatory framework by the different Supreme Courts of Justice. Consequently, similar norms and measures were endorsed by some other *CCAA* and rejected by others, as it is well known. As described in

Chapter I.2, it was particularly positive that Navarre's Supreme Court of Justice approved most of the proposed foral orders, appropriately justified in terms of needs, suitability, and proportionality, as was recognized in almost all occasions by the High Court. Another welcomed idea, which became systematic, was to submit the draft standards to preliminary consideration by the Court. A basic legislation for this type of health emergencies at state level is advisable for future crisis, as it would provide a clear and explicit regulatory framework to activate and protect the exceptional measures to be adopted in all the territories (Refer to Chapter 1.2).

From the beginning of the crisis, the principle of the *minimum* and *essential* concerning restrictions and limitations was applied in Navarre, an extremely complex and difficult to manage task. We tried to keep this principle in mind in all and each important decision, and our experience, results, and evidence are lessons for the future. Eventual future restrictions of basic rights should take into account past critical judgement and experience and the authoritarian impulses observed in some cases.

Regarding the regulations that fully affected humanizing care strategies, a critical review should be performed of visitation and accompaniment policies in health centres and farewells to the deceased. Humanizing strategies and patient-centred care underwent significant and inevitable limitations; but in the light of what we know to date, an in relation to the above-mentioned aspects, we should analyse some regulations and policies applied in Navarre. This should be done hand in hand with groups and associations of patients, and the population concerned. The commitment and humanity of health professionals, minimized the negative effect of the applied policies (refer to Chapter 5.10).

Based on this preliminary overview on governance we can say that further insight is needed with more evidence, probably a better perspective, and overcoming the tension of partisan political debates. But for now it seems quite clear there are strategies, policies, and decisions to be taken that are convenient for the entire State and in some cases the EU and globally. Local measures must be implemented at the level of the Community following the logic of public health, principle of subsidiarity, and competence autonomy. Although it is too early to analyse in this report, shared governance between the Ministry of Health and the CCAA seems to have worked reasonably well. In general, coordination has been useful, although at least from the experience in Navarre, we should have probably anticipated certain decisions taking into account the reality and the conditions in our community. In fact, this was done in certain occasions (the *pase foral* - foral pass), which were later welcomed.

EU governance regarding the purchase of vaccines worked well. However, global inequalities when it comes to the capacity to pay for the vaccines and other protection systems - as is the case of Africa - are unbearably clumsy and painful. Internationally, the role of supra-national organizations, e.g., the WHO, should be clearly reconsidered, particularly with regard to its intelligence, monitoring, and vigilance functions, and early alert and rapid response capacity.

The pandemic experience has showed us that the development of a model of governance based on real engagement by professionals and citizens (by reviewing citizen participation), must include a three-level improvement. Improve the micro-management participation (patient autonomy regarding the relationship with health professionals), meso management (health and government councils in territories and institutions…), and macro management (healthcare policy models that encourage active citizen participation mainly in health strategies and health plans).

Finally, leadership, maximum political consensus, and participation of the community are essential for the management of this crisis. Political and technical leadership and political and social consensus are key for managing the pandemic. Fortunately, the level of tension and political dissent in Navarre have been lower in comparison to a State level; but what has been learned from comparing with international analyses indicates it is necessary to continue working to reach the maximum consensus possible.

THE NEED OF STRENGTHENING PUBLIC HEALTH CAPACITIES (Chapter 2)

Professionals and functions that focus on the population, community, collectives, and health problems structure Public Health services. Traditionally, in Spain, their capacity is insufficient, distanced from the recognition and innovation of clinical services, particularly those linked with hospital care.

There has been little development of these services, particularly regarding Public Health information and vigilance tasks. There is much data and information, but limited *intelligence* to accompany and support the decisions. The capacities of Navarre's Institute of Public and Occupational Health (*Instituto de Salud Pública and Laboral de Navarra*) must be strengthened and the focus put particularly on the so-called *public health intelligence*. Moreover, a vigilance and follow-up unit of cases and contacts should also be created –closely interconnected with primary care and other health mechanisms–, allowing its restructuring and expansion dur-

ing critical situations, while providing prompt response of their assigned functions. Looking ahead, the creation of community *social intelligence* of social groups, media, and social networks should be considered, as well as the recruitment of anthropologists, sociologists, and social psychologists in public health teams.

It is necessary to maintain epidemiological vigilance, including the appearance of new variants. Monitoring of the genetic material of SARS-CoV-2 and its variants in sewage is an added vigilance tool.

Having an equipped effective clinical microbiology service with well-prepared professionals allows offering quality daily diagnoses and better assess any potential infectious disease alerts, as well as keeping in permanent contact with experts throughout Spain to coordinate the *know-how*. An updated information system is cucial to remain in touch with authorities and experts. In our case, this has been adequately solved, even when referring to massive sequencing, which has been key in this pandemic (refer to Chapter 2.2).

Something similar occurred with occupational health organizational aspects. An example of this collaboration is the great effort carried out by Navarre's Institute of Public and Occupational Health and Primary Care to set into motion the procedures for the management of a large number of vaccine doses of different types, with the demanding maintenance conditions, as well as the vaccination campaign. In the face of the challenge to our health system, we have been able to adapt by overcoming different barriers: technological, spatial, staff resources, demands from the population, etc. (refer to Chapter 2.6).

The activation of the executive coordination of Occupational Risk Prevention services and its assignment to the Occupational Health Service (Motion 604/2020 from the Health Director-General) was very useful to activate private preventive resources of the work centres. Thus, preventive, regulative, of assistance, organizational, management, and research interventions were developed. As for the population attended, besides meeting the needs of the labour force, the Occupational Health Service focused their efforts on the most vulnerable groups, i.e., seasonal farmworkers who were included in the universal health coverage through telematic means (refer to Chapters 2.3.3 and 6.2).

A facilitating factor in implementing many of the interventions was that the Epidemiological Surveillance and Health Promotion, and Navarre's Institute of Public and Occupational Health services are part of the same Institution, and because Medical Inspection is part of the Occupational Health Service, which is not the case in other *CCAA* (refer to Chapter 2.4).

Some interventions may now be considered out of place (lack of control in mask use), which makes us rethink the preventive system in companies. If the data on occupational accidents illustrate the safety limitations, the pandemic has showed us its significant limitations towards biological risk. Most Occupational Risk Prevention services adhered to temporary employment regulations, and their technical staff teleworked. Consequently, responses to the requirements and needs of the companies were scarce and uneven. Moreover, there were Occupational Risk Prevention services in Navarre that lacked technical resources. However, no proceedings were initiated against companies nor Occupational Risk Prevention services for non-compliance or lack of collaboration from occupational or health authorities (refer to Chapter 2.4).

In Navarre, vaccination against COVID-19 significantly reduced hospitalizations, ICU admissions, and COVID-19-related deaths, entirely changing the seriousness and fatality of this disease. This can be explained by the high transmissibility of SARS-CoV-2, high efficiency of the vaccine for preventing serious events, high level of vaccination coverage, and vaccination prioritization of more vulnerable individuals. Convergence of these circumstances has promoted the success of this vaccination program, greatly surpassing any previous ones (refer to Chapter 2.6).

The pandemic has not had the same effect on the different types of populations, explained by diverse social determinants associated to the disease that lead to inequalities. The gender gap and traditional social and economic variables have emerged as sources of inequality. Public health should be capable of incorporating this inequality analysis view to create programs aiming equality (Chapter 6).

Preventive measures to reduce the transmission of COVIDd-19 and other respiratory illnesses have been key in this pandemic; e.g., mask use, hand hygiene, and ventilation (refer to Chapter 2.1).

In health alert and crisis situations, the collaboration between professionals in all affected fields is key to ensure the implementation and functioning of prevention and control tasks. This requires continuous learning and improvement to maintain the quality and appropriateness of the interventions. In this sense, there was high commitment by health and education professionals, as well as by the families in complying with the measures and controls during the pandemic.

It is important to assess the risk of transmission in any given activity based on the known factors: incidence of the infection within the community, ventilation of the site, agglomeration of people, the use or not of face covering, are people silent, talking, or shouting, and the duration of the activity.

Thus, the preventive measures taken in different scenarios have been of great relevance, particularly before reaching sufficient vaccine and natural immunity to avoid serious infection-related complications. Monitoring the pandemic's follow-up indicators and the proportionality of the adopted measures is key to help build a balance between the benefits for health in terms of preventing infection, social-economic consequences, and emotional wellness, which also unevenly affect the different types of populations.

Thus, the policy of favouring face-to-face in all educational levels in Navarre (primary, secondary, higher) - beyond the weeks of forced confinement - was successful and an example of a good decision in comparison to the current international evidence.

A contingency plan to face future pandemics and/or emergencies, including all technical and organizational aspects learned during the pandemic should be prepared, and coordinate the various involved authorities.

INFORMATION SYSTEMS FOR DECISION-MAKING (Chapter 3)

The COVID-19 pandemic has provided a unique opportunity to speed up Health Information and Communications Technologies (ICTs) and show their key value in the health organization as a critical element that ensures transversal information relevant for decision-making. Almost none of the activities described in this monograph would have been possible without information systems. Digital transformations in information systems was accelerated by the pandemic and pending transformations are following the same trend.

ICTs were developed as needed, were flexible, and adapted perfectly to the changing requirements. Prior existence of these systems has allowed to have relevant and essential clinical information to control the pandemic, make key decisions to slow down the spread of infections, and have been clear reducers of the impact of the infections in preventive isolation and reduce contacts, as well as for the follow-up of the pandemic.

Solid information system structures need to be established. Moreover, we need to be able to anticipate potential future emergencies and have professionals trained for specifically managing and interpreting the data. Particularly at the beginning of the pandemic, data allowed to know who, where, and how people got infected. The staff welcomed the campaign that allowed knowing the seroprevalence among professionals; it allowed reducing the impact on mental health (anxiety and fear of being infected) and

knowing the distribution of these infections. Preventive screenings helped prevent the spread of the disease by detecting positive cases in symptomatic and asymptomatic individuals.

COMMUNICATION IN TIMES OF PANDEMIC (Chapter 4)

Communication has been a major challenge and a weakness in this pandemic. It is a key leadership aspect in times of crisis, requiring proximity, empathy, and respect. The following points are relevant: confidence (simplicity, transparency, humility, serenity, *control of the scene*), credibility (coherence, that is logical and credible, with common sense), relative transparency (only the needed to avoid overwhelming, for self-protection and be able to take care of one-self), and some assurance, without denying uncertainties.

The idea is to send the message that whoever takes the lead knows what she/he has in her/his hands and has the experience despite past and present uncertainties. Managing the uncertainties has been one of the most complex challenges in Navarre and everywhere. The media, sectors, and actors asked for certainties; however, science and evidence don not work with certainties and even less in situations such as the emergency caused by COVID-19.

In the future, it is important to communicate only what is necessary for the people and the community; prevent and avoid the *infodemic* we have activated, with the consequent known effects and impact on mental health, particularly on the most fragile and vulnerable individuals. Besides, the society should be treated as individuals with rights, of legal age, and governance. At times, we may have contributed to the *infantilization* of people through our messages and communications.

Leadership in times of crisis, and particularly communication, requires a critical, documented, calm review for similar crisis in the future. The intense and extensive work with many actors and aspects offers, as occurs in strictly health management, a significant repertoire of hits and misses, although with a reasonably positive balance. More specifically, it leaves us with many lessons learned, e.g., the need to strengthen and stabilize the currently embryonic communicative structure of the health system, as well as to acknowledge the relevance of communication in health-related policies, particularly in public health.

In times crisis and uncertainty it is not just a matter of *communicating management*, but *of managing communication*. Language and communica-

tion aids need updating (particularly in social networks and the audiovisual sector) in a very fluid world in which globalized immediacy demands rapid and reliable response from the administration for it to be a credible and effective source, as well as managing a media agenda with great sensitivity towards health topics and with a certain trend towards hyperbole.

In a near future, we have to ask ourselves what have we learned on health communication after the pandemic and if we have been able to adapt new messages and channels to populations afar from our daily discourse. A new challenge for communicators, health professionals, managers, and educators.

HEALTH AND SOCIAL SYSTEMS (Chapter 5 and Chapter 6)

One of the most important lessons to be learned is the need to strengthen our system, particularly Navarre's Health System - Osasunbidea. The health sector has been in the first line of protection and care of public health, and has laid down the importance of ***health for*** all policies, including the defence of the economy. The WHO's illusory slogan has become spectacularly true. Strengthening the health system implies more and better investment in health - to date we are still below European standards -, where it provides added value for improving the health status of the community and people who make it up. Essentially, the service must be capitalized in terms of human resources, and investment in training, innovation, and research.

To achieve the above-mentioned goal, health strategic investment must be accompanied by structural pending renovations, particularly economic and professional management. Without this, it will be impossible to achieve the desired health results and current needs and expectations of our Community through the Service. The healthcare system in our Community was able to reasonably adapt and respond to such challenge because within the framework of the Alarm Decree and foral decree that adapted it in Navarre it was possible to make changes, adjustments, and transformations that under *normal* circumstances would have been either impossible or taken years. E.g., to transform into hours the Iruña Park hotel in hospitalization units dependent of Navarre's University Hospital is inconceivable for such a structurally strict system, and particularly the management of human resources.

In such critical moments, it is necessary and urgent to have robust public health services, both for assistance and public health (vigilance, vaccination). The *de facto* universal healthcare is a very valuable service, recog-

nized as such by the population. As for hospital beds, particularly ICU beds, in Navarre, together with the private health network, we provided a powerful care response from the *de facto* formed network. However, the pandemic has added stress to the system crudely showing the pre-existing structural weaknesses, especially in Primary Care, as well as a lack of professionals. There is a certain level of *posttraumatic stress* in the services and amongst professionals. A major lesson is the urgency of strengthening Primary Care by renovating, reinforcing, and investing, particularly in human capital. Professionalization and assessment of healthcare management is now, more than ever, a pending subject.

The shortfalls and problems identified in Primary Care during the pandemic suggest first the need to prepare a contingency plan, should a new health emergency occur. Secondly, a work plan is necessary to overcome all difficulties: existing ones, those that occurred, and those that may occur.

Hopefully, the past years of pandemic taught us how to provide a more rapid and efficient response from Primary Care in future similar situations with the aid of new protocols and operating procedures, the use of new diagnostic tests, management of new treatments, organization, and processes of mass vaccination.

The provision of the required material has been improved. Consequently, more supplies are kept in store departments, Primary Care centres, and consulting rooms to ensure the protection of professionals when attending COVID-19 patients.

This greater provision will also be of help in potential shortage situations. Also considered essential is the inclusion of prevention protocols and use of personal protective equipment in the annual training plan offered to professionals in all Basic Health Areas. In collaboration with the Occupational Risk Prevention service, updated online permanent training on how to use the personal protective equipment is available for all staff members.

There was great impact on **mental health**: fear, anxiety, loneliness, uncertainty, as powerful stressors of the situation. Strategies to increase healthcare responsiveness were introduced, e.g., redistribution of professionals from different areas of the Mental Health network, development of multidisciplinary work strategies, prioritization of the most serious cases by reviewing the referral reports, and the creation of exceptional first consultations.

Hospitalization resources (total and partial) had to adapt the healthcare activity along the different stages of the pandemic, modifying the capacity, spaces, and care pattern, subdividing patients into cohabitation units, and

developing intervention plans in a flexible manner (in groups, individual). Despite the differences in action protocols among these resources, the aim was to focus on covering the care needs of people with serious mental disorders trying to preserve the social interaction in these resources and, to the extent possible, with their close relatives and usual social group. The relevance of promoting the social interaction of these patients with their community is key for their functional recovery. The increase of suicide rate may occur in the medium-long term; thus, this risk should be monitored and introduce more strategies for suicide prevention. Within this context, mental health promotion becomes more relevant, not only based on healthcare strategies but also on public health and social/sanitary policies.

Decisions have to be made and concrete actions carried out; e.g., strategic storage of protection equipment and basic healthcare material, including pharmaceutical products and personal/collective protective equipment, all of great importance. Local suppliers must ensure the provision of basic material. Likewise, contingency plans must be prepared (in Primary Care, Hospital Care, Mental Health, Emergency departments, and Communication departments), including protocols that must be updated regularly, and ensuring the availability of all the resources, public and private, healthcare and social, central and peripheral.

As for the **social aspects of the pandemic**, fragile and unprivileged social groups are particularly vulnerable. Pandemics, as diseases and health in general, have class bias. As described in Chapter 6, measures aimed to cover specific needs and special situations were established. For example, some infrastructures were made available free of charge (private hotels at the beginning, hostels, and residencies) for people and families who were unable to isolate as required. Many individuals in these vulnerable groups were migrants who lived in shared overcrowded places lacking barely adequate habitable conditions. The situation of seasonal workers is worth of mention; special measures were taken with this population group in collaboration with the primary sector (selective diagnostic tests and vaccination at their work sites). Looking ahead, assessment and fight of the emergency (as everything else) must be done focusing on social health determinants and health inequalities. The vaccines and hospital and ICU beds *even up* the population. However, the realities and specific needs of vulnerable groups within the population must be recognized. For social and public health justice (refer to Chapter 6, Section 1 and Section 2).

Some every day aspects and interventions in nursing homes are discussed in Chapter 5.5; clearly, there is still much to learn and improve with the elderly population, a task that should not be postponed any longer. The most vulnerable individuals are those who have suffered the most in

this pandemic, particularly those living in nursing homes. Areas of isolation must be ensured for residents in these facilities, as well as for visitors.

Regarding healthcare in nursing homes, two clear phases can be distinguished in Navarre. During the first weeks, people mainly remained confined; responses by the different basic health areas were intense, variable, and with clear weaknesses. From mid-April 2020 on, healthcare executive coordination was created in public and private nursing homes; there was proactive and close involvement in nursing homes healthcare by the joint social and health unity of action, the Direction, and Primary Care structures.

The join action of the Health and Social Rights departments was key for an adequate approach of outbreaks in social and health centres; in particular, we want to point out the creation of intermediate resources (two in the first wave and two from June 2020 on). These resources are inoperative since March 31, 2022, due to milder manifestation and decrease of SARS-CoV-2 infections as the result of vaccination.

The social and health system cannot function as a closed entity. The coordination between the different care and non-care levels are needed to achieve specific goals in the near future.

Currently, all nursing homes should have contingency plans approved by the Health and Social Rights Departments and adapted to their reality. The staff should be properly informed on these plans, which should consider the following points:

- Early detection protocols to speed up diagnostic tests;
- Availability of certified personal protective equipment (prevision in case of an outbreak in the centre);
- Reinforcement plans for the staff in potential situations of reduced personnel due to work leave or absence;
- Management of the infrastructure of the centre: compartmentalization, isolation areas, dining rooms, sitting rooms, common areas for the personnel, etc.;
- Ventilation control and CO2 detectors;
- Facilities in which clean/dirty circuits can be installed: staff and residents, visits, laundry and kitchen, residues, etc.

Coordination must be improved and promoted, ensuring simultaneous care with the different involved actors: members of the Social/Healthcare Unit of Primary Care Management, healthcare authorities in the nursing homes, Primary Care, Hospital Care, Navarre's Institute of Public and Occupational Health, Occupational Risk Prevention services, and authorities of Social Rights services, to ensure adequate protection of residents and staff members.

TO CONCLUDE, THE MOST IMPORTANT

It is very important to learn from this experience. An effort must be done to document, account, and assess the pandemic, as has been initiated in the present report. This will help draw conclusions of what happened to create new programs and improve extremely conservative cultures in healthcare services and public administrations, be more flexible, and develop new organizational models.

Throughout this chapter, particularly along the general text, activities, devices, or criteria have been suggested, which should be maintained. Healthcare professionals will only remember the inhuman schedules, the fear of being alone, the obsession of not infecting our families, the uncertainties regarding preventive measures, the hope of vaccines, etc.

We must remember all people working in supermarkets, shops, public transportation, police, and law enforcement authorities who were at the forefront of the battle for days, weeks, and months. Thank you very much.

Also in our minds are our colleagues, care and public health professionals, pharmacists and drugstore workers, and people who gave a hand with social devices in hospitals and ICUs in occupational and primary care centres…. Thank you very much, *eskerrak aunitz*.

Above all, we will remember the people who passed away alone, without their families, in company of health professionals with whom they shared the last caress, their last smile. Pride, memory, and emotion. We will always remember you. Our best tribute to them is to learn from our experience.