

Considerations in adjusting public health and social measures in the context of COVID-19

Interim guidance

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Background

Across the globe, countries have implemented a number of control measures to comprehensively prepare for and respond to COVID-19. The overarching goal of the WHO global COVID-19 response strategy¹ is for all countries to control the pandemic by slowing down transmission and reducing mortality associated with COVID-19, with the ultimate aim of reaching and maintaining a state of low-level or no transmission. Based on local epidemiology, some countries are in the process of scaling up public health and social measures, while others are or currently considering scaling down these measures.

Although the goal in all countries is to suppress transmission and provide care for all patients, the intensity of implementation of control measures to achieve this — including identification, testing, isolation and care for all cases, tracing and quarantine of all contacts, public health and social measures at individual and community levels, etc.— varies based on the transmission scenario each country is facing (no cases, first cases, clusters of cases, or community transmission).²

Public health and social measures

Public health measures include personal protective measures (hand hygiene, respiratory etiquette), environmental measures, physical distancing measures, and travel-related measures. Physical distancing measures apply to individuals (e.g. isolation of cases and quarantine of contacts) or to communities, specific segments of the population, or to the population as whole. These measures are not mutually exclusive.

WHO recommends that all suspected cases be identified, tested, isolated and cared for, and their contacts identified, traced, and quarantined.³

Additional large scale public health and social measures (PHSM), including movement restrictions, closure of schools and businesses, geographical area quarantine, and international travel restrictions have been implemented by a number of countries. These are sometimes referred to as “lockdown” or “shutdown” measures.

An assessment of the public health impact of PHSM for COVID-19 is not yet available but is needed. This assessment needs to take into account the social consequences and economic costs of such measures, which may be considerable. As such, a careful risk assessment and staged approach is needed to balance the benefits and potential harms of

adjusting these measures, so as not to trigger a resurgence of COVID-19 cases and jeopardize the health of the population. Until specific and effective pharmaceutical interventions (e.g. therapies and vaccines) are available, countries may need to continue to loosen or reinstate measures throughout the pandemic.

Decisions to tighten or loosen or re-institute PHSM should be based on scientific evidence and real-world experience and take into account other critical factors, such as economic factors, security-related factors, human rights, food security, and public sentiment and adherence to measures.

Individual measures, including medical masks for symptomatic people,⁴ isolation and treatment of ill individuals, and hygiene measures (hand hygiene, respiratory etiquette) should be sustained.

This document is intended for national authorities and decision makers in countries that have introduced large scale PHSM and are considering adjusting them. It offers guidance for adjusting public health and social measures, while managing the risk of resurgence of cases.

Scenarios

WHO has previously defined four transmission scenarios to describe the dynamic of the epidemic: no reported cases (whether truly no cases or no detected cases), sporadic cases, clusters of cases, and community transmission.² A country or area can move from one transmission situation to another (in either direction) while experiencing different situations at subnational levels. Each transmission scenario requires a tailored control approach at the lowest administrative level.²

Although it is unknown how the pandemic will continue to evolve, three outcomes can be envisaged:

- i. complete interruption of human-to-human transmission;
- ii. recurring epidemic waves (large or small); and
- iii. continuous low-level transmission.

Based on current evidence, the most plausible scenario may involve recurring epidemic waves interspersed with periods of low-level transmission. This guidance has been developed in the context of these scenarios and will be updated as knowledge of the dynamics of the pandemic evolves.

Risk assessment

The decision to introduce, adapt, or lift PHSM should be based on a risk assessment with a standard methodology⁵ to balance the risk of relaxing measures, capacity to detect a resurgence in cases, capacity to manage extra patients in health facilities or other locations, and ability to re-introduce public health and social measures, if needed. A national risk assessment should be supported and implemented through subnational or even community level risk assessment, as the transmission of COVID-19 is not typically homogenous within a country.

The risk assessment must address the following questions:

1. What is the likely impact of adjusting public health and social measures in terms of the risk of case resurgence?
2. Is the public health system able to identify, isolate, and care for cases and quarantine contacts?
3. Is the public health system able to rapidly detect a resurgence of cases?
4. Is the health care system able to absorb an extra patient load and provide medical care in case of resurgence?

The risk assessment should be based on the following indicators:

1. **Epidemiological factors:** incidence of confirmed and probable COVID-19 cases; rate of hospitalizations and ICU admissions; number of deaths; percent positive among people tested; results of serological testing (providing availability of reliable assays).^a
2. **Health care capacities:** health system (hospital and non-hospital) functions and capacity (admissions and discharges), health care workers, ICU and non-ICU bed capacity, triage at health care facilities, stocks of personal protective equipment, treatment of COVID-19 and non-COVID-19 patients according to national standards and crisis standards of care; health workforce.
3. **Public health capacities:** rate of identification and testing of new suspected cases, isolation of new confirmed cases, identification and quarantine of contacts, number of public health rapid response teams to investigate suspect cases and clusters.
4. **Availability of effective pharmaceutical interventions:** Currently there are no COVID-19 specific therapeutics or vaccines. WHO, in collaboration with international partners, is implementing protocols for clinical trials to develop specific treatments and vaccines⁶ for COVID-19. The future availability of safe and effective pharmaceutical tools will be important in decision to implement or lift PHSM.

^a WHO is working with global partners to understand the sero-epidemiology of COVID-19 and the extent of immunity in the population to support policy-making. Knowing the proportion of potentially immune individuals by age group may help to estimate the risk of resurgence after relaxing measures and help to decide

Guiding principles when considering the adjusting of public health and social measures

Deciding which measures and in which order measures could be lifted should be based on a number of considerations:

- The adjusting of measures should not be undertaken all at once, but should be considered at the sub-national level, starting in areas with lowest incidence. Basic individual measures (e.g. isolation and care of suspect and confirmed cases, quarantine of contacts, hand hygiene and respiratory etiquette) should be maintained.
- In principle and when feasible, measures should be lifted in a controlled, slow, and step-wise manner, for example, using two-week (one incubation period) intervals to identify any adverse effects. The time interval between relaxation of two measures depends largely on the quality of the surveillance system and capacity to measure the effect.
- In the absence of scientific evidence on the relative and independent efficacy of each single measure, and as a general principle, measures with the highest level of acceptability and feasibility and the fewest negative consequences could be introduced first and removed last.
- Protection of vulnerable populations should be central in the decision to maintain or lift a measure.
- Some measures (e.g. business closures) could be lifted first where the population or individual density is lower (rural versus urban, small/medium versus large cities, small stores versus shopping malls), and could be lifted for part of the workforce before allowing 100% of the workforce to return to a business.

Implementation of the adjusting of public health and social measures

The adjusting of PHSM, including large-scale movement restrictions, needs to minimize the risk of a resurgence in COVID-19 cases:

1. **COVID-19 transmission is controlled** to a level of sporadic cases and clusters of cases, all from known contacts or importations; at a minimum, new cases would be reduced to a level that the health system can manage based on health care capacity.

Transmission can be controlled through two complementary approaches: (i) breaking chains of transmission by detecting, testing, isolating, and treating

what measures are most appropriate depending on the most affected age group.

<https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/early-investigations>

cases and quarantining contacts and (ii) monitoring hot spots of disease circulation through respiratory disease or influenza-like illness surveillance, coupled with serological surveys.

2. **Sufficient public health workforce and health system capacities are in place** to enable the major shift from detecting and treating mainly serious cases to detecting and isolating all cases, irrespective of severity and whether there is local transmission or an importation:

- Ensure that systems are in place to identify and break chains of transmission through detecting, testing, isolating, and treating all cases. A sufficient and trained workforce needs to be in place to find cases, test cases, and care for cases in medical facilities (WHO recommends that cases are isolated either in special wards in health facilities, in ad hoc COVID-19 facilities,⁷ or at home with adequate support).⁸
- For each case, sufficient workforce needs to be in place to identify and monitor contacts, and facilities to quarantine contacts ensured.⁹ Monitoring of contacts can be done through daily virtual visits of community volunteers, phone calls, or messaging.
- The health workforce and hospital capacity will need to be assessed, and possibly enhanced and in place to care for any resurgence in cases. The health workforce should be trained and provided with appropriate personal protective equipment.
- Robust information systems are needed for assess risk, measure response performance, and evaluate progress.

3. **Outbreak risks in high-vulnerability settings are minimized**, which requires all major drivers or amplifiers of COVID-19 transmission to have been identified, with appropriate measures in place to maximize physical distancing and minimize the risk of new outbreaks.

- Reduction of nosocomial transmission (e.g. appropriate infection prevention and control in health care facilities,¹⁰ including triage and screening of severe patients, appropriate infection prevention and control measures in residential care settings).¹¹
- Prevent transmission in enclosed spaces that prevent adequate physical distance and may have limited ventilation (e.g. cinemas, theatres, night clubs, bars, restaurants, gyms).
- Increase physical distancing in crowded public spaces (e.g. public transportation, supermarkets, markets, universities and schools, places of worship, mass gatherings such as sporting events, etc.).¹²

4. **Preventive measures are established in workplaces**, including the appropriate directives and capacities to promote and enable standard COVID-19 prevention measures in terms of physical distancing, hand washing, respiratory etiquette and, potentially, thermal monitoring. Teleworking, staggered shifts, and other practices should also be encouraged to reduce crowding.¹³

5. **Manage the risk of exporting and importing cases from communities with high risks of transmission.**

This can be done through an analysis of the likely origin and routes of importations, the epidemiological situation of areas of origin and destination, and measures in place to rapidly detect and manage suspected cases among travellers both at departure and at destination.¹⁴ This includes exit and entry screening and capacities for isolation of sick travellers, as well as capacity to quarantine individuals arriving from areas with community transmission. It is also important to consider, through multisectoral engagements, measures that can be taken at airports or points of entry to diminish the risk for travellers, such as passenger and facility management, and airside operations and safety¹⁵.

6. **Communities are fully engaged¹⁶** and understand that the transition away from large-scale movement restrictions and PHSM, from detecting and treating serious cases to detecting and isolating all cases, is a 'new normal' in which prevention measures would be maintained, and that all people have key roles in preventing a resurgence in case numbers.

- The public should be regularly informed and consulted about when and how PHSM will be implemented or lifted.
- The public needs to be enabled and in some cases will be critical to the implementation of PHSM as well as contributing to mitigating the social and economic impact of certain measures (e.g. community food-supply chains).
- The infodemic that is associated with every epidemic should be managed at all stages of the response. It is important to provide the right information at the right time to the right people through trusted channels (e.g. community leaders, family doctors, social influencers). The information should explain the situation, the interventions and the response plan, with an indication of the duration of the measures in place. This communication is essential not only for compliance to the public health measures but also for the development of adaptive social measures.

WHO continues to monitor the situation closely for any changes that may affect this interim guidance. Should any factors change, WHO will issue a further update. Otherwise, this interim guidance document will expire 2 years after the date of publication.

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