

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

Interim guidance

14 June 2021



## Key Messages

- Public health and social measures (PHSM) have proven critical to limiting transmission of COVID-19 and reducing deaths.
- The decision to introduce, adapt or lift PHSM should be based primarily on a situational assessment of the intensity of transmission and the capacity of the health system to respond, but must also be considered in light of the effects these measures may have on the general welfare of society and individuals.
- Indicators and suggested thresholds are provided to gauge both the intensity of transmission and the capacity of the health system to respond; taken together, these provide a basis for guiding the adjustment of PHSM. Measures are indicative and need to be tailored to local contexts.
- PHSM must be continuously adjusted to the intensity of transmission and capacity of the health system in a country and at sub-national levels.
- When PHSM are adjusted, communities should be fully consulted and engaged before changes are made.
- In settings where robust PHSMs are otherwise in place to control the spread of SARS-CoV-2, allowing the relaxation of some measures for individuals with natural or vaccine-induced immunity may contribute to limiting the economic and social hardship of control measures. Applying such individualized public health measures must take into account a number of ethical and technical considerations.

## Introduction

Public health and social measures (PHSMs) are being implemented across the globe to suppress SARS-CoV-2 transmission and reduce mortality and morbidity from COVID-19. PHSMs include personal protective measures (e.g. physical distancing, avoiding crowded settings, hand hygiene, respiratory etiquette, mask-wearing); environmental measures (e.g. cleaning, disinfection, ventilation); surveillance and response measures (e.g. testing, genetic sequencing, contact tracing, isolation, and quarantine); physical distancing measures (e.g. regulating the number and flow of people attending gatherings, maintaining distance in public or workplaces, domestic movement restrictions); and international travel-related measures. In this context, it does not include medical countermeasures such as drug administration or vaccination. PHSMs act in concert, and a combination of measures is required to ensure adequate control. Measures should be implemented by the lowest administrative level for which situational assessment is possible and tailored to local settings and conditions.

Several important developments have occurred since the publication of the previous *Considerations for implementing and adjusting public health and social measures in the context of COVID-19*.<sup>2</sup> First, several COVID-19 vaccines have been approved by national regulatory authorities and through WHO Emergency Use Listing (EUL).<sup>3</sup> Vaccination has begun in most countries, bringing the prospect of significantly reducing severe disease and mortality further. Initial observational studies following rollout of vaccines suggest that vaccines may lead to protection against infection and a reduction in transmission,<sup>4-6</sup> which in addition to PHSMs will help control the spread of the virus. Second, four WHO-classified variants of concern (VOCs) have emerged since December 2020,<sup>7,8</sup> which are more transmissible and some of which may cause more severe disease<sup>9</sup> and/or lead to a degree of vaccine escape, requiring potential adjustments to response measures to account for their different characteristics, including their impact on vaccine effectiveness. Several other variants of interest (VOIs) are also being monitored. Finally, more evidence is now available on the effectiveness of a range of individual and community-level measures (outlined in Table 3 below).

Control of SARS-CoV-2 will depend on: i) the prevalence of infection and of circulating variants; ii) the rate of growth or decline in incidence; iii) the types, use of and adherence to control measures in place; iv) the speed with which vaccination occurs; v) the targeting and uptake of the vaccines among high-risk groups; and vi) vaccine effectiveness and natural immunity in the population.<sup>10</sup> National vaccination strategies should prioritize older individuals at highest risk of severe outcomes and health workers, to rapidly reduce mortality and the burden of disease and protect health care services. However, with successful COVID-19 vaccination of older populations following the prioritization of vulnerable groups, the virus may continue to spread among unvaccinated younger population groups.<sup>11</sup> After achieving high vaccination coverage of SAGE priority groups for stage

I and stage II (as outlined in the WHO SAGE Roadmap For Prioritizing Uses of COVID-19 Vaccines in the Context of Limited Supply)<sup>12</sup> across all countries, accelerating vaccination of other priority groups will be required to lower the infection rate, especially in areas of high population density.<sup>13</sup>

While vaccination is underway, PHSMs will need to continue to be implemented, in a tailored and agile way, particularly considering uncertainty in vaccine performance against known and potentially emerging VOCs and limited sequencing capacity to detect variants worldwide.<sup>14</sup> Moreover, significant inequities in global vaccine access mean that, globally, control of disease will continue to rely on PHSM for the foreseeable future, modulated by different levels of vaccination. Implementation of stricter PHSMs, however, needs to be balanced against their socio-economic impacts, especially in settings with high dependence on daily wages and informal economy. Decisions to tighten, loosen, or introduce PHSMs to control COVID-19 must be weighed against the positive and negative impacts these measures have on societies and individuals. Considerations include impacts on health, economy, security, mental health, and psychosocial wellbeing, human rights, food security, socioeconomic disparities, continuity of other public health programmes, treatment and management of medical conditions other than COVID-19 and gender-based violence. Other important considerations include vaccine acceptance and uptake, confidence, trust, motivational elements to get vaccinated and public sentiment and adherence to PHSMs. The overall health and wellbeing of communities should therefore be at the forefront of considerations when deciding on and adjusting PHSMs.

As the pandemic continues to evolve, PHSMs should be regularly reviewed and adjusted according to the local epidemiology. This requires agile decision-making based on ongoing situational assessments at the most local administrative level possible in a coherent and coordinated manner with neighbouring areas at the sub-national and national levels. Such assessments should be based on available data and take a risk/benefit approach considering the local epidemiology, the health system's capacity to respond and other contextual considerations (such as upcoming mass gathering events that may alter transmission or capacity). Epidemiological indicators and their thresholds will depend on a country's testing and surveillance strategies and capacities, data collection capacity, vaccination strategy and coverage and the overall COVID-19 response strategy. In settings where COVID-19 surveillance or testing capacities are limited, it is important to identify and utilize additional indicators on morbidity, mortality and pressure on the health system, such as bed occupancy for both regular hospital beds and ICU beds, to complement available epidemiological data

This document provides guidance to help Member States assess the situation at national and sub-national levels, as well as key recommendations about the implementation of PHSMs. It should be read in conjunction with WHO interim guidance documents on *Critical preparedness, readiness and response actions for COVID-19*<sup>1</sup> and *Considerations for implementing a risk-based approach to international travel in the context of COVID-19*<sup>15,16</sup>, which address several other elements of preparedness, readiness and response for COVID-19 beyond PHSMs.

This guidance document is intended for public health and health services decision-makers at all levels at which decisions about tailored PHSMs are made and technical actors involved in relevant sectors (e.g. community engagement, education, social services) supporting or impacted by PHSMs.

The guidance will be updated as our knowledge evolves, in particular in relation to the impact of VOCs on vaccine-induced and natural immunity, the impact of various COVID-19 vaccines on transmission and the impact of PHSMs on VOCs.

## Changes from the previous version

This updated guidance provides updates on the assessment framework that drives decision-making for PHSMs, particularly on the type of indicators and the thresholds in different epidemiological settings, and in the context of vaccine roll-out and circulation of VOCs.

It also contains a new section on considerations for individualized public health measures based on a person's SARS-CoV-2 immunity status following COVID-19 vaccination or past infection in the context of contact tracing, international travel, and private social gatherings.

Recently published WHO scientific briefs and guidance were reviewed and key findings were summarised in Table 3. For the evidence on COVID-19 natural immunity, the document is based on the latest WHO scientific brief on *COVID-19 natural immunity*.<sup>17</sup> For the evidence of vaccines effectiveness, the document relies on the following published work: *SAGE working groups Annexes to WHO interim recommendations for use of the COVID-19 vaccine BIBP: GRADE and Evidence to Recommendations*<sup>18</sup>; *Annexes to the interim recommendations for use of the ChAdOx1-S [recombinant] vaccine against COVID-19 (AstraZeneca COVID-19 vaccine AZD1222, SII Covishield, SK Bioscience)*<sup>19</sup>; and *Background document on the mRNA-1273 vaccine (Moderna) against COVID-19*.<sup>20</sup>

## Transmission scenarios

Knowing the level of transmission is key to assessing the overall COVID-19 situation in a given area and guiding decisions on response activities and tailoring epidemic control measures.<sup>1</sup>

The community transmission (CT) classification is divided into four levels, as shown below. These definitions are abbreviated; details about the transmission classifications can be found in the Annex to this guidance.

- No (active) cases
- Imported / Sporadic cases
- Clusters of cases
- CT1: Low incidence of locally acquired widely dispersed cases detected in the past 14 days
- CT2: Moderate incidence of locally acquired widely dispersed cases detected in the past 14 days
- CT3: High incidence of locally acquired widely dispersed cases in the past 14 days
- CT4: Very high incidence of locally acquired widely dispersed cases in the past 14 days.

The transmission level classification for a geographic area may improve or worsen over time, and different geographic areas within a country will likely experience different levels of transmission concurrently. In settings with limited surveillance and diagnostic capacities, additional indicators – such as influenza-like-illness (ILI) / severe acute respiratory infection (SARI), all-cause excess mortality trends and all-cause hospitalization rates – should be identified to complement information on COVID-19 cases and deaths. These indicators are meant to capture pressure on the health care system and outcomes from undiagnosed COVID-19 cases and can support assessment of local transmission levels when triangulated with COVID-19 epidemiological data.

The process for determining transmission classification is outlined in the Annex to this document.

## Health system response capacity

In addition to assessing the level of transmission, it is also necessary to understand the health system response capacity. Depending on whether there is adequate, moderate or limited capacity, the same level of transmission can result in a drastically different situations and require a different degree of PHSMs. For the purpose of this document, ‘response capacity’ encompasses both health and public health services, including COVID-19 vaccination, and is measured in terms of both the actual ability to deliver services and the performance of those services.

## Situational assessment using transmission level and response capacity

### **Whether or not vaccination has begun, countries should continue to monitor transmission level and take measures as needed.**

Where there is a high level of vaccine-acquired immunity among prioritized groups, the epidemiology may start to change. A decoupling may occur between incidence and hospitalization and/or death rates because individuals most prone to hospitalization and death will have been immunized. In this situation, a greater proportion of cases will occur among younger, less vulnerable population groups. Here, recalibrating the incidence thresholds, focusing on hospitalization and ICU rates and analyzing incidence data by age group – as well as assessing the potential caseload of undiagnosed COVID-19 cases – are essential to guiding the adjustment of PHSMs.

As new variants of concern emerge, PHSMs may need to be adapted in the presence of variants that may be more transmissible, cause more severe disease and/or evade immunity induced by vaccination and/or natural infection. All epidemiological and health system indicators should be followed closely and PHSMs applied according to the prevailing epidemiological and health system situation. A greater disease transmissibility (as for all currently identified VOCs) may require keeping PHSMs in place for a longer period or may require intensifying the implementation of existing PHSMs to maintain effects on transmission.

Based on the joint assessment of the transmission scenario and the health system response capacity – which will inform whether and how to adjust PHSMs – a situational level should be assigned to a geographic area (see Table 1). The assessment should rigorously and comprehensively examine quantitative and qualitative information from multiple sources, which should be triangulated to provide an additional reality check on the assessed situational level. The resultant **situational levels should only be considered indicative**, because they may not correspond well to the response required in a specific context and to the COVID-19 control objectives of the country. For example, in a small country with limited capacity or remote areas with limited access to health services, stringent PHSMs may be warranted in the context of a relatively low level of transmission.

**Table 1: Situational level assessment matrix using transmission level and response capacity indicators to guide adjustment of PHSMs**

Transmission level*	Response capacity*		
	Adequate	Moderate	Limited
No cases	0	0	1
Imported/Sporadic cases	0	1	1
Clusters of cases	1	1	2
• Community - CT1	1	2	2
• Community - CT2	2	2	3
• Community - CT3	2	3	3
• Community - CT4	3	3	4

\*Please refer to the Annex for transmission level definitions.

- **Situational Level 0** corresponds to a situation with no known transmission of SARS-CoV-2 in the preceding 28 days. The health system and public health authorities are ready to respond, but there are no significant domestic measures in place and thus no significant restrictions on daily activities.
- **Situational Level 1** is a situation where basic measures are in place to prevent transmission; or if cases are already present, the epidemic is being controlled through effective measures around the cases, with limited and transient localized disruption of social and economic life.
- **Situational Level 2** represents a situation with low community incidence or risk of community transmission beyond clusters. Additional measures may be required to control transmission; however, disruptions to social and economic activities can still be limited. In the context of vaccination, Situational Level 2 may also include areas with moderate levels of community transmission, but limited health service impact given adequate vaccination coverage in at-risk and older age groups.
- **Situational Level 3** is a situation of community transmission with limited additional capacity to respond and a risk of health services becoming overwhelmed. A larger combination of measures may need to be put in place to limit transmission, manage cases, and ensure epidemic control.
- **Situational Level 4** corresponds to an uncontrolled epidemic with limited or no additional health system response capacity available, thus requiring extensive measures to avoid overwhelming of health services and substantial excess morbidity and mortality.

## Adjusting public health and social measures

### Key principles

Decisions on which measures to implement, lift or strengthen, and the order in which these measures should be implemented, should be based on the following guiding principles:

- Measures with the highest level of acceptability and feasibility and proven effectiveness – and which minimize the negative consequences on health and wellbeing of all members of society and the economy and – should be adopted, using *the COVID-19 Global Risk Communication and Community Engagement Strategy – interim guidance*.<sup>21</sup> Acceptability and feasibility should be determined through participatory approaches and shift away from directives and one-way communications. Engaging with the community for this assessment will help to maximize the likelihood of adherence. Effectiveness and potential negative effects of PHSMs should be evaluated through an evidence-based assessment (e.g. literature review, WHO guidance, etc.) and active monitoring of the impact of implemented PHSMs.
- Additional measures should be considered as soon as the situational level rises. Delays in implementation of measures will lead to increased morbidity and mortality and the need for more stringent measures to regain control. In particular, efforts should be made to prevent an intensification in transmission from ‘clusters’ to ‘community transmission’.
- When feasible, measures should be adjusted (implemented or lifted) in a controlled, stepwise manner to allow better understanding of the effects of each measure on transmission dynamics.
- Any decision to apply PHSMs must be weighed against the wider impact of the measures on health and well-being (lives lost in the short and long term compared to lives saved by applying PHSMs).

- Public health surveillance data and findings from case and cluster investigations may provide important information on conditions associated with transmission or severity. This is particularly important in the context of circulating VOCs, and potential new variants, since the lifting of PHSMs may provide a better understanding of the transmission and severity characteristics of these variants. Such information may help targeting application or intensification of certain PHSMs without imposing the measures universally on all settings (e.g. settings without these variants).
- Any available information on the level of immunity in the general population – either natural or vaccine-induced – must be taken into consideration when assessing the likely impact on SARS-CoV-2 transmission of lifting PHSMs.
- Protection of vulnerable populations,<sup>12</sup> including those clinically at risk for severe disease should be central in the decision to implement, maintain or lift a measure. Vulnerable populations include people aged  $\geq 60$  years and/or with comorbidities that increase risk of serious COVID-19 disease; disadvantaged groups such as marginalized populations, vulnerable migrants and refugees; and those in high density/low resource settings and lower income groups. Vulnerable communities and disadvantaged individuals may face immediate challenges in meeting their basic life needs – such as income, shelter and food – when PHSMs are implemented and if implemented without adequate support.<sup>22</sup> It is crucial that those essential needs be taken into account when designing different packages of PHSMs and addressed before these packages are implemented to avoid or minimize harm and improve effectiveness. It is critical to safeguard vulnerable and disadvantaged populations by implementing specific measures to support them, mobilizing resources and engaging all relevant sectors and communities to learn about their concerns and receive feedback. This includes ensuring access to health services (using community-based service delivery), which is especially challenging when transportation, clinics/hospitals and other government services are closed or have long waits. Other essential services include supplementary income or food provision; safe places for survivors of and/or those at risk of violence, including gender-based violence; and improvement of infrastructure and safety of public transport (which is used most by workers in vulnerable populations and essential workers) to make it compatible with PHSMs.
- The potential impact of lifting PHSMs on the health and public health systems capacities to rapidly respond to any new increase in cases should be considered. For example:
  - Adequate health system capacities should be in place to detect, test and manage new cases and their contacts.
  - The risk of outbreaks and/or severe disease in settings with vulnerable individuals should be minimized. This requires identifying all major drivers of SARS-CoV-2 transmission (e.g. various types of closed settings such as health care facilities and care homes) in the local context and understanding the vaccination coverage of priority populations in that context, with appropriate measures in place to maximize physical distancing and minimize the risk of outbreaks.
  - Key drivers of transmission in the area under assessment must be well understood using local surveillance data, and measures should be rapidly re-implemented should incidence increase. A particular focus should be on prevention and early detection of potential superspreading events.
- Basic risk mitigation measures aimed at reducing travel-associated exportation, importation and onward transmission of SARS-CoV-2 should always be maintained. For details, please refer to *Considerations for implementing a risk-based approach to international travel in the context of COVID-19*.<sup>15,16</sup>
  - In all cases, international travel should be prioritized for emergencies and humanitarian actions (such as emergency medical flights and medical evacuations); travel of essential personnel (such as emergency responders, providers of public health technical support, and critical personnel in the transport and security sectors such as seafarers); repatriations; and cargo transport for essential supplies such as food, medicines, and fuel.
  - Specific considerations are outlined in this document for the implementation of an individualized approach to quarantine and testing for international travellers with natural or vaccine-acquired immunity.

## Community engagement and risk communication strategy

When PHSMs are adjusted, communities should be fully and regularly informed, engaged and enabled before changes are made, to allow them to take ownership of the selected PHSM.<sup>23</sup> It is critical to build and foster trust, especially in contexts where there is little or no involvement of the local population in decision-making. Clear, concise and transparent risk communication, including an evidence-based rationale for adjusting measures, should be developed with communities targeted for PHSM.

In particular:

- Communities should be given recognized roles to provide input and take ownership of when and how PHSMs will be implemented or lifted.
- Communities will be critical to implementing population-wide PHSMs and contributing to the mitigation of the social and economic impact of certain measures (e.g. disrupting availability of food and other needed supplies).
- Civil society organizations, faith-based organizations (FBOs) and volunteers play a critical role in fortifying community services (e.g. provision of food, medicines, mental health and other support services, tests and vaccinations) for those in need (e.g. people who are isolated or quarantined).

- Feedback mechanisms should be established to ensure that any societal impact of changes to PHSMs is quickly identified and reported for action. Communities should lead solutions to ensure adoption of measures that best meet local needs (for example by considering local cultural practices), which can increase the likelihood of adherence.
- Local community-level networks should be leveraged for sustained efforts by building capacity through training of local leaders.
- The infodemic<sup>24</sup> that has emerged from COVID-19 information overload and misinformation should be managed at all stages of the response by providing the right information at the right time to the right people through trusted channels (e.g. community and faith leaders, family doctors and other influential members of society). There should be a monitoring system in place to capture emerging trends (e.g. vaccine confidence and hesitancy, adherence to PHSM) to enable delivery of a targeted communication package.
- A communication and community engagement strategy should be developed before any changes to PHSMs are implemented or adjusted.<sup>3</sup> The strategy should be developed in consultation with relevant stakeholders from government, civil society, FBOs and community groups. Plans should include, at a minimum, behavioural objectives, target audiences, priority channels and a mix of strategies and activities to inform and engage the community.
- The key messages of such plans should cover information important to the community, such as the extent and estimated duration of the measures in place.
- Governments should regularly communicate epidemiological data to the public to further foster trust and increase acceptance and sustained adherence to PHSMs.

### **Adjustment of PHSMs based on situational assessment**

Table 2 provides more detail on the types of domestic measures that may be implemented for each situational level. The measures at each level are only indicative, because some measures may be more or less feasible or appropriate in specific contexts and locations. Note that overall recommendations on international travel can be found in the interim guidance *Considerations for implementing a risk-based approach to international travel in the context of COVID-19*.<sup>15,16</sup>

Measures should be time-bound and regularly re-assessed, at least every two weeks, along with the situational level. The adherence to PHSMs should also be monitored, using sources such as mobility data, and this should be used to further inform future adjustment of PHSMs and the risk communications and community engagement strategy.

At all Situational Levels, individuals should apply personal protective measures such as hand hygiene, physical distancing, respiratory etiquette, staying home if unwell and wearing a mask where appropriate, and environmental measures (e.g. cleaning, disinfection, ventilation). Clear information should be provided to the public about what to do if unwell and whom to contact for advice, testing and/or treatment.

**Table 2: Guidance on the implementation of domestic PHSMs for each Situational Level**

Situational level	Considerations for implementation of PHSMs by situational level*
<p><b>Situational level 0:</b></p> <p>No known transmission of SARS-CoV-2 in the preceding 28 days. The health system and public health authorities are ready to respond, but there are no significant restrictions on daily activities.</p>	<p>Surveillance should ensure that any new case can be detected and managed as early as possible, but there should be no restrictions on daily activities.</p> <p>Authorities may consider implementing the following measures:</p> <ul style="list-style-type: none"> <li>• Continue strengthening emergency preparedness, readiness and response actions,<sup>1</sup> ensuring adequate stockpiles of medicines and medical equipment and that sufficient staff have been recruited and trained to handle anticipated surges in cases.</li> <li>• Implement or maintain robust surveillance<sup>25</sup> to rapidly detect and investigate suspected SARS-CoV-2 cases and clusters<sup>26</sup> and ensure public health measures such as isolation and supported quarantine<sup>27</sup> are undertaken to reduce onward spread if cases are confirmed and contacts are identified, respectively.</li> <li>• Apply a risk-based approach based on the three steps of risk evaluation, risk mitigation and risk communication to inform the decision to restrict, modify, postpone, cancel or proceed with holding any mass gatherings, including medium and small events. For public gatherings, the risk assessment should be undertaken by local and national public health authorities and event organizers with input from all relevant stakeholders (emergency management, transport, safety and security, etc.).<sup>28,29</sup></li> </ul>
<p><b>Situational level 1:</b></p> <p>Basic measures are in place to prevent transmission; or if cases are already present, the epidemic is being controlled through effective measures around the cases, with limited and transient localized disruption to social and economic life.</p>	<p>Specific measures should be taken around cases and/or clusters, and individual measures should be strengthened, with limited impact on social and economic activities.</p> <p>In addition to measures on emergency preparedness, readiness and response actions<sup>1</sup> and surveillance, personal protective measures and risk communications, authorities may consider implementing the following measures:</p> <ul style="list-style-type: none"> <li>• Emphasis should be placed on case and cluster detection, investigation, and tracing of contacts.</li> <li>• Promote avoidance of the ‘3 Cs’ – Closed spaces, crowded places and close-contact settings.</li> <li>• Apply a risk-based approach based on the three steps of risk evaluation, risk mitigation and risk communication to inform the decision to restrict, modify, postpone, cancel or proceed with holding any mass gatherings, including medium and small events. For public gatherings the risk assessment should be undertaken by local and national public health authorities and event organizers with input from all relevant stakeholders (emergency management, transport, safety and security, etc.).<sup>28,29</sup> Daily activities and services, such as educational settings<sup>30</sup>, businesses<sup>31</sup> and leisure/tourism can remain open with precautionary measures in place to limit the risk of spread.</li> <li>• Put in place measures to protect the most vulnerable, particularly ensuring that there are appropriate measures in place in long-term care<sup>32</sup> and other residential facilities.</li> </ul>
<p><b>Situational level 2:</b></p> <p>Low community incidence or a risk of community transmission beyond clusters. Additional measures with respect to Situational level 1 may be required to control transmission; however, disruptions to social and economic activities can still be limited</p>	<p>Measures should be applied to limit the number of physical encounters with others outside of the household, while ensuring services can remain open with precautionary measures in place. A wider range of PHSMs may be required to control transmission.</p> <p>In addition to measures on emergency preparedness and response and surveillance, personal protective measures and risk communications, authorities may consider implementing the following measures:</p> <ul style="list-style-type: none"> <li>• Education settings remain open with precautionary measures in place.</li> <li>• Businesses remain open, with precautionary measures in place, with teleworking encouraged as much as possible.</li> <li>• Improve local transport infrastructure to comply with PHSMs (improve availability, frequency, extension of schedules, etc.).</li> <li>• Apply a risk-based approach based on the three steps of risk evaluation, risk mitigation and risk communication to inform the decision to restrict, modify, postpone, cancel or proceed with holding any mass gatherings, including medium and small events. For public gatherings the risk assessment should be undertaken by local and national public health authorities and event organizers with input from all relevant stakeholders (emergency management, transport, safety and security, etc.)<sup>28,29</sup>.</li> <li>• If required, place further emphasis on protecting the most clinically vulnerable, through strict application of infection prevention and control measures, heightened surveillance and managing visits in long-term care and other residential facilities.</li> <li>• If contact tracing is overwhelmed, consider prioritization of contact tracing (see <i>Contact tracing in the context of COVID-19</i>.<sup>33</sup>).</li> </ul>

Situational level	Considerations for implementation of PHSMs by situational level*
<p><b>Situational level 3:</b></p> <p>Community transmission with limited additional capacity to respond and a risk of health services becoming overwhelmed. A larger combination of control measures may need to be put in place to limit transmission, manage cases, and ensure epidemic control.</p>	<p>Strengthening of all PHSMs is needed to avoid more stringent restrictions on movement and other related measures applied under level 4. All individuals should reduce their social contacts, and some activities may need to close while allowing for essential services, particularly schools, to remain open. In settings with high dependence on daily wages and informal economy, mitigation of the potential socio-economic costs of strengthening PHSMs needs to be planned properly in advance.</p> <p>In addition to measures on emergency preparedness and response and surveillance, personal protective measures and risk communications, authorities may consider implementing the following measures:</p> <ul style="list-style-type: none"> <li>• Adapt the functioning of businesses to minimize COVID-19 risk, including through remote working, modified service provision, or closure where necessary.</li> <li>• Improve local transport infrastructure to comply with PHSMs (improve availability, frequency, extension of schedules, etc.).</li> <li>• Consider limiting in-person university teaching, and institute e-learning.</li> <li>• Childcare services and primary and secondary schools should remain open with adequate safety and surveillance measures in place as long as the local context allows. Continuity of education for children for their overall well-being, health and safety should be at the forefront of all relevant considerations and decisions.</li> <li>• Due to risk of further transmission in an already high transmission level with limited healthcare resources, all PHSMs may be best applied without relaxing any measures according to individuals' immune status. See section below on "individualized public health measures".</li> <li>• Apply a risk-based approach based on the three steps of risk evaluation, risk mitigation and risk communication to inform the decision to restrict, modify, postpone, cancel or proceed with holding any mass gatherings, including medium and small events. For public gatherings the risk assessment should be undertaken by local and national public health authorities and event organizers with input from stakeholders (emergency management, transport, safety and security, etc.)<sup>28,29</sup>.</li> <li>• Quantify the needs in advance and provide the necessary socio-economic support for low-income individuals and households and those at risk of falling into poverty, ensuring no-one is left behind. Socioeconomic recovery for these vulnerable groups and the general population should also be prepared for in advance and resources secured to the extent possible.</li> </ul>
<p><b>Situational level 4:</b></p> <p>An uncontrolled epidemic with limited or no additional health system response capacity available, thus requiring extensive measures to avoid overwhelming of health services and substantial excess morbidity and mortality.</p>	<p>Reducing transmission in the community will be challenging, and stringent movement restrictions and related measures will need to be put in place to significantly reduce the number of in-person encounters. Such measures should be geographically limited to where they are needed and be time-bound and aimed to be as short as reasonably possible.</p> <p>In addition to measures on emergency preparedness and response and surveillance, personal protective measures and risk communications, authorities may consider implementing the following measures:</p> <ul style="list-style-type: none"> <li>• All individuals, including fully vaccinated, partially vaccinated and recovered individuals, should stay at home and limit physical contact with people outside the household.</li> <li>• Essential workers will need to continue activities, with maximum support and safety measures in place. Improve local transport infrastructure to comply with PHSMs (improve availability, frequency, extension of schedules, add private transport to public transport infrastructure, etc.).</li> <li>• Close non-essential businesses, and institute remote working.</li> <li>• Consider all options for continuity of in-person learning. If not possible, limit in-person contact. Options may include in-person or blended learning strategies that strictly limit the number of</li> </ul>

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