



Organización de Aviación Civil Internacional

Oficina Regional Sudamericana

**Séptima Reunión del Grupo Estratégico de la Región Sudamericana
sobre la Respuesta al COVID-19**

(Plataforma Zoom, 21 de julio de 2021)

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Nuevas guías sobre medidas sociales y de salud pública de la OMS en el contexto del COVID-19

(Presentada por la Secretaría)

RESUMEN

Esta nota presenta una nueva guía de la OMS sobre medidas sociales y de salud pública, incluida una que permitiría la flexibilización de medidas a individuos con inmunidad natural o inducida por vacunas y otras disposiciones.

Acciones sugeridas: ver Sección de esta nota de estudio

1. INTRODUCCIÓN

1.1 El pasado 14 de junio la Organización Mundial de la Salud (OMS) publicó una orientación provisional sobre “Consideraciones para la implementación y adecuación de las medidas sociales y de salud pública en el contexto del COVID-19” (*Considerations for implementing and adjusting public health and social measures in the context of COVID-19*), disponible actualmente en inglés bajo la dirección <https://www.who.int/publications/i/item/considerations-in-adjusting-public-health-and-social-measures-in-the-context-of-covid-19-interim-guidance>).

1.2 Este documento es una actualización de la guía provisional publicada el 4 de noviembre de 2020 titulada “*Considerations in adjusting public health and social measures in the context of COVID-19*”. Las medidas sociales y de salud pública (PHSM) han demostrado ser fundamentales para limitar la transmisión del COVID-19 y reducir las muertes. Estas medidas incluyen intervenciones individuales y sociales no farmacéuticas para controlar COVID-19. Esta versión actualizada introduce consideraciones para la relajación de algunos PHSM para personas con inmunidad natural o inducida por vacunas.

1.3 Una copia del documento en su versión original se anexa como Adjunto A de esta nota de estudio.

2. CAMBIOS DESDE LA PASADA VERSIÓN

2.1 Esta guía proporciona actualizaciones sobre el marco de evaluación que impulsa la toma de decisiones para los PHSM, en particular sobre el tipo de indicadores y los umbrales en diferentes entornos epidemiológicos, y en el contexto de la implementación de vacunas y la circulación de variantes de preocupación (o VOC por sus siglas en inglés).

2.2 También contiene una nueva sección sobre consideraciones para medidas de salud pública individualizadas basadas en el estado de inmunidad al SARS-CoV-2 de una persona después de la

vacunación COVID-19 o una infección pasada en el contexto de rastreo de contactos, viajes internacionales y reuniones sociales privadas.

3. IDEAS CLAVE

3.1 El documento presenta las siguientes ideas clave (*Nota: extracto de traducción no-oficial del documento en cuestión*):

- Las medidas sociales y de salud pública (PHSM) han demostrado ser fundamentales para limitar la transmisión del COVID-19 y reducir las muertes.
- La decisión de introducir, adaptar o levantar PHSM debe basarse principalmente en una evaluación situacional de la intensidad de la transmisión y la capacidad del sistema de salud para responder, pero también debe considerarse a la luz de los efectos que estas medidas pueden tener en la situación general, bienestar de la sociedad y de las personas.
- Se proporcionan indicadores y umbrales sugeridos para medir tanto la intensidad de la transmisión como la capacidad del sistema de salud para responder; en conjunto, estos proporcionan una base para orientar el ajuste de PHSM. Las medidas son indicativas y deben adaptarse a los contextos locales.
- Las PHSM debe ajustarse continuamente a la intensidad de transmisión y capacidad del sistema de salud en un país y en los niveles sub nacionales.
- Cuando se ajustan los PHSM, se debe consultar y participar plenamente a las comunidades antes de realizar los cambios.
- En entornos donde existen PHSM robustos para controlar la propagación del SARS-CoV-2, permitir la relajación de algunas medidas para individuos con inmunidad natural o inducida por vacunas puede contribuir a limitar las dificultades económicas y sociales de las medidas de control. La aplicación de tales medidas de salud pública individualizadas debe tener en cuenta una serie de consideraciones éticas y técnicas.

4. ACTUALIZACIÓN DE OMS - Consideraciones técnicas para implementar un enfoque basado en el riesgo para los viajes internacionales en el contexto de COVID-19

4.1 Como anexo a la guía publicado el pasado mes de junio, la OMS publicó un anexo a esta guía con consideraciones directamente aplicables a los viajes internacionales en el contexto de COVID-19 la cual se puede descargar del portal: <https://www.who.int/publications/i/item/WHO-2019-nCoV-Risk-based-international-travel-2021.1> . El mismo se incluye como Adjunto B a esta nota.

4.2 Como puntos clave de este documento se encuentran:

- Durante la pandemia de COVID-19, los viajes internacionales siempre deben priorizarse para fines esenciales, incluidas misiones de emergencia y humanitarias, viajes de personal esencial, repatriaciones y transporte de carga de suministros esenciales.
- A medida que los países reanudan o reajustan gradualmente los viajes internacionales no esenciales, la introducción de medidas de mitigación de riesgos destinadas a reducir la exportación, la importación y la transmisión ulterior del SARS-CoV-2 asociadas con los viajes debe basarse en evaluaciones de riesgo exhaustivas realizadas de manera sistemática y rutinaria.
- La aplicación de un enfoque de precaución está justificada en presencia de incertidumbres científicas, como la aparición de variantes de preocupación (VOC) o variantes de interés (VOI)
- No se debe exigir prueba de vacunación COVID-19 como condición para la entrada o salida de un país.

- Las autoridades nacionales que implementan las pruebas o la cuarentena como condición para la entrada de viajeros internacionales pueden considerar enfoques individualizados para eximirlos de estas medidas basándose en la inmunidad adquirida por vacunación o infección previa por SARS-CoV-2.
- Todos los viajeros internacionales deben seguir respetando las medidas de protección personal, como el uso de máscaras y el distanciamiento físico, tanto en los medios de transporte como en los puntos de entrada.
- Los viajeros internacionales no deben ser considerados por defecto como casos o contactos sospechosos de COVID-19 o como un grupo prioritario para las pruebas.
- La salud y el bienestar general de las comunidades deben estar a la vanguardia de las consideraciones al decidir e implementar medidas internacionales relacionadas con los viajes, que deben comunicarse públicamente y de manera oportuna.

5. **OTRAS INFORMACIONES DE INTERÉS**

5.1 En adición a la publicación de este documento de la OMS, se suma la reciente publicación el pasado 17 de junio de nuevas pautas *EASA / ECDC de transporte aéreo para tener en cuenta la vacunación y la evidencia científica más reciente* (disponible en <https://www.easa.europa.eu/newsroom-and-events/press-releases/easaecdc-updates-air-travel-guidelines-factor-vaccination-and>)

6. **ACCIÓN SUGERIDA**

6.1 Se invita a la Séptima Reunión del Grupo Estratégico GESAM a:

- a. Tomar nota del contenido de esta nota de Estudio y las disposiciones de la OMS incluidas en el adjunto A y B;
- b. Comentar al respecto de las nuevas disposiciones y su impacto en las interacciones Autoridades de Aviación Civil – Autoridades de Salud;
- c. Cualquier acción que disponga la Reunión.

ADJUNTO A

Orientación provisional “*Consideraciones para la implementación y adecuación de las medidas sociales y de salud pública en el contexto del COVID-19*” (Disponible solo en inglés)

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*.² First, several COVID-19 vaccines have been approved by national regulatory authorities and through WHO Emergency Use Listing (EUL).³ 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,⁴⁻⁶ 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,^{7,8} which are more transmissible and some of which may cause more severe disease⁹ 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.¹⁰ 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.¹¹ 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)¹² across all countries, accelerating vaccination of other priority groups will be required to lower the infection rate, especially in areas of high population density.¹³

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.¹⁴ 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*¹ and *Considerations for implementing a risk-based approach to international travel in the context of COVID-19*^{15,16}, 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*.¹⁷ 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*¹⁸; *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)*¹⁹; and *Background document on the mRNA-1273 vaccine (Moderna) against COVID-19*.²⁰

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.¹

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*.²¹ 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,¹² 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 ≥ 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.²² 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*.^{15,16}
 - 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.²³ 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 infodemic²⁴ 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.³ 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*.^{15,16}

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>Situational level 0:</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"> • Continue strengthening emergency preparedness, readiness and response actions,¹ ensuring adequate stockpiles of medicines and medical equipment and that sufficient staff have been recruited and trained to handle anticipated surges in cases. • Implement or maintain robust surveillance²⁵ to rapidly detect and investigate suspected SARS-CoV-2 cases and clusters²⁶ and ensure public health measures such as isolation and supported quarantine²⁷ are undertaken to reduce onward spread if cases are confirmed and contacts are identified, respectively. • 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.).^{28,29}
<p>Situational level 1:</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 actions¹ and surveillance, personal protective measures and risk communications, authorities may consider implementing the following measures:</p> <ul style="list-style-type: none"> • Emphasis should be placed on case and cluster detection, investigation, and tracing of contacts. • Promote avoidance of the ‘3 Cs’ – Closed spaces, crowded places and close-contact settings. • 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.).^{28,29} Daily activities and services, such as educational settings³⁰, businesses³¹ and leisure/tourism can remain open with precautionary measures in place to limit the risk of spread. • Put in place measures to protect the most vulnerable, particularly ensuring that there are appropriate measures in place in long-term care³² and other residential facilities.
<p>Situational level 2:</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"> • Education settings remain open with precautionary measures in place. • Businesses remain open, with precautionary measures in place, with teleworking encouraged as much as possible. • Improve local transport infrastructure to comply with PHSMs (improve availability, frequency, extension of schedules, etc.). • 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.)^{28,29}. • 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. • If contact tracing is overwhelmed, consider prioritization of contact tracing (see <i>Contact tracing in the context of COVID-19</i>.³³).

Situational level	Considerations for implementation of PHSMs by situational level*
<p>Situational level 3:</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"> • Adapt the functioning of businesses to minimize COVID-19 risk, including through remote working, modified service provision, or closure where necessary. • Improve local transport infrastructure to comply with PHSMs (improve availability, frequency, extension of schedules, etc.). • Consider limiting in-person university teaching, and institute e-learning. • 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. • 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". • 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.)^{28,29}. • 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.
<p>Situational level 4:</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"> • All individuals, including fully vaccinated, partially vaccinated and recovered individuals, should stay at home and limit physical contact with people outside the household. • 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.). • Close non-essential businesses, and institute remote working. • 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 people physically on site (exceptions would include children of essential workers and their teachers) and remote learning. The closure of educational facilities should only be considered when there are no other alternatives. • All long-term care and other residential facilities should consider strict measures to limit the risk of infection, up to and including temporary suspension of in-person visits. • Cancel or postpone any mass gatherings. • Quantify needs (in advance) and provide necessary socio-economic support for low-income individuals and households and those at risk of falling into poverty, ensuring no-one is left behind. Carefully monitor the impact of strict PHSMs on the livelihoods and well-being of these vulnerable groups. Socio-economic recovery for these vulnerable groups and the general population should also be planned in advance and resources secured to the extent possible.

*The specific measures implemented at each level will need to be carefully considered based on the guiding principles outlined above. The measures at each level are only indicative, since some measures may be more or less feasible or appropriate in specific contexts and locations

Considerations for the implementation of individualized public health measures

In settings where robust PHSMs are otherwise in place to control the spread of SARS-CoV-2, allowing the relaxation of some measures for some individuals may contribute to limiting the economic and social hardship of control measures. The differential “personal protective measures” for immune (fully vaccinated or recovered from infection) versus non-immune individuals will be referred to as **individualized public health measures**.

Applying **individualized public health measure** recommendations based on someone’s immunity status must be carefully considered in the light of a number of aspects, including: the level of transmission of SARS-CoV-2; the evidence around the impact of various COVID-19 vaccines in preventing transmission; effectiveness against disease and duration of vaccine-induced immunity; the level and duration of protection conferred by natural immunity; the COVID-19 response strategy and risk tolerance of the implementing country; the potential circulation of immune-escape VOCs; and important ethical considerations, particularly given current limited availability of vaccines worldwide and existing inequities in vaccine availability across and within countries and population groups.

Ethical considerations

Details on the ethical considerations related to individualized public health measures in the context of COVID-19 are provided in other WHO publications.^{17,34} Key considerations can be found below:

- **Proportionate and inclusive approach:** Before implementing individualized public health measures, governments or other competent authorities should, as much as possible, reduce barriers to vaccination; consider measures that least infringe of the rights and liberties of non-vaccinated individuals; and consider options for non-vaccinated individuals such as the results of reliable negative COVID-19 tests and making tests accessible to all (e.g. free testing once a week) or issuing immunity certificates for recovered individuals. This may help ensure that measures for non-vaccinated individuals are proportionate and as socially inclusive (defined here as removing or reducing barriers that prevent people from participating in civil, social and economic life) as possible.
- **Exemptions:** A system of recording and verifying exemptions from COVID-19 vaccination based on medical reasons, or other reasons provided for in law or relevant regulations, should be established if vaccination certificates are introduced to impose individualized public health measures on vaccinated and non-vaccinated individuals. Careful attention should be paid to ensuring that the collection, storage and use of such data are limited to scientifically and ethically justified purposes compatible with sustained public trust and confidence.

Technical considerations for individualized public health measures

Although vaccinated individuals or individuals with documented past infection may still be able to be (re-)infected and transmit the infection, growing evidence (see Table 3) suggests that the risk of infectiousness is substantially lowered. On this basis, countries may decide to relax quarantine requirements for individuals with evidence of immunity, since the burden of quarantine may outweigh the risk of transmission. However, if circulation of variant(s) able to evade established immunity becomes evident, such relaxation may not be advisable, because variants could still be transmitted efficiently.

The lower risk of infection following full COVID-19 vaccination likely varies by COVID-19 vaccine; given the paucity of data for all available COVID-19 vaccines, WHO recommends countries adopt a risk-based approach. This should also consider the local epidemiological context, and the context of the exposure (risk assessment of exposure), as some settings like health-care facilities may pose a higher risk, leading to classification of health-care workers as high-risk contacts.⁵

Table 3 below summarizes the main technical considerations around individualized public health measures in the context of vaccine-induced and natural immunity. The table was drafted based on evidence available as of 14 June 2021.

Table 3: Review of existing evidence on SARS-CoV-2 past infection, COVID-19 vaccines and variants of concern, and main technical considerations for individualized public health measures in the context of vaccine-induced and natural immunity

Element	Considerations
SARS-CoV-2 infection	<ul style="list-style-type: none"> Natural immunity confers high levels of protection against reinfection, with estimates varying from around 81% to close to 100% protection in people younger than 65 years or among health workers during follow up of at least five to seven months.^{6,35–37} Protection against reinfection appears to vary by age group and is lower (approximately 47%) among people aged 65 years and older.^{35,38} Evidence of immunity to SARS-CoV-2 is most commonly determined by measuring antibodies in sera. Within four weeks following infection, 90-99% of individuals infected with the SARS-CoV-2 virus develop detectable neutralizing antibodies.^{14,39,40} While correlates of protection are yet to be fully established, currently the presence of neutralizing antibodies is the best indication for protection against re-infection. How long protection lasts remains unclear and may differ depending on disease severity. Protection after infection with common cold coronaviruses, which often cause mild disease, is highly transient; and for SARS-CoV-2, there is evidence that immunological memory is 6-8 months.^{41,42} While protection is high, natural immunity does not provide 100% sterilizing immunity. Individuals who have natural immunity are still have a potential risk of reinfection and may be infectious.⁴³
COVID-19 vaccination	<ul style="list-style-type: none"> Different vaccine products may differ in their effectiveness, including against VOCs. The risk of onward transmission and duration of protection also may vary. Waning immunity and vaccine effectiveness over time will need to be documented as vaccination rollout progresses. At the time of publication, in human clinical trials, all WHO Emergency Use Listed (EUL) vaccines have demonstrated efficacy (63% to 95%) against symptomatic, laboratory-confirmed COVID-19.^{20,44–46} In human clinical trials, all vaccines that currently have WHO EUL (as of the time of publication) have demonstrated high efficacy (over 89%) against severe COVID-19, indicating that the chance of developing severe disease in a fully vaccinated person is very low for younger and middle-aged adults and very low to moderate for older adults or other persons with underlying risk factors.^{47,48} Results from post-introduction observational studies have reported vaccine effectiveness estimates ranging from 64% to over 97%. The duration of protection remains unclear, because vaccine effectiveness has been measured only shortly after the introduction of the vaccines; but a recent eight-month follow up of recipients of one vaccine reported a durable response to the studied vaccine.⁴⁹ One studied vaccine prevented infection for 70% of individuals at 21 days after a single dose and 85% of individuals at 7 days after two doses, providing real-world estimates of vaccine protection against infection.⁵⁰ There is emerging evidence that vaccination substantially reduces the risk of onward transmission of SARS-CoV-2 to susceptible contacts.^{51,52} There is also emerging evidence that use of COVID-19 vaccines at the population level has a positive impact on the disease dynamics in the population.^{53,54}
Variants of concern (VOCs) (as of the time of publication)	<ul style="list-style-type: none"> Some SARS-CoV-2 variants, including all currently identified VOCs (i.e. Alpha [B.1.1.7], Beta [B.1.351], Gamma [P.1] and Delta [B.1.671.2]), exhibit increased transmissibility as compared to previously/co-circulating variants.⁸ This primarily influences transmission levels and the potential need to keep general PHSMs in place for longer or at a higher intensity, rather than specifically influencing considerations for individualized public health measures. Evidence of increased resistance of some SARS-CoV-2 variants (including all four VOCs) to natural or vaccine-induced neutralizing antibodies has been reported, raising the concern that reinfection after natural infection or breakthrough infection after vaccination may increase in settings where such VOCs circulate widely.^{8,55} The convergent evolution of mutations thought to be associated with higher transmissibility or immune escape (e.g. N501Y, E484K) in VOCs highlights the fact that variants will likely continue to emerge under selective pressures such as population immunity.⁵⁶

Note: references cited do not represent an exhaustive list of all relevant references on these topics

Implementation of individualized public health measures based on available evidence (as of 14 June 2021)

After taking into consideration ethical and technical considerations and transmission levels, countries may consider relaxing some measures for individuals meeting either of the following criteria:

- completion of full vaccination with one of the WHO EUL vaccines or approved by a stringent regulatory authority (and at least two weeks after completion of vaccination)
- SARS-CoV-2 infection confirmed by RT-PCR within the past 6 months and no longer infectious as per WHO's Criteria for releasing COVID-19 patients from isolation.⁵⁵

Depending on the transmission level, below are some options for individualized measures in:












- waiving quarantine following close contact with a confirmed COVID-19 case
- waiving testing and/or quarantine requirements in the context of international travel
- allowing congregating in indoor private settings with other fully vaccinated or recovered individuals without wearing masks and without applying physical distancing.

Decision makers should apply a risk-based approach when considering the use of masks for the general public regardless of vaccination or natural immunity status. In areas of known or suspected community or cluster SARS-CoV-2 transmission: WHO advises that the general public should wear a non-medical mask in indoor (e.g. shops, shared workplaces, schools) or outdoor settings where physical distancing of at least 1 metre cannot be maintained. If indoors, unless ventilation has been assessed to be adequate, WHO advises that the general public should wear a non-medical mask, regardless of whether physical distancing of at least 1 metre can be maintained.⁵⁶ As part of the risk-based approach, local authorities may consider allowing congregation of fully vaccinated or recovered individuals without wearing masks and without applying physical distancing in indoor **private** settings in regions with low SARS-CoV-2 incidence (<20/100000 population). **In community or health care settings, where measures such as mask wearing are recommended, they should continue to apply to everyone.**

Figure 1 provides guidance for a risk-based approach to individualized public health measures, which takes into consideration both risk to individuals and to the population. This figure, which is based on the evidence in Table 3, shows that as the transmission level increases (left column), the risk of infection for individuals and the overall risk of additional infections and onward transmissions increases (arrows in columns 2-5), as does the overall risk of additional cases of severe disease arrows in columns 6-9. The differing gradients of the arrows in columns 2-9 further show that the degree of increased risk varies according to an individuals' age and immunity status.

The resulting options are shown in the column labelled "options for individualized public health measures". At the lowest levels of transmission, individualized measures (waiving quarantine in the context of close contact, waiving quarantine and/or testing in the context of domestic and international travel, freely congregating in private settings with other fully vaccinated or recovered individuals without wearing masks or physical distancing) can be considered for all immune individuals. At the highest transmission levels, measures should be retained for all individuals, irrespective of immune status. At intermediate levels of transmission, there is a disproportionately high risk of transmission and severe disease in recovered individuals ≥ 60 and/or with underlying risk factors, and authorities may consequently wish to consider retaining measures for this group. Considerations may need to be further tailored to local contexts. For example, in situations with no known domestic circulation, a full quarantine may be required for all travellers, regardless of immunity status, to control the residual risk of importation. Further, in situations where healthcare capacity is extremely limited, measures may need to be retained at relatively lower levels of transmission to avoid overburdening the health care system with any additional cases.

Figure 1. Options for Individualized Public Health Measures

Exposure risk (transmission level)	Factors involved in informing options for individualized public health measures								Options for individualized public health measures	Factors that could increase the risk
	Fully vaccinated $\geq 60^*$ and/or with underlying risk factors	Fully vaccinated < 60	Recovered individuals ≥ 60 and/or with underlying risk factors	Recovered individuals < 60	Fully vaccinated ≥ 60 and/or with underlying risk factors	Fully vaccinated < 60	Recovered individuals ≥ 60 and/or with underlying risk factors	Recovered individuals < 60		
	Infection risk / Net transmission Risk				Net risk of severe disease					
Lower  Higher									Relax measures for all immune individuals [†]  Consider retaining measures for recovered individuals ≥ 60 and/or with underlying risk factors [‡]  Retain measures for all individuals [§]	Presence of immune escape variants

* Most transmission evidence uses an age category of 65 and older, while most severity evidence references persons 60 years and older; for consistency, the more conservative grouping of 60 years and older is retained in this table.

[†] Relaxing of restrictions and preventive measures (waiving quarantine in the context of close contact, waiving quarantine and/or testing in the context of and international travel, freely congregating with other fully vaccinated or recovered without wearing masks or physical distancing in private settings) for all immune individuals

[‡] Due to increasing risk of severe disease and of transmission

[§] Due to moderate to high risk of further transmission, all individuals should stay at home and limit physical contact with people outside the household.

The risk matrix presented above is informed by the scientific evidence on SARS-CoV-2 past infection, COVID-19 vaccines and SARS-CoV-2 variants of concern available at the time of this writing. *Infection risk* is a product of the *exposure risk* (which is proportionate to the level of transmission of the virus) and the *susceptibility to infection, if exposed*. The *net transmission risk* is the product of the *infection risk* and the *risk (if infected) of transmitting infection* to non-immune individuals. Given the lack of evidence to the contrary, for the purposes of this framework *the risk (if infected) of transmitting infection* by individuals with reinfection / vaccine-breakthrough infection is assumed to be equal to that seen in primary infection; thus, the *net transmission risk* is assumed to be proportionate to the *infection risk*. *Net risk of severe disease* is the product of the *infection risk* and the *risk (if infected) of severe disease*.

Considerations for quarantine

As per the evidence presented in Table 3, contacts who are fully vaccinated or contacts without risk factors who have recovered from COVID-19 could be considered lower-risk contacts, both in terms of the likelihood of becoming infected and the severity of disease if infected. Consequently, some countries may decide to exempt them from quarantine. However, these contacts should be advised to monitor their symptoms following their exposure; if symptoms develop, they should be tested for SARS-CoV-2, and isolated if they are found to be infected with SARS-CoV-2. Countries may also need to take into consideration the context of the exposure (risk assessment of nature of exposure), because some settings like health-care facilities may pose a higher risk, leading to classification of health-care workers as high-risk contacts. Tailored adjustment for key groups with low risk tolerance may be considered, such as for health care workers or staff of long-term care facilities for the elderly, to minimize risks of potential onward transmission.

As lower risk contacts may still pose some residual risk for onward transmission, countries may opt to quarantine lower-risk contacts if there are concerns about transmission of immune-escape variants, or if their goal is elimination of local transmission.

International travel risk-mitigation measures

At present, WHO does not support the introduction by national authorities or by conveyance operators of requirements for proof of vaccination or natural immunity against SARS-CoV-2, neither as a condition for exiting or entering a country, nor as a condition for traveling internationally.³⁷

In the context of the COVID-19 pandemic, international travel should always be prioritized for emergencies and humanitarian actions; travel by essential personnel; repatriations; and cargo transport of essential supplies such as food, medicines and fuel.

At present, international travellers are not considered contacts of SARS-CoV-2 in principle unless a traveller meets the definition of a contact.^{15,16} Furthermore, international travellers should not be categorized as suspected COVID-19 cases. Therefore, WHO does not recommend healthy travellers as a priority group for SARS-CoV-2 testing, in particular when resources are limited, to avoid diverting resources from settings and patients where testing can have a higher public health impact and drive action.^{15,16}

In line with the individualized approach to public health measures outlined earlier in this guidance, countries may consider fully vaccinated or recovered individuals as lower-risk travellers and may consider waiving testing and/or quarantine of arriving international travellers. Such decisions should be based on a detailed risk assessment that takes into account the COVID-19 control objectives of the arrival country and the SARS-COV-2 incidence, and prevalence of VOCs, in the departure country. For more details, updated interim guidance: Considerations for implementing a risk-based approach to international travel in the context of COVID-19 is forthcoming.¹⁵

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Annex

Public health criteria to adjust public health and social measures in the context of COVID-19

Introduction

In response to the COVID-19 pandemic, countries around the globe have implemented public health and social measures (PHSM) for the control of SARS-CoV-2 transmission. As the local epidemiology of the disease changes, vaccines are rolled out and new variants of concern (VOCs) emerge, regular adjustment of such measures will be necessary.

This annex updates the annex to *Critical preparedness, readiness and response actions for COVID-19* published on 4 November 2020 and outlines a process for decision-making on adapting PHSMs to the epidemiological situation, taking into account surveillance and testing capacities, the vaccination coverage in the target population and the health system's capacity for response. It should be read in conjunction with the main body of this document and the earlier interim guidance.¹

This annex is intended for the public health divisions of national and sub-national authorities in locations that have introduced PHSMs and are considering adjusting them. Its guidance is restricted to the public health domain. Other documents published by WHO address different considerations that should enter into decision-making about introducing or loosening PHSM, including the welfare of a population.

How to use the guidance in this annex

The public health criteria in this annex are grouped into two dimensions that should be evaluated to address two main questions:

1. **Epidemiological situation/Transmission classification** – Is the epidemic controlled?
2. **Health system and public health services capacity and performance** – Is the health system able to detect and cope with COVID-19 cases while maintaining other essential health services?

These two dimensions should further be considered in the context of the national COVID-19 response strategy. Thresholds for action may depend on the country's overall strategy, and whether it is pursuing an elimination or control strategy.

The criteria are not prescriptive, and it may not be feasible to assess some of them, because of a lack of data, for example. Countries should focus on the criteria most relevant for them to inform decision making. In countries with limited surveillance data, vaccination coverage data among target groups can help steer decisions about PHSM, together with indicators from sentinel surveillance in health facilities or bed occupancy. The thresholds are indicative and may need to be revisited as further information about the epidemiology of COVID-19 and the impact of measures become available. It is recommended to systematically assess these criteria at least biweekly at the **lowest operational subnational administrative level** that is practical to inform tailored local responses.

This Annex also includes a third section presenting risk matrices for informing individualized public health measures.

1. Epidemiological situation/Transmission classification

Transmission classification categories can be used to determine the extent to which the epidemic can be considered controlled within each country/area and at sub-national levels. The transmission categories in one country, if published, are also useful to others when considering adjusting policies on trade and travel.

Defining transmission classification

The transmission classification developed in the last guidance has been maintained, with seven categories, as outlined in Table 1.

Annex Table 1: Definition of the categories for transmission classification

Category name	Definition
No (active) cases	<i>Countries/territories/areas with:</i> No new cases detected for at least 28 days (two times the maximum incubation period), in the presence of a robust* surveillance system. This implies a near-zero risk of infection for the general population.
Imported / Sporadic cases	Cases detected in the past 14 days are all imported, sporadic (e.g. laboratory acquired or zoonotic) or are all linked to imported/sporadic cases, and there are no clear signals of further locally acquired transmission. This implies minimal risk of infection for the general population.

Clusters of cases	Cases detected in the past 14 days are predominantly limited to well-defined clusters that are not directly linked to imported cases, but which are all linked by time, geographic location and common exposures. It is assumed that there are a number of unidentified cases in the area. This implies a low risk of infection to others in the wider community if exposure to these clusters is avoided.
Community transmission – level 1 (CT1)	Low incidence of locally acquired, widely dispersed cases detected in the past 14 days, with many of the cases not linked to specific clusters; transmission may be focused in certain population sub-groups. Low risk of infection for the general population.
Community transmission – level 2 (CT2)	Moderate incidence of locally acquired widely dispersed cases detected in the past 14 days; transmission less clearly focused in certain population sub-groups. Moderate risk of infection for the general population.
Community transmission – level 3 (CT3)	High incidence of locally acquired, widely dispersed cases in the past 14 days; transmission widespread and not focused in population sub-groups. High risk of infection for the general population.
Community transmission – level 4 (CT4)	Very high incidence of locally acquired widely dispersed cases in the past 14 days. Very high risk of infection for the general population.

* Note that in situations where COVID-19 surveillance is not robust, a lack of identified cases should not be interpreted as an absence of transmission; alternate indicators (see Table 5) should be examined to assess the possibility of undetected COVID-19 cases.

Primary indicators for assessing the level of community transmission

Four primary indicators to determine community transmission are proposed in Table 2. They are based on data that should be routinely collected during the pandemic. The relative importance of each available indicator will vary according to the local context (e.g. the reliability of the data for each indicator); and described limitations to interpreting each indicator should be taken into account. Indicators should be measured at the lowest administrative level of operations possible to inform targeted public health interventions. To develop transmission classification at a higher administrative level, a separate analysis should be conducted using indicators for that level, rather than attempting to aggregate lower-level transmission classifications.

These indicators should be used alongside other epidemiologic information available either routinely or through special studies or modelling estimates, as well as non-epidemiologic data and other considerations, for informing strategic and operational decisions.

It is recommended that these indicators be assessed biweekly, adopting the epidemiological week definition used in the country.

Ranges for the four indicators in Table 2 were developed through a review of existing data. They can be used to guide the application of the transmission classification at sub-national levels. These ranges are indicative and may require adjustment to local contexts and based on the performance (e.g. sensitivity, representativeness) of the local surveillance system and testing strategy and should be revisited periodically. Caution should be exercised when interpreting changes in indicators that occur in the context of changes to the surveillance system (e.g. an increase in testing rate or a change in the population under surveillance). Note that some indicators (e.g. overall incidence) may be higher in the presence of very large clusters, as in the case of superspreading events, than during community transmission.

It is helpful to monitor the testing rate as a measure of the coverage of surveillance. A minimum recommended rate is at least one person tested per 1000 population per week. Testing should not be limited to specific populations (e.g. only those in urban settings with high access to testing, or travellers). Denominator data must be available at the level of disaggregation being assessed (e.g. district, province). Some authorities may choose to specifically track these indicators among groups of individuals at greatest risk for severe disease and death.

After all available indicators are calculated, if the levels calculated based on each indicator are different, a qualitative review should be undertaken to determine the final transmission classification. It is recommended that if data are not available (or reliable) for all indicators, more weight should be given to the indicators considered more reliable in the local context. In many cases, indicators listed higher in Table 2 may be more reliable than those lower in the table.

In places where indicator values are not reliable, but the system is stable, trends can be used as an alternative assessment. One example would be a situation in which there is a very low testing rate, and many cases are likely missed, but the testing strategy is not changed.

Annex Table 2: Primary epidemiological indicators and proposed ranges to assess the level of COVID-19 transmission

Domain	Indicator	Description/Rationale	Major limitations	Level of community transmission			
				CT 1	CT 2	CT 3	CT 4
Hospitalization Rate	New COVID-19 hospitalizations per 100 000 population per week*	A subset of all incident cases require hospitalization; thus, this is an indirect indicator of incidence. Unlikely to be subject to surveillance policy changes/differences.	May be influenced by hospitalization policy, e.g. if even mild cases are hospitalized for isolation purposes. Delayed measure of incidence.	<5	5 - <10	10 - <30	30+
Mortality	Number of COVID-19-attributed deaths per 100 000 population per week*	A subset of all incident cases are fatal, and thus this is an indirect indicator of incidence. Minimally influenced by surveillance policy if testing is comprehensive.	Delayed measure of incidence. At low levels and in small geographical regions, can be sensitive to minor fluctuations (e.g. one versus two deaths).	<1	1 - <2	2 - <5	5+
Case Incidence	New confirmed cases per 100 000 population per week*	Direct measure of incidence	Heavily influenced by surveillance system performance, testing policy and laboratory capacity. At low levels and in small geographical regions, can be sensitive to minor fluctuations in case counts, particularly due to batch reporting.	<20	20 - <50	50 - <150	150+
Testing	Test positivity rate per week (non-sentinel)*	This may be useful if there are limited sentinel sites. It may capture atypical cases better than sentinel surveillance.	Heavily influenced by testing strategy and capacity.	< 2%	2% - < 5%	5% - <20%	20%+

*Consider averaging over a two-week period to minimize the effect of random fluctuations.

Note: the thresholds in this table may be updated as additional data become available.

Additional indicators

Additional indicators that can provide further evidence to help classify the level of transmission are listed in Table 3. These indicators may not be readily available at the lowest administrative level of operations, however. They are therefore considered secondary to the primary four indicators listed in Table 2. Furthermore, they may not directly reflect transmission or force of infection of SARS-CoV-2 or may be more difficult to interpret and compare than those listed in Table 2. Thresholds are not presented for the secondary indicators, due to a lack of available data, high local variability or both.

As a last resort, where no indicator values are available, subjective assessment can be used, but this should be done over several weeks to avoid influences from transient or anecdotal observations.

Annex Table 3: Additional epidemiological indicators to assess level of COVID-19 community transmission*

Indicator	Description/Limitations
Intensive care unit (ICU) proportional occupancy	The proportion of new ICU admissions attributed to COVID-19, out of all ICU admissions for the same period (alternatively, proportion of current ICU beds occupied by patients with COVID-19, out of all occupied ICU beds)
Instantaneous reproduction number (Rt)	The instantaneous reproduction number is the average number of secondary cases each current case would produce if conditions remained the same. Rt should be estimated over successive weekly time windows and should be considered in combination with the number of cases at a given time. When there is a large volume of cases at a given time, Rt near 1.0 would sustain a high number of cases. While this is a widely used indicator of transmissibility, it requires familiarity with the various methods for calculation and sufficiently reliable and timely data on incidence. It also assumes a known serial interval distribution, which can in practice be hard to estimate for COVID-19 due to limited data on transmission chains.
Daily growth rate	The daily growth rate measures the epidemic growth or decline of an epidemic. It is approximately the percent of increase/decrease in daily case incidence.
Doubling time	The number of days required for the daily incidence to double. This is directly determined by the daily growth rate r and linked to Rt and the serial interval distribution. All else being equal, higher Rt will lead to shorter doubling times.
Proportion of unlinked cases among new cases	This is defined as the proportion of cases not previously listed as contacts (alternatively, the proportion not linked to known clusters/transmission chains). It is a measure of the spread in the community beyond known clusters. It is heavily influenced by case investigation and contact tracing capacity.
Test positivity proportion from sentinel sites averaged over a two- week period	Minimally influenced by testing strategy or capacity. Can provide a good, standardized way to monitor evolution over time if adequate number of samples are collected and sites are geographically representative. May not be representative of the general population if there are only limited sentinel sites.
Influenza-like-illness (ILI) or Severe Acute Respiratory Infection (SARI) trends	This is not directly indicative of COVID-19 cases, but sentinel surveillance for ILI and SARI can also capture a proportion of COVID-19 cases, and thus this is useful for monitoring trends for COVID-19. This measure may be helpful where COVID-19-specific surveillance is not robust.
Secondary attack rates (SAR)	This captures the probability that a contact person is infected following exposure to a confirmed case during their infectious period. Comparison of secondary attack rates in different contexts (e.g. vaccinated versus non-vaccinated individuals, different types of exposures, different variants) can shed light on risk factors for increased transmission.

All-cause hospitalization rate trends	This is not directly indicative of COVID-19 hospitalizations but, where COVID-19 cases make up a substantial proportion of hospitalizations, this can be useful for identifying trends in COVID-19 cases. These rates may decline due to restricted service provision and other public health measures. Trends must be analysed in the context of other potential causes of changes in hospitalization rates (e.g. concurrent influenza circulation). These trends may be helpful where COVID-19-specific surveillance is not robust.
All-cause (excess) mortality trends	This measure is not directly indicative of COVID-19 cases/deaths, but where COVID-19 deaths make up a substantial proportion of overall deaths, this can be useful for identifying trends in COVID-19 cases. Trends must be analysed in the context of other potential causes of changes in mortality rates (e.g. concurrent influenza circulation) and ideally compared with baseline data on mortality to identify excess above expected (e.g. seasonal) fluctuations. While this is a widely used indicator of transmission, it requires careful consideration of the inherent biases in mortality estimation methods. ³ This may also be a delayed indicator, depending on death and vital records system processes. These trends may be helpful where COVID-19-specific surveillance is not robust.
Cumulative vaccination uptake (by first dose or fully vaccinated)	<p>Defined as the proportion of individuals who received a) the first dose, or b) the full recommended series of any COVID-19 vaccine, as percentages of the total population of a country or area.</p> <p>Cumulative vaccination uptake can provide a useful indication of population coverage[†], especially in the short term. Over longer timeframes, using uptake data to infer vaccination coverage also needs to take into account changes in the population denominator (including by age group), especially mortality among targeted groups. Uptake and coverage data may provide an indication of population protection from COVID-19 disease during the months following vaccination. It is currently unknown whether such protection might wane over longer timeframes or whether new virus variants might affect vaccine efficacy and effectiveness. Evidence about the role of vaccination in preventing infection and preventing transmission is being assessed.</p>

*This list should not be considered exhaustive. † For further information on COVID-19 vaccination uptake, rate, and coverage, please refer to *Monitoring COVID-19 Vaccination*, Page 5.⁴

Trends in transmission

In addition to calculating the category of transmission classification, it is also important to understand the direction of the trends of contributing indicators (stable, decreasing or increasing) over several weeks. This can assist in determining whether measures implemented are improving the epidemiological situation in the area, and for planning future changes, or putting in place anticipatory changes to public health measures based on a likely change in the transmission classification.

2. Health and public health services capacity and performance

The capacity to respond to the existing epidemiologic situation of COVID-19 (i.e., the transmission classification) is a key consideration in the decision to adapt PHSM. Clinical care and public health services are two key domains that reflect the ability of a country to adapt and respond to the requirements of both the COVID-19 caseload and the burden of disease more generally. Sufficient clinical care capacity is required to treat both inpatient and ambulatory cases of COVID-19 while ensuring that the health system is not overwhelmed and can continue to treat the regular caseload of patients with other conditions, particularly during seasonal peaks, such as the influenza season, and at times of rapid or large increases in SARS-CoV-2 transmission. The public health response relies on the capacity of the surveillance system to detect and respond to changes in SARS-CoV-2 transmission and focuses on key activities including case detection, diagnostic testing and contact tracing. Each of the two domains (health services and public health) is divided into two principal sub-domains, namely capacity (output indicators) and performance (outcome and impact indicators).

While this section is not aimed to be overly prescriptive, it provides quantitative thresholds (Table 4) to categorize response capacity and performance into three categories: adequate, moderate and limited. It is important to note that capacity needs to be assessed in the context of the current transmission classification. Response capacity that has been considered adequate may, under a higher incidence scenario, be reduced to moderate or limited response capacity.

Assessing the overall level of health system and public health services capacity and performance

To assess the overall capacity and performance of the health system and public health services, authorities should use the same approach as outlined for transmission classification. This includes:

- prioritizing those indicators that are available and reliable and adjusting thresholds to local contexts and reliability of the data
- interpreting changes to indicators in the context of changes to data collection mechanisms
- undertaking a qualitative review to determine the final health system capacity level if the levels calculated based on each indicator are different
- using trends instead of quantitative thresholds where data are not reliable, but denominators are stable
- using subjective assessment as a last resort if no data are available
- observing trends in indicators to anticipate future changes to the health system and public health services capacity and performance level.

Additional indicators that can be used for triangulation are provided in Table 5. Assessments should be updated biweekly.

Annex Table 4: Primary indicators and proposed ranges to assess level of COVID-19 health system and public health services capacity and performance

Domain	Indicator	Description/ n/	Major limitations	Capacity to respond		
				Adequate	Moderate	Limited
Clinical care capacity	Proportion of occupied hospital beds	High morbidity and mortality will occur if there is insufficient capacity to hospitalize severe cases. Should count all hospitalizations, not only COVID-	May be influenced by hospitalization policy (e.g. if all cases are isolated in hospital), which does not indicate true saturation of hospital capacity.	<75% [†]	75-<90% [†]	90%+ [†]
Clinical care performance	Case fatality rate of resolved (i.e., outcome known) hospitalized cases	Overall impact indicator of adequate COVID-19 care.	Highly dependent on age and various biases. ³ Must take into account any changes in case detection or testing strategy.	Decreasing trend	Stable trend	Increasing trend

Public health response capacity	Number of persons tested per 1000 population per week, averaged over a two-week period	Without sufficient testing, it is difficult to appropriately isolate and treat cases.	Not all laboratories are able to report individuals tested; if possible, can count number of new rather than repeat tests; otherwise can count number of tests, but this may be misleading due to repeat testing. Laboratories not reporting location of cases may mask disparities in testing (e.g. among non-urban populations). If using rapid diagnostic tests, these should be used according to guidance, and thresholds may need to be raised.	4+	1 - < 4	<1
Public health response performance	Proportion of cases for which an investigation has been conducted within 24 hours of identification	This indicates the capacity to identify transmission risks and exposed contacts. Where investigation is not recorded directly, can be measured by proxy indicator - proportion of cases with contacts listed.	May be difficult to obtain timely data.	80%+	60 - <80%	<60%
Public health response performance	Support for / adherence to PHSMs (can be further subdivided into personal protective measures versus other measures)	Qualitative assessment based on observation, media monitoring, perception or behaviour surveys, hotlines, focus groups, etc. Analysis including forecasting of effectiveness of PHSM to be considered, it is important to identify not only the current status but any barriers or enablers to improvement.	May be highly variable between sub-groups and across individual PHSMs and over time.	High (nearly universal adherence to most PHSMs).	Moderate (modest adherence to most PHSMs, or variable adherence across individual PHSMs).	Low (minimal adherence to most PHSMs).

† Hospital occupancy routinely varies considerably between countries and health systems. Therefore, baseline (pre-COVID-19) occupancy must be taken into consideration.

** A significantly low hospital occupancy rate may also indicate barriers to access to hospital care, requiring investigation into the causes and remedial actions to be taken. In situations of community transmission, low hospital utilization may indicate large numbers of community deaths, which would potentially not be captured in facility-based mortality reports.

Annex Table 5: Additional indicators to assess level of COVID-19 health system and public health services capacity and performance*

Indicator	Description/Limitations
Number of trained ICU staff per 10 000 population	This indicates sufficient clinical capacity to respond to cases most likely to lead to mortality. This indicator may be more relevant when measured against a population of clinically vulnerable ⁱ persons, if data are available. This indicator is difficult to measure. It is a necessary but insufficient measure of ability to provide intensive care.
Number of ICU beds per 10 000 clinically vulnerable population ⁱ	Mortality from COVID-19 will be highest if capacity for intensive care is exceeded. Strictly counting the number of ICU beds does not guarantee successful care if there is inadequate staffing, equipment or supplies.
Proportion of occupied ICU beds	This indicator assesses sufficient clinical capacity to respond to cases most likely to lead to mortality. It may not be useful in countries with very few ICU beds (can be substituted with proportion of occupied hospital beds +/- oxygen in these situations). If this indicator is very low, overall health system capacity should be considered limited, regardless of adequate levels of other capacity indicators.
Proportion of occupied beds with access to oxygen supply	Oxygen is an important treatment for COVID-19, and sufficient capacity to provide oxygen can be useful even in the absence of ICU capacity. This indicator may be difficult to measure and may not be useful in countries with very low capacity.
Crude case fatality rate of COVID-19	This is an overall impact indicator of adequate COVID-19 care. It is highly dependent on age, other risk factors and various reporting biases. ³ Analysis of trends should consider any changes in case detection or testing strategy. Countries are advised to collect additional information on age, as this measure will be heavily affected by the age structure of the population.
Number of contact tracers per 100 000 population [alternatively per number of new cases in a week]	This indicates capacity to conduct sufficient contact tracing to interrupt transmission. It is an input indicator that may not correlate well with actual contact tracing outcomes. There is minimal evidence base for determining thresholds. This may be difficult to accurately measure where contact tracing is done by persons other than formally designated “contact tracers”.
Number of points of entry surveillance officers per 100 000 daily travellers	This is a measure of the ability to successfully mitigate the risk of importation. It is a poor indicator of actual internal domestic capacity; is minimally relevant during widespread community transmission; and may be achieved when human resources are inappropriately diverted from internal domestic use.
Proportion of newly confirmed or probable cases interviewed for contact elicitation within 24 hours of identification	This indicator measures the timeliness of contact listing, which shortens exposure to potentially infected persons. A better metric of contact listing timeliness is the actual proportion of contacts identified and traced/quarantined within 48 hours.
Proportion of contacts of new cases who are monitored for 14 days (or locally specified period)	This indicates that contacts are monitored until no longer at risk for becoming secondary cases (linked to a particular source case). This indicator may be particularly important for assessment of public health system performance in the imported/sporadic and clusters transmission scenarios. It can be spuriously inflated by poor contact listing.
Proportion of identified cases isolated within 24 hours of positive test result (or determination as a probable case)	This indicates that investigation and isolation of new cases is sufficiently rapid to minimize the generation of secondary cases. This indicator may be particularly important for assessment of public health system performance in the imported/sporadic and clusters transmission scenarios.
Time from symptom onset to case confirmation	This measures the ability of the surveillance system to promptly detect, test and confirm symptomatic cases. Individual components (i.e., time from symptom onset to detection, detection to testing and test turnaround time) can also be measured independently.
Proportion of cases arising from contact lists	This describes the extent to which new cases are already captured by and known to the surveillance system through adequate case investigation. When this is low, it suggests widespread existence of “hidden” chains of transmission and/or poor-quality case investigation.
Number and proportion of samples sequenced	Wherever resources allow, laboratories could consider genomic sequencing of SARS-CoV-2 PCR-positive sentinel specimens.

*This list should not be considered exhaustive.

ⁱ ‘Clinically vulnerable’ in this context refers to individuals aged ≥ 60 years and/or with comorbidities that increase risk of serious COVID-19 disease, including heart disease, asthma and diabetes.

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The Epidemiology Technical Advisory Group: Gabriel Leung, Richard Hatchet, Neil Ferguson, Vernon Lee, David Heymann, Olivia Tulloch, Paul Fine, Ibrahim Abubakar, John Amuasi, Ximena Aguilera, A. Pillay, Marc Lipsitch, Nada Melhem

From the World Health Organization: Abdinasir Abubakar, Jennifer Addo, Maya Allan, Brett Archer, Lisa Askie, Sara Barragan Montes, Jessica Barry, David Bennett, Richard John Brennan, Nilesh Buddh, Finlay Campbell, Ishata Nannie M. Conteh, Carmen Dolea, Ute Enderlein, Ann Fortin, Melinda Frost, Thomas Grein, Abdou Salam Gueye, Maung Maung Hitke, Yuka Jinnai, Masaya Kato, Mika Kawano, Maria van Kerkhove, Franciscus Konings, Abdi Rahman Mahamud, Emmanuel Onuche Musa, Pierre Nabeth, Patricia Ndumbi Ngamala, Nsenga Ngoy, Nam Phuong Nguyen, Dorit Nitzan, Babatunde Olowokure, Boris Pavlin, Ihor Perehinets, Emilie Peron, Olivier le Polain, Nataschja Ratanoprayul, Dalia Samhoury, Tanja Schmidt, Catherine Smallwood, Mary Stephen, Ambrose Talisuna, Jos Vandelaer, Katelijn Vandemaele, Ninglan Wang, Roland Kimbi Wango, Pushpa Wijesinghe and Zabulon Yoti.

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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 two years after the date of publication.

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ADJUNTO B

Orientación provisional “*Consideraciones técnicas para implementar un enfoque basado en el riesgo para los viajes internacionales en el contexto de COVID-19*” (Disponible solo en inglés)

Technical considerations for implementing a risk-based approach to international travel in the context of COVID-19

Interim guidance

Annex to: Policy considerations for implementing a risk-based approach to international travel in the context of COVID-19

2 July 2021



Key points

- During the COVID-19 pandemic, international travel should always be prioritized for essential purposes, including emergency and humanitarian missions, travel of essential personnel, repatriations, and cargo transport of essential supplies.
- As countries gradually resume or readjust non-essential international travel, the introduction of risk mitigation measures aiming to reduce travel-associated exportation, importation and onward transmission of SARS-CoV-2 should be based on thorough risk assessments conducted systematically and routinely.
- The application of a precautionary approach is warranted in the presence of scientific uncertainties such as emergence of variants of concern (VOCs) or variants of interest (VOIs).
- Proof of COVID-19 vaccination should not be required as a condition of entry to or exit from a country.
- National authorities implementing testing or quarantine as a condition for entry of international travellers may consider individualized approaches to exempting them from these measures based on acquired immunity from vaccination or previous SARS-CoV-2 infection.
- Adherence to personal protective measures such as mask use and physical distancing must continue to be respected by all international travellers, both while on board conveyances and at points of entry.
- International travellers should not be considered by default as suspected COVID-19 cases or contacts or as a priority group for testing.
- The overall health and well-being of communities should be at the forefront of considerations when deciding on and implementing international travel-related measures, which should be communicated publicly and in a timely manner.

Background

As the COVID-19 pandemic continues to unfold, Member States should take appropriate measures to reduce transmission of SARS-CoV-2 associated with international travel, recognizing that even comprehensive public health measures adapted to the local epidemiologic context and capacities can mitigate the risk substantially but cannot yield “zero risk”. Therefore, a risk-based approach to international travel is needed.

The World Health Organization (WHO) advises that international travel for essential purposes as defined by national authorities – which should include 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 – should not be impeded by border closures or suspensions of travel.

This updated interim guidance document provides national authorities with key considerations for establishing their policies for international travel via air, sea¹ or land between countries, territories or sub-national areas². It is divided into three main sections: risk assessment, risk mitigation and risk communication. The document aims to support countries as they gradually increase the volume of international travel with the objective of reducing travel-associated exportation, importation and onward transmission of SARS-CoV-2.

The document is an update to the original interim guidance document entitled ‘Considerations for implementing a risk-based approach to international travel in the context of COVID-19’, which was published on 16 December 2020. The original document was the result of extensive consultations across all relevant departments and Regional Offices of WHO, as well as with the members of the Strategic and Technical Advisory Group for Infectious Hazards (STAG-IH) (1) and of an ad-hoc Technical Advisory Group for the development of a risk-based approach to the gradual increase of international travel in the context of COVID-19.

Changes from the previous version

There have been several important developments since the publication of the original version of this document, including the approval of several COVID-19 vaccines through the WHO Emergency Use Listing (EUL) (2); the start of COVID-19 vaccination in many countries; and growing evidence on protection against developing severe COVID-19 disease following vaccination and, to a lesser extent, protecting against infection and reducing transmission. In addition, several WHO-classified variants of concern (VOCs) and variants of interest (VOIs) have been identified since December 2020(3).

Consequently, this version provides key updates on:

- considerations regarding COVID-19 vaccination in the context of international travel
- guidance on how to account for SARS-CoV-2 VOCs and VOIs when assessing risk to inform mitigation measures for international travel during the COVID-19 pandemic
- updated evidence on the effectiveness and broader impact of risk mitigation measures implemented in the context of international travel during the COVID-19 pandemic.

All relevant departments and Regional Offices of WHO were consulted, as were members of the STAG-IH. Other WHO advisory groups consulted for this update include the Strategic Advisory Group of Experts on Immunization (SAGE) (4) and the International Working Group on Ethics and COVID-19 (5). The recommendations related to testing and quarantine of international travellers and border closure or suspension of travel are informed by the deliberations of the WHO Guideline Development Group for International Travel and Health (GDG ITH) (6).

The document is an annex of the WHO document “Policy considerations for implementing a risk-based approach to international travel in the context of the COVID-19 pandemic” and it should be read in conjunction with the WHO interim guidance “Considerations for implementing and adjusting public health and social measures in the context of COVID-19” (7).

Risk-assessment approach to the implementation of risk mitigation measures for international travel

National authorities should conduct thorough, systematic and regular risk assessments as new information emerges to inform the introduction, adjustment and discontinuation of risk mitigation measures in the context of international travel.

For international inbound travel, the following factors should be considered:

- the local epidemiology (8) in departure and destination countries
- the volume of travellers between countries and existing bilateral and multilateral agreements between countries to facilitate free movement
- public health and health services performance and capacity (7) to detect and care for cases and their contacts in the destination country, including among vulnerable travellers, such as refugees, migrants and temporary or seasonal workers whose livelihoods largely depend on cross-border activities
- public health and social measures implemented to control the spread of COVID-19 in departure and destination countries and available evidence on adherence and effectiveness of such measures in reducing transmission
- contextual factors, including economic impact, human rights and feasibility of applying measures.

For a limited number of key travel routes, it may be possible for countries to make bilateral arrangements to identify additional information on the aforementioned epidemiological and operational factors. This can help to inform risk assessments associated with specific groups of travellers.

¹ For the purpose of this document, sea travel relates to international voyage via sea or an inland body of water. Nonetheless, cruise ships are out of the scope of this guidance given the many specificities of this type of conveyance.

² To facilitate the reading of this guidance document, the formula “countries, territories or sub-national areas” will hereinafter be referred to as “countries” or “country”.

WHO encourages national authorities to publish in the public domain up-to-date data on COVID-19 incidence, public health and health services capacity and implemented public health and social measures. This includes epidemiological information on unexpected trends or signals that may indicate the emergence of VOCs or VOIs (9). Detailed information on the global impact and characteristics of each variant is provided and regularly updated in WHO's weekly epidemiological updates (3).

The impact of the circulation of new VOCs and VOIs on SARS-CoV-2 transmission will be reflected in the local epidemiology of countries of departure or destination. Nonetheless, if new variants appear to be more transmissible, cause more severe disease, and/or have the potential to partially evade natural or vaccine-acquired immunity, national authorities in countries of destination may prefer to implement stringent travel-related measures, using a precautionary approach. Such measures should not be unnecessarily biased towards countries readily sequencing and sharing findings. WHO encourages all countries to strengthen sequencing capacities for the early identification of new variants and to rapidly and transparently share that information (9).

Rapid publication and reporting to WHO of epidemiological and sequencing data allows national authorities to make informed decisions for both outbound and inbound travel. It is important to have and use sub-national epidemiological information, because this enables the application of travel-related measures at the lowest possible administrative level.

Where there is a high level of vaccine-acquired immunity among prioritized groups, epidemiology changes may start to be observed. 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, and in the absence or the limited use of public health and social measures, a greater proportion of cases may occur among younger, less vulnerable population groups. Consequently, there will be a need to recalibrate incidence thresholds, focusing on the analysis of hospitalization and ICU admission rates and incidence by age group and to assess the potential caseload of undiagnosed COVID-19 cases. For further information, see the interim guidance document "Considerations for implementing and adjusting public health and social measures in the context of COVID-19" (7).

National authorities should publish their risk assessment methodology and the list of departure countries to which restrictions apply on their government websites; and these should be updated regularly to reflect any changes.

Key questions to guide risk assessment

The following overarching questions may guide national and sub-national decision-making processes for implementing travel-related risk mitigation measures and providing advice to travellers.

- For inbound travel:
 - Will the number of cases to be imported from the country of departure likely have a significant impact on the current transmission level in the country of destination?
 - What is the probability of individuals from the country of departure being infected?
 - Are any variants classified by WHO as VOIs or VOCs that are not present in the country of destination predominant in the country of departure? Are there unexpected epidemiological trends or signals in the country of departure that may indicate the appearance of new VOCs or VOIs? Do variants that are present in the country of departure evade immunity?³ Or, if the country of departure has limited sequencing capacities, have VOCs or VOIs been widely detected among travellers arriving from this country?
 - Is an individualized approach to public health measures based on a person's SARS-CoV-2 immunity status being implemented in the country of destination (7)?⁴
 - What is the air, land and sea route-specific volume of travellers?
 - Are the current response capacities in the country of destination sufficient to cope with the potential rise of imported cases from the country of departure? This should include risk communication capacities to inform incoming travellers, in appropriate languages, about mechanisms for seeking care and public health and social distancing measures in place. Are such public health and health care capacities accessible to all travellers, including refugees, migrants and temporary or seasonal workers?
- For outbound travel:
 - How likely are travellers to be infected in the country of destination compared to their likelihood of getting infected in the country of departure, taking into consideration the potential circulation of VOIs and/or VOCs in the country of destination?

³ Any measures implemented to prevent or delay the importation of new variants must be continuously adjusted in light of emerging information; without bias towards countries that are sequencing and sharing findings; based on thorough assessments of risk; and continuously adapted to emerging information.

⁴ Note that national authorities and conveyance operators should not require proof of vaccination as a condition of entry or exit. Further information is provided in the section "Proof of COVID-19 vaccination in the context of international travel" below.

- What travel-related measures are implemented for inbound travellers in the country of destination, including the use of individualized public health measures based on a person's SARS-CoV-2 immunity status following COVID-19 vaccination or natural infection (7)?
- Does the country of destination have sufficient response capacity to treat travellers who may need medical care while traveling?
- Does the country of departure have sufficient capacity to enforce mandatory public health and social measures on return of travellers?
- In line with the principle of shared responsibility for global health, national authorities should also consider measures to limit exportation of cases, particularly when new VOCs or VOIs emerge.

Other considerations

The overall health and well-being of communities should be at the forefront of considerations when deciding on and implementing international travel-related measures. Special attention must be paid to vulnerable groups that may be at higher risk for COVID-19 because of limited access to health care; poor living conditions; inability to adequately apply physical distancing and other public health and social measures; poor access to COVID-19 information in relevant languages; reduced income; increased discrimination and stigmatization; and increased exposure to psychological harms (10, 11). Additional relevant guidance can be found in the WHO interim guidance "Considerations for implementing and adjusting public health and social measures in the context of COVID-19" (7); and through the United Nations Development Programme (UNDP) (12), the World Tourism Organization (UNWTO) (13), the International Civil Aviation Organization (ICAO) (14), the International Labour Organization (ILO) (15), the International Maritime Organization (IMO) (16), the International Organization for Migration (11) and the World Bank (17).

Risk mitigation measures for international travel

This section describes the key considerations to be taken into account for the implementation of basic and supplementary risk mitigation measures. While basic risk mitigation measures should always be in place; the use of supplementary risk mitigation measures during the COVID-19 pandemic should be guided by a risk assessment, as outlined in the section above.

Basic risk mitigation measures

Travel advice

- Confirmed, probable and suspected cases, and contacts of confirmed or probable cases should not travel. Confirmed, probable and suspected cases should be in isolation; and contacts of confirmed or probable cases should be in quarantine.
- Persons with any signs or symptoms compatible with COVID-19 should not travel, unless SARS-CoV-2 infection has been ruled out as the cause for illness.
- Persons who are unwell should be advised to postpone travel and seek medical care.
- Persons who have not been fully vaccinated or do not have proof of previous SARS-CoV-2 infection and are at increased risk of developing severe disease and dying, including people 60 years of age or older or those with comorbidities that present increased risk of severe COVID-19 (e.g. heart disease, cancer and diabetes) should be advised to postpone travel to areas with community transmission.
- Depending on local restrictions, persons residing in areas where community-wide movement restrictions are in place may not be allowed to travel for non-essential purposes.
- All incoming travellers must follow recommendations and continue to adhere to personal protective measures such as the use of masks and physical distancing both while on board conveyances and at point of entry.

Self-monitoring for international travellers

WHO recommends that travellers self-monitor for the potential onset of symptoms for 14 days on arrival and report symptoms and travel history to local health authorities, as per instructions received by authorities in the host country, prior to departure and/or on arrival. Travellers should be provided with necessary information and instructions on how and when to contact local health authorities. Arrangements for supervision of self-monitoring should be planned and organized by national or sub-national authorities, for instance, through the use of phone messaging or digital tools. Apps for the daily reporting of health status should be in line with WHO guidance on the use of digital tools for this purpose (18).

Any traveller identified as a contact of a COVID-19 case should be supported and quarantined – as part of national response strategies (19) in accordance with WHO guidance for quarantine (20) – and tested if symptoms develop at any point during the quarantine period. All incoming travellers must adhere to those personal protective measures (such as the use of masks and physical

distancing measures) implemented in countries of destination. These measures may include movement restrictions as per national or sub-national legislation.

Multisectoral coordination and planning for disease prevention and control, surveillance and case management

Preventing cases and contacts from travelling will require establishing mechanisms to exchange information between health and immigration authorities. Countries should have a clear surveillance strategy and sufficient public health capacity to reliably identify cases and trace contacts, including among incoming travellers, in alignment with national and sub-national COVID-19 surveillance and response efforts.

National and, where needed and applicable, sub-national authorities involved in the risk assessment process should:

- inform all public and private entities responsible for the implementation of international travel measures about the requirements in place
- make operational arrangements to facilitate the compliance with such requirements, including the timely exchange of information with health authorities (for example through passenger manifests for contact tracing purposes and completion and collection of passenger locator forms)
- coordinate with conveyance operators to comply with countries' requirements for the submission of the Maritime Declaration of Health, Annex 8 of the IHR (2005) (22), and the Health Part of the Aircraft General Declaration, Annex 9 of the IHR (2005) (22).

The digitalization of passenger locator forms may facilitate the exchange of information but should be conducted in line with privacy and personal data protection as per WHO guidance (18).

International contact tracing

When a cluster or chain of SARS-CoV-2 transmission involves more than one country – including, for example, when cases are identified on conveyances, at points of entry or in persons with a history of travel while infectious – international contact tracing should be conducted rapidly in a coordinated and collaborative manner through national IHR focal points (NFPs). In line with WHO guidance for contact tracing (19), national authorities should identify contacts who were exposed to:

- a symptomatic case: 2 days before and 10 days after symptom onset, plus at least 3 additional days without symptoms (including without fever and without respiratory symptoms), for a minimum of 13 days total after symptom onset
- an asymptomatic case: 2 days before and 10 days after the date on which a sample led to confirmation of SARS-CoV-2 infection.

Bilateral exchanges between countries may facilitate case investigation aiming at identifying the source of infection and requiring retrospective tracing of cases up to two weeks before an identified case developed symptoms or was tested positive (23). Data protection must be considered throughout the contact tracing process. Whenever health information and/or personal details of an identifiable individual are exchanged between countries, these should be kept confidential in line with Article 45 of the IHR (2005) and national legislation. The use of encrypted and password-protected communication is encouraged in these circumstances.

International contact tracing is particularly important for countries with no cases, imported/sporadic cases or a small number of cluster cases. In countries where community transmission is ongoing and surveillance capacities are overwhelmed, international contact tracing may be challenging.

The NFPs are accessible at all times and can receive direct support from the WHO IHR contact points, hosted by the six WHO Regional Offices. The contact details of all NFPs and WHO IHR Contact Points are available on the secure WHO Event Information System (EIS), which is accessible to NFPs. When contact tracing involves contiguous areas in two or more bordering countries, existing bilateral and/or multi-country agreements may facilitate cross-border contact tracing.

Digital tools, such as mobile phones and apps for proximity tracing, can support and complement contact tracing efforts, but such technology cannot replace the public health contact tracing workforce required to carry out the critical functions of finding, communicating with and supporting people throughout the contact tracing process. Furthermore, the effectiveness of digital proximity tracing apps relies on their uptake and active use by the general population. For international travellers, issues of interoperability of information management systems and data sharing regulations between countries need to be considered. Legal and ethical aspects related to individual privacy and personal data protection should be considered in line with WHO guidance (18).

Environmental controls and public health and social measures at points of entry

Crowd control, physical distancing, mask use and hand hygiene measures should be put in place to minimize the risk of transmission at points of entry during check-in, passport control, in rest rooms, security areas, areas for interviews of COVID-19 suspected cases, waiting areas, boarding, disembarking, customs, baggage pick-up and any other areas where travellers congregate. Appropriate cleaning and disinfection procedures should be followed as per WHO guidance (24), with particular emphasis on surfaces that are frequently touched. Table 1 provides specific recommendations to adapt premises at points of entry.

Table 1. Considerations for adapting point of entry premises to limit the spread of COVID-19

Crowd control	Engineering modification	Enhanced compliance
<p>Limit numbers of people and maintain physical distance of at least 1 metre between persons throughout premises at points of entry, and in particular for closed and poorly ventilated areas such as shops, restaurants, lounges, rest rooms and offices.</p> <p>Reduce crowding by staggering arrival and departure times of conveyances, managing flow of travellers with separate pathways, increasing the number of security and passport control booths to shorten queues, ideally taking into consideration the disease transmission in countries of departure and destination.</p> <p>Consider fostering cross-border collaboration for managing crowding at ground crossings.</p> <p>Establish a dedicated and accelerated route for transiting passengers, with special considerations for space for long transits or lay-overs.</p>	<p>Introduce physical barriers (cones, ropes, poles, etc.) or floor markers to ensure distance between people or limit access while in higher volume areas such as baggage or immigration.</p> <p>Establish spacious waiting areas to complement the crowd control strategy.</p> <p>Implement separating screens, shields and transparent barriers to be utilized at counters or windows where close contact is expected.</p> <p>Ensure proper ventilation throughout the premises at points of entry.</p> <p>Provide hand sanitizer stations strategically placed throughout the points of entry.</p>	<p>Place signs reinforcing individual protection measures and behaviour (i.e. hand hygiene, safe mask wearing where appropriate and respiratory etiquette).</p> <p>Use loudspeaker announcements or video loops providing instructions and information in appropriate languages.</p> <p>Strategically place staff throughout the points of entry to enforce compliance with public health measures and appropriate distancing/spacing.</p>

Environmental controls and public health and social measures on conveyances

Environmental control measures and public health and social measures should be promoted and complied with on board conveyances. These are outlined in detail in the ICAO Council Aviation Recovery Task Force (CART) Take-off: Guidance for Air Travel through the COVID-19 Public Health Crisis (25), IMO COVID-19 guidance (16), and WHO guidance documents on the management of ill travellers at points of entry (26); and controlling the spread of COVID-19 at ground crossings (27), on board ships (28) and in aviation (29).

Supplementary risk mitigation measures

If the country of destination has a low risk tolerance – for example, because it has no (active) cases or is experiencing sporadic cases or a small number of clusters – supplementary risk mitigation measures can also be considered. WHO regularly evaluates the scientific evidence on the effectiveness, safety and impact of public health measures implemented to reduce travel-associated exportation and importation of SARS-CoV-2.

Point of entry authorities should have the capacities necessary to implement supplementary risk mitigation measures, as determined by national health authorities.

Exit and entry screening for signs and symptoms of COVID-19

Screening is defined as “the presumptive identification of unrecognized disease or defect by the application of tests, examinations, or other procedures which can be applied rapidly” (30).

Historically, temperature screening at points of entry has been implemented for a variety of diseases, but there is currently no high-quality evidence available to support entry screening based on temperature measurement as an effective measure for COVID-19. First, people may be travelling during the incubation period (between exposure and symptom onset). Second, they may not exhibit fever early in the course of the disease (the proportion of COVID-19 asymptomatic cases is estimated to be approximately 20% of all cases (31)). Last, they may have taken antipyretic medications to reduce fever.

WHO encourages countries that are implementing temperature measurement at exit and/or entry to share their evaluations of the use of this measure, since they are critical to build and evidence base and increase the understanding of its effectiveness and impact in the context of COVID-19.

WHO recommends visual screening of departing and arriving travellers for signs and symptoms (e.g. such as cough and difficulty breathing) and interviewing passengers (when necessary) about signs and symptoms and any exposure to confirmed or probable cases during the 14 days prior to travelling. If digital health declaration forms are used, this should be done in line with privacy and

personal data protection as per WHO guidance (18). Travellers who have symptoms or are identified contacts of COVID-19 cases should not be allowed to travel and should be referred for further medical assessment to pre-designated facilities, according to protocols in place at the point of entry and national guidance.

In addition, national authorities may ask incoming travellers to provide their contact details, so that they can be located for health monitoring during the first 14 days after arrival at destination or for international contact tracing. WHO recommends that travellers fill out a health questionnaire online before travelling or during travel to avoid crowding at arrival. Authorities may also require arriving passengers to download and utilize a national COVID-19-control app if such an app has been established in the destination country to facilitate health monitoring and contact tracing on arrival.

Summary of evidence review on effectiveness and impact of screening for signs and symptoms of COVID-19 in the context of international travel

WHO commissioned a rapid review of evidence (32) using a systematic approach to collecting studies available up to 13 November 2020 on the public health effectiveness and impact of symptom/exposure-based screening of international travellers. The review identified a limited number of studies, which had varying results. The review found one modelling study reporting that global implementation of screening measures would reduce the number of cases exported per day by 82% (33). Four modelling studies predicted delays in epidemic development, although there was wide variation between the studies in the results obtained (34, 35, 36, 37). Four additional modelling studies predicted that the proportion of cases detected would range from 1% to 53% (38, 39, 40, 41). Across nine observational studies, the proportion of cases detected by entry and/ or exit screening measures ranged from 0 to 100% (42, 43, 44, 45, 46, 47, 48, 49, 50). For symptom and temperature screening, one of these observational studies reported that the measure detected 100% of cases (46); however, all other studies reported substantially lower proportions of cases detected, ranging from 0% to 53% (42, 43, 44, 45, 47, 48, 49, 50).

SARS-CoV-2 testing for international travellers

International travellers are not considered suspected COVID-19 cases by default. Therefore, healthy travellers should not be considered as a priority group for SARS-CoV-2 testing, in particular when resources are limited, to avoid diverting resources from settings and patients where testing can have a higher public health impact and drive action. In general, high-risk settings should be prioritized for testing, as should high-risk groups including people at risk of developing severe disease and vulnerable populations and health workers, in line with WHO guidance (51).

Despite the high specificity of SARS-CoV-2 antigen-detecting rapid diagnostic tests (Ag-RDTs), false positive results will occur often in low prevalence populations like travelers. Therefore, the use of Ag-RDTs is not recommended in healthy traveller populations with low expected prevalence of disease, especially where confirmatory nucleic acid amplification testing (NAAT), such as real-time reverse-transcription polymerase chain reaction (rRT-PCR), is not readily available (52, 53).

If a country has the capacity to conduct testing in all high-risk settings and high-risk groups and decides to additionally implement testing requirements for incoming travellers, decisions on the type of assay to be used should take into account the key considerations outlined in the WHO scientific brief “COVID-19 diagnostic testing in the context of international travel” (53).

Summary of evidence review on effectiveness and impact of SARS-CoV-2 testing in the context of international travel

A WHO-commissioned rapid review of evidence (32) conducted using a systematic approach to collection of studies available up to 13 November 2020 on the public health effectiveness and impact of testing in the context of international travel found a total of 14 studies (6 observational and 8 modelling studies) that met the review inclusion criteria. An additional literature search up to 4 May 2021 identified 9 additional studies (6 observational, 2 modelling and 1 review). Several of the observational studies found that the proportion of positive cases detected through testing among arriving international travellers ranged between 58.3% and 90.24%, depending on the timing of the tests (e.g. on-arrival or two or more days afterwards) (42, 43, 48, 54, 55). rRT-PCR tests conducted two days after arrival were more effective in detecting cases. One modelling study suggested that rRT-PCR testing of all incoming travellers on arrival followed by the isolation of those testing positive and requiring a negative test at the end of isolation reduced the proportion of imported cases by 90% for a 7-day isolation period and 92% for a 14-day period (56). Other studies have shown that a single rRT-PCR test at arrival captured two-thirds of positive cases among arriving international travellers, with most of the rest detected through a second test at day 7 (57).

If molecular testing is not feasible or easily accessible, several studies have suggested that rapid antigen tests could be used to support public health strategies based on early mass screening in settings such as points of entry (57, 58, 59, 60). However, the effectiveness of using rapid tests depends on many factors, such as the disease reproductive number, the volume of travellers, test sensitivity and COVID-19 prevalence among travellers (61). One review concluded that the effectiveness of scent detection by trained dogs is comparable to or better than rRT-PCR or antigen testing procedures, suggesting that it can likely be used to screen and identify positive cases in a non-intrusive manner in settings such as points of entry (62). Some studies have evaluated the impact of testing and quarantine combined. Several modelling studies show that rRT-PCR testing combined with 14-day quarantine is the most effective strategy. Nonetheless, there is diminishing impact of quarantine beyond 10 days, when this is combined with rRT-PCR testing prior to release. Shorter quarantine of at least 5 days, combined with a negative rRT-PCR test before release, can still prevent a substantial amount of transmission, with one modelling study estimating probability of releasing an infected individual under such conditions as 23% (compared to 0% for 14-day quarantine with or without testing) (57, 59).

The available evidence shows that factors influencing the likely effectiveness of SARS-CoV-2 testing for international travellers include the cost; test type; timing of the test; whether testing is voluntary or compulsory; whether testing is monitored or used with

concomitant measures such as quarantine, isolation of symptomatic travellers and other travel-related measures; and the mitigation strategy of the receiving country. It is important to recognize that SARS-CoV-2 testing for travellers may be associated with a range of indirect psychosocial, physical and economic harms, sociodemographic inequities, infringement of human rights, disruption to travel and trade and reductions in workforce mobility.

Quarantine for international travellers

International travellers are not considered contacts of COVID-19 in principle unless a traveller meets the definition of a contact (19). Countries with no (active) cases, imported/sporadic cases, a small number of clusters of cases or that have controlled transmission and are striving to maintain this status may decide to implement restricted movement, and quarantine measures for incoming travellers while respecting travellers' dignity, human rights and fundamental freedoms and minimizing any discomfort or distress associated with the health measures applied to them, as outlined in the IHR (2005).

Summary of evidence review on effectiveness and impact of quarantine of international travellers in the context of COVID-19

A WHO-commissioned rapid review of evidence (32) conducted using a systematic approach to collection of studies available up to 13 November 2020 on the public health effectiveness and impact of restriction of movement (referred to as quarantine) in the context of international travel found a total of 12 modelling studies that met the review inclusion criteria. An additional literature search up to 4 May 2021 identified 5 additional studies, including 1 observational study and 2 modelling studies on the effectiveness of quarantine on air travellers and 1 qualitative study on the impact of quarantine on repatriated individuals.

A consistent, largely positive estimated effect was observed, suggesting that quarantine of travellers may reduce the incidence of and mortality from COVID-19. The results ranged from limited to substantial effects, depending on duration and compliance with quarantine, the levels of community transmission, the volume of travellers and other public health and social measures in place. Quarantine may be most applicable to countries with a low incidence of COVID-19 and/or relatively high volumes of arriving air travellers, as well as countries at the tipping point of exponential growth and/or with limited public health and health system capacities to detect and care for new cases. The positive benefits of quarantine in reducing SARS-CoV-2 transmission must be balanced against the related risks of infringement of human rights, psychosocial and economic harm, disruption to travel and trade, reductions in the movement of essential goods and workforce mobility.

One modelling study estimated that quarantining all incoming travellers reduced the proportion of imported cases by 55% for a 7-day quarantine period and by 91% for a 14-day quarantine period (63). One observational study reported that, out of all positive cases among incoming air travellers, almost 50% tested positive on arrival, and around 13% remained asymptomatic but tested positive on day 14 of quarantine, concluding that asymptomatic patients with COVID-19 represented a potential reservoir of infection.

Evidence continues to be confounded by the fact that quarantine is rarely used as a single mitigation measure. Several studies conclude that the combination of quarantine with other public health and social measures improves its effectiveness; and that combining quarantine with SARS-CoV-2 testing, particularly repeated testing, may not only improve effectiveness but also reduce the duration of quarantine. Quarantine could theoretically have indirect benefits, such as discouraging infected or exposed people from travelling, raising awareness, facilitating access to health care for other conditions detected at the point of entry and reducing the incidence or importation of other infectious diseases, such as seasonal influenza, into the receiving country.

Border closure or suspension of travel

As noted earlier, WHO recommends that essential international travel should be maintained under all circumstances. It is worth recognizing, however, that the selective or complete closure of national borders, at entry or exit, to non-essential international travel may adversely affect societies and economies – especially those population groups that are reliant on cross-border activities for a living, such as seasonal or temporary workers, and workers and students living abroad.

Nonetheless, in the context of the COVID-19 pandemic, several countries have closed their national borders as a means to prevent or delay the importation and possible subsequent onward transmission of the SARS-CoV-2 virus, with varying provisions to allow uninterrupted essential international traffic. Such measures have sometimes been applied under a precautionary principle.

Summary of evidence review on effectiveness and impact of border closure or suspension of travel in the context of COVID-19

A WHO-commissioned rapid review of evidence (32) conducted using a systematic approach to collection of studies available up to 13 November 2020 on the public health effectiveness and impact of closing borders or suspending travel found 34 modelling studies that assessed the effect of these measures in avoiding the exportation or importation of cases or their reduction in the community and in shifting the epidemic development. Most studies showed reductions in imported or exported cases and transmission in the community varying from no significant reduction to a large number or proportion of cases prevented. Two studies showed reductions in numbers of deaths ranging from a small effect to a large reduction (64, 65). Three modelling studies suggested reductions in the R_t (66, 67, 68), and six studies showed that travel restrictions may delay the time to an outbreak, ranging from less than 1 day to 85 days, and decrease the risk of the outbreak, with reductions ranging from 1% to 37% (69, 70, 71, 72, 73). The variation in results may be explained by differences in study methodologies, including the assumptions on which the models were predicated, as well as differences in the volume of passengers, the severity of restrictions/border closures, the level of transmission in the country of departure, co-interventions, the mitigation strategies of the destination country, the porosity of its

borders and the timing of implementation. Restrictions to international air travel were associated with a substantial decrease in the growth acceleration of the epidemic progression across 62 countries (-6.05%).

Evidence, however, suggests that border closures and travel restrictions may be associated with the harms, disruptions and inequities cited earlier and infringement of the human right “to leave any country and return to one’s own” (74).

Proof of COVID-19 vaccination in the context of international travel

Proof of COVID-19 vaccination as a requirement for exit or entry

National authorities and conveyance operators should not require proof of vaccination as a condition of entry or exit, given the limited (although growing) evidence about the performance of vaccines in reducing transmission and persistent inequities in global vaccine supply. The WHO Director General issued this recommendation to all States Parties to the IHR (2005) on two occasions, after the 6th and 7th meetings of the IHR Emergency Committee on COVID-19 (75, 76).

Proof of COVID-19 vaccination or recovery status to exempt individuals from testing or quarantine requirements for travelling internationally

As COVID-19 vaccination roll-out progresses in most countries, and evidence grows about the performance of vaccines against development of severe COVID-19 disease and death and, to a lesser extent, protection against infection and reduction of transmission, and about performance against VOCs, national authorities in countries of destination may consider implementing an individualized approach to the application of public health measures. They may consider exempting from SARS-CoV-2 testing and/or quarantine requirements to incoming international travellers who:

- are fully vaccinated, meaning they have received the last recommended dose of a vaccine against COVID-19 listed by WHO for emergency use or approved by a stringent regulatory authority (77) at least two weeks prior to travelling
- have proof of previous SARS-CoV-2 infection confirmed by rRT-PCR received within the past 6 months and are no longer infectious as per WHO’s criteria for releasing COVID-19 patients from isolation (78).

Nonetheless, data from vaccination studies show that some vaccinated persons may still become infected and develop disease, which in most instances is mild. Hence, international travellers who are vaccinated are unlikely to develop severe COVID-19 disease and consequently they do not impose increased strain on health systems at the countries of destination. However, their ability to infect others and the risk they pose for further transmission remain unknown. For this reason, countries with a low risk tolerance and whose primary goal is elimination of local transmission may prefer not to implement this individualized approach to international travellers who have been recently infected and recovered or vaccinated. This may also apply if there are concerns about possible transmission of immune-escape variants. This guidance will be updated as more evidence emerges. In all situations, countries should continue to inform any testing or quarantine requirements for international travel with a thorough and continuously updated risk assessment, as outlined earlier in this document. The use of serologic assays is not recommended to prove recovery status given the limitations that are outlined in the scientific brief “COVID-19 natural immunity” (21).

Irrespective of their vaccination status, all incoming travellers must adhere to personal protective measures (e.g. use of masks) and physical distancing measures implemented in countries of destination, including movement restrictions as per national or sub-national legislation.

Further information is available in the guidance document “Considerations for implementing and adjusting public health and social measures in the context of COVID-19” (7).

The rapid proliferation of national and international certificates to prove vaccination status or recovery status has given rise to challenges related to compatibility, data protection, certification and authentication at borders. National authorities may use the International Certificate of Vaccination and Prophylaxis (ICVP) – colloquially known as “yellow booklet” – to record proof of vaccination against COVID-19 under the section “other vaccinations”. However, such proof must not be used as a requirement for entry or exit, as outlined earlier in this document.

Other key considerations applicable to all risk mitigation measures

Costs associated with public health measures for international travel

In accordance with the provisions in article 40, paragraph 1, of the IHR (2005), “except for travellers seeking temporary or permanent residence, and subject to paragraph 2 of this Article, no charge shall be made by a State Party pursuant to these Regulations for the following measures for the protection of public health:

- any medical examinations provided for in these Regulations, or any supplementary examination which may be required by that State Party to ascertain the health status of the traveller examined
- any vaccination or other prophylaxis provided to a traveller on arrival that is not a published requirement or is a requirement published less than 10 days prior to provision of the vaccination or other prophylaxis
- appropriate isolation or quarantine requirements of travellers
- any certificate issued to the traveller specifying the measures applied and the date of application
- any health measures applied to baggage accompanying the traveller” (21).

In the context of the COVID-19 pandemic, and given the high costs associated with measures currently required in many countries for international travellers as a condition of entry or exit, the WHO Director General issued a temporary recommendation following the advice of the IHR Emergency Committee on COVID-19 after its 7th meeting in April 2021. It advises countries to reduce the current financial burden on international travellers for the measures applied to them for the protection of public health (e.g. testing, isolation/quarantine, and vaccination) (76).

Risk communication

One of the most important and effective interventions in a public health response to any event is to proactively communicate with the population what is known, what is unknown and what is being done by responsible authorities to get more information. The objectives are saving lives, minimizing adverse consequences and maintaining trust and compliance of the population with public health measures. Disseminating messages targeting specific groups is an essential part of risk communications, and travellers are one such group. Clear and consistent messages should be agreed on by all entities needing to convey messages to the travelling public and those managing the travel process.

It is essential to proactively communicate to travellers in advance of their trip to help them with personal planning. Overarching changes to travel guidance that affect the general public and operators should be shared through traditional media, social media, COVID-19 helplines and travel websites (such as airline, airport and hotel booking sites). Communication on travel guidance should include:

- travel information and advice, such as travel-related measures or temporary restrictions, and their rationales; recommendations on who should travel; and information on public health and social measures at countries of destination for national and international travellers.
- information on where to find accurate and timely information on the latest COVID-19 situation at the destination, including circulation of VOIs and/or VOCs.
- personal protection measures, such as information on how to seek medical care if needed at the countries of destination; and the potential risk of travel and the measures required to reduce it, including personal and hand hygiene, respiratory etiquette, maintaining physical distance of at least one metre from others and use of a mask as appropriate.

Messages should be consistent, in appropriate languages and accompanied by easy-to-understand images to provide tailored advice and build trust. They should aim to increase compliance with health advice and prevent the spread of false information or rumours (see WHO's guidance on risk communication and community engagement readiness and response to COVID-19 (79)).

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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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