



## Official guidelines on social distancing and testing

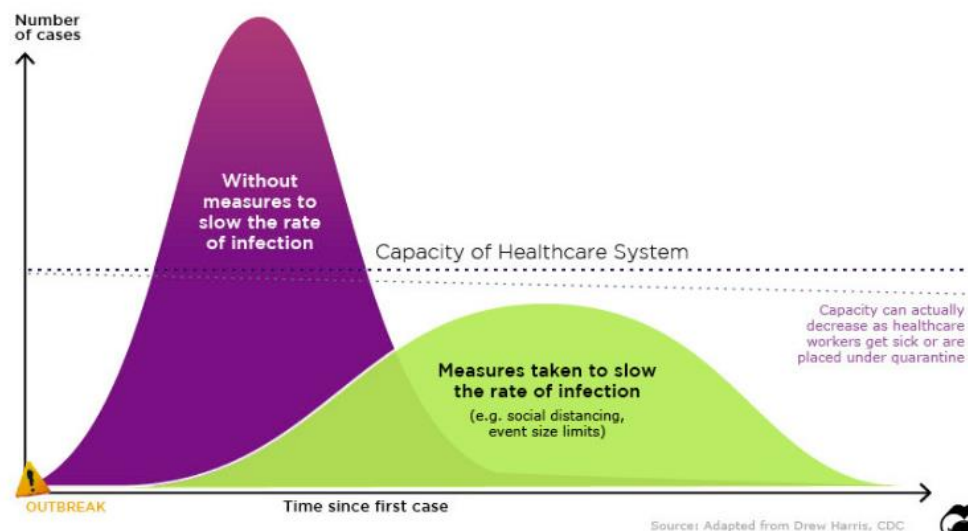
### COVID19

- ❖ ECDC guidelines on social distancing
- ❖ European Commission, Advisory Panel guidelines on testing

Brussels, 20 March 2020

Europe lives in an unprecedented state of pandemics. The COVID19 is triggering strict measures from governments attempting to limit social contact and thus preventing contagion. Flattening the curve is the goal to achieve in order to avert already fragile healthcare systems from collapsing. For that purpose, the number of reported cases must be smaller than the actual number of infections. The [European Centre for Disease and Control \(ECDC\)](#) and the [European Commission COVID19 Advisory Panel](#) put together essential guidelines for healthcare professionals and civil society to deal with this crisis.

Flattening the COVID-19 Case Curve



A rapid “doubling rate” can spell big trouble, as even countries with advanced healthcare systems can become overwhelmed by the sheer number of cases.

Image: Drew Harris, CDC



## ❖ ECDC guidelines on social distancing

The European and Centre Disease Control (ECDC) published **Guidelines for the use of non-pharmaceutical measures to delay and mitigate the impact of 2019 n-CoV** detailing some proposed measures referring specifically to certain phases of the epidemic (containment or mitigation phases), and that can be adapted depending on the assessed severity/impact of the infection.

### **1) Personal protective measures**

#### **a) Hand hygiene**

The risk of transmitting or acquiring 2019-nCoV infection can be reduced by the correct application of hand hygiene. Hand hygiene refers to the frequent washing of hands with soap and water or cleaning of hands with alcoholic solutions, gels or tissues. Hands should be washed regularly using soap and water for 20–40 seconds.

Alcohol-based hand sanitisers provide limited added benefit over soap and water in community settings, and if used should contain 60–85% alcohol. If hands are soiled, soap and water should precede the use of alcohol based hand sanitisers. Since the 2019-nCoV virus can be transmitted by direct contact through droplets or indirectly through hand-mediated transfer of respiratory or possibly other secretions, we recommend applying hand-hygiene measures in all community settings (home, schools, workplaces, etc.) during all phases of the epidemic. Proper hand hygiene would also prevent the transmission of other communicable diseases.

In healthcare settings, proper hand hygiene will need to be performed immediately before and after contact with a patient, before wearing or removing personal protective equipment (PPE) and after contact with potentially infectious material, such as respiratory or other secretions. The same applies to patients or people caring for patients at home.

Recommending hand hygiene is considered to be a rational precaution, involving limited costs and no significant associated risks. Its effectiveness is likely to increase in combination with other measures (e.g. facemasks used in healthcare settings). The effectiveness of hand hygiene depends on the ability to ensure that people comply, through appropriate and repeated training and an adequate and regular supply of soap, tissues and alcohol-based hand sanitisers.

## **b) Cough etiquette**

Cough etiquette refers to covering the mouth and nose when coughing and sneezing (e.g. using a paper tissue or cloth handkerchief) with the aim of reducing person-to-person transmission through droplets which are a known mode of transmission for coronaviruses.

Cough etiquette is widely recommended in public health guidelines for all community settings (home, schools, workplaces, healthcare settings, etc.) at all times. Supply of materials (e.g. tissues, no-touch waste bins, etc.) needs to be ensured. It is important that tissues are properly disposed of immediately after the use and hands are then washed with soap and water, as described in the hand hygiene section of this document.

## **c) Face masks and respirators**

This measure refers to the use of facemasks or respirators. For optimal use of these non-pharmaceutical countermeasures, it is important to have a sound estimate of the duration of the infectious period - which is not as yet available for 2019-nCoV infection.

Facemasks range from simple, even homemade masks, to cloth and surgical (medical) masks. They vary in thickness and permeability. They can protect against larger respiratory droplets but are not guaranteed to protect users from airborne infection. Cloth/gauze masks may induce moisture retention and poor filtration and it is unclear whether they confer clinical protection.

Respirators are specifically designed to protect users from small airborne particles, including aerosols. They are usually available in three sizes (small, medium or large) to allow for differences in face contours. European standard (EN 149:2001+A1:2009) defines classes for respirators entirely or substantially constructed of filtering material [filtering face pieces (FFP) 1-3]. Because the various respirators fit users differently, they need to be fitted individually in order to match each user with the appropriate respirator.

Surgical masks or respirators should be changed frequently in order to maintain their effectiveness. The frequency of change depends on several factors. As a general rule, a mask should be changed as soon as it becomes moist and, in healthcare settings, whenever moving from one patient to another.

## **d) Use of facemasks and respirators in healthcare settings**

In healthcare settings, facemasks or respirators are used to reduce transmission and protect healthcare workers, patients and visitors against infection. Suspected 2019-nCoV cases should be offered a surgical mask which they should wear correctly while in public areas or while visiting areas where other people are present. Suspected cases arriving in healthcare settings should, where possible, immediately be offered a surgical mask in order to mitigate the risk of droplet spread when in triage or waiting areas or during transportation within the facility.

During the assessment of a suspected case or the management of a confirmed case, healthcare workers should use FFP respirators class 2 or 3 (FFP2 or FFP3) which protect both from droplet and aerosol transmission. In the absence of FFP respirators, a surgical mask should be worn that protects from droplet transmission. It is recommended that healthcare workers performing procedures that are likely generate aerosol should wear an FFP3 respirator. If FFP2 or FFP3 respirators are not available, the use of a surgical facemask is recommended. When using this type of PPE, the limitations and risks connected to its use should be assessed on a case-by-case basis. Proper mask disposal and combined measures (e.g. proper hand hygiene) will probably increase the effectiveness of individual measures. For more information please consult the ECDC document on 'Infection prevention and control for the care of patients with 2019-nCoV in healthcare settings'. ECDC has also published an adaptable template leaflet providing advice to healthcare workers on handling and caring for patients.

#### **e) Use of facemasks in other high-exposures situations**

It is still unclear whether the use of surgical facemasks by healthy people who might be exposed to 2019-nCoV will be beneficial. This uncertainty is mainly due to the low filtration efficiency of surgical masks, the risk of infection due to inappropriate use of the mask in high-risk community settings and the false sense of security offered by wearing a mask. The following groups at risk of high-exposure could consider the use of surgical masks:

- care-providers for symptomatic suspected 2019-nCoV cases (before their hospitalisation);
- people in occupations who have extensive face-to-face contact with the public where there is ongoing transmission.

Furthermore, the wearing of a surgical mask can be considered for groups at risk of developing severe complications if infected (e.g. individuals in older age groups or having underlying conditions). Relevant documents for the management of cases on ships and aircraft have been published by EU Healthy Gateways Joint Action: 'Interim advice for preparedness and response to cases of the 2019-nCoV acute respiratory disease at points of entry in the European Union

(EU)/EEA Member States’. Proper use and disposal of masks and proper hand hygiene need to be ensured by training users before distributing masks.

#### **f) Use of facemasks in community settings**

Surgical masks may be used as an infection control measure or as a mitigation measure in community settings when worn by individuals with respiratory symptoms before seeking medical advice and while being assessed. In the event that a symptomatic person cannot wear a facemask, close contacts should consider wearing one instead. During the containment phase, suspected cases can be offered a facemask as a precautionary measure. There is no evidence on the usefulness of facemasks worn by persons who are not ill as a community mitigation measure. In the EU, it is not customary for health people to wear masks in the wider community. If masks are used, best practices for should be followed donning, doffing, and disposing of them. The hand hygiene measures detailed above should always be followed after removing a mask.

#### **g) Other personal protective equipment**

Other personal protective equipment (PPE), such as eye protection (goggles, face shield or procedural masks), body protection (long-sleeved water-resistant gowns), and hand protection (gloves), should be used by healthcare workers or those caring for a patient or suspected 2019-nCoV case, especially when performing aerosol-generating procedures or when the risk of exposure to body secretions is high. Although the most common route of 2019-nCoV transmission is via respiratory droplets, it is not yet clear to what extent other secretions play a role. The use of PPE must be accompanied by appropriate training. Disposable PPE needs to be disinfected and disposed of immediately after use in accordance with routine safety procedures and used in combination with proper hand hygiene measures. There are separate ECDC documents on ‘Infection prevention and control for the care of patients with 2019-nCoV in health care settings’ and ‘Personal protective equipment (PPE) needs in healthcare settings for the care of patients with suspected or confirmed novel coronavirus (2019-nCoV)’.

## **2) Environmental measures**

Environmental measures refer to:

- routine cleaning of frequently used surfaces, clothes and objects;
- minimising the sharing of objects;

These measures aim to enhance protection and reduce the risk of infection for 2019-nCoV and other communicable diseases in various settings (healthcare settings, long-term care facilities, educational settings, workplaces, public places and homes). The survival time of 2019-nCoV in the environment is currently unknown. The survival of SARS-CoV is estimated to be several days and MERS-CoV >48 hours at an average room temperature (20°C) on different surfaces.

Although available evidence on the effectiveness of environmental measures in mitigating the impact of respiratory virus epidemics is limited, it is plausible that these measures may reduce viral transmission and, as such, it is recommended that they are used at all times and in all settings during the containment and mitigation phases of the epidemic. Such measures include the routine cleaning of frequently used surfaces and objects (such as phones, tablets, doorknobs, toilets and keyboards) with water and detergent (such as bleach solution), washing laundry according to the detergent manufacturer's instructions at the warmest indicated temperature, and minimal sharing of objects (such as drinking glasses, eating utensils, towels and bed linen).

Air ventilation in rooms is especially important in settings where people gather regularly. Lessons learnt from the SARS-CoV outbreaks show that it is possible for the virus to spread within a building through the mechanical ventilation system and therefore building maintenance measures should be taken into account.

In healthcare settings, it is especially important that thorough cleaning and disinfection is consistently performed. Cleaning with water, detergent and common hospital disinfectants should be sufficient, although there is lack of specific evidence for their effectiveness against 2019-nCoV virus. Routine safety procedures for disinfection and/or disposal of PPE, medical equipment, utensils, laundry and contaminated waste should be applied in case of 2019-nCoV suspected and confirmed cases. ECDC has published a document 'Interim guidance for environmental cleaning in non-healthcare facilities exposed to 2019-nCoV'.

### **3) Social distancing measures**

#### **a) Quarantine or self-isolation of 2019-nCoV cases and contacts during the containment phase**

Quarantine and self-isolation imply that a person should remain in a designated setting or at home for a defined period after exposure to a situation where transmission of 2019-nCoV virus may have occurred. Evidence relating to influenza pandemics indicates that quarantining



exposed people may delay the peak of local epidemics during the early stages of an epidemic, thus helping to reduce the burden of disease and delay further spread.

Therefore, this option can be considered during the early stages of 2019-nCoV virus introduction into Europe, as part of the Member States' containment efforts. When implementing quarantine measures, Member States should be aware of the disadvantages and possible compliance issues in order to weigh these against expected benefits.

The duration of the quarantine depends on the estimated incubation period of the virus. Early estimates indicated that the mean incubation period for 2019-nCoV is 5.2 days (95% confidence interval [CI], 4.1 to 7.0), with the 95th percentile of the distribution at 12.5 days. A duration of 14 days is therefore considered sufficient for monitoring persons having had contact with 2019-nCoV cases.

These guidelines will be updated if new data reveals different incubation and infectious periods. Rapid identification of cases enhances the effectiveness of quarantine measures. There are considerable logistical, social and communication challenges in implementing quarantine measures. Education on infection control using personal protective and environmental measures in the home or other quarantine setting would be necessary.

The efficiency and resources needed to implement quarantine or self-isolation are dependent on the definition and, in particular, the scale of exposure in the target population. The more specifically the exposure is defined and confined, the more feasible such a measure will be. Implementing quarantine measures for subsets of healthy populations with unclearly defined exposure is unlikely to be an efficient use of resources. ECDC's contact management technical report should be used to assess the potential risk and plan the actions associated with visitors from areas with presumed community transmission of 2019-nCoV. Quarantine is unlikely to be effective as soon as multiple introductions start to occur into EU/EEA countries and the UK from places other than China. Suspected, probable or confirmed cases of 2019-nCoV should be reported to the public health authorities and managed in accordance with national guidance and/or WHO's patient management guidelines. Contacts should be isolated and/or monitored in accordance with national guidance and/or ECDC's technical document 'Public health management of persons having had contact with novel coronavirus cases in the European Union'. This document classifies contacts as 'close' or 'casual' and proposes actions, including self-isolation of close contacts and self-monitoring of casual contacts. If symptoms of illness occur, the quarantined persons should then self-isolate and seek medical advice.



## **b) Voluntary isolation of symptomatic 2019-nCoV cases not requiring hospitalisation during mitigation phase**

Self-isolation of individuals with symptoms of a respiratory infection is one of the most important measures for reducing disease transmission and limiting the spread of the virus in the community during an epidemic. During a community mitigation phase, this measure refers to persons presenting with an acute respiratory infection and probable or confirmed 2019-nCoV virus infection, who do not need hospital care. These individuals would usually be requested to voluntarily remain at home or in a designated setting, in a single, dedicated, adequately ventilated room and preferably use a dedicated toilet while displaying symptoms or for a defined period of time. This recommendation will be revised if new information becomes available on the infectious period for 2019-nCoV.

Early identification of cases to ensure rapid isolation is of paramount importance to prevent further spreading of the virus in the community. Based on current knowledge of 2019-nCoV clinical presentation, the most commonly observed symptoms are fever, cough, myalgia, fatigue and other non-specific respiratory symptoms, similar to those for other respiratory virus infections. This makes clinical suspicion particularly challenging during the influenza season.

Fever has been the most commonly reported symptom for 2019-nCoV but this may not be present in some patients, such as the very young, elderly or immunocompromised persons. A small number of patients have reported gastrointestinal symptoms (such as vomiting and diarrhoea). The effectiveness of voluntary isolation would be reduced if there were transmission via asymptomatic or pre-symptomatic cases. A combination of personal protective and environmental measures during isolation will increase intervention effectiveness. There are complicated logistical issues associated with this measure (e.g. food provision, medical supplies, medical care) and training and supplies will therefore be essential to ensure support and infection control (e.g. PPE, proper waste disposal) for household members caring for the person who is ill. In the absence of strong evidence on the infectious period, it is not possible to make evidence-based recommendations for isolation by case classification or stage of infection. These guidelines assume that infectiousness coincides with the symptomatic period, which is currently a reasonable assumption. Suggested non-pharmaceutical measures for cases and contacts during the containment and mitigation phases are summarised in the table below.





**Table 1. Non-pharmaceutical measures during containment and mitigation phases: quarantine, self-isolation and self-monitoring of confirmed, probable and suspected cases and close or casual contacts**

**A. Containment phase**

Case	Suggested measure
Confirmed	Isolation (at home or in healthcare setting depending on clinical conditions) and monitoring by public health authorities in accordance with national guidance
Probable	Isolation (at home or in healthcare setting depending on clinical conditions) and monitoring by public health authorities in accordance with national guidance
Suspected	Immediate testing for 2019-nCoV and application of non-pharmaceutical measures throughout the process.
Contact of confirmed or probable case	
Close contacts	Isolation at home or in dedicated settings and active daily monitoring by public health authorities in accordance with national guidance <sup>1</sup>
Casual contacts	Self-monitoring - seek public health and medical assistance if symptoms develop.

**B. Mitigation phase**

Case	Suggested measure
Suspected	Contact local healthcare services for advice on clinical management and on the need for testing. Suspected cases with mild clinical symptoms may be advised to self-isolate at home or to limit social contacts for the duration of symptoms.
Confirmed (symptomatic)	Follow the recommendations from the healthcare service that made the diagnosis and adhere to national guidelines for dealing with confirmed cases during the mitigation phase.

❖ **European Commission, Advisory Panel guidelines on testing**

The President explained the latest developments in the EU and the on-going discussions with Member States.

The discussion moved to the agreed agenda:

**Health screening at internal and external EU borders**

The Panel explained the limitations of border controls in order to limit the spread of the epidemic. Literature shows that health screening has limited success in detecting affected people due to the long incubation period and the possibility of asymptomatic carriers (only about a quarter of infections would be detected). Such controls deviate resources from more urgent tasks such as contact tracing or support in healthcare centres. If external border restrictions were to be imposed, it was agreed that they should include sufficient flexibility to allow the movement of essential products and healthcare related workers (including researchers). Considering the situation in the EU, it is important to issue travel advice to all citizens. The President explained that Member States are increasingly setting internal border closures and that travel restrictions at the external border could help overcome this issue.



Internal border closures can delay the travel of essential personnel as well as create bottlenecks for the transport of food, medicines and medical devices. The President explained the agreement reached with France and Germany following their “export bans”. The agreed approach would allow circulation within the EU and authorised exports on a case by case basis.

### **Testing strategies in a situation of scarcity of tests – Who and how to test?**

With an increasing number of COVID-19 cases, prioritisation strategies for testing must be developed to avoid delays and creating scarcity. It must be made clear that not everyone needs to be tested.

The Panel generally supported the strategy proposed by the ECDC:

1. Testing of hospitalised patients with Severe Acute Respiratory Infections (SARI) in order to inform appropriate clinical management, including isolation and PPE measures;
2. Testing any cases of acute respiratory infection in hospitals or long-term care facilities (LTCF) in order to guide infection control and PPE use to protect both vulnerable persons and healthcare European Commission – COVID-19 advisory panel 2 staff; testing of symptomatic healthcare staff, even with mild symptoms, to guide decisions on exclusion from and return to work; the aim is to protect health and social care services;
3. Testing of patients with ARI/ILI in sentinel outpatient clinics and among patients admitted to hospitals with SARI in order to assess virus circulation in the population.
4. Elderly people with underlying chronic medical conditions such as lung disease, cancer, heart failure, cerebrovascular disease, renal disease, liver disease, diabetes, and immunocompromising conditions exhibiting signs of acute respiratory illness, given that they may more rapidly need respiratory support. Particular attention should be given to vulnerable environments, for example homes for elderly persons, especially when the virus has been detected there.

The Panel explained that testing strategies must be understood, and communicated, together with containment measures (e.g. how to consider households with COVID-19 patients, nursing homes, etc.).

It was agreed that laboratories are either already or will soon be under pressure. In view of the high number of cases, it was suggested to stop testing asymptomatic cases and stop any double testing/sampling to save time and resources. Samples sent to laboratories should have indications about their relative priority and certain flows of samples may need to be prioritised for rapid response needs.

The need to develop faster and cheaper tests was raised. International experiences must be closely looked at and replicated when possible.

Members of the Panel advised on the need to have clear communication on the antibodies tests being used as these are less effective than other methods.

The President and Commissioner Kyriakides agreed to raise the issue of testing strategies with Member States and to quickly work on EU guidelines. They invited the Panel to rapidly submit written input by email so that they can be considered.

**1. Social behaviour measures (social distancing, school closures, etc.): hierarchy in terms of effectiveness and exit strategies**

The President outlined the situation in the EU concerning social distancing measures. Most Member States have adopted drastic measures but there are still some that have to. The President asked for advice on a possible hierarchy of measures.

A member of the Panel outlined the measures taken in his home country with different steps gradually increasing their severity. It was agreed that closing nightclubs, cinemas, theatres, museums and sporting centres was essential to limit social contact. Closure of schools and universities could help in limiting the spread, though it was noted that school closures follow the logic used for influenza while there is no evidence yet that it is an effective measure for coronavirus. School closures may, for example, have a negative impact on grandparents looking after grandchildren. These suggestions followed closely the ECDC recommendations (14/03/2020 Rapid Risk Assessment).

Restricting commercial activity (restaurants, shops, etc.) was also seen as contributing to limiting social contacts. Advising remote work was also highlighted as important.

The **importance of supporting healthcare workers during the pandemic was raised**. Measures such as **keeping certain day-care facilities open for such workers were praised**.



The Panel agreed that protecting vulnerable groups was essential. In particular, the elderly must be isolated as much as possible during the outbreak, though the age threshold may differ from one country to another.

As time passes, it is important to start communicating that the virus will likely be part of our lives (like other viruses); it cannot be eliminated, but its spreading can be delayed and managed through social distancing measures.

It was agreed to develop and communicate EU guidelines on social distancing measures. The Panel was invited to submit written input including on their length.

Follow-up:

- Next phone conference on Wednesday 18 March at 18:00
- Panel invited to suggest topics for discussion (refugee populations was already flagged)
- Panel invited to share input on testing and social distancing measures

