Checklist for modification of COVID-19 Public Health and social measures

Pacific Community
Communauté du Pacifique

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Representative Office for the South Pacific

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Objective of the checklist

This checklist is a complement to interim guidance for Pacific Governments considering easing lockdown conditions issued on the 8th of May by the JIMT. This document offers public health authorities a detailed planning tool to ensure preparations to respond to emergent cases are in place.

Notes on the checklist:

- The six criteria below, with specific expectations for each, serve as a checklist when considering modification of COVID-19 public health and social measures.
- Decisions about modifying public health and social measures must be based on a thorough understanding of the current situation, achieved through risk assessment at national, sub-national and community levels.
- The capacity and vulnerability of the health system is the key consideration in deciding to modify public health and social measures.
- It is recommended that any modifications are undertaken in a phased, stepwise manner with a minimum of two weeks between phases.
- The checklist does not attempt to relate any of the criteria to any specific public health intervention relaxation as this very much depends on the transmission scenario of Pacific islands countries or areas (PICs).
- For Pacific countries without COVID-19 cases, it is vital that a high level of vigilance is maintained to reduce the chance of case importation and to detect and respond to suspected cases while also implementing appropriate public health and social measures.
- For Pacific countries with COVID-19 cases, suppressing transmission or achieving a level of no transmission is vital before considering reduction of public health and social measures while still maintaining effective surveillance and capacity to respond rapidly to sporadic cases and clusters of disease.

Criteria	Yes/No
1. COVID-19 transmission is controlled to a level of sporadic cases and clusters.	
A high-level national authority or taskforce with representation from key ministries and agencies has been charged with the responsibility for planning and responding to COVID-19.	
All new cases are from known contacts or importations.	
At a minimum, new cases are suppressed and held at a level that the health system can manage based on health care capacity and have clinical capacity in reserve. *The hospitalization and ICU needs can be estimated using the modelling in Annex 1.*	
There is availability of testing for COVID-19 or access to reference laboratories for confirmation of cases.	
There is active surveillance of influenza-like illness (ILI) in place.	
There is active surveillance of severe acute respiratory illness (SARI) and atypical pneumonia in place.	
There is active event-based surveillance (EBS) in place with high suspicion for atypical case presentation and unexplained increases in reported deaths.	
A hotline is available for the public to contact health facilities 24/7.	
2. Sufficient health system and public health capacities and capabilities are in place to enable the major shift from detecting and treating serious cases to detecting and isolating all cases.	
Public health staff have received training on the investigation of cases and completion of the case reporting form and line list.	
Standard Operating Procedures, or similar, for undertaking contact tracing and management have been developed and tested including a system of daily monitoring of contacts.	
Public health staff and other surge workforce has been identified and trained for tasks including contact tracing and follow-up (both telephone or in-person), data entry and administrative functions, and template rosters have been developed.	
Facilities across the country to be used as quarantine or isolation sites have been identified and prepared.	
Plans and resources are in place for the cleaning and supply of quarantine and isolation facilities and welfare of people at facilities.	

Have care pathway across case management function in place and in particular options for the isolation of cases not requiring hospitalization (including home isolation) have been identified and staffing, equipment and consumable requirements have been considered.	
Resources and processes are in place to support cases with mild disease who are isolated at home.	
Staff have been identified who are able to assess home facilities for use as quarantine or isolation sites.	
Standard Operating Procedures, or similar, have been developed and tested for managing a person in quarantine who develops symptoms.	
Standard Operating Procedures, or similar, have been developed and tested for managing a person in isolation who requires hospitalization.	
Staff in emergency departments (EDs) and/or COVID-19 clinics have been trained in the early management of suspected COVID-19 cases and necessary infection prevention and control (IPC) measures.	
Triage arrangements are in place in EDs and COVID-19 clinics to ensure separation of suspected cases from the general population.	
Hospitals have identified specific areas designated as isolation facilities for COVID-19 cases.	
Clinical staff responsible for the management of cases of COVID-19 cases have received training on clinical case management and appropriate IPC measures.	
A mechanism to monitor the use of personal protective equipment (PPE) has been established and a supply of further PPE has been identified.	
Sufficient laboratory testing capability for COVID-19 is available in-country to allow testing of suspected cases and verify virus negative status of recovered cases.	
A COVID-19 Health Task Force or similar has been established and meets regularly (and on an emergency basis as necessary) and undertakes an ongoing risk assessment process including an assessment of the status of the health system.	
Surveillance data (Indicator Based Surveillance and EBS) and other information are used by a COVID-19 Health Task Force, or similar, to inform the decisions on changes to health system arrangements.	
In the event of a resurgence in case numbers, a surge workforce of clinical staff, necessary consumables (including PPE), and equipment have been identified.	

3. Outbreak risks in high-vulnerability settings are minimized.	
Mechanisms are established in health care facilities for triage and management to ensure rapid identification and isolation of suspected COVID-19 cases.	
Isolation and cohorting measures are in place in residential care facilities.[1]	
Staff in health facilities have appropriate training and resources to adhere to standard precaution IPC practices. This includes: • hand hygiene with access to soap and water and alcohol-based hand rubs; • PPE requirements and supplies (gowns, goggles, mask, gloves) commensurate with facility capacity; and • educational materials in place.	
Staff in health facilities managing COVID-19 cases have appropriate training and resources to adhere to transmission-based precautions (contact and droplet precautions).	
There are active protocols, equipment, resources and supervision for environmental cleaning and disinfection.	
Appropriate signage and IPC is at the entrance and strategic locations to inform IPC requirements for visitors to health care facilities.	
Visitors and communal activities are limited in high vulnerability settings.	
Staff have been identified and trained in management of COVID-19 cases.	
There are active protocols regarding admission and transfer of residents or patients to minimize the risk of infection transmission.	
4. Preventive measures are established to reduce risk in workplaces and other essential places, including schools.	
COVID-19 preventive measures are established in workplaces and schools: • physical distancing, which may involve limitations on numbers, teleworking, staggering shifts, and other practices to reduce crowding; • maintain minimal requirements for hand hygiene (soap and water, alcohol-based hand rubs and wipes) and respiratory etiquette; • protocol for regular disinfecting of surfaces and environmental cleaning; and • temperature monitoring.	
Unwell persons are excluded from entry to workplaces and schools.	
As public health and social measures are further modified, minimizing the risk of transmission in enclosed and public spaces will be important and will include: • physical distancing, which may involve limitations on numbers; • respiratory etiquette;	

• hand hygiene measures; and • enhanced environmental disinfection.	
As public health and social measures are further modified, minimizing the risk of transmission at events (large funerals, christenings, sporting events, cultural events) where physical distancing may be challenging to achieve, will be considered and include: • an action plan to mitigate risks at events[2]; • establishment of an integrated organizing committee having a response plan for infectious disease during events[3]; • enhanced surveillance systems during events; • entry and exit thermal screening arrangements at lodging and event venues; • proper recording of participant information such as place of residence, contact details, country of origin, travel details; and • designated area is established on site to be used for isolation of symptomatic persons prior to transfer.	
5. Management of the risk of imported cases.	
At points of entry there is active exit and entry screening (i.e. trained staff for case identification, temperature screening, clinical assessment of symptoms, mandatory reporting of symptoms and recent travel history, collection of up-to-date contact details for all travelers including location of seat on aircraft).	
At points of entry there is an active protocol to manage symptomatic arrivals including location for isolation (e.g. hospital or isolation facility), transport to the location, staff to escort travelers, and PPE for the staff and traveler.	
At points of entry there is an active protocol to manage asymptomatic arrivals who require a period (e.g. 14 days) of quarantine including location for quarantine (e.g. hospital, quarantine facility or home), appropriate transport to the quarantine location minimizing opportunities for transmission to others, and quarantine requirements listed above.	
Airports and seaports provide PPE for staff and hand sanitizer for staff and travelers.	
Airports and seaports areas frequently touched and handled by passengers, personnel and crew are cleaned after the arrival of each aircraft and ship/boat.[1]	
Consult your Public Health Emergency Contingency Plan (PHECP) For more information and guidance: International health regulations (2005) : a guide for public health emergency contingency planning at designated points of entry.[4]	

[1] See also WHO and SPC Guidance on protecting cargo handlers from the potential risk of COVID-19.

6. Communities are fully engaged and understand that the transition entails a major shift, from detecting and treating only serious cases to detecting and isolating all cases.	
Community engagement and communication has achieved a level of public understanding about the modification to restrictions. This may include an understanding that behavioural prevention measures must be maintained for a longer period, and that all individuals have key roles in enabling and, in some cases, implementing new control measures. Specific initiatives include: • Posters on personal hygiene including cough etiquette, hand washing, and physical distancing which are visible in public areas such as parks, markets, schools, restaurants, malls or other common areas in the community. • Similar messages routinely aired on all broadcast media (television, local radio stations) and other community announcements. • Similar messages included in local print media in appropriate languages for the audience(s). • Community/church leaders have a set of procedures to implement and conduct regular monitoring of their public areas to ensure the implementation of physical distancing. • Implementation of physical distancing on public transport including maximum number of passengers based on guidelines used by all drivers. • Measures are in place to address public transport demands affected by the physical distancing measures, such as increasing transport frequency. • Public awareness campaigns using multi-media have been conducted.	

Annex 1. Modelling Hospitalization and ICU needs

Proportion of people with COVID-19 who require hospital and ICU, by age		
Age group	**% Hospitalised**	**% Require ICU**
0-9 years	0.062	0.018
10-19 years	0.062	0.018
20-29 years	0.78	0.23
30-39 years	2.9	0.85
40-49 years	5.1	1.5
50-59 years	9.9	2.9
60-69 years	15.5	4.55
70-79 years	35.8	10.5
80+ years	65.9	19.4
Overall		
Mean bed days for inpatients		
Hospital	7.5 days	
ICU	10 days	

Additional Modelling Parameters				
	Scenario 1: No mitigation	**Scenario 2: Quarantine and isolation**	**Scenario 3: Quarantine, isolation and social distancing**	**Scenario 4: Quarantine, isolation and social distancing**
Infection Rate	89.1%	67.5%	37.7%	11.6%
Hospitalization Rate	5.4%	4%	2.2%	0.8%

References:

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2. Q&A on Mass Gatherings and COVID-19. In: WHO/Coronavirus disease (COVID-19) Pandemic [website]. Geneva: World Health Organization; 2020 (https://www.who.int/emergencies/diseases/novel-coronavirus-2019/question-and-answers-hub/q-a-detail/q-a-on-mass-gatherings-and-covid-19, accessed 11 May 2020).
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4. International health regulations (2005): a guide for public health emergency contingency planning at designated points of entry. Manila: World Health Organization; 2005 (https://www.who.int/publications-detail/international-health-regulations-(-2005)-a-guide-for-public-health-emergency-contingency-planning-at-designated-points-of-entry, accessed 11 May 2020).
5. Impact of COVID-19: Theoretical modelling of how the health system can respond [online]. Canberra: Australian Government; 2020 (https://www.health.gov.au/sites/default/files/documents/2020/04/impact-of-covid-19-in-australia-ensuring-the-health-system-can-respond-summary-report.pdf, accessed 11 May 2020).

This document has been developed in accordance with global guidance and contextualized to the Pacific context by the COVID-19 Pacific Joint Incident Management Team.