

WHO Criteria for Transitioning Between the COVID-19 Pandemic Response to Recovery Phase¹

Countries should meet the WHO's six criteria for Transitioning. The WHO recommends that all decisions about when and where to transition must be evidence based, data driven and implemented incrementally. For many countries, managing a controlled and deliberate transition from a scenario of community transmission to a sustainable, steady state of low-level or no transmission is, at present, the best-case outcome in the short and medium term in the absence of a safe and effective vaccine. For countries yet to report community transmission, preventing the escalation of transmission and maintaining a steady state of low-level or no transmission may be feasible. Achieving either of these aims will hinge on the ability of national authorities to ensure that six key criteria are satisfied:

1. **Capability to control COVID-19 transmission** to a level of detectable sporadic incident cases and manageable clusters of cases, all from known contacts or importations and the incidence of new cases should be maintained at a level that the health system can manage with substantial clinical care capacity in reserve.
Two suggested complementary approaches for controlling transmission are: (i) breaking chains of transmission by detecting, testing, isolating, and treating cases and quarantining contacts; and (ii) monitoring hot spots of disease circulation through respiratory disease or influenza-like illness surveillance, and where possible, coupled with serological surveys.
2. **Sufficient health system and public health capacities are in place** to enable the major shift from detecting and treating mainly serious cases to detecting and isolating all cases, irrespective of severity and origin:
 - 2.1. Overall Surveillance and containment measures should include:^{2,3}
 - 2.1.1. **Robust surveillance system** at all levels of health care to detect suspected cases quickly after symptom onset through active case finding, self-reporting, entry screening, and other approaches.
 - 2.1.1.1. Monitoring of disease trends and epidemic profile to identify resurgent clusters at the national and sub national levels
 - 2.1.1.2. Risk profile of high-risk areas and enhanced surveillance implemented for high risk and vulnerable populations in settings such as Aged care, children's homes, people living with disabilities, Wards of the State, detention centers and prisons, High density housing, high density workplace settings).
 - 2.1.2. **Testing of all** suspected cases with test results provided within 24-48 hours of identification and sampling, and measures to confirm the virus-free status of patients who have recovered;⁴
 - 2.1.3. **Isolation of** all confirmed cases effectively in hospitals and/or designated housing for mild and moderate cases, or at home with sufficient support if designated housing is not available) immediately and until they are no longer infectious;⁵

¹ WHO COVID-19 Strategy update 14 April 2020 accessed from https://www.who.int/docs/default-source/coronavirus/covid-strategy-update-14april2020.pdf?sfvrsn=29da3ba0_19

² Lee VJ, Chiew CJ, Khong WX. [Interrupting transmission of COVID-19: lessons from containment efforts in Singapore](#)

³ The end of exponential growth: The decline in the spread of coronavirus:

<https://www.timesofisrael.com/the-end-of-exponential-growth-the-decline-in-the-spread-of-coronavirus/>

⁴ For guidance on the strategic use of diagnostic testing in different COVID-19 transmission scenarios see: https://apps.who.int/iris/bitstream/handle/10665/331509/WHO-COVID-19-lab_testing-2020.1-eng.pdf

⁵ For advice on home care of individuals with suspected COVID-19 see: [https://www.who.int/publications-detail/home-care-for-patients-with-suspected-novel-coronavirus-\(ncov\)-infection-presenting-with-mild-symptoms-and-management-of-contacts](https://www.who.int/publications-detail/home-care-for-patients-with-suspected-novel-coronavirus-(ncov)-infection-presenting-with-mild-symptoms-and-management-of-contacts)

2.1.4. **All close contacts traced**, quarantined, and monitored for 14 days, whether in specialized accommodation or self-quarantine. Monitoring and support can be provided through a combination of visits by community health workers or volunteers, phone calls, or messaging.⁶

2.1.5. For each case, sufficient workforce needs to be in place to identify and monitor contacts.

2.1.6. Adequate health workforce and hospital capacity in place to care for any resurgence in cases; and health workforce trained and provided with appropriate personal protective equipment.

3. **Outbreak risks in high-vulnerability settings are minimized.** This requires all major drivers and/or amplifiers of COVID-19 transmission to have been identified, with appropriate measures in place to minimize the risk of new outbreaks (in high risk settings - See 2.1.1.2) and of nosocomial transmission (e.g. appropriate infection prevention and control, triage, and provision of personal protective equipment in health care facilities and residential care settings).⁷

3.1.1. Special considerations for protection of high risk and vulnerable groups, such as those in residential and aged care, children's homes, people living with disabilities, Wards of the State, detention centers and prisons, high density housing and workplace settings, temporary migrant housing.

4. **Workplace preventive measures are established** to reduce risk, including the appropriate directives and capacities to promote and enable standard COVID-19 prevention measures in terms of physical distancing, telework and staff rotation, hand washing, worksite sanitization, respiratory etiquette, appropriate mask wearing and, potentially, temperature monitoring. This should include preventing transmission in enclosed spaces that prevent adequate physical distance and may have limited ventilation (e.g. cinemas, theatres, night clubs, bars, restaurants, gyms, schools).⁸

4.1. Reduction of nosocomial transmission (e.g. appropriate infection prevention and control in health care facilities,¹⁰ including triage and screening of severe patients, appropriate infection prevention and control measures in residential care settings.¹⁸

5. **Risk of imported and exported cases managed** through an analysis of the likely origin and routes of importations, and measures in place to rapidly detect and manage suspected cases among travelers (including the capacity to quarantine individuals arriving from areas with community transmission).
This should include multisectoral engagements to implement measures that can be taken at airports or points of entry to diminish the risk for travellers; such as exit and entry screening and capacities for isolation of sick travellers, passenger and facility management, and airside operations and safety.⁹

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, that behavioral prevention measures must be maintained, and that all individuals have key roles in enabling and in some cases implementing new control measures.

⁶ For guidance on quarantine of individuals see: [https://www.who.int/publications-detail/considerations-for-quarantine-of-individuals-in-the-context-of-containment-for-coronavirus-disease-\(covid-19\)](https://www.who.int/publications-detail/considerations-for-quarantine-of-individuals-in-the-context-of-containment-for-coronavirus-disease-(covid-19))

⁷ For IPC guidance for long-term care facilities see: https://apps.who.int/iris/bitstream/handle/10665/331508/WHO-2019-nCoV-IPC_long_term_care-2020.1-eng.pdf

⁸ For all guidance related to schools, workplaces and institutions see: <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/guidance-for-schools-workplaces-institutions>

⁹ Airport Council International. Airport operational practice. Examples for managing COVID-19. ACI, 2020.

<https://store.aci.aero/wpcontent/uploads/2020/04/Airport-OperationalPractice-Examples-for-Managing-COVID19.pdf>

- 6.1. The public is regularly informed and consulted about when and how measures will be implemented or lifted; and provide input into strategies for mitigating the social and economic impact of certain measures (e.g. community food-supply chains, psychosocial support for aged residents and people living with disabilities).
- 6.2. The right information is provided at the right time to the right people through trusted channels (e.g. community leaders, family doctors, social influencers), that enables the development of adaptive social measures.

Practical Considerations to be factored in:

1. ALL decisions about when and where to transition should be undertaken with extreme caution, and must be evidence based, based on reiterative in-depth analysis of epidemiological data, health service data, level of community engagement and implemented incrementally.
2. Any transition must be gradual, prioritized, and planned for (e.g. staggered mobility of productive segments of the population such as by car plates number; staggered opening of businesses by typology; and encouraging social distancing measures, hygiene of surfaces and other measures adapted to each sector opening of schools by grade; etc.). Each step should be taken 28 days apart.
3. It is essential to have real-time, accurate data on the testing of suspected cases, the nature and isolation status of all confirmed cases, the number of contacts per case and completeness of tracing, and the dynamic capacity of health systems to deal with COVID-19 cases.
4. It is imperative that each country clearly demonstrates the stage of the pandemic that they are in through their epidemiological data; and identify their gaps and measures needed to achieve the WHO criteria.
5. For countries yet to report community transmission, preventing the escalation of transmission and maintaining a steady state of low-level or no transmission may be feasible.
6. Each country should undertake a risk assessment based on a standard methodology that includes assessment of risks at subnational and community level. This assessment should balance of the risk of relaxing measures, the country's capacity to detect a resurgence in cases, health sector capacity to manage extra patients in health facilities or other locations, and ability to re-introduce public health and social measures, if needed.¹⁰
7. Countries must be able to clearly identify and implement evidence informed risk mitigation strategies that will be guided by the epidemiological surveillance data. For countries yet to report community transmission, preventing the escalation of transmission and maintaining a steady state of low-level or no transmission is the desired outcome.
8. Risk assessments may eventually benefit from serological testing, when reliable assays are available, to inform understanding of population susceptibility to COVID-19.
9. To reduce the risk of new outbreaks, measures should be lifted in a phased, step-wise manner based on an assessment of the epidemiological risks and socioeconomic benefits of lifting restrictions on different workplaces, educational institutions, and social activities (concerts, religious & sport events).
10. Ideally there should be a minimum of 4 weeks (corresponding to twice the incubation period of COVID-19) between each phase of the transition, to allow sufficient time to understand the risk of new outbreaks and to respond appropriately. This would also enable countries to implement 'phases within phases' that enables them to monitor the impact of implemented measures for two full incubation periods (14 days x 2) before taking further actions within that phase, and then gradually moving on to the next phase.

¹⁰ Rapid risk assessment of acute public health events https://www.who.int/csr/resources/publications/HS_E_GAR_ARO_2012_1/en/