African Union

AFRICA CDC
Centres for Disease Control and Prevention
Safeguarding Africa's Health

Africa Centres for Disease Control and Prevention

Guidance on Community Physical Distancing During COVID-19 Pandemic

Physical Distancing, Social Support

Contents

1 Purpose of this guidance document

This guidance document outlines physical distancing approaches for coronavirus disease 2019 (COVID-19) that focus on maintaining public health benefit while reducing negative health, social and economic impacts.

2 Background information

In Africa, the number of COVID-19 cases and affected countries has been increasing steadily. As of 24 April 2020, over 27,000 cases and 1,300 deaths have been reported in 52 countries. Community transmission is now widespread. The epidemic has the potential to result in substantial death and suffering in Africa due to four major factors:

1. **increased risk of transmission,**
2. **increased risk of infection leading to severe illness,**
3. **increased risk of death from severe illness,**
4. **increased suffering among those who survive the pandemic.**

This guidance document addresses how physical distancing (referred to in previous guidance documents as 'social distancing') can help slow down transmission.

This document replaces the previous Africa CDC 'Guidance on Community Social Distancing During COVID-19 Outbreak' published on 17 March 2020. The term 'physical distancing' replaces 'social distancing' to emphasize the importance of maintaining social support and solidarity, while ensuring physical distancing helps reduce the transmission of disease.

Physical distancing is an accepted strategy to delay and reduce the magnitude of outbreaks of respiratory pathogens such as pandemic influenza. At the individual level, physical distancing involves the use of non-contact greetings,
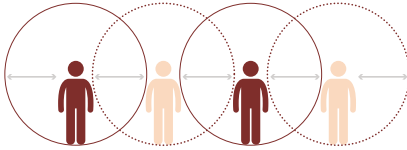
maintaining at least one metre distance from others,

and staying homewhen ill. At the community level, physical distancing can involve shielding the medically vulnerable, and closure of any events or settings in which people gather together, including schools, workplaces, houses of worship, and cultural, social, and sports events. Many African Union Member States have already introduced individual physical distancing measures and are considering how best to implement community physical distancing. For COVID-19, physical distancing is necessary at the individual and community level, because:

- transmission occurs frequently from person-to-person;
- transmission may occur from people who are not visibly unwell (e.g. those who are infected and do not yet have symptoms, or who never develop symptoms);
- infection causes severe illness in approximately 5 percent of people, especially the medically vulnerable (people over the age of 60 years, people with lung conditions, people with heart conditions, people with diabetes, and people who are obese);
- no population immunity exists;
- no vaccine or cure currently exists.

Reducing contact between people reduces the cumulative number of opportunities for transmission and helps delay and limit the peak of the epidemic and protect people who are at high-risk for severe COVID-19 disease.

Without a vaccine, transmission of COVID-19 cannot be prevented altogether. The primary aim of community physical distancing is to slow transmission and reduce daily case numbers, to permit:

- health facilities to attend to a manageable number of COVID-19 patients without overwhelming the healthcare system;
- public health officials to apply new knowledge to target interventions more precisely;
- researchers time to develop vaccines and medications;
- protection of people who are at high-risk of developing severe COVID-19 disease.

Since the previous guidance document was published, more has been known about COVID-19 and the effectiveness of community physical distancing for prevention, mostly from experience in higher income countries and from modelling studies. Some of this information can be helpful to guide African Union Member States, although interpretation should be cautious considering the differences in context.

What we know as of April 2020

1. For the most similar comparable infection, influenza virus, **individual and community physical distancing, combined with good hand and respiratory hygiene and rigorous isolation of people with symptoms** (confirmed or suspected cases), **delays and reduces the magnitude of outbreaks.**

2. **Transmission is facilitated by proximity, duration, and number of contacts.** Community physical distancing aims to reduce the number, closeness and length of time spent with contacts as much as possible. Full lockdown may not be feasible, but all effort should be made to prevent as many unnecessary opportunities for contact as possible.

3. **Community physical distancing should be instituted**, at a minimum, as soon as there is any evidence of community transmission and before healthcare facilities become overstretched with critically ill patients.

4. **Physical distancing measures should be maintained or repeated for prolonged periods** if they are to be effective at reducing transmission, and should be reduced slowly based on epidemiological and socioeconomic indicators.

5. **Specific transmission characteristics of COVID-19 suggest that community physical distancing can delay and reduce the magnitude of outbreaks because:**
    a. transmission occurs frequently among close contacts (direct physical contacts or prolonged face to face contacts of 15 minutes of more);
    b. transmission may occur from people who are infected and do not yet have symptoms;
    c. transmission may occur from people who are infected and never develop symptoms; and
    d. reducing contact between people reduces the opportunity for transmission of COVID-19.

6. **Rigorous application of community physical distancing** (alongside huge increases in critical care capacity and widespread testing and contact tracing) in China and other locations **has slowed transmission**.

7. Community physical distancing can inequitably impact economic, social, and cultural activity. **Measures should be adapted to local contexts and needs, in consultation with communities.**

8. **Careful community engagement can mitigate negative effects,** alongside forward-looking multi-sectoral planning to consider how to support livelihoods, access to food, non-COVID-19 health needs, and security.

9. **Community physical distancing should be carefully planned in advance.** To ensure that any measures are as effective as possible, it is critical that they include consideration for food security, livelihoods support, non-COVID-19 health needs and security issues.

3 Engaging communities for physical distancing and individual hygiene practices

1. Member States, at all levels of government, **should maintain and intensify prominent public messaging about individual physical distancing,** particularly:

   a. Use non-contact greetings;

   b. Practice good hand and respiratory hygiene;

   c. Enhance environmental hygiene, especially of frequently touched public surfaces (e.g. public and private taps, elevator buttons, handrails, doorknobs, shopping carts, etc.);

   d. Maintain one metre distance when in public places and where feasible;

   e. Stay home if you are ill, except to obtain medical care. While at home, wear a medical mask, and isolate yourself from other people in your household as much as possible, especially the elderly or other vulnerable people. If you need to leave home to seek medical care, you should wear a medical mask, and perform hand hygiene frequently. **You should seek immediate medical care if you have high fever and shortness of breath**.

2. Member States, at all levels of government, **should increase risk communication activities through trusted channels and actors, key opinion and faith leaders, and the public about the reasons and plans for community physical distancing.** Messaging must be clear, consistent, and culturally respectful. Information must be provided about the importance of such measures and in advance of their application, to give people time to prepare psychologically and practically.

3. **Acceptance of these measures by the community can be improved by emphasizing personal/social responsibility** and emphasizing that physical distancing is a means of protecting oneself, family, and community.

4. **Community acceptance of the measures will be facilitated by announcing them with an anticipated end-date,** but it should also be made clear that the end-date could be extended if there is another wave of transmission.

5. As much as possible, **community physical distancing should be implemented with community consent and by encouraging social responsibility through trusted authorities and channels.** As a last resort, governments should review their laws at national and sub-national levels to ensure that they have the authority to implement community physical distancing.

6. Governments and public health agencies **should listen to concerns and obstacles to community physical distancing,** and seek community contribution to solutions.

7. **Risk communication should include different audiences,** e.g. minority languages, and the channels used should be able to reach everyone.

4 Supporting organizations and individuals to practice physical distancing

1. All levels of government and non-government entities **should ensure widespread availability of hand hygiene materials** such as soap and water and alcohol-based hand rub **at the entrance of every building and in every bathroom facility.**

2. Sufficient public transportation **should be kept open to facilitate access to food, medical services, and other social support.** Reducing the frequency of transportation services[1] should be considered carefully to avoid increasing overcrowding on public transport.

3. Physical force **should not be used to restrict movement of people outside their homes or outside the geographic unit** that is implementing community physical distancing.

4. Government agencies **should consider all possible mechanisms to provide food, financial, medicines, religious, and social support to all individuals adversely impacted by community physical distancing,** with particular focus on socially and economically vulnerable groups.

5. Authorities **should proactively address the potential stigma associated with measures such as quarantine** by promoting a sense of solidarity in the population: **"everyone is at risk", and "we are all in this together".**

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1   See Africa CDC Guidance for the Transportation Sector

5 Implementing physical distancing

1. **Community physical distancing should be implemented carefully** and with consideration for mitigating the social and economic impacts, as well as possible public health benefits.

2. **Efforts should be made to maintain acute and chronic essential health services,** protect the health workforce, and maintain trust in the health system.

3. **Community physical distancing should be implemented immediately after populations have been sensitized** and with consideration for social and political sensitivities and the epidemic phase (Table 1).

4. **The triggers to implement community physical distancing include:** when any cases or deaths are detected outside of known chains of transmission, or when 'containment' activities such as test, trace, and treat are becoming overwhelmed (Epidemic Phase 3–4)[2].

5. Community physical distancing **should only be used in the most limited geographic unit necessary to achieve the desired impact.**

6. Several layers of physical distancing **should be instituted simultaneously, rather than one by one** (see Table 1).

7. Member States, at all levels of government, **should monitor adherence** to individual physical distancing and infection prevention and control standards **in healthcare facilities and congregate settings,** such as prisons and nursing facilities.

8. Member States **should carefully monitor the effects** (epidemiological, social, economic) of community physical distancing **and be prepared to increase or decrease measures in response** to those effects.

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2   See Africa CDC Recommendations for Stepwise Response to COVID-19

9. Member States should **ensure that any legal enforcement** of community physical distancing, isolation, and quarantine **is conducted with full respect for human rights and dignity.**

10. Community physical distancing should also include:

    a. **Working with faith leaders to adapt religious services[3] to support physical distancing,** e.g. worshiping outdoors, maintaining a minimum distance between worshippers of one metre, avoidance of sharing utensils or consumables.

    b. Special consideration for **communities living in informal settlements[4],** where implementing community physical distancing is likely to have a specific set of challenges.

    c. Maintaining individual physical distancing precautions in **routine gathering places** such as bus stations and markets, e.g. one metre distance from other people and non-contact greetings.

    d. **Employers working with their staff to increase physical distance between employees,** including changing shift patterns and staggering work schedules, allowing work-from-home, moving work activities outdoors, and limiting work-related gatherings.

    e. **Employers providing paid sick leave,** support for parents to provide childcare, and incentivizing workers to stay at home if they have any respiratory symptoms.

    f. **Prominent public messaging encouraging people aged 60 years or older** and other medically vulnerable groups **to strictly limit the time they spend in public places and restrict any travel.**

    g. Prominent public messaging instructing people with fever, cough, or other flu-like symptoms to:

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3   See Africa CDC Guidance for Faith Communities

4   See Africa CDC Guidance for Informal Settlements

i. **isolate themselves** in their homes except to seek medical care on other related illnesses, such as malaria, and contact relevant public health authorities for local advice on next steps;

ii. **immediately seek medical care** if they have symptoms, such as **high-grade fever and shortness of breath;**

iii. **follow effective infection prevention measures in the household** and receive support from government and/or community to do so.[5]

Shielding the vulnerable

1. **Widespread distancing measures may not always be feasible to implement,** particularly in settings like informal settlements or other crowded urban environments and/or may cause more harms than benefits through indirect effects on access to healthcare and on livelihoods.

2. In these circumstances, Member States **should consider protecting those medically vulnerable** to COVID-19 by keeping them isolated from the rest of the community (a strategy called 'shielding' or 'cocooning') and reducing their risk of infection as an alternative to widespread community physical distancing measures.

3. With this strategy, an administrative unit, such as house, village, or city, would **identify people who meet specific criteria** (e.g. people over 60 years of age) and an area where they can be kept away from close contact with anyone else, other than those similarly shielded.

4. For example, **a facility could be designated for high-risk people** in which all services are provided by people living in the facility or by a small subset of people who live as on-site care staff, supported by the community from which the high-risk people come.

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5 https://www.who.int/publications-detail/home-care-for-patients-with-suspected-novel-coronavirus-(ncov)-infection-presenting-with-mild-symptoms-and-management-of-contacts

5. Community-led shielding **should be supported by the provision to the community of appropriate hygiene materials** as well as risk communication and information about how to implement shielding.

6. Alternatively, shielding **could be implemented at household level,** with members of the household identifying an area within the house exclusively reserved for the high-risk person and applying rigorous measures to keep everyone else away from those areas. Sick individuals should wear masks when around other individuals, including inside the home.

7. **Facility shielding carries the risk of co-locating vulnerable people** with someone who is infected with the virus; it therefore should be implemented before there is widespread transmission and/or implemented with careful screening of those people who are to be shielded together.

8. To be effective, **shielding may need to be maintained for several months,** and consideration should be given to the risk of stigmatization for those being 'shielded', and efforts made to address this within communities.

9. In all situations, governments **should provide clear communication to communities** about the purpose and mechanisms for shielding. Governments also need to provide support for safe access to healthcare, food, water, and direct payments to individuals who are being shielded to make it possible for them to adhere to movement restrictions.

Key points for implementing community-level shielding

- Discuss shielding as a concept with **trusted community actors.**

- If accepted by communities, **identify individuals who are vulnerable** to severe disease and poor outcomes due to age and/or medical condition within a defined geographical area.

- **Identify shielding locations** which can be adequately equipped, supplied and supported by the community in that area.

- Identify ways to **allow family members to see and speak to those shielded** at a distance of more than two metres.

- Provide technical support to ensure appropriate public health measures (e.g. **good hand hygiene, respiratory hygiene, and environmental cleaning**) are in place in the shielding location.

- Ensure that community members and anyone providing care within facilities are **well informed** about the public health measures and **have the materials and supplies needed** to implement them.

- **Provide specific information** to families and informal/formal caregivers on how to look after a person who is shielding.

- Ensure that **government support for income, food and essential services** is provided.

Key points for implementing household-level shielding

- As already indicated, **discuss the concept** of shielding and reasons for household shielding at community level.

- Ensure that households **understand the principles and practices** of shielding.

- **Provide guidance on the practicalities** of implementing and managing shielding in homes.

- **Assist materially,** where possible, with protective measures such as provision of personal protective equipment.

- Ensure that **government support for income, food and essential services** is provided.

> **Note:** Tuberculosis patients require dedicated isolation facilities, to avoid tuberculosis transmission to other vulnerable patients.

6 Discontinuing community physical distancing measures: loosening the tap rather than opening the floodgates

Although it is critical that societies facing epidemics promptly implement physical distancing measures, it is equally critical that policymakers plan how to relax the measures in a gradual and measured fashion, ready to implement them again if cases increase again. The following approach is recommended:

1. **Discontinue only one or two physical distancing measures at a time.** Removal of physical distancing measures should begin with those that are the most socially and economically detrimental to the community.

2. **Monitor the impact** on patient caseload and health system capacity for at least two weeks before discontinuing additional physical distancing measures.

3. **Inform the population** of the approach being taken, what they can do to assist, and when and why it may be necessary to re-implement measures.

4. **Consider 'shielding' medically vulnerable people** away from workplaces, schools, and public places for longer than other people.

This adaptive approach to physical distancing measures will help minimize the disruption they can cause while ensuring caseloads remain within the capacity of clinical services and public health systems to respond.

Table 1 – Triggers for physical distancing measures

Transmission scenario[6]						
Measure	Phase 0	Phase 1	Phase 2	Phase 3	Phase 4	Considerations
Rapid identification, testing, and isolation of cases				✓**	✓**	• Symptomatic people in isolation should be given proper medical care. Their privacy should be protected as much as possible, while allowing for contact tracing. Isolation of cases in crowded households can result in household transmission, which can be either mitigated by identifying areas within the household (e.g. separate room), house-swapping, or assuming all household members are contacts and voluntary quarantine of the household. • Testing and contact tracing capacity will be exceeded at the peak of the outbreak (Phase 3–4); when community transmission is widespread, contact tracing should only be performed in areas reporting first cases or in high-risk settings[7]. Ill persons should be advised to isolate at home except to seek medical care, and to seek immediate medical care if they have a high-grade fever and shortness of breath. Before transmission begins to decline, contact tracing capacity should be brought back up to levels seen in Phases 2 and 3 by hiring, training, organizing, and equipping teams of contact tracers so they are ready to deploy again as soon as needed.

Phase 0	Phase 1	Phase 2	Phase 3	Phase 4
No COVID-19 case	**Early stage outbreak** • One or more imported cases • Limited local transmission related to imported cases	**Expanding outbreak** • Increasing numbers of imported cases • Increased local spread but all cases linked to known transmission chains • Outbreak clusters with a known common exposure	**Advancing outbreak** • Localised outbreaks start to merge • One or more cases or deaths occur outside known transmission chains • Sustained person to person transmission –multiple generations in transmission chains • Cases are detected among SARI case with no known exposure	**Large Outbreak with nationwide transmission** • Widespread sustained community transmission • Multiple generation transmission chains can be identified but most cases occurring outside of chains • Communitywide transmission throughout all or nearly all the country

6   See Africa CDC's Guidance on Contact Tracing for COVID-19 Pandemic: https://africacdc.org/download/guidance-on-contact-tracing-for-covid-19-pandemic/

Measure	Phase 0	Phase 1	Phase 2	Phase 3	Phase 4	Considerations
Voluntary quarantine of contacts	✓	✓	✓			• Voluntary rather than mandatory quarantine should be used. Meaningful and sustained community engagement through local leaders and timely and accurate information from central credible sources will be needed to promote adherence. • Food, livelihood support, employment protections, childcare, medical and psychosocial support will be needed for sustained and effective implementation. Undue securitization or quarantine of communities should be avoided. If mandatory quarantine must be enforced, complaint and redress mechanisms should be established and publicized.
Relevant, accurate, and timely risk communication tailored to communities	✓	✓	✓	✓	✓	• Risk communication at each transmission phase should be tailored to ensure public understanding and acceptance of, and adherence to, the measures being implemented. Such efforts, which include meaningful and sustained community engagement, can build trust in the implemented measures, address informational gaps, and help motivate adherence. • Communication should use plain language, be age-appropriate (also targeting children) and be available in multiple languages, including for those with low or no literacy, or belonging to minority groups.
Measures for institutional populations, e.g. care homes, prisons, psychiatric institutions		✓	✓	✓	✓	• These institutions house a large percentage of people at high-risk for severe disease and poor outcome, and are often densely populated. Outbreaks of COVID-19 can lead to significant morbidity and mortality in such institutions. • Measures should include limiting external visitors and limiting contact between the inmates/patients in confined settings.

Measure	Phase 0	Phase 1	Phase 2	Phase 3	Phase 4	Considerations
Hand and respiratory hygiene	✓	✓	✓	✓	✓	• Hand hygiene practice likely reduces transmission, particularly in combination with other measures. There is evolving evidence to support the use of face masks among the public to prevent infection. Medical masks and respirators should be reserved for healthcare workers, and medical masks are recommended to reduce transmission from persons who are already ill. Non-medical masks should be recommended for public use when community transmission is widespread. • Subsidized access to water and soap or hand sanitizers might be required. Price gouging and hoarding should be prohibited. Provision of hand-washing stations at central points and outside businesses and schools can improve adherence and act as a reminder of risk.
Infection prevention and control and protecting healthcare workers	✓	✓	✓	✓	✓	• Strategies including provision of sufficient personal protective equipment for healthcare workers, dedicated COVID-19 treatment units and implementing administrative controls at existing health facilities to minimize spread, may be effective when lacking minimal resources for appropriate infection prevention and control measures. Such measures will be critical to prevent disruption of essential health services, which can result in non-COVID-19 specific deaths.
Shielding vulnerable populations most at-risk	✓	✓	✓	✓	✓	• While there is limited evidence for a "shielding" strategy, certain groups are at increased risk for severe outcomes (intensive care unit admission, death) for COVID-19. Increased precautions and prolonged social distancing measures for these populations, in combination with appropriate livelihood, food, and medical support, may allow for the phased lifting of other physical distancing measures while protecting vulnerable populations until a safe and effective vaccine is available. Shielding may also be the best strategy for protecting the medically vulnerable in settings where widespread physical distancing measures are not possible (e.g. informal settlements).

Measure	Phase 0	Phase 1	Phase 2	Phase 3	Phase 4	Considerations
Cancellation or adaptation of mass gatherings			✓	✓	✓	• Conduct within a week of detecting local transmission and sustain throughout the pandemic response. Discouraging mass gatherings may slow spread and prevent superspreading events. Rules should be widely communicated with clear and consistent thresholds for maximum attendance or density (e.g. one person per square metre), and reasonable exemptions for essential service. • Engage with community and religious leaders to articulate value-based decisions and encourage local adoption. Adaptation of existing events, including outdoor services or services in shifts, may be helpful in communities where cancellation of gatherings is not practical. Special care should be taken to maintain continuity of government functions (legislature, judiciary, elections) and other essential services.
School closures			✓	✓	✓	• It is unclear how effective proactive school closures are in reducing transmission, and they may have severe impacts on livelihoods. They may risk putting vulnerable people at greater risk of transmission (e.g. by increasing inter-generational mixing). Delaying school closures so that they are reactively implemented in response to an identified case in the community can mitigate the household and livelihood impacts. Community acceptance may be stronger if alternative childcare and student learning services and provision of nutrition are established.

Measure	Phase 0	Phase 1	Phase 2	Phase 3	Phase 4	Considerations
Work closures			√	√	√	• Voluntary work adjustments such as teleworking, variable shift scheduling, and desk spacing may be encouraged as soon as community spread is identified. If restrictions on mass gatherings, isolation, and quarantine fail to sufficiently slow spread, further work closures of non-essential businesses may be considered, but should be mindful of the associated financial hardships.
International travel restrictions and entry screening	√***	√***				• International travel restrictions may delay, but cannot prevent, importation; island states may achieve the greatest benefit. Entry screening is not effective to identify cases, although incoming travellers should be provided with disease and contact information for testing and isolation if needed. Entry screening may have greater benefit if rapid point of care testing becomes available. • Targeted limitations on incoming travel from transmission hotspots may delay importation, but will be of minimal benefit after importation has occurred. If implemented, international travel restrictions can only be imposed by law, for a legitimate purpose, and when the restrictions are proportionate, and must include considerations of their impact on the response capacity of Member States (e.g. through affecting access to medical supplies).

Measure	Phase 0	Phase 1	Phase 2	Phase 3	Phase 4	Considerations
Internal travel restrictions or cordon sanitaire		✓***				· Consider during initial containment stage, in combination with other measures, to reduce the peak of the epidemic and to "buy time" for preparedness in other jurisdictions; however, there is no evidence of long-term benefit of internal travel restrictions or cordon sanitaire alone, unless other physical distancing measures are put in place. These measures will likely need to be in place for several weeks or months to be effective, and may have severe negative impacts. · There is a high risk of discriminatory impact and other human rights violations for the targeted community, which can further erode trust in public health officials. If community quarantine is enacted, substantial services and provisions for livelihoods, access to food, and psychosocial support will be required. · Internal travel restrictions can only be imposed by law, for a legitimate purpose, and when the restrictions are proportionate, including considerations for their impact.

** Continue where possible, but testing capacity and contact tracing capacity will likely be exceeded during widespread community transmission. Testing efforts should then be directed towards sentinel sites and detecting new areas of transmission where a containment strategy might prevent further spread. When testing capacity is exceeded, Member States should consider using a probable (rather than confirmed) case definition to maintain an understanding of the epidemiological situation.

*** Inconsistent evidence for the recommendation, but some early modelling studies suggest these measures may be effective to limit spread for COVID-19

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