Guidance for implementing non pharmacological public health measures in populations in situations of vulnerability in the context of COVID-19

PAHO

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Purpose of this guide

The purpose of this guide is to offer recommendations for improving the implementation of non pharmacological public health measures during the COVID-19 response and compliance with these measures by population groups in situations of vulnerability. This requires determining the main barriers to implementing these measures so that we can identify the groups and territories most affected during the different phases of the pandemic. With this objective in mind—and within the framework of an equity, human rights, and diversity approach—, policies, strategies, and interventions to accompany the implementation and flexibilization of the measures are recommended to ensure that no one is left behind.

Target audience

This guide is for decisionmakers, technical teams, and policy implementers in national and local governments. The recommendations should be adapted to the context of each country, territory, and community..

Methodology

This guide was prepared using an analytical framework designed by an expert panel comprised of PAHO professionals. This framework made it possible to identify barriers and adverse effects associated with implementation of preventive measures, groups in situations of vulnerability affected by these barriers and effects, and strategies to address them.

The analytical framework was designed on the basis of a search for information in centers and platforms such as EvidenceAID, Epistemonikos, LILACS, Cochrane, the Campbell Collaboration, McMaster Health Forum, Oxford CEBM, ePPICENTRE, United Nations agencies, development banks (Inter-American Development Bank and World Bank), PAHO and WHO databases, networks of experts, and country documents.

In addition, the Latin American and Caribbean Center on Health Sciences Information (BIREME) conducted a search in the Virtual Health Library, EMBASE, and PUBMED using key words related to topics previously identified by the expert panel. A taxonomy was developed in consultation with the panel to organize the information regularly published in a virtual library created with the Zotero software.

This collection is updated weekly and included 1,304 bibliographic references as of the date of publication of this guide. The articles, reports, and data were reviewed and systematized using the aforementioned taxonomy to identify barriers and effects associated with the implementation of the measures, as well as potential strategies to address them. It should be noted that 48% of the implementation recommendations and strategies come from the recommendations of PAHO and WHO, 40% from other United Nations agencies, 7% from published articles, and 3% from country reports.

The guide's value lies in the consolidation of information from different sources, which is then linked with each non-pharmacological public health measure for easier understanding. It should be pointed out, however, that the generation of evidence on COVID-19 is ongoing, meaning that much of the information available to date comes from case studies, observational studies, surveys, and predictive models.

See the following link for the sources of information used to identify barriers, adverse effects, groups in situations of vulnerability, and implementation strategies: https://www.zotero.org/groups/2488689/covid_y_grupos_vulnerables.

Abstract

The COVID-19 pandemic has not only exposed the vast inequalities and inequities in the Region of the Americas but has also exacerbated them. In response to the pandemic, the countries of the Region have adopted non-pharmacological public health measures, including home confinement and school and business closures, but for these measures to be effective, the entire population must be able to comply with them.

Successful and sustained implementation of the measures is a direct function of the social, economic, and cultural status of the different population groups and territories. The pandemic has shown that vulnerability extends beyond individual and biological characteristics and is determined by the social, economic, and political context. Informal workers, migrants, people living in overcrowded conditions, etc., have proven especially vulnerable during the pandemic. Power distribution mechanisms have created a series of inequities associated with social class, race, gender, income level, and geographic location. For example, informal settlements, where the migrant population faced harsh situations of insecurity and exclusion prior to the pandemic, have been especially impacted by factors such as informal employment, lack of social protection, and limited access to health services.

It is essential to create conditions that ensure compliance with public health measures. This implies eliminating barriers or obstacles that have arisen during their implementation (for example, by facilitating the access to water and soap for handwashing). At the same time, it is necessary to address the adverse effects and consequences of implementing these measures, whether social, economic, or health-related (for example, by extending social protection to informal workers and people who have lost their income).

The purpose of this document is to offer guidance for improving the implementation of non pharmacological public health measures during the COVID-19 pandemic, as well as compliance with these measures in populations and territories in situations of vulnerability. The target audience for this guide is decisionmakers, technical teams, and national and local government policy implementers.

This document examines the barriers and adverse effects associated with the following non-pharmacological public health measures: individual quarantine of detected cases and their contacts; home confinement; the closure of nonessential workplaces and businesses; school closures; the isolation of congregate settings such as nursing homes and prisons; limitations on gatherings and mass events; transport restrictions; hand hygiene; management of the public health measures at the territorial level; continuity of services; and protection of essential workers.

This guide also offers cross-cutting recommendations related to risk communication, social and community participation, human rights, and monitoring and evaluation of each public health missing.

The proposed recommendations and strategies facilitate adaptation of the measures for their implementation in the different phases of the pandemic, from an intersectoral perspective that addresses the social determinants of health and equity. The implementation of inclusive social policies will lower barriers and mitigate adverse effects of the public health measures, which unequally affect the target population, depending on their living and working conditions. It is also essential for local governments and community leaders to play an active role in decision-making and the implementation and in adapting the measures to each context.

This guide was prepared by a multidisciplinary panel of experts from the Pan American Health Organization (PAHO). Its value lies in the integration of recommendations by PAHO and the World Health Organization (WHO), United Nations agencies, and information found in country publications and reports, and their link with each non-pharmacological public health measure. It should be noted, however, that the generation of evidence on COVID-19 is still ongoing. Quality research is required in order to address knowledge gaps.

1. Background

Since early 2020, the world has been in the throes of an unprecedented health, social, and economic crisis caused by the pandemic unleashed by the SARS-CoV-2 virus, the pathogen responsible for COVID-19 (1, 2). Around the world, the pandemic response has required the implementation of public health measures, which have had a greater impact on certain social groups and territories, exposing pre-existing social, economic, and health inequalities (3). The Economic Commission for Latin America and the Caribbean (ECLAC) projects a 9.1% decline in the region's gross domestic product (GDP) as a result of the pandemic. This decline is expected to push the unemployment rate to 13.5% in 2020 and increase poverty by seven percentage points to 37.3% (impacting 231 million people). Meanwhile, extreme poverty is projected to jump to 15.5%, affecting a total of 96 million people in the region (4, 5). ECLAC projects increases in the Gini coefficient of 1.1% to 7.8% (6), representing an amplification of inequalities (7, 8) and their corresponding impact on health outcomes (9).

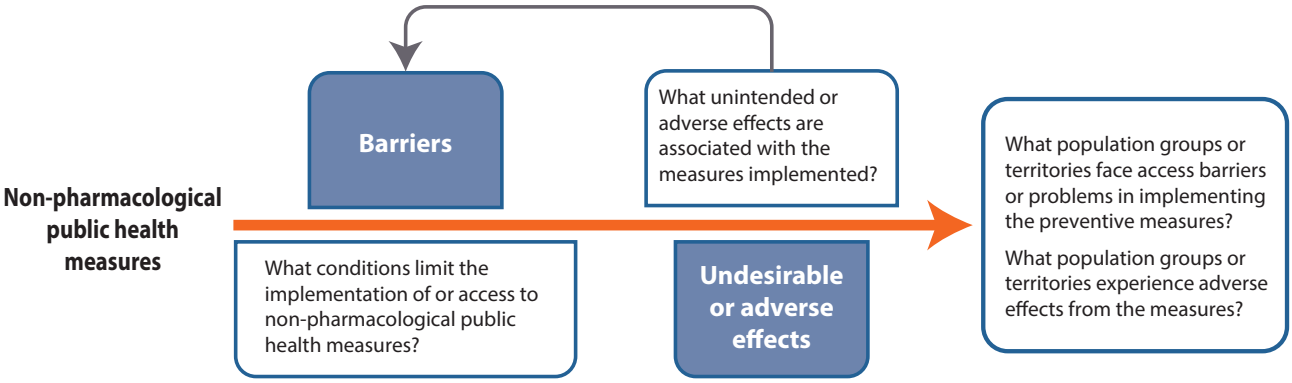
This guide focuses on non-pharmacological public health measures—specifically, individual isolation or quarantine, home confinement, school and workplace closures, restrictions on public transit, the control of congregate facilities, including voluntary extended-stay facilities and detention centers, as well as restrictions on gatherings, and the promotion of hand hygiene.

Its objective is to identify the barriers or obstacles that have arisen when implementing the measures, as well as their adverse effects, including social, economic, and health effects (direct or indirect). This guide does not discuss barriers specifically associated with access to health services, testing, or tracing, but rather, those stemming from the implementation of non-pharmacological public health measures whose effects on the continuity of care have been reported by the health services (10, 11).

A panel of experts from several PAHO programs was tasked with identifying the barriers and adverse effects associated with the public health measures. To do so, it employed a matrix of key questions based on a theoretical assessment (12, 13). This first expert assessment was compared with different guidelines and recommendations published by the Pan American Health Organization (PAHO), the World Health Organization (WHO), and other international organizations, with systematic reviews of the literature on topics associated with COVID-19, and with the available studies and opinion pieces, country reports, and news.[1] Figure 1 presents a summary of the questions and framework used in evaluating and systematizing the barriers and adverse effects identified.

1 For more information in this regard, see section on the methodology for preparing this guide.

Figure 1. Framework for the study of barriers, adverse effects, and population groups in situations of vulnerability in the context of COVID-19



This diagram shows that certain non-pharmacological measures have adverse effects that are not necessarily barriers to their implementation, as in the case of school closures; others, in contrast, present problems with implementation and also produce adverse effects, as is the case with confinement measures. Furthermore, there is interaction and positive reinforcement between many of the measures, while some become more important with the passage of time or at certain points in the pandemic, resulting in a complex dynamic system. By identifying barriers and adverse effects, it has been possible to determine which population groups could be facing these problems and thus be in situations of particular vulnerability to the pandemic.

The three elements identified in Figure 1 (barriers, adverse effects, and groups in situations of vulnerability) are of key importance when implementing non-pharmacological public health measures tailored to the local context, which is essential for guaranteeing that the measures are feasible, acceptable, and sustainable (14, 15). These elements also play a significant role and need to be taken into account when lifting the measures or making them more flexible. Analysis of the three elements should always consider the conditions of COVID-19 transmission, response capacity in the health services, etc.

2. Implementing non-pharmacological public health measures: barriers and adverse effects

The effectiveness of a public health intervention depends not only on the intervention itself but on the modality and degree of implementation achieved (16). Therefore, the process of adapting the measures is crucial, taking the different contexts and needs of the population into account (17, 18), along with the social and economic impact of a particular measure on groups in situations of vulnerability (19-21).

WHO has noted the need to balance public health measures with the conditions and risk factors in the target communities, strengthening local structures and systems through community participation (3). Governments have a responsibility to take action to control COVID-19 risks and mitigate the adverse effects of the measures taken (22). This implies recognizing that public health measures cannot be implemented with equal ease in all communities, even when they are compulsory. Not everyone can, with the same ease, comply with physical distancing, voluntarily "stay at home," or frequently wash their hands, even when these measures are compulsory.

In Jamaica, for example, more than 40 communities in metropolitan Kingston have reported problems with physical distancing and handwashing. In these communities, many informal settlements lack water and basic sanitation and have high levels of overcrowding. Consequently, the difficulty of implementing these public health measures puts these places at higher risk for COVID-19 transmission (23, 24).

In Chile, disparities were documented in the degree of compliance with measures to reduce mobility following school closures and the imposition of territorial quarantines.[2] These disparities are correlated with different income levels: while high-income districts showed significant reductions in mobility, even in non-compulsory periods, the reduction in low-income districts was much smaller, even in periods of compulsory quarantine. In some of these districts, the reduction in mobility during compulsory periods did not exceed 20-30% (25).

The authors conclude that people's mobility is closely linked with socioeconomic factors; thus, the effectiveness of measures to reduce mobility depends to a large extent on the design and implementation of complementary public policies that facilitate compliance with the measures. This disparity in mobility reduction may be explained by the fact that a vast majority of workers[3] cannot stay at home because it would mean losing their daily income. The International Labour Organization (ILO) indicates that only 23% of workers can continue working by doing so remotely (26).

At the same time, some groups require special consideration. For example, many persons with disabilities depend on caregivers for their daily existence, whether in assisted living facilities, group homes, or in their own homes. This makes social distancing virtually impossible for these groups, especially for those with lower incomes (27, 28). The World Bank estimates that 20% of

2 The movements of residents in the Metropolitan Region were analyzed using statistical data and information from telecommunications use, disaggregated by census area.

3 In this document, the term *worker* refers to all workers, male and female.

the world's poorest people have some type of disability and are usually considered the most disadvantaged people in their communities (29).

Another group requiring special consideration is indigenous communities. It is essential to consider the sociocultural, work, mobility, and housing patterns of these communities, along with their different concepts of health and disease, to avoid poor implementation of the measures and prevent increased risk of exposure (30).

For example, some indigenous communities in the region, such as the Mixe people in Mexico (31), have resisted compliance with territorial quarantines due to the cultural importance of domestic and cross-border movement.

Furthermore, the lack of information in indigenous languages has limited implementation and compliance with social distancing measures in rural Mapuche communities in Chile (32). In Inuit communities in Canada and the United States, who live in groups where meals and activities are shared in communal spaces, social distancing has proven difficult (33, 34).

It should also be noted that new vulnerable population groups have emerged during the pandemic due to loss of employment. These new situations of vulnerability are the result of business closures, restrictions on school operations and cultural activities, or a halt in economic activity for self-employed persons and workers in the informal economy (35, 36).[4]

A significant portion of migrant workers[5] throughout the world are on the front lines of the COVID-19 pandemic, since they perform essential but generally poorly paid work, for example as caregivers, janitors, or laundry workers––jobs that pose a high risk of exposure to the virus. Many of them have irregular immigration status or work in the informal sector. This is especially true of women in domestic service with unstable contracts, no paid leave, or the ability to work from home (37). The situation of these women entails a much higher risk of abuse and exploitation, particularly for those who cannot return to their home country due to travel bans and border controls that leave them stranded far from home (38). Furthermore, due to the economic recession caused by COVID-19, migrant workers are sending home fewer remittances, further exacerbating the vulnerability of families that depend on this income (39, 40).

These brief examples show the importance of considering the cultural, economic, and political characteristics of the place where people live and work, and they reveal a scenario where the conditions for implementing public health measures are unequal and protection from COVID-19 transmission and its impact depends on factors such as income, social protection, and employment , ethnicity, and gender. These factors determine to a large extent how hard it is for certain groups or territories to access, implement, comply with, and sustain the recommended public health measures.

4 *Informal economy* refers to all economic activity by workers and economic units that are, in law and practice, not covered by formal arrangements. This includes wage workers without social protection or other formal arrangements in both informal and formal enterprises, self-employed workers such as street vendors, and domestic and family workers. Source: International Labour Organization. ILO Monitor: COVID-19 and world of the work. Second edition. Updated estimates and analysis. Geneva: ILO; 2020. Available from: https://www.ilo.org/wcmsp5/groups/public/---dgreports/---dcomm/documents/briefingnote/wcms_740877.pdf .

5 The IOM defines migration as the movement of persons away from their place of usual residence, either across an international boundary or within a State. Source: International Organization for Migration. Key Migration Terms. Geneva: IOM; Available from: https://www.iom.int/key-migration-terms.

These contexts, conditions, and environments are related to the social determinants of health (SDH),[6] which, in turn, become mechanisms for exclusion and inequity in access to public health interventions and to health services (41, 42). Notwithstanding their importance, the SDH have not been given sufficient weight in the design and implementation of interventions. As a result, the concept of vulnerability in the context of the pandemic has often been limited to people with multiple comorbidities associated with COVID-19 severity and mortality.

This approach poses the inherent risk of not knowing or not adequately considering social and economic dimensions, which can increase exposure to the virus, as well as the morbidity and mortality associated with COVID-19 and other health problems (43, 44). It is, therefore, necessary to identify and define the conditions that make certain groups and territories more vulnerable in the context of COVID-19, so that they can be taken into account when implementing non-pharmacological public health measures.

6 *Social determinants* are understood as those in the structural realm of society that are related to the political, social, and economic context, as well as those that refer to daily living and working conditions. From this perspective, the approach is related to the concept of *social determination of health*, considering the distribution of power in society and at the global level as the main driver of the generation of social and health inequities.

3. Determining the additional burden of vulnerability in the context of COVID-19

Different agencies, PAHO and ECLAC among them, have noted the importance of considering additional measures to protect special populations and groups in situations of vulnerability (14, 45). This requires identification of the population groups and territories in situations of vulnerability.

Vulnerability is a key concept for understanding risk and expected outcomes in disasters and dangerous situations such as the COVID-19 pandemic. Numerous vulnerability mechanisms have been described, along with different approaches to their use and implementation, and they can also be defined from an operational standpoint or in terms of their intended use. (46-48).

Risk, as a technical term, is often defined as a neutral value. Vulnerability, however, is defined in relation to the social, economic, and political context, thus reflecting patterns of social stratification (49).

Starting from these definitions, we have prepared an overview of the "concept of vulnerability" in the framework of the pandemic, and specifically, with respect to the implementation of public health measures. This concept emphasizes the social conditions that create and perpetuate situations of vulnerability in the population. By identifying the barriers and adverse effects people experience when implementing the public health measures, it was possible to identify the affected groups (50). This concept leads to better understanding of the mechanisms that produce and amplify inequities and social exclusion during the pandemic. In the context of COVID-19 and the implementation of non-pharmacological public health measures to contain the pandemic, a vulnerable group is defined as follows:

A population group or territory in which preexisting social conditions of exclusion and inequity are exacerbated by the pandemic. This situation not only presents barriers or constraints to the implementation of the necessary public health measures, resulting in a greater risk of exposure and infection, but the measures themselves also have adverse effects that impact health and the quality of life. This is compounded by the fact that certain subgroups in situations of vulnerability also suffer from comorbidities that heighten COVID 19 severity and mortality.

Within this context, it is necessary for each county or territory to undertake a review of the groups and ter-

ritories in situations of vulnerability, since the eruption of the pandemic has revealed that certain groups, such as workers in the informal economy, have not been prioritized. In addition, the pandemic has worsened the existing exclusion and discrimination against groups such as migrants and their families, and the indigenous population, Afro descendants, among others.

The barriers and adverse effects associated with the implemented public health measures have been systematized and grouped in this guide under concept of *burden of vulnerability*, whose components and expression in the region are presented below, based on the information available to date.

a) Vulnerability associated with a deepening of **preexisting inequities and adverse social conditions**, with negative effects on socioeconomic circumstances, quality of life, and health

Preexisting social and health inequities are generated and reproduced in societies through the unequal distribution of resources and power, resulting in limited access to decent material conditions, limited exercise of rights, life trajectories marked by exclusion and discrimination, and little political influence. This situation exposes these groups to greater adversity while limiting response capacity (51, 52), leading to higher COVID-19 prevalence and severity (53, 54).

One of the structural conditions of inequities in the region, whose impact has intensified during the pandemic, is associated with quality of employment and access to social protection. Lack of social protection for certain population groups in the informal economy, whose working conditions tend to be precarious, has created obstacles to compliance with certain measures and has had a significant impact on their household economy. A high prevalence of informal work negatively affects the well-being of the population and hinders inclusive growth (4).

The majority of precarious and informal workers perform manual labor in sectors significantly more affected by the interruption of economic activities due to the pandemic, such as small retail businesses, restaurants, hotels, services, manufacturing, transportation, agriculture, construction, and domestic service due to the pandemic (55). On average, for 54% of the economically active population in the region (approximately 325 million people), most of them women, work in the informal sector (56).

Some 65.8% of informal workers have no access to social protection systems or social assistance programs. Furthermore, almost half of informal workers living in poverty do not benefit from traditional social welfare programs, such as cash transfers and solidarity (noncontributory) pensions. This implies a return to poverty aggravated by the pandemic for a significant portion of this population (57).

Employment conditions become obstacles to compliance with quarantines and the requests to stay home, since many people must leave the house to search for work to earn their daily income. This situation is even more critical for migrant workers, whose access to health services is limited and who live in conditions marked by greater discrimination in the already existing climate of uncertainty and fear.

Box 1. Informality and precarious employment: barriers to compliance with measures among domestic workers

Domestic workers, mostly women (80%), many of them migrants, account for a substantial portion of the informal workforce and are among the most vulnerable groups of workers. The COVID-19 pandemic has had a significant impact on this group; it is estimated that 73% of them in the region have lost their job. Domestic workers' organizations in the Dominican Republic report that workers fear getting infected and not being able to see a doctor. The COVID-19 test in the Dominican Republic costs US$86, or roughly half the monthly wage of a domestic worker. These workers, moreover, express concern about financial problems, as they do not have enough money to purchase food and cannot go to work or look for a new job, since many employers do not want domestic workers to enter their home. Although the government has a program called Quédate en casa [Stay at home] that supplements the income of these workers, it is estimated that only 40% of domestic workers in the Dominican Republic have benefitted from it.

Note: Unión Nacional Fenamutra Trabajadoras del Hogar (UNFETRAH) represents 1,200 domestic workers in the Dominican Republic, including some that are Haitian migrants.

Sources: 1 International Labour Organization. Work in times of pandemic: The challenges of the coronavirus disease (COVID 19). Geneva: ILO; 2020. Available from https://www.ilo.org/wcmsp5/groups/public/---americas/---ro-lima/documents/presentation/wcms_745583.pdf.

2 International Labour Organization. COVID-19 shows why domestic workers need same rights and protection as others. Geneva: ILO; 2020. Available from: https://iloblog.org/2020/06/16/covid-19-shows-why-domestic-workers-need-same-rights-and-protection-as-others.

3 King T, Hewitt B, Crammond B, Sutherland G, Maheen H, Kavanagh A. Reordering Gender Systems: Can COVID-19 Lead to Improved Gender Equality and Health? The Lancet; 396(10244): 80-81; 2020. Available from: https://doi.org/10.1016/S0140-6736(20)31418-5.

Within this framework of structural inequities, another invisible group that experiences high levels of social exclusion and stigmatization are incarcerated persons. This group resides in enclosed facilities with a high risk of exposure and transmission.

Prisons in different countries concentrate the most vulnerable populations in each region, punishing in particular the poor, racial minorities, and, in certain areas, migrants, among others (58-60). There is a greater likelihood in prisons of finding people with mental illness (61-63) and a high risk of infection with communicable diseases such as HIV, hepatitis B and C, influenza, and tuberculosis (64).

WHO has alerted the authorities of various countries to the fact that prisons and other detention centers pose a greater risk of infection by COVID-19. This is due to their high levels of overcrowding and limited access to water and health services (65, 66). The situation is especially serious in Latin America, where the level of overcrowding is higher than the world average and where there are more prisoners than space to house them. By June 2020, more than 93,000 persons deprived of liberty in 88 countries had been infected with COVID-19, with 1,529 deaths from the pandemic in the prisons of 36 countries (67, 68).

Growing fear and disinformation have created tension and stress among persons deprived of liberty —especially those living with their children in prisons, which has significantly increased the levels of violence in penal institutions. As a consequence, jail breaks, riots,

fights, and deaths have occurred in prisons in Argentina, Brazil, Bolivia (Plurinational State of), Chile, Colombia, and Peru (69-74). Special attention must be paid to children and youth in conflict with the law, who have often grown up in a violent environment and are at greater risk in this new context (75).

b) Vulnerability associated with **difficulties adopting and complying with the recommended measures**, creating **greater risk of exposure to the SARS-CoV2 virus**

The risk of exposure to the virus is not uniformly distributed among different population groups and territories. Certain groups are at greater risk, either because they cannot adequately comply with the recommended preventive and protective measures due to the nature of their work and their housing and working conditions (76).

This is compounded by the adverse effects of the measures themselves, which increase public rejection of the measures and thus, exposure levels. For example, confinement measures are hard to comply with in situations marked by overcrowding and a lack of income; and prolonging them imposes serious economic constraints on households without protection or with limited social assistance, risking a progressive deterioration in the family's mental health.

Handwashing or avoiding physical contact is difficult for the 20% of the urban population in Latin America and the Caribbean who live in slums or informal settlements with substandard housing and no access to basic services (clean water, for example) and where an average of up to three people share every room (77). In addition, the residents of these informal settlements are mainly poor and consist of women heads of household (36), migrants from other countries, and people (often indigenous) who have migrated from rural areas to the cities (78). This vulnerability is also observed in many essential workers, who must travel through cities on public transit to get to their jobs, further increasing the risk of exposure.

Box 2. Essential workers and greater exposure to COVID-19

High rates of infection have been found among essential workers. Studies in the United States show that frontline workers earn lower-than-average wages and disproportionately come from groups that are socioeconomically disadvantaged in comparison with the general workforce. For example, Latinos represent slightly less than 40% of the workforce in all essential industry sectors in California. This figure rises to 80% in essential farm labor, 50% in the food sector, and almost 60% in construction jobs. In California, more than 80% of the patients hospitalized with COVID-19 in May were Latino, many of them under the age of 50 and from different professions: roofers, cooks, janitors, dishwashers, delivery workers, etc. In New York City, 4,000 workers tested positive for COVID 19 by July 2020, and 131 transit workers had died of causes related to the virus, the majority of them city subway and bus drivers. Since 15 March 2020, almost 3,800 transit workers have tested positive for COVID-19.

Sources: [1] D Blau F, Koebe J, Meyerhofer PA. Essential and Frontline Workers in the COVID-19 Crisis. ECONOFACT; 2020. Available from: https://econofact.org/essential-and-frontline-workers-in-the-covid-19-crisis.

[2] Branson-Potts H, Reyes-Velarde A, Stiles M, Campa AJ. The price of being 'essential': Latino service workers bear the brunt of coronavirus. Los Angeles Times; 2020. Available from: https://www.latimes.com/california/story/2020-05-17/latino-essential-workers-coronavirus.

[3] Markowitz J, Goldbaum C. Transit Workers Were N.Y.C.'s Pandemic Lifeline. These 3 Paid a Price. The New York Times; 2020. Available from https://www.nytimes.com/interactive/2020/07/26/nyregion/nyc-covid-19-mta-transit-workers.html.

c) Vulnerability associated with the **adverse effects of the non-pharmacological public health measures themselves, which create health problems unrelated to COVID-19**

The population's health has also been impacted by the efforts to combat the pandemic, as a result of confinement, unemployment, lack of income, economic uncertainty, the additional burden of care, restricted access to health services, etc. The short-, medium-, and long-term health effects can include malnutrition due to lack of food or poor-quality food; anxiety and depression; the worsening of pre-existing pathologies due to lack of access to timely medical services and procedures, interruptions in check-ups and care, increased alcohol and tobacco use, etc. An increase in domestic violence has also been observed, directly impacting the health of families and particularly affecting women, children, and older persons.

Violence also has consequences for sexual and reproductive health, including sexually transmitted infections, HIV, or unplanned pregnancies. The continuity of support services is therefore essential.

Box 3. Effects that amplify inequities: Violence and abuse of women in the context of COVID

Domestic violence has adverse health effects, among them a greater risk of chronic diseases, depression, post traumatic stress disorder, substance use, and even suicide. The highest rates of gender-based violence, reflected in a marked increase in calls to helplines, occur in disasters, humanitarian crises, or emergencies such as the pandemic. In Colombia, reports of domestic violence during quarantine are up by 175% as compared to the same period last year. In Mexico, calls to domestic violence hotlines increased by 60% in the first weeks of the shut down. In the Dominican Republic, the violence service of the Ministry of Women's Affairs received 619 calls during the first 25 days of quarantine. These data show an uptick in the risk of violence, which can dramatically increase if the quarantine is prolonged. In other countries, the number of reports has fallen, suggesting new access barriers for survivors due to the reorganization of health and protective services or limitations on their availability.

Sources: [1] Pan American Health Organization. COVID-19 and violence against women, What the health sector/system can do. Washington, D.C.: PAHO; 2020. Available from: https://apps.who.int/iris/bitstream/handle/10665/331699/WHO-SRH-20.04-eng.pdf?sequence=1&isAllowed=y

[2] Anurudran A, Yared L, Comrie C, Harrison K, Burke T. Domestic violence amid COVID-19. Int J Gynecol Obstet; 1-2; 2020. Available from: https://obgyn.onlinelibrary.wiley.com/doi/full/10.1002/ijgo.13247.

[3] Campbell AM. An increasing risk of family violence during the Covid-19 pandemic: Strengthening community collaborations to save lives. Forensic Science International: Reports 2020;2:100089. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7152912.

[4] Plan International. Surge in violence against girls and women in Latin America and Caribbean. Woking: Plan International; 2020. Available from: https://plan-international.org/news/2020-05-19-surge-violence-against-girls-and-women-latin-america-and-caribbean.

d) Vulnerability associated with **risk factors and co-morbidities** that worsen the clinical picture and mortality from COVID-19

People with underlying health conditions – for example, noncommunicable diseases (NCDs) such as cardiovascular disease, chronic respiratory diseases, diabetes, and cancer – are at greater risk of developing serious illness and have a greater probability of dying from COVID-19 (79). And the prevalence of NCDs is higher precisely in populations living in extreme poverty, making them more likely to experience complications from COVID-19 (80). Besides being more susceptible, low-income people experience higher rates of infection, morbidity, and mortality from COVID-19 (42, 81).

Box 4. Inequalities: COVID-19 in African-American communities in the United States

Deaths from COVID-19 in the United States are disproportionately higher among African Americans than the general population. In Washington, D.C., African Americans account for approximately 47% of the population and 76% of COVID-19 deaths in the city. In the United States, they are disproportionately represented in essential jobs in supermarkets, public transit, cleaning, or public safety. This population group, moreover, has low health insurance coverage and limited access to health services, including COVID-19 testing. In terms of housing, African American communities generally live in poor areas with a high density of dwellings, high crime rates, and little access to healthy food. These conditions partly explain the high infection and mortality rates and serious COVID-19 illness in these groups, exacerbated by the structural racism in the country.

Fuentes: [1] Yancy CW. COVID-19 and African Americans. JAMA; 323(19):1891-1892; 2020 Available from: https://jamanetwork.com/journals/jama/fullarticle/2764789.

[2] Van Dorn A, Cooney RE, Sabin ML. COVID-19 exacerbating inequalities in the US. Lancet; 395(10232):P1243-P1244; 2020. Available from: https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30893-X/fulltext.

[3] Eligon J, Burch ADS. Questions of Bias in Covid-19 Treatment Add to the Mourning for Black Families. The New York Times; 2020. Available from: https://www.nytimes.com/2020/05/10/us/coronavirus-african-americans-bias.html.

[4] Egede LE, Walker RJ. Structural Racism, Social Risk Factors, and Covid-19: A Dangerous Convergence for Black Americans. New England Journal of Medicine;383:e77; 2020. Available from: https://doi.org/10.1056/NEJMp2023616.

An analysis of the data on positive COVID-19 tests reveals a similar situation in New York City (United States). Data disaggregated by zip code (ZCTA[7]) show a socioeconomic gradient linked to the positivity rate.[8] The highest rates were observed in residents [9]of the most disadvantaged areas with higher poverty, higher percentages of overcrowding, and a higher proportion of African American residents (19, 53).

Finally, it is important to emphasize the **intersectionality** of inequities associated with social class, race, gender, income level, and territory, which together shape the mechanisms underlying the distribution of power and the generation of inequalities (82). These mechanisms relegate different groups and communities to a particular stratum or position in society, limiting their access to satisfactory material conditions and the exercise of their rights, leading to exclusion and discrimination and limiting their political influence (50, 83). This situation increases their level of exposure while decreasing their capacity to respond to adverse situations such as the COVID-19 pandemic. For example, intersectionality is expressed in informal settlements, where migrants from other countries and cities tend to reside, and where adverse situations of insecurity and exclusion existed prior to the pandemic. These settlements also house indigenous populations, who, in turn,

7 Zip code tabulation area (ZCTA)

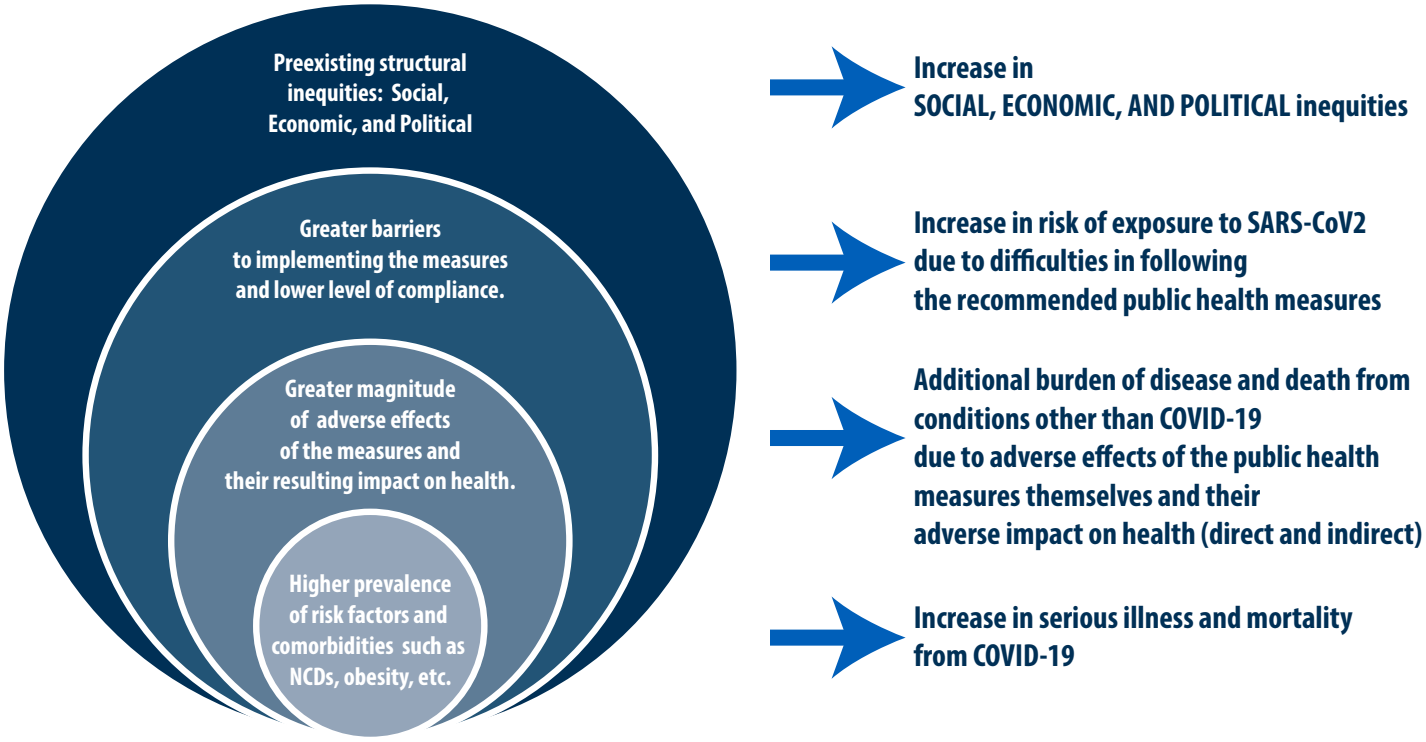
8 The most disadvantaged areas compared with the most advantaged, according to the index of concentration at extremes (1,603.6 per 100,000 population versus 1,067.5 per 100,000, respectively); degree of overcrowding (1,699.0 per 100,000 population versus 1,219.4 per 100,000, respectively), and the percentage of African-American population (1,771.5 per 100,000 population versus 1,248.6 per 100,000, respectively). The highest positivity rate was observed in residents of the two most disadvantaged counties, disaggregated by poverty categories by ZCTA (15%-19.9% poverty: 1,553.0 per 100,000 population; 20%-100% poverty: 1,504.3 per 100,000 population; 0%-4.9% poverty: 1,046.7 per 100,000 population).

9 Does not refer to migration status but to the place of usual residence.

have lower educational levels and tend to work in the informal economy without social protection and with limited access to health services.

Figure 2 summarizes the dimensions of the burden of vulnerability in the framework of COVID-19, as well as the public health measures described.

Figure 2. The additional triple burden: groups in situations of vulnerability related to COVID-19



Source: Authors.

Figure 2 reflects the complexity of the response to the pandemic and particularly highlights the challenges to organizing an integrated and intersectoral equity-based response that addresses the medium- and long-term effects of the pandemic. This complexity lies in part in the multiple vulnerabilities that must be addressed simultaneously and at different administrative and sectoral levels.

4. Strategies to address the barriers and adverse effects associated with non pharmacological public health measures

As long as effective COVID-19 vaccines and treatments (84, 85) are unavailable, it will be necessary to maintain and improve non-pharmacological public health measures based on the situation in each location, accompanying them with policies, strategies, and actions that remove barriers and mitigate the adverse effects associated with their implementation (86).

A set of recommendations based on currently available evidence and information has been prepared and systematized. This information is taken from different sources (mentioned in the chapter on the preparation of this document), including guidelines and technical papers from PAHO, WHO, and other international and national organizations, taking the cumulative experience in the Region into account.

It is worth considering that most of the evidence on COVID-19 is still preliminary, given the unprecedented nature of the pandemic. Thus, more experience with the implementation of public health measures will be required to verify their effectiveness. The recommendations range from specific immediate actions to sweeping public policies that require greater political commitment and effort. The underlying principles for these recommendations are:

1) equity;

2) human rights;

3) gender equality;

4) cultural relevance;

5) community participation, and

6) intersectorality.

The pandemic has demonstrated once again that health progress and outcomes are highly dependent on policies, strategies, and actions which do not fall under the direct control of the ministries of health. What is needed, therefore, is an intersectoral participatory approach that involves not only the various government sectors and administrative levels (national, subnational, and local) but also communities and civil society, as well as the private sector.

It is essential for ministries of health to engage in health advocacy with the different sectors. The sectors that should be involved in the implementation of public health measures include housing, social security and social protection, labor, public safety, water and sanitation, agriculture, transportation, education, and especially, the economic sector. The health services should also promote intersectoral action, following the principles of primary health care (87).

Local governments play a key role in the pandemic response (88). Territorial leaders and community leaders in particular are those who best know the specific needs for implementing the measures and can help identify the barriers to consider during their adaptation to each specific context. To improve the response, it is essential to identify the most vulnerable population groups, neighborhoods, and households at the territorial level in order to include their communities and civil society organizations in the adaptation of the response (89-92). Innovative solutions can be found, and channels of communication developed at the local level; this approach makes it possible, above all, to strengthen social cohesion and community solidarity (93).

Table 1 presents a matrix summarizing the main barriers and adverse effects associated with non pharmacological public health measures. They are divided into 12 structural areas or factors, with an indication for each them of the possible intermediate factors or ways in which these barriers and adverse effects are manifested, as well as their relation to each of the measures. Factors associated with access to health services, testing, or tracing, among other things, are not included.

Table 1. Matrix summarizing the main barriers and adverse effects associated with certain non-pharmacological public health measures

Structural areas or factors	Intermediate factors (ways)	Individual quarantine	Home confinement	School closure	Workplace closure	Public transit restrictions	Congregate settings	Limitations on gatherings	Handwashing with water and soap
1. Material living conditions, including neighborhood infra-structure	- Lack of housing - Overcrowded housing - Collective practices in community life - Absence of or irregular water supply. - Limited public areas	■	■				■		■
2. Income and employment	- Lack of income - Lack of unemployment benefits - Inability to get to work		■			■		■	■
3. Social protection	- Absence of social rights - Absence of labor rights - Absence or weakness in the welfare state	■	■		■				
4. Education and learning	- Changes in school operations and learning - Lack of experience and means for distance learning			■					
5. Cultural relevance	- Clash with ancestral community values, traditions, symbols, beliefs, and behavioral practices	■	■				■	■	■
6. Psychosocial risk and healthy environments	- Social isolation - Deterioration in community relations - Conditions adverse to healthy behaviors - Greater uncertainty	■	■	■	■		■	■	
7. Gender inequity and burden of care	- Caregiver overload - Overload of housework - Loss of women's autonomy		■	■	■				
8. Delivery of basic services and supplies	- Difficulty or inability to access food vendors or the purveyors of other services - Difficulty accessing or purchasing medicines - Difficulty accessing essential protection services for children at risk of violence, persons with disabilities, etc.		■	■	■	■			
9. Access and continuity of health care	- Lack of continuity in follow-ups, medical exams, and health care - Lack of access to health services - Postponement of consultations and neglect of health needs		■			■	■		
10. Human rights	- Rights violations - Greater discrimination - Gender-based violence and violence against children and adolescents	■	■				■		
11. Social participation and intersectoral work	- Lack of participation in the adaptation and implementation of measures - Lack of coordination between sectors and local actors	←	—	—	—	—	—	—	→
12. Communication	- Lack of information for persons with disabilities - Inability to understand the official language - Lack of regular and timely access to the media	←	—	—	—	—	—	—	→

Source: Authors.

Grouping the barriers and adverse effects by structural areas or factors facilitates the identification of strategies to address them, as well as potential partners or key actors to work with. This information is described in greater detail in the recommendations chapter. This approach also makes it possible to identify the public health measures that create the greatest barriers and result in lower levels of compliance, as well as the information that can be included in their design and especially, in adaptations needed for the different contexts and phases of the pandemic, particularly at the local level.

The matrix also indicates potential intermediate factors and the ways in which these barriers and adverse effects are manifested. These should be examined in each specific context (national, subnational, or local) with the aim of designing specific activities and interventions to eliminate these problems or mitigate their effects both during and after implementation.

5. Recommendations and strategies to respond to the needs of groups in situations of vulnerability in the context of COVID-19

Based on the identification of adverse effects and barriers in the context of COVID-19, and the population groups and territories in situations of vulnerability, a number of strategies and recommendations have been formulated to address situations of inequity. These recommendations focus on groups and territories in situations of vulnerability and correspond to each proposed non pharmacological public health measure.

First, the barriers and adverse effects associated with the non-pharmacological public health measures included in this guide are described, together with their effects on population groups in situations of vulnerability.

Afterwards, the main recommendations and strategies for adapting and implementing the measures are described (15), including potential policies and actions to eliminate the barriers and mitigate the adverse effects.

The selected non-pharmacological public health measures are:

a) Individual quarantine of cases and contacts

b) Home confinement

c) Closure of nonessential workplaces and businesses

d) School closures

e) Congregate facilities (nursing homes, quarantine centers, penitentiaries, extended-stay facilities, shelters, etc.): E.1. Extended-stay facilities E.2. Facilities for confinement under judicial remand

f) Restrictions on gatherings and mass events (cultural, sports, social, religious, and political events)

g) Transit restrictions

h) Handwashing with water and soap

i) Territorial management of public health measures

j) Special considerations for the continuity of essential services (markets and other workplaces that provide essential services[10])

To offer a complete vision of the strategies and actions that must be implemented in connection with each non-pharmacological public health measure, some of the recommendations and strategies will be repeated because they are applicable to different measures.

10 Health services are not included, as this topic has been extensively explored in other documents.

Cross-cutting recommendations to complement each public health measure are also included, such as:

1. Risk communication
2. Social and community participation
3. Human rights
4. Monitoring and evaluation

Strategies and recommendations for implementation of non-pharmacological public health measures

Some of the structural recommendations are common to the entire set of measures. These policies, programs, and actions are essential for responding to the COVID-19 pandemic and preventing a future pandemic from producing economic and social consequences of the magnitude we are experiencing with COVID-19. Four of the key structural recommendations concerning the right to health, social protection, work, and water are to:

1. Guarantee universal access to health and universal health coverage for the entire population. To accomplish this, it is essential to raise public investment in health to at least 6% of national GDP and to make the primary health care strategy the basic priority (4, 94, 95).
2. Extend social protection to the entire population. This will require increasing the coverage of existing programs, with special attention to groups in situations of vulnerability (e.g., informal workers and migrants) (4, 6, 7, 8, 96, 97).
3. Increase and improve unemployment insurance coverage, extending it to the majority of the working population and their families (4, 6, 8, 96, 98).
4. Expand the water distribution network, providing free water to groups that cannot pay for it, and facilitate the construction of rainwater catchment systems and the use of other technologies that increase access to water (99). This must be done in order to guarantee a minimum daily volume of clean water for all households in situations of vulnerability that are not connected to the water supply system (99).

Each non-pharmacological public health measure, with its respective barriers, adverse effects, and recommendations, is presented below.

A. Individual quarantine of cases and contacts

IMPLEMENTATION BARRIERS AND ADVERSE EFFECTS	POPULATION GROUPS IN SITUATIONS OF VULNERABILITY
• **Material housing conditions** It is problematic to impose individual isolation and quarantine of cases and their contacts in dwellings with limited space/overcrowding[11] and limited access to water for handwashing. This situation is especially serious in households with people at high risk for COVID-19. • **Social protection** Quarantine often means absence from work (4), in many cases with no sick leave, only a few days of sick leave, or partial remuneration for formal workers, signifying a loss of income (35). Informal workers have no social security or unemployment insurance coverage, and thus, no right to sick leave (100). • **Cultural relevance** Physical isolation measures restrict the cultural practices of certain communities and, in the case of indigenous peoples, their ancestral practices, (101) thus reducing compliance with the measures. • **Access and continuity of health care** Quarantine results in social isolation, which can exacerbate the situation of people with mental disorders. At the same time, the continuity of care for people who require regular check-ups for chronic disease, ongoing treatment, or a disability can also be affected. • **Psychosocial risk** The physical isolation, fear, and uncertainty caused by the pandemic results in stress and tension in cases, contacts, and families. • **Human rights** The fear and uncertainty caused by the pandemic can lead to social exclusion and discrimination against infected people and their close contacts and can result in violations of the rights of these individuals.	The population groups most affected are those living substandard housing (19) or informal settlements (102) or camps.

RECOMMENDATIONS
Action prior to or immediately after implementation of the measure 1. Guarantee a safe distance of one meter between cases and their close contacts, good ventilation in the home, use of masks, and adequate isolation, as well as information and support (103, 104). For people in conditions unsuitable for isolation in the home or who live with high-risk family members, alternative residential facilities should be set up that provide food, water, hygiene products, and other basic articles so that cases and their contacts remain in isolation for the required period (14, 103, 105, 106). 2. Improve household hygiene and disinfection following the recommendations, and offer alternatives when soap is unavailable (103, 107, 108). 3. Provide food, water, hygiene and disinfection products, and other basic articles for cases and their contacts during the isolation and quarantine period (103, 109). 4. Ensure the continuity of treatments and medical exams for people with chronic diseases, especially those whose treatment is critical––for example, oncology services (110). Health checks should also be provided for quarantined cases and their close contacts at home or in alternative residences through home visits or remote consultations (87, 111). 5. Provide support in indigenous communities through the establishment of community facilities for the isolation of COVID-19-positive cases, suspected cases, and their contacts, in keeping with the local situation and culture (78, 112). 6. Guarantee income during sick leave or preventive quarantine through existing protection systems and emergency mechanisms (4, 8, 95, 98).

B. Home confinement

11 *Overcrowding* is considered to be any situation in which more than 2.5 or 3 people share a room or a limited amount of square footage.

IMPLEMENTATION BARRIERS AND ADVERSE EFFECTS	POPULATION GROUPS IN SITUATIONS OF VULNERABILITY
• **Material living conditions, including neighborhood infrastructure** Substandard housing poses obstacles to physical distancing, especially in informal settlements, due to high levels of overcrowding[12] (3, 113, 114) in dwellings. The same holds true for slums and the neighborhoods where these dwellings are located, since the few open public spaces and public services are rapidly saturated by local residents (102, 115). • **Income and employment** Home confinement can lead to the loss of employment or income for people who cannot work from home (26). This can lead to poverty or impoverishment, which, in turn, becomes a barrier to the sustainability of the measures (6, 20, 96, 100, 116). • **Social protection** Lack of support or absent or limited social protection are a barrier to the implementation of home confinement measures, because people must leave their home to look for work despite the restrictions, especially those in the informal economy (4, 42, 117, 118). • **Cultural relevance** The measures' lack of cultural relevance is a barrier to maintaining physical distancing and home confinement. There may be lack of acceptance because the measures fail to acknowledge the idiosyncrasies, language, territoriality, and world view of different communities––for example, indigenous communities (78, 119). • **Healthy environments** Home confinement creates an unhealthy environment, since it hinders physical exercise, use of recreational facilities, and access to healthy food, and undermines healthy eating habits, resulting in an increase in alcohol, tobacco, and drug use. This situation can trigger family conflicts or heighten the risk of domestic violence against women, children, adolescents, and older persons. • **Psychosocial risk** Home confinement increases psychosocial risk (120), especially in dwellings with limited physical space. This is compounded by the additional burden of care created by school closures and uncertainty about the course of the pandemic, leading to high levels of tension and stress in the population. Another effect is social isolation, which is critical in populations with limited or nonexistent social support networks and a high dependency on third parties. This is the case of persons with disabilities and single person households (often older persons) (121). Another effect on children that should be noted is the social impact of restrictions on movement and physical distancing, limiting their right to play and relax with other children. This has major implications for their psychosocial development (122). At the collective level, adverse psychosocial conditions (123) could result in the destruction or weakening of social cohesion, exacerbating discrimination and exclusion, particularly impacting social groups in situations of vulnerability. • **Gender inequity and the burden of care** The adverse effects of home confinement are compounded by the additional burden of care created by school closures––a burden that nearly always falls on women––in addition to the loss of independence that accompanies the loss of work and income (124). • **Delivery of services and basic supplies** Home confinement can result in limited food availability and poor-quality food. This is compounded by the interruption of basic utilities such as electricity, water, and heating due to the non-payment of bills caused by loss of income. Evictions have occurred when rent is not paid, especially affecting migrants and their families.	Populations living in makeshift informal settlements (50, 102) with high levels of overcrowding. Workers who cannot work from home and lose their job because they are fired or the business closes, as well as self employed persons. Workers in the informal economy (96, 117) or employed in poorly paid essential services, migrant workers (20, 127) and their families. Working women heads of household (128, 129) with children to care for, women of all ages, children, and adolescents living in situations of violence (130) or great adversity (131). Persons with disabilities (132) and people requiring third-party care, such as older persons, among others. People residing in single-person households and remote rural territories. The homeless population and street people.

Continue >>

12 *Overcrowding* is considered to be any situation in which more than 2.5 or 3 people share a room or a limited amount of square footage.

IMPLEMENTATION BARRIERS AND ADVERSE EFFECTS	POPULATION GROUPS IN SITUATIONS OF VULNERABILITY
• **Health care access and continuity** Access to health services is affected by restricted availability, with an impact on continuity of care (e.g., health checks). In addition, patients with acute and chronic pathologies (125) delay seeking medical care for fear of infection (126). Postponement of the search for essential care is especially troubling in the case of sexual violence. In the short and medium term, the barriers and adverse effects associated with this measure will lead to mental health problems and increased severity of anxiety and depressive disorders. This impact also will be felt in the areas of noncommunicable chronic diseases, such as cardiovascular disorders and malnutrition, and alcohol and tobacco use (4). • **Human rights** Home confinement restricts people's rights, especially freedom of movement. If these measures are suddenly imposed without offering sufficient information and ensuring cultural relevance, they can lead to rights abuses and violations, especially in groups with limited power, such as indigenous and Afro descendant populations already living in adverse conditions (for example, informal settlements and camps).	

RECOMMENDATIONS

Actions prior to or immediately following implementation of the measure

1. Guarantee the supply of essential goods, including healthy food and hygiene products, and consider strengthening support systems through networks of neighbors, community volunteers, municipal personnel, food delivery systems, etc. (4, 96)
2. Facilitate measures to adapt homes so as to ensure physical distancing. For example, prioritize alternative spaces for the high-risk population, provide adequate ventilation, separate beds, etc. (103, 108, 133)
3. Create temporary residences (shelters) for homeless people or people unable to isolate at home, and facilitate the monitoring of basic prevention measures, including frequent handwashing with water and soap and sanitation in these centers (134-137).
4. Provide preventive solutions in dwellings, tailoring them to the national and local cultural context to ensure their acceptance by the entire population. These solutions include ventilation, cleaning, and disinfection, especially for housing in indigenous communities (houses, tambos, malocas, rancherías, community council rooms, quilombos, kumpanias, etc.) (78, 112, 138).
5. Authorize measures and residences that facilitate safe departure from the home for people seeking help or at risk of violence (98, 139, 140).
6. Improve dissemination and monitoring of the standards and regulations governing the control of alcohol and weapons sales, as well as drug-dealing practices and locations (98, 139, 140).
7. Limit entry of outsiders to indigenous territories and help indigenous communities remain in their territories by guaranteeing the availability of essential supplies (78, 30, 112).
8. Provide free health care to informal workers and their families, as well as people who have lost their jobs and associated health insurance as a result of the pandemic (4, 94, 95, 96, 98, 141-143).
9. Facilitate healthy settings by promoting physical activity and good nutrition on television, radio, and online (144-146).

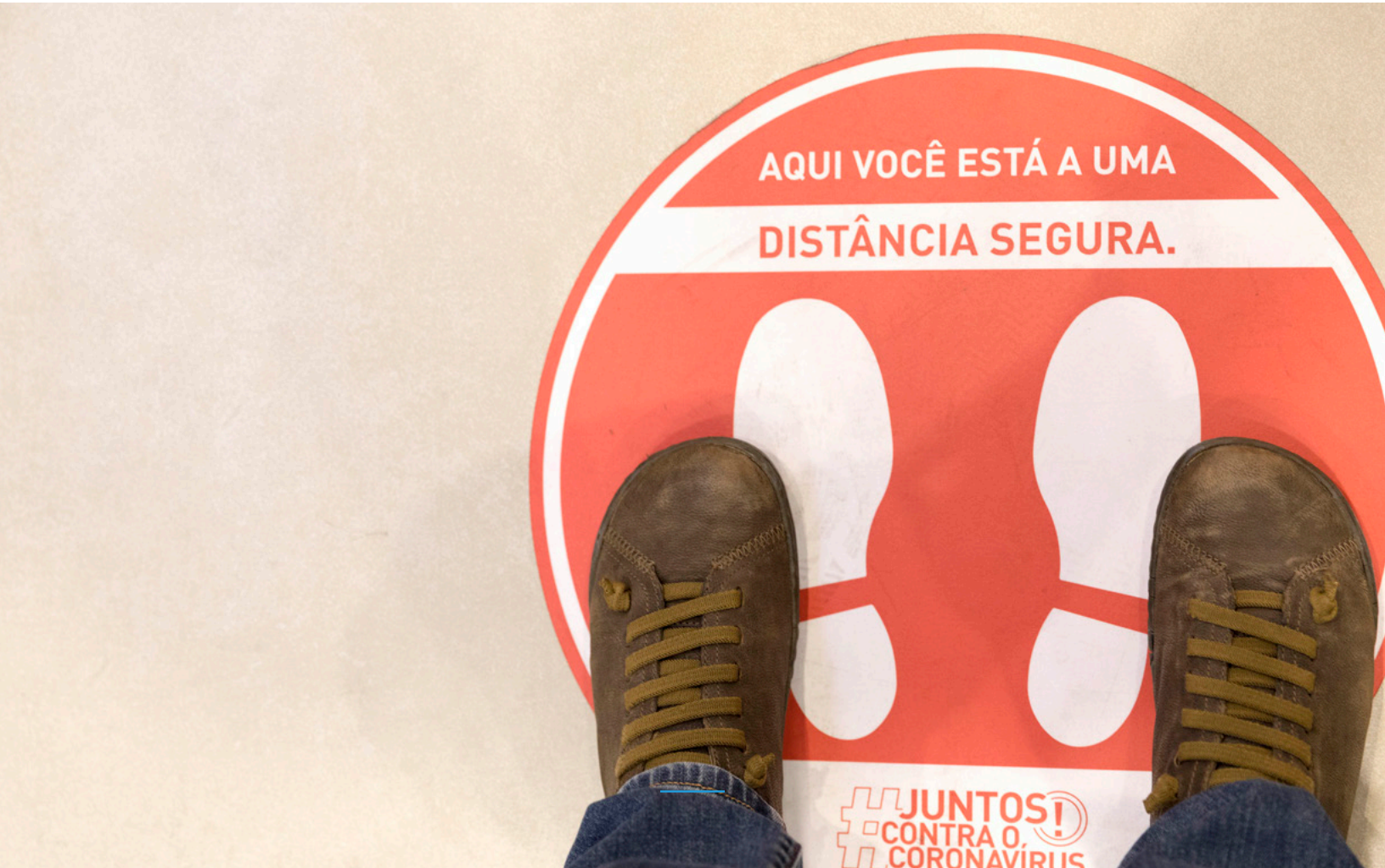
Short-term actions

1. Prevent the social isolation of people living alone through call systems, home visits, and support from networks of neighbors, community volunteers, municipal personnel, etc. (102, 147, 148).
2. Provide stress management and mental health information and recommendations tailored to the situation of populations, setting up emergency telephone hotlines, mass media, networks of community psychologists, and telehealth and telemedicine services (147, 149, 190).
3. Ensure the continuity of medical care for patients with chronic diseases through home visits and follow-up calls, as well as the provision of medicines (150-152).
4. Support mothers, fathers, and caregivers through tools that support healthy parenting in the context of teleworking or teleschooling (153).
5. Set up a system for monitoring families at risk of domestic abuse and violence, facilitating access to abuse emergency key codes and strengthening community networks and support (98, 139, 140).
6. Guarantee that survivors of violence (including older persons and children) have access to social services and free helplines, including telephone and text messages, chats, or silent calls (98, 139, 140, 154).
7. Waive or subsidize payments for public utilities such as water, electricity, and heating to guarantee the basic conditions for implementing the measures (8).
8. Provide rent support, including installment options; do not raise rents; and suspend evictions (6, 95).
9. Establish an emergency basic income equivalent to the poverty line for six months for the entire population living in poverty in 2020. This would imply an additional cost of 2.0% of GDP. This income would make it possible to maintain consumption and meet basic needs, promoting compliance with social distancing and quarantine measures (6).
10. Provide support against hunger to keep the pandemic from leading to a food crisis. This could take the form of money transfers, food baskets, or food vouchers for the entire population living in extreme poverty for a six-month period. (6, 95, 96).

C. Closure of nonessential workplaces and businesses

IMPLEMENTATION BARRIERS AND ADVERSE EFFECTS	POPULATION GROUPS IN SITUATIONS OF VULNERABILITY
• **Income and employment** This measure has had a direct impact on the loss or reduction of workers' income. Many jobs have been lost due to the closure or bankruptcy of businesses, especially micro-, small- and medium-sized enterprises (MSME), which account for 99% of all businesses in the region and create more than half the jobs (4, 155). This measure has also affected the working situations of people who can telework; this remote work modality reduces the direct financial impact of company closures but entails other problems: it increases inequalities among workers, since six out of every 10 households in the bottom income quintile do not have an internet connection fast enough for work and studies (26, 57, 156). • **Social protection** Workers and their families have lost their health coverage and other benefits (such as health insurance, check-ups for occupational diseases, income associated with preventive leave or sick leave, etc.) or have seen them reduced (100). This loss may be because these services were linked to their employment or the inability to pay. This situation is exacerbated by the fact that the vast majority of workers do not qualify for unemployment insurance, or the benefits are very limited, resulting in lost income (6). • **Psychosocial risk and setting** Workers who switch to teleworking have found themselves lacking the necessary competencies, tools, and conditions at home, added to the care that they have had to provide due to school closures (157). This additional burden creates tension and stress in the home, resulting in a potential increase in unhealthy behaviors such as alcohol use (120, 158, 159). • **Gender inequity and burden of care** Continuing tele-schooling imposes an additional burden of care that falls largely to women, increasing tension in the home, particularly among working women or fathers responsible for caring for the children (124). • **Provision of services and basic supplies** The availability of services and supplies has been limited by the closure of businesses, resulting in a greater need for mobility to obtain provisions, as well as price increases in many cases.	The populations likely to be most affected are workers with precarious contracts, workers with low qualifications for teleworking, workers without social protection (informal workers), people who have lost their job, migrants, refugees, etc. In the Region, Only 15% of poor workers and 25% of workers in situations of vulnerability in the Region have access to a computer with an internet connection in their home, and only around 10% of workers have a medium or high level of computer skills and problem-solving capabilities in technology-rich environments (160).

RECOMMENDATIONS
Actions prior to or immediately following implementation of the measure
1. Facilitate internet and computer access to create suitable conditions for teleworking whenever the type of work and job permits it (161, 162).
2. Adopt measures to maintain employment and limit mass layoffs (161).
3. Provide free health care for informal workers and their families, as well as people who lose their jobs and associated health insurance.
4. Establish paid occupational sick leave (workers compensation) if COVID-19 is contracted in the workplace, and in cases of preventive quarantine.
5. Introduce supplementary measures such as cash subsidies and basic goods for workers who lose their job and income, especially for informal workers and their families (6).
6. Guarantee the supply of basic goods (healthy foods, hygiene products, and essential medicines).
Short-term actions
1. Expand social protection, increasing the coverage of existing programs (horizontal) or the amount or duration of the benefits (vertical) to compensate for the loss of income in the population, particularly among groups in situations of vulnerability.
2. Provide inclusive unemployment benefits for an adequate period for workers who have lost their jobs.
3. Provide information and recommendations on stress management and mental health tailored to the situation of groups in situations of vulnerability, addressing family life, the burden of caring for others, teleworking, and other issues.
4. Increase access to telephone hotlines to meet mental health needs (147, 149).
5. Waive or subsidize payments for public utilities such as water, electricity, and heating to guarantee the basic conditions for implementing the measures (8).
6. Provide rent support, including installment options; do not raise rents; and suspend evictions (6, 95).



D. School closures

IMPLEMENTATION BARRIERS AND ADVERSE EFFECTS	POPULATION GROUPS IN SITUATIONS OF VULNERABILITY
• **Education and learning** School closures interrupt the continuity of education (163), widening the education gap between social classes (7, 164) because part of the population lacks the necessary tools for distance learning (computers, Internet access, etc.) (254). Furthermore, low-income children and adolescents do not receive adequate support from teachers or from family members whose competencies are for the most part limited (100). It should also be noted that using virtual technologies as alternative learning methods can engender new types of violence, such as cyberbullying (139, 165). • **Psychosocial risk and environment** Closing schools, which normally serve as protection against violence, increases the risk of violence (166, 167). Care and support for home schooling create an additional burden of care for parents, especially women, increasing stress in the household and family tensions. This can trigger dysfunctional behaviors and increase the risk of domestic violence. School closures lead to a lack of structure and stimulation for children, resulting in fewer opportunities to obtain social support for mental well-being (120). Furthermore, children who experience extreme deprivation can endure acute stress, impairing their cognitive development and resulting in mental health problems in the long term (168, 122). • **Gender inequity and the burden of care** Care and support for home schooling create an additional burden of care that usually falls to women, increasing tension in the home, especially among working women or fathers who assume the responsibility of caring for the children (124). • **Provision of basic services and supplies** School closings result in the suspension of certain social support services – for example, the provision of food (169), psychosocial support and other protection, and health programs (170, 182).	The population groups most affected by this measure are 171 million students (100) and their families. Children in precarious social and economic conditions are especially affected, since it is estimated that less than 30% of households in situations of vulnerability in Latin America have access to a computer (171). Some 85 million children in the region who receive a school breakfast, snack, or lunch would be especially affected (169). Parents, especially mothers, and children at risk of violence. Students with disabilities (101).

RECOMMENDATIONS
Action prior to and immediately after implementation of the measure 1. Facilitate the provision of food outside schools, replacing school breakfasts and school food (97, 172, 173, 174). 2. Support families and schools, providing them with tools for distance learning (connectivity, equipment, etc.) (172, 175, 176) 3. Propose alternative forms of learning (e.g., distance learning, guidance from library staff or older siblings, or networks of telephone friends) (101, 175, 177, 178). 4. Facilitate the continuity of school psychosocial support programs through telephone or virtual follow-up, and implement strategies to prevent cyberbullying (139, 167, 179, 180). 5. Promote measures to help workers with care responsibilities harmonize them with their paid work. For example, create and maintain opportunities for alternative care, such as daycare centers or schools that practice hygiene and strict physical distancing for the children of essential workers, depending on the phase of the pandemic (124, 101, 172). 6. Create virtual forums for dialogue with parents, teachers, and students to discuss the options available after school closures in terms of school programs, home schooling, care, etc. (172). **Short-term actions** 1. Upgrade the competencies of teachers and schools, providing the technical support they need to develop learning strategies that consider the socioeconomic situation of students (177). 2. Target and channel support to children in situations of vulnerability due to abuse, neglect, violence, etc., including children with disabilities (98, 122, 139). 3. Provide information, recommendations, and options for managing stress and promoting the mental health of children and their families tailored to the situation of groups in situations of vulnerability (120, 181, 182). 4. Provide support for achieving equitable distribution of the burden of care between men and women, raising awareness through campaigns promoting the participation of boys and adult men to ensure that they are doing their part in shouldering household chores (183).

E. Enclosed facilities (nursing homes, quarantine centers, penitentiaries, extended-stay facilities, shelters, etc.)

E.1. Extended-stay facilities

IMPLEMENTATION BARRIERS AND ADVERSE EFFECTS	POPULATION GROUPS IN SITUATIONS OF VULNERABILITY
• **Physical living conditions in the facilities** The insecure and overcrowded situations of extended-stay facilities are a barrier to the implementation of physical distancing measures and handwashing with water and soap (3, 14, 115). • **Psychosocial risk and environment** The absence of contact with family and support networks favors physical distancing but results in greater isolation, leading to an increase in abuse, violence, and mental health disorders such as stress, anxiety, and depression. • **Health care access and continuity** Extended-stay centers such as nursing homes and child care centers are not connected with the public health network or health services, creating an access barrier to treatment, monitoring, tracing, and the isolation of cases in these facilities. This situation increases the risk of infection both for residents and essential workers. • **Human rights** The measures have restricted people's rights, particularly those of people in extended-stay facilities where physical distancing is hard to maintain and family visits are limited. Non-pharmacological public health measures can lead to abuse and rights violations, especially in population groups with greater privation and limited opportunity to exercise their power, such as older persons, persons with disabilities, children, etc. (184, 185).	Residents in extended-stay facilities (186), such as older persons, are likely to be those most affected by this measure. For example, in the United States 4.5% of older persons (nearly 1.5 million people) live in nursing homes (187). Persons with disabilities or under non-parental care (for example, court-ordered care), including children and adolescents.

RECOMMENDATIONS
Action prior to and immediately following implementation of the measure
1. Identify children in situations of vulnerability due to mistreatment, abuse, or overcrowding, and provide support (136, 188).
2. Introduce and ensure physical distancing in these institutions (136, 189).
3. Facilitate frequent handwashing with water and soap and regularly disinfect the facility (136, 190, 191).
4. Restrict visits and provide alternative contact methods, such as telephone calls or video conferences with families and close relatives (136).
5. Educate the staff of nursing and retirement homes and extended-stay facilities, as well as their residents, about the importance of personal protective measures and physical distancing, with special emphasis on older persons, given their higher risk of death (136, 191).
6. Develop rapid procedures for returning people under alternative care (children, persons with disabilities) to their families and communities. Their reintegration should be a priority whenever feasible (101, 136, 184, 185, 188).
Short-term actions
1. Ensure that extended-stay facilities for older persons have policies and procedures in place to respond to violence (136, 139).
2. Improve psychological support for residents of extended-stay facilities (136, 188, 191).
3. Offer guidance to asylums, shelters, and other institutions to facilitate ongoing support for violence survivors and individuals at risk (192).

E.2. Enclosed facilities under judicial authority

IMPLEMENTATION BARRIERS AND ADVERSE EFFECTS	POPULATION GROUPS IN SITUATIONS OF VULNERABILITY
• **Physical living conditions, including infrastructure** Precarious conditions and overcrowding in enclosed facilities under judicial authority are a barrier to the implementation of physical distancing measures and handwashing with water and soap (100). • **Cultural relevance** Lack of cultural relevance and respect for ancestral ceremonies and rites (193), the absence of interpreters at these centers, and the failure to translate prevention messages into the respective languages are barriers to proper implementation of the measures. • **Psychosocial risk** The absence of contact with family and support networks results in greater isolation and vulnerability to abuse, violence, and mental health disorders. Furthermore, support channels and mental health monitoring are lacking.[13] • **Access and continuity of health care** The fact that penitentiaries are often not linked with the public health network creates a barrier to access, treatment, monitoring, tracing, and the isolation of cases in these institutions, increasing the risk of infection for both inmates and essential workers. • **Human rights** The measures have restricted people's rights, especially those of inmates living in facilities under judicial authority, with harsh conditions, problems maintaining physical distancing, restricted family and attorney visits, and limited screening, testing, and isolation of cases, all of which can heighten abuse and rights violations. People awaiting judicial sentencing, as well as detainees in immigration centers, who are confined in close quarters under substandard conditions, are also affected (68, 194). Finally, it is important to highlight the situation of indigenous populations in facilities under judicial authority, who experience discrimination when seeking health care (195).	The most affected people are inmates in prisons and detention centers (186) (migrants, refugees, indigenous population, etc.). An estimated 1.7 million people (196) live in these centers, with 200% occupancy in Latin America (67).

RECOMMENDATIONS
Actions prior to and immediately following implementation of the measure. 1. Introduce and ensure physical distancing in activities in these institutions. 2. Facilitate frequent handwashing with water and soap and regularly disinfect the facility (197). 3. Restrict visits and provide alternative means of contact, such as telephone calls or video conferences with family and close friends, as well as attorneys (66). 4. Educate staff and inmates about the importance of personal protective measures and physical distancing, with special emphasis on older persons, given their higher risk of death (66). 5. Improve psychological support for inmates, both adults and young people (136). **Short-term actions** 1. Reduce the prison population and provide alternatives to imprisonment for inmates who have committed minor and non violent offenses, those who have almost served out their sentence, and those in preventive or administrative detention[14]. Special care should be provided for older persons or persons with chronic or respiratory diseases, guaranteeing their human rights (67, 198, 67). 2. Seek alternative solutions for people detained for immigrating or because of their immigration status, guaranteeing their human rights (66). 3. Ensure that penitentiaries have policies and procedures in place to respond to violence (136).

13 There is a higher incidence of mental health disorders in prisons, where up to nine out of ten inmates may be affected. These individuals are four to six times more likely than the general population to suffer from psychosis and severe depression and have a 10 times higher probability of suffering from a personality disorder. Sources: Andersen HS. Mental Health in Prison Populations. A review—with special emphasis on a study of Danish prisoners on remand. Proceedings Psychiatr Scand: 110 (Suppl. 424): 5-59; 2004; Saavedra J, López, J. Riesgo de suicidio de hombres internos con condena en centros penitenciarios. Rev Psiquiatr Salud Men; 2013; Mundt A, Alvarado R, Fritsch R, Poblete C, Villagra C, Kastner S, Priebe S. Prevalence Rates of Mental Disorders in Chilean Prisons. PLOS One. 8(7): e69109; 2013; Brugha T, Singleton N, Bebbington P, Farrell M, Coid J, Fryers T, Melzer D, Lewis G. Psychosis in the Community and in Prisons: A Report From the British National Survey of Psychiatric Morbidity. American Journal of Psychiatry. 162:774-780; 2005.

14 This group constitutes 37% of prisoners in Latin America and the Caribbean. Source: Vivanco JM, Acebes CM. Cómo evitar que las cárceles de América Latina se conviertan en una incubadora del coronavirus. The New York Times; 2020. Available from: https://www.nytimes.com/es/2020/05/21/espanol/opinion/prisiones-covid.html.

F. Restrictions on gatherings and mass events (cultural, sports, social, religious, and political events)

IMPLEMENTATION BARRIERS AND ADVERSE EFFECTS	POPULATION GROUPS IN SITUATIONS OF VULNERABILITY
• **Cultural relevance** The interruption of religious activities, practices, or ancestral rites that encourage gatherings is a barrier to implementing this measure because of the need to continue community customs and celebrations. In the case of ancestral rites, this measure can affect a community in a number of ways, including its sense of identity and social cohesion. • **Psychosocial risk and environment** Suspending cultural activities can cause a deterioration in emotional well-being and weaken social networks and social cohesion. Furthermore, closing sports and cultural venues leads to a reduction in physical activity which, coupled with confinement, results in an increase in unhealthy behaviors (14). Furthermore, in the case of funerals, where, in addition to mourning the loss of a loved one, traditional farewell rituals cannot be followed, an increase in the prevalence of depression has been observed in the population. • **Income and employment** The imposed restrictions have hindered cultural, political, religious, and sports, and recreational activities in parks. This has had a significant impact on workers in the arts, who have experienced a major loss of employment and income (26, 199).	The people most affected are those who reside in neighborhoods without recreational activities or spaces, religious people who regularly attend services; indigenous populations who perform ancestral rites and ceremonies; and groups that participate in the cultural celebrations of their community, town, or country.

RECOMMENDATIONS
Actions prior to and immediately following implementation of the measure 1. Promote healthy living conditions by promoting physical activity and healthy nutrition through media such as television, radio, the internet, etc. 2. Conduct spiritual practices or rites virtually through different media (television, radio, internet) and include persons with disabilities (200). 3. Facilitate the dissemination of cultural content and virtual alternatives for cultural, social, and religious events through the media and social networks (199, 201). **Short-term actions** 1. Facilitate access by workers in the country's arts and culture industry, and their families, to healthy food, medicines, and basic services such as water, electricity, sanitation, and internet , and generate cultural and recreational content through alternative media (199).

G. Restrictions on public transit

IMPLEMENTATION BARRIERS AND ADVERSE EFFECTS	POPULATION GROUPS IN SITUATIONS OF VULNERABILITY
• **Income and employment** Limiting the mobility of essential and informal workers can result in the loss of employment and income if they cannot get to work. • **Provision of services and basic supplies** Transit restrictions have made it difficult to travel to essential workplaces such as supermarkets, pharmacies, hospitals, etc. Furthermore, people living in areas far from their workplace who lack their own means of transportation spend a great deal of time on public transportation, with the consequent risk of exposure and infection due to enclosed spaces and inadequate ventilation (202, 203). At the same time, the limited availability of mass transit means that buses and/or trains can become overcrowded, as can associated public areas such as bus stops, ticket offices, etc., which become areas of crowding and transmission (202, 203). Some cities have witnessed an increase in the use of informal transportation, where safety and hygiene measures are less likely to be observed and there is less control (204). • **Health care access and continuity.** This measure makes it hard to reach health services, including for health workers.	The most affected people are workers in the informal economy, essential workers, migrants, indigenous populations, people living in marginalized areas and informal settlements, etc.

RECOMMENDATIONS
Actions prior to and immediately following implementation of the measure
1. Prioritize continuity of the transportation routes used by groups in situations of vulnerability, especially in the more remote areas (205).
2. Ensure that safe transit[15] is available for people who need to go to work and require access to essential services (204, 206-208).
3. Facilitate physical distancing in critical spaces associated with public transportation, as such as bus stops, train stations, pedestrian walkways, and the vehicles themselves (buses, metro, trains, etc.) (209, 210).
4. Reduce the time spent on public transportation (to not more than 30 minutes), limit the number of passengers, and ensure adequate ventilation of the vehicles to help reduce infection (204, 210).
5. Facilitate payment by means other than cash (204).
6. Facilitate options for handwashing and regular hygiene in bus stations, metros, and trains, guaranteeing access for persons with disabilities (101, 203, 205, 211).
7. Issue clear messages and facilitate compliance with physical distancing and personal protective measures (206, 212).
Short-term actions
1. Facilitate and promote dialogue with the community to identify the areas with the greatest need for public transportation and priority routes (213).
2. Facilitate access to and the use of other modes of transportation and mobility, widening bicycle lanes and facilitating pedestrian traffic, for example (204, 205, 214).

15 That employs COVID-19 disinfection and hygiene measures.

H. Handwashing with water and soap

IMPLEMENTATION BARRIERS	POPULATION GROUPS IN SITUATIONS OF VULNERABILITY
• **Material living conditions, including neighborhood and household infrastructure** The main barrier to frequent proper handwashing is the absence or limited availability of water in houses, territories, and public areas (102, 207). This may be due to a lack of a water supply network in neighborhoods and dwellings (availability); inability to pay for the service (financing); water shortages in the territory (drought); or absence of public sinks or adapted facilities for persons with disabilities (access) (101, 215). Another implementation barrier is that not all people have access to soap or an alternative product (30). • **Cultural relevance** The lack of socially and culturally relevant messages on handwashing with water and soap and the lack of alternatives constitute a barrier to both the implementation of this measure and compliance. This is the case for population groups that lack water and communities whose custom is to use alternative products instead of soap (78).	An estimated 64 million people in the region still lack basic facilities in the home for washing their hands with water and soap (216). The people most affected by this measure are those living in informal settlements, remote rural areas, drought-stricken areas, substandard dwellings, or who are homeless, as well as low-income population groups, persons with disabilities (101) and indigenous populations in their communities.

RECOMMENDATIONS
Action prior to and immediately following implementation of the measure 1. Guarantee a minimum daily volume of drinking water for all households in situations of vulnerability that are not connected to the water supply system through unconventional solutions (e.g., the distribution of water to homes or to specific points in the community, water tankers, water kiosks, etc.), always ensuring physical distancing (water access points separated at least by 1 m) (104). 2. Guarantee the accessibility and availability of water in households, neighborhoods, and territories, providing information and guidance on alternative forms of water capture (99, 101, 207, 217). 3. Establish basic vital water consumption for families free of charge, anticipating an increase in water use due to better hygiene and the confinement of many people in their homes (99, 217). 4. Provide free hand-washing stations with clean water and soap for the entire population in all public spaces and at critical points, guaranteeing access for persons with disabilities (99, 217). **Short-term actions** 1. Facilitate provision of water (e.g., by water trucks) and ensure water supply in cases of non-payment (99).

I. Management of public health measures at the local level

Many of the problems affecting populations in situations of vulnerability are found at the local level––for example, in informal urban settlements, urban areas with high population density, remote rural areas, and indigenous territories (51). These situations have a significant impact on the proper implementation of public health measures.

Problems at the local level include a lack of a regular water supply, limited green space, risk of crowding, and limited availability of and access to essential services (health services, healthy food, hygiene and disinfection products, etc.), and other support services. Local governments play a key role (218) in coordinating and supporting organized communities through community leaders, civil society organizations, and other groups.

RECOMMENDATIONS
Local management and planning
1. Adopt strategies for micromanaging public areas, especially at points of access to public and recreational services, and in particular, during periods of voluntary confinement and during the gradual easing of the measures (207, 104, 219, 220).
2. Create a one-way pedestrian walkway system, with markers on the ground and physical barriers in public settings to facilitate physical distancing (207, 104).
3. Establish local containment lines and quarantine areas in high-risk neighborhoods, guaranteeing the provision of essential supplies (food, medicines, basic services, etc.) (106, 221, 222).
4. Design strategies for the safe delivery of supplies and services (e.g., public health corridors) (222, 223).
5. Establish different time schedules for accessing public services and community provisions to prevent gatherings, whenever the context permits (104, 224).
Basic and community services
1. Prioritize the provision of basic services, including water, and guarantee the availability of services in informal settlements (99, 104, 207, 225)
2. Install and guarantee the availability of public handwashing facilities in places where sufficient access to water is limited (95, 99, 207).
3. Guarantee access to mental health and psychosocial support services, including on-site services, emergency telephone hotlines, and other remote options, and disseminate key information on resilience strategies (120, 147, 104).
Community participation
1. Facilitate local dialogue to identify and designate appropriate sites or spaces in the community for quarantine, isolation, and the care of cases, reorganizing facilities with adequate infrastructure (water and sanitation, bathrooms, electricity, and ventilation) (226).
2. Facilitate local dialogue with communities and include the indigenous population, persons with disabilities, women, young people, etc. (78, 101, 227).

J. Special considerations for essential workers and the continuity of the services they provide[16]

Ensuring the continuity of activities linked to essential services means that some workers and their families are exposed to a greater risk of infection. The situation is especially concerning for those essential workers who are in direct contact with people infected with COVID-19 (228), who also have precarious contracts without social protection or the right to sick leave, and who live in precarious conditions without space for physical isolation in the home. Many essential workers can be found in businesses where public health measures are not properly observed. This situation is even more critical in the case of migrant or undocumented workers.

For example, food production and sales (e.g., wholesale markets and food markets) is a major focus of SARS-CoV-2 infection, and epidemic outbreaks with high infection and case-fatality levels that have been documented (229-231). This may be due to the fact that venues where food is sold and eaten are places where physical distancing, disinfection, and frequent handwashing are often difficult. The very nature of these venues, as well as the culture of the buyers and the public at large leads to crowding (232-234). Frequent visits to these markets is often due to poverty: many customers do not have refrigerators at home. Outbreaks in the food production and processing chain have also been documented – for example, in meat packing plants and farms, largely among migrant workers who harvest the crops (228, 235).

Regarding the continuity of essential services, the general recommendation is to follow the specific guidelines developed by PAHO and WHO, governments, health centers, and hospitals (236-238).

RECOMMENDATIONS
For essential workers
1. Merchants in the risk group established by the ministry of health (people over the age of 65, patients with chronic diseases or those who are immunosuppressed) should refrain from working at markets in their districts, municipalities, towns, etc., or at least, refrain from serving the public (239).
2. Strengthen and follow the occupational health and safety guidelines using the hierarchy of controls (240-242).[17]
3. Guarantee the provision of personal protective equipment (240-243).
4. Guarantee cleanliness and hygiene in essential workplaces (240-243).
5. Introduce physical distancing, frequent disinfection, and use of personal protective measures in workplaces (211, 240).
6. Ensure f sick leave policies for workers.
7. Create opportunities for dialogue with essential workers, including unions, to learn about their concerns and needs in order to ensure the continuity of their work (240).
8. Designate an isolated space in the home to enable essential workers to minimize the risk of infecting their family, or open residences for essential workers with high-risk family members (236).
Burden of care on essential workers
1. Provide additional support for essential workers, especially female health workers, to care for their children (due to school closures) and other dependents (98).
2. Distribute the burden of care among the different members of the household (98, 183).
For the customers of markets and other food vending locations
1. Take administrative steps to limit the number of people in the facility, through appointments, home delivery, schedules that designate specific hours for high-risk groups, etc. (219, 232, 244)
2. Facilitate physical distancing at market entrances and in aisles, etc. (219).
3. Facilitate the use of alternative modes of payment, limiting the use of cash.
4. Facilitate options for regular handwashing and hygiene in facilities, with a view to providing access for persons with disabilities (233, 234).
5. Issue clear messages and facilitate the observance of physical distancing and personal protection.
6. Prevent customers from directly handling products (prepackaged bags, direct contact with the supplier, protection with plastic, prepackaged boxes for certain products – for example, a weekly basic basket) (239, 245).

Cross-cutting recommendations

When implementing the recommendations, it is essential to guarantee community participation in decision-making and provide community leaders with timely information to prevent the virus from spreading and protect people infected with COVID-19. Furthermore, it is necessary to strengthen civil society engagement in effective im-

16 The health services are not included, since they have been exhaustively discussed in other documents. For more information, visit https://www.paho.org/es/documentos-tecnicos-ops-enfermedad-por-coronavirus-covid-19#servicios-salud.

17 The hierarchy of controls aims to provide a systematic approach to increase occupational safety and health, eliminate hazards, and reduce or control occupational safety and health risks. The hierarchy includes the following phases, in descending order of effectiveness: elimination of risk, substitution, engineering controls, administrative controls, and finally, personal protective equipment. Source: Pan American Health Organization. Prevención y control de Infecciones COVID-19. Washington, DC.: PAHO; Available from: https://www.paho.org/arg/index.php?option=com_docman&view=download&alias=478-covid-19-paho-stempliuk-prevencion-control-infecciones-2020-04-16&category_slug=presentaciones&Itemid=624.

plementation. For this to happen, it is essential to couple these measures with a risk communication strategy that takes into consideration the context and the population's social, economic, and cultural situation.

a. Recommendations for RISK COMMUNICATION

Risk communication is a key component in the implementation of each of these measures, since it determines how they are transmitted to the public. There have been cases in which an adequate communication plan was lacking; where the plan had not been translated or lacked the necessary cultural relevance to the customs and way of living of the population; or the plan did not take advantage of the available media (254) or communication channels most accessible to the population. All these factors result in limited public understanding of the public health messages and measures, and a lack of compliance to measures that are not culturally acceptable or messages that may not even have been received.[18] Lack of communication causes the community to lose trust in decisionmakers when there is a failure to recognize local and community leadership, resulting in an absence of collaborative dialogue.

To promote compliance with public health measures, it is important to accompany them with risk communication strategies and messages tailored to the situation of each population group.

CROSS-CUTTING RECOMMENDATIONS
• Provide the population with regular, timely, specific, user-friendly, audience-appropriate, and reliable information on the status of the pandemic and the public health measures adopted; this includes where the measure is being implemented in a territory and how long it will remain in effect. Information about the measures should be updated periodically and it should meet the different needs of the population (246).
• Regularly disseminate messages through the various communication channels (radio, television, print, etc.) that are appropriate to the population and territory and that are adapted for persons with hearing and visual impairments (246, 247).
• Adopt risk communication strategies that guarantee the rights of individuals, with clear messages tailored to the situation of groups in situations of vulnerability, including persons with disabilities and indigenous populations (246-250).
• Guarantee the cultural relevance of the messages and adapt them to the respective languages and dialects of each country (78, 248, 251).
• Work with influential people and community networks to provide timely information (249).
• Monitor and respond to rumors, questions, and comments through reliable channels (249).
• Develop communication strategies to counter false information (infodemic[19]) and social stigma (252).
• Facilitate community participation, including indigenous communities in the preparation of messages, and provide community leaders with timely information to protect people infected with COVID-19 (78, 227, 246).

18 Some 30% to 80% of the population in the countries have internet access through a mobile device. Source: Economic Commission for Latin America and the Caribbean. El desafío social en tiempos del COVID-19. Santiago, Chile: CEPAL; 2020. Available from: https://www.cepal.org/es/publicaciones/45527-desafio-social-tiempos-covid-19.

19 Infodemic means information overload(in some cases, accurate information; in others, inaccurate) that prevents people from finding reliable sources and guidance when they need it. Source: Pan American Health Organization. Understanding the Infodemic and Misinformation in the Fight against COVID-19. Washington, D.C.: PAHO; 2020. Available from: https://iris.paho.org/handle/10665.2/52052

b. Recommendations to facilitate SOCIAL AND COMMUNITY PARTICIPATION

Another critical aspect when tackling inequalities exacerbated by the pandemic is social and community participation in the planning, implementation, and evaluation of the COVID-19 response (107, 100). Failure to include the population in these processes delays and limits compliance with the measures and hinders follow-up on implementation. At the same time, lack of participation results in poor adaptation of the measures to local contexts, limited cultural relevance, and weak communication strategies. It also entails the risk of community distrust of decisionmakers (253).

Social participation is a basic principle in the construction of health and in empowering communities to be key actors and leaving no one behind. It strengthens preparedness, response, and recovery strategies, ensuring that they are appropriate and effective; helps secure community commitment, which is key for risk communication; fights stigma and discrimination; and facilitates the tailoring of messages to the community reality (107), strengthening resilience.[20] Community networks, organizations, and leaders facilitate the identification of practical solutions consistent with community needs to promote and strengthen collective responses (93, 254).

CROSS-CUTTING RECOMMENDATIONS
• Identify community organizations and assets, to work with them on risk communication strategies and adaptation of the measures (108, 110, 227).
• Ensure that community needs are considered when jointly developing preparedness, response, and recovery plans, taking into account the core principles of equity and social justice (109).
• Facilitate and strengthen community empowerment, fomenting community and solidarity-based responses developed by organizations to meet the unmet needs of the population (for example, the organization of soup kitchens in Chile and Peru, and fishermen's distribution of part of their catch to families that have lost their income in Panama) (110, 255).
• Provide and communicate all the available information, engaging all social agents: volunteer groups, authorities, media, institutions, etc. to promote a culture of self protection and community empowerment to deal with adversity (108, 110).
• Strengthen existing partnerships and forge new ones with broader community networks to increase trust among community leaders, communities, and key groups in situations of vulnerability.
• Strengthen existing community governance structures and build capacity among national and local stakeholders (107, 108).

c. Recommendations to guarantee respect for HUMAN RIGHTS

Respect for human rights should be a core value in the implementation of the measures.

CROSS-CUTTING RECOMMENDATIONS
• Ensure that restrictive measures that limit civil, political, economic, social, and cultural rights are evidence based and consistent with the principles of legality, proportionality, need, and temporariness and that their sole purpose is to protect public health (250, 256).
• Ensure that the strategies adopted take human rights into consideration, especially the principle of nondiscrimination (247, 257).
• Ensure that penalties for citizens who fail to comply with confinement, quarantine, business closure, and other measures are rational and proportional to the infraction (78, 250).
• Provide special care for children in situations of vulnerability (due to mental health issues, disability, overcrowding) who are exposed to abuse and neglect (247, 250).
• Prioritize service delivery in remote areas and informal settlements to guarantee the availability of basic public services, including water (207, 225, 250).

d. Recommendations for MONITORING AND EVALUATING the measures

20 The pillars of community resilience are: a cohesive social structure, government honesty, cultural identity, collective self esteem, and a social disposition.

A third aspect to highlight is the monitoring and evaluation of public health measures (258, 259). There has been insufficient monitoring of their implementation, and robust evaluations have not been conducted (18), resulting in limited adaptation of the measures. Moreover, there has been little information on groups in situations of vulnerability in the existing analyses and there has been little communication of findings to communities and local governments.

Monitoring and evaluation are essential for proper implementation and adaptation of the measures based on disaggregated data, information on community perceptions of the measures, and analysis of this information to ensure effective responses consistent with the needs of the different populations and territories.

CROSS-CUTTING RECOMMENDATIONS
• Strengthen capacity for monitoring and evaluation of the implementation of the public health measures at the national and local level by collecting data on compliance by groups and territories in situations of vulnerability (disaggregated by sex, age, ethnicity, socioeconomic status, geography, and the areas of vulnerability detailed in Table 1) and analyzing the results, based on the morbidity and mortality associated with the situations of vulnerability (260, 45, 261)
• Improve the collection and analysis of data on inequalities detected in the public health measures and identify where these inequalities are created or exacerbated (45, 261).

In this scenario, it is essential to prioritize monitoring of the aforementioned recommendations and maintain accurate records and information on their implementation and results in order to evaluate their impact. It would also be advisable to design study models for evaluating the effectiveness of the recommendations in the different contexts in which they are implemented.

6. Final thoughts

As noted in the ECLAC and PAHO report (4), several countries in Latin America have become the epicenter of the pandemic and lead the world in cases. COVID-19 has spread rapidly across the Region of the Americas, and countries have instituted public health measures at different levels with different degrees of intensity (262). The pandemic has triggered an unprecedented economic and social crisis, and there have been warnings that if urgent steps are not taken, it could develop into a food, humanitarian, and political crisis.

The balance between the implementation of measures and the "new normalcy," with the reopening of businesses, workplaces, and schools, once again introduces a false dichotomy between health and the economy. Public health is necessary to recover from economic devastation. Opening up national and local economies without instituting public health measures, testing, tracing, and isolation can lead to an even greater disruption of the economy, making new quarantines necessary (263).

It is impossible to consider opening up the economy without first controlling the pandemic. To adequately tackle the pandemic in all phases, health, social, and economic policies must be integrated, coordinated, participatory, and tailored to each national and subnational context, guided by principles that emphasize life, health, and well-being as fundamental prerequisites for reactivating the economy.

In this context, it is necessary to give the social determinants and equity the same priority as public health measures and the medical response. From this perspective, addressing social conditions should be part of the pandemic response, so that socioeconomic consequences and health inequalities receive an integrated response from the health sector and other sectors, rather than treating the socioeconomic consequences as 'collateral damage' of the pandemic (44).

Despite the severity of the COVID-19 pandemic, this crisis offers us an opportunity. The countries have elevated the responsibility for managing the pandemic to the highest level of government, while society and political leaders have recognized the importance of intersectoral action, the search for new solutions, and innovative interventions, as well as the need to address the social determinants of health and equity in health.

This is the right moment to address the structural factors of inequality by investing in inclusive economic and social policies grounded in solidarity that have a positive impact on health and well-being. Now is the time to construct a new normalcy and work toward a recovery that puts health, social justice, and equity squarely at the center of the policy agenda; toward building a society that leaves no one behind (264, 265). The reduction of inequalities should be embraced as the "guiding policy principle, so that everything done during and after this crisis is geared to the construction of more egalitarian, inclusive, and resilient societies" (4).

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