Group of Experts on the Exit Strategy

2de Nota aan Eerste Minister en Kern ter voorbereiding van de Nationale Veiligheidsraad dd. 24/4/2020*

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**Dit document bevat advies van de experten die deel uitmaken van de GEES. Het gaat daarbij onder meer om persoonlijke meningen die uit vrije wil en op vertrouwelijke basis worden verstrekt aan de federale regering.*

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The purpose of this 2nd report of the GEES is to recommend a sequence and potential timing for the gradual reduction of the confinement measures taken in the context of COVID-19. The recommendations in this report will critically depend on the evolution of the epidemic, and a number of critical conditions still to be put in place including availability of masks, testing and large-scale contact identification, and behavior significantly determined by protocols and communication.
This report has been compiled based on scientific evidence, international experiences, discussion with key-stakeholders in the different fields over a very short timeframe. It is therefore per definition limited.

1. Objective and outline

The gradual reduction of the actual confinement measures needs to balance multiple objectives. It is fundamentally based on preserving public health/ **minimizing the risk of resurgence of the epidemic** and **reducing negative social and economic impac**t of the confinement. In determining the strategy and related phasing, the GEES based itself on 1) the likely evolution of the epidemic and the capacity of our health system to deal with the epidemic, 2) the impact on the economy and economic life, 3) the impact on education and schools and, to a limited extent at this stage, (4) the social impact and the impact of confinement on the life of people, particularly the most vulnerable.

The **restart will have to be gradual** and might sometimes need to be turned back – partially or fully - to avoid a large second or third epidemic wave requiring full confinement. Real-time monitoring of the epidemic evolution, and extensive testing and contact identification will help identify the markers to move forward or dial back the release of the confinement measures.

2. Current state of outbreak

Following the outbreak early March 2020, severe confinement measures have been taken from March 13th onwards which have drastically reduced the number of contacts in professional and private life and thereby greatly helped to "flatten the curve" and avoid the number of hospital and ICU cases exceed our health system capacity as has been the case in some other countries.

Against the background of early strict confinement of nursing homes, the COVID-19 outbreak seems to have evolved into two outbreaks: one in the general population and one in the nursing homes. Hospital admissions and hospital occupancy are the key criteria to assess the evolution of the COVID-19 epidemic in Belgium up to now – given the testing strategy has evolved over time.

An overall declining trend in the number of new hospitalizations is observed, though there is considerable geographical heterogeneity and there currently is still a substantial pressure on the healthcare system. Relaxing measures can only be done provided this decline is confirmed over the next few days and provided the pressure on the healthcare system decreases further. Note that the confirmed cases and hospital admission data lags by approximately 11 days and thus we are looking at the past. At the time of writing (April 22nd 2020), there are still 4527 patients admitted in the Belgian hospitals, among whom 993 in intensive care units (ICU).

3. Phasing of the restart

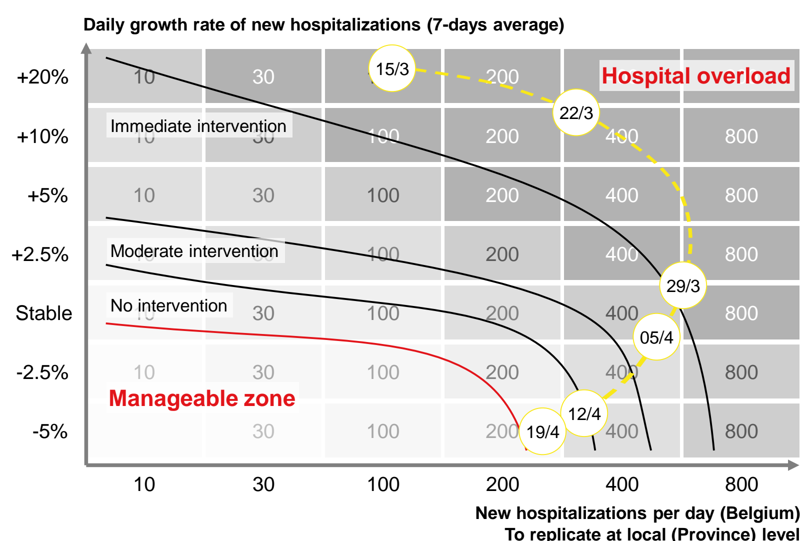
Despite the recent positive evolution of the epidemic, society will need to continue to drastically reduce to a strict minimum the number of contacts both in business, in retail shops and in everyday life and ensure they respect physical distancing to the maximum extent, to avoid resurgence of the virus in the foreseeable future. This will mean that **not all parts of society will be able to fully re-open in the short-medium term** and that **even the parts that will re-open will need to function in a fundamentally different way**. We do not expect in the near/midterm to evolve to zero cases and will on an ongoing basis need to steer the "restart of society" to stay in an acceptable/safe zone from a health perspective.

The restart will need to be phased. We do not know with certainty by how much we do need to reduce the number of contacts to avoid resurgence of the epidemic. Going step-by-step will enable us to learn and course-correct when needed for reducing the risk of exceeding the health care system capacity. The phases will a priori be country-wide, but may be refined at local level if and when needed. The phasing is also needed as time will be needed to fully put in place sufficient testing, contact investigation and ensure sufficient mask availability. Phasing also allows to build some more "time buffers" and learn more from the evolution of the epidemic in Belgium and abroad

The launch of phase I and of every subsequent phase of deconfinement is conditional on (i) the further positive evolution of the epidemic, (ii) physical distancing applied and masks being used, (iii) testing and contact investigation being in place, (iv) clear protocols under which each activity will need to happen being implemented and respected, and (v) clear information of the general population.

For the epidemic to stay under control, one needs to operate in a "Manageable zone" (of evolution) of cases and health care capacity. This must be measured by a combination of indicators. This will first be measured by the new hospitalizations per day and the 7-day growth rate of hospitalizations. **This will as information becomes available be further refined by the number of patients with likely COVID (or flu-like symptoms) reported by General Practitioners, and the number of new positive COVID-tests in the community.** The way flare-up's will be managed is further detailed later in this report.

In addition, the share of ICU beds available in case of flare-up will need to remain above 25% (with possible additional 25% surge buffer). These will in a combined way inform whether one week before the launch of the next phase the government can decide to move ahead.



In addition, we will need to ensure that the epidemic in closed communities (e.g. elderly homes) is contained, that we have tight controls on “imported cases” and that sufficient medical material (drugs, personal protective equipment) necessary to treat patients and protect health care workers is available.

The tentative dates for the subsequent phases would be the following, each strongly conditional as mentioned above

- Phase 0: actual situation
- Phase 1: May 4th
- Phase 2: May 18th or later
- Phase 3: not earlier than June 8st and in more gradual sub-steps depending on the evolution of the outbreak

In deconfining the economy, it is important to note that today’s confinement measures make a clear distinction between essential and non-essential sectors. While essential sectors can continue to operate on-site even when physical distancing cannot be respected, non-essential sectors can only continue to operate on-site in case physical distancing can be respected at all times. Both sectors are required to maximize remote work wherever feasible.

In subsequent phases, essential sectors will continue to operate (possibly under updated protocols). Non-essential sectors will also re-start or operate at fuller capacity, respecting protocols/guidelines, which will also guide how they should operate when physical distancing cannot be respected.

Within this context, the main elements of each phase across (i) private and public sectors, (ii) education, (iii) healthcare, and (iv) sports, culture, leisure, life moments and religion can be summarized are as follows:

Proposed scenario for medium-term restart

Building blocks		Phase 0	Medium-term restart: Phase 1	Medium-term restart: Phase 2
Private sector	**Industry and B2B services**[1]	Essential sectors OK; Non-essential sectors only if physical distancing can be respected (regardless of protocols)	Essential sectors OK; Non-essential sectors OK if protocols are fully respected	Idem
	Retail	(Pet) food, pharmacies, do-it-yourself stores, garden centers, newspaper stores / kiosks OK	Idem + Following order by call / online: pick-up and home delivery services On appointment: vehicle delivery (pre-ordered), inspection and repair, real estate Stores: bike shops, fabric shops, drugstore and cleaning products, building materials shops[4]; all only if protocols are respected	Idem + other retail once protocols are validated by responsible authorities and with full respect of those protocols
	Horeca / Arts, entertainment and recreation[2]	Closed except for hotels which can open without bar / restaurant / meeting room; delivery and take-away OK	Idem	Idem
Public sector / non-profit[3]		Essential OK; Non-essential only if physical distancing can be respected	Restart / increase capacity of critical services to meet public needs	Idem
Education		E-learning, limited back-up for working parents; pre-teaching as of April 20 for primary and secondary	Idem	Primary and /or secondary school: re-start of in-person classes for a maximum of 3 grades, and under specific conditions[6]
Healthcare		Only essential consultations, examinations and interventions (inpatient and outpatient)	All measures taken by the Surge Capacity-committee remain in place ; recommendations on re-start of non-COVID to be developed	Selective and gradual restart of elective health care depending on advice from working groups
Sports, culture, leisure and life moments		Limit contacts beyond people living together; Walk and horse-riding with one (and the same) friend allowed ; funerals with maximum 15 people and religious and civil weddings in presence of witnesses	Non-contact outdoor sports activities (including walking) with maximum 2 other people; outdoor sports training in club context and in presence of a trainer[5]; Private gatherings at home in small groups will be further examined	To be further examined: extended number of people for outdoor sports, protocols for funerals and weddings (indoor gatherings >50 people unlikely), trips to coast and other touristic hotspots, use of second residences ; individual or family visits for musea (1 person per 15 m2)

1. Agriculture, forestry and fishing (NACE A), Mining and Quarrying (NACE B), Manufacturing (NACE C) and other Industry (NACE D-E), Construction (incl. B2C services) (NACE F), Transportation and storage (NACE H, excluding airlines or equivalent except for essential tasks), Wholesale trade (NACE G46), Professional, scientific and technical activities (NACE M), Administrative and support service activities (NACE N), Other service activities (NACE S), Self-employed 2. Accommodation and food service activities (NACE I)/ Arts, entertainment and recreation (NACE R)
3. Public administration and defense; compulsory social security (NACE O) 4. Including retail shops for tiles, wooden floors, "quincaillerie", paint, sanitary facilities, building materials and wood, carpets, lighting, kitchen designers 5. Only clubs which are member of recognized sports federations
6. Flanders; other communities subject to local decisions. Classes are split into smaller groups and receive classes simultaneously or are split in small groups which receive blended education. Focus on graduation years, students with high learning needs and professional study orientations

GEES

Phase 0 - situation as of April 23rd

- **Private and public sectors:**
  - Essential sectors are able to operate; Non-essential sectors: mandatory telework wherever possible, if not possible, physical distancing >1,5m required
  - Retail and wholesale trade: Closed except for (pet) food, pharmacies, newspaper stores, do-it-yourself stores, garden centers and wholesale
  - Horeca: Closed except for hotels (which cannot open bars, restaurants or meeting rooms) and delivery and take-away operations
  - Arts / entertainment / recreation: Closed
  - Public administration: Continued operation of essential administrations (e.g. police); mandatory tele-working for all non-essential administrations
  - Non-profit: Continued operation of essential work (e.g. social workers); mandatory tele-working for all non-essential
- **Education:**
  - Preschool, primary, secondary: Classes suspended – remote education only; Schools remain open for the care of children whose parents (1) work in health care or other essential sectors (2) have no other options for child care while they are working; on distance pre-teaching as of April 20 for primary and secondary
  - Higher education: e-learning only
- **Healthcare:**
  - Guideline by HTSC-committee to suspend or delay all non-essential consultations, examinations and interventions in all hospitals
  - Measure also applicable to outpatient care in private practices as per Sciensano guidelines
  - Mental health care to be strengthened for public and health care workers
  - Working groups set up on re-organising health care structures in COVID-times (first line, second line intra/extramuros)
  - Awareness campaign under preparation for hidden non-COVID-patients
- **Sports, culture leisure, life moments and religion**

- Sports: Limited types of individual physical activity in the presence of one (and the same) friend or of persons living under the same roof
- Culture / leisure: No non-essential movements (limited exceptions for people with reduced mobility); mass events suspended until end August
- Life moments / religion: Religious and civil weddings only in presence of witnesses; Funerals with maximum 15 people; confessional gatherings suspended

- **International travel**: Borders are closed, except for work and some other essential travel. Belgians and residents can return to the country but must self-isolate for 14 days.

Phase 1

- **Economy: private and public sector – partial lifting of confinement measures for non-essential sectors – mandatory teleworking where possible – respecting protocols** validated by the responsible authorities, e.g. requiring masks if physical distancing cannot be respected, hygiene and cleaning requirements,…
  - Industry and B2B services (including self-employed) can restart non-essential activities once protocols are validated by the responsible authorities and with full respect of those protocols, notably:
    - Agriculture, forestry and fishing
    - Manufacturing, mining and quarrying and other industry
    - Construction (incl. B2C services)
    - Transport and storage (excl. airlines and related or equivalent, except for essential tasks)
    - Wholesale trade
    - Professional, scientific, technical, administration and support service activities in support of B2B
  - A limited number of non-essential B2C activities can restart once protocols are validated by the responsible authorities and with full respect of those protocols, notably:
    - Pick-up and home-delivery services (following order by phone or on-line)
    - Retail shops for tiles, wooden floors, ‘quincaillerie’, paint, sanitary facilities, building materials and wood, carpets, lighting, drugstore and cleaning products, kitchen designers;
    - Delivery by vehicles sellers of vehicles awaiting delivery, on appointment;
    - Auto repair garages, on appointment
    - Technical inspection of vehicles, on appointment
    - Real estate activities, on appointment
    - Stores that sell alternative transport means: bike shops, on appointment, and bike repair shops
    - Fabric shops that sell fabric that can be used for mouth masks;
    - Subject to approval by the municipality, individual market stalls for food products; markets remain prohibited.
    - One-by-one services for animals can open on appointment and with respect to physical distancing
  - Contact-professions (e.g. hairdresser, massage, pedicure) remain closed
  - Certain critical services in administration should be re-opened and operate at sufficient capacity to meet public needs including:
    - The early childhood sector operates today not a full capacity (less than 5% attending); it is necessary to examine to what extent it could resume its activities in support of children and parents, including of vulnerable families, with full respect of protocols validated by the responsible authorities;

- For the majority of other personal services, the level of activity is relatively high but under conditions of non-optimal distancing which have to be compensated by a strengthening of protective measures and priority testing for workers in these sectors of the economy or nonprofit sector.

▪ Essential activities continue or resume operation, with maximum use of teleworking (unless critical to be on site). Protocols approved by the competent authorities should be implemented where this is not yet the case.

o **Healthcare:**
  ▪ COVID: All measures taken by the Surge Capacity-committee remain in place; development of "resurgence plan" by HTSC.
  ▪ Non-COVID: awareness campaing continues, working group will make priority list of urgent, elective procedures consultations, hospitalisations; on that basis, recommendations will be developed on re-start of each sub-sector

o **Education:**
- Preschool, primary, secondary: Classes suspended – remote education only; schools remain open for the care of children whose parents have resumed work in sectors opening again and who have no other options for child care while they are working; on distance pre-teaching as of April 20 for primary and secondary
- Higher education: e-learning only

o **Sports, culture, leisure, religion and life moments**
  ▪ Local authorities can decide to reopen parks and public spaces, including graveyards (excluding playgrounds which still need to remain closed).
  ▪ Allow outdoor walking or sports activities with maximum 2 other people (or a higher number of people living under the same roof – if not within the same household, it should be the same person over time) that do not involve physical contact and respecting physical distancing.
  ▪ Cantines and dressing rooms/showers remain closed. In addition to walking, biking, jogging and skating (allowed already) this includes for example tennis, fishing, horse riding, pétanque, surfing, canoeing, Kajak, sailing, golf, athletics).
  ▪ For group sports, allow outdoor physical training in club context (only clubs which are member of recognized sports federations) in the presence of a trainer and respecting physical distancing, but no contact activities. Cantines and dressing rooms/showers remain closed.

- **Public transport:** as it will not at all times be possible to respect 1,5m physical distancing, wearing a nose-mouth masks or equivalent on public transport and within stations and at bus/tram stops should be made mandatory (cfr. RMG guideline). This should allow passengers to occupy every other seat in public transportation and diminish the social-distancing rule to 1 meter for standing passengers. Help from Securail and the municipal police will be needed for enforcement. Alternative means of transport (bike, foot, cars, private busses) should be encouraged where possible. If capacity turns out not to be sufficient, further congestion management measures should be taken (eg restricting certain hours for transport to work or school).

Phase 2

- **Economy**
  - o **Re-open B2C, once protocols are validated by the responsible authorities and with full respect of those protocols, except for sectors explicitly excluded such as restaurants, cafés, dancings, banquet halls, congress facilities, theatres, cinemas, leisure parks, etc.**
  - o Hairdresser and other individual contact professions: restart under consideration with adequate nose-mouth masks or equivalent.
- **Education:**
  - o Kindergarten: classes remain suspended at least until the end of the month May

  - Primary and /or secondary school: re-start of in-person classes for a maximum of 3 grades per education level, with a certain number of days to be decided (Flanders; other communities subject to local decisions). Classes are split into smaller groups and receive classes simultaneously at school or are split in small groups which receive blended education. As a deviation from the suggested phasing, it can be possible to start, as a pilot, on May 15th. Focus on graduation years, students with high learning needs (who may be invited individually at school) and professional study orientations
  - Schools remain open for the care of children whose parents have resumed work in sectors opening again and who have no other options for child care while they are working
  - Travel (including cross-border) in education is considered to be essential travel.
- **Healthcare**: Selective and gradual restart of elective health care depending on advice from working groups
- **Sports, culture, leisure, religion and life moments**
  - The possible extension of the number of people for outdoor walks or sports has not yet been decided and will be further examined. Likewise private gatherings at home in small groups will be further examined.
  - Examine how protocols for funerals and wedding ceremonies can be adjusted in phase II. Wedding parties and other indoor gatherings/parties > 50 people are unlikely to be possible for a longer period of time (i.e. including summer).
  - Examine with local authorities if and how day trips to the coast and other touristic hot-spots, rentals and use of second residences and can be allowed in phase II.
  - Musea: individual or family visits are possible, with online or telephonic ticketing system, with a maximum number of visitors per time slot (1 person per 15m2), with one-way directions and audience guidance supervising physical distancing. The museum shops will follow the directions for the B2C, and cafetaria's remain closed (following horeca regulation).
- **Public transport**: As for phase I (with possibility to reduce physical distancing rule relative to phase 1 if mask wearing is effectively generalized by all passengers).

- GEES will review these in the next 2 weeks based on additional input from stakeholders, international experiences and based on the evolution of the epidemic.

Phase 3

Economy

  - Examine in close cooperation with the sectors, if and under what conditions, remaining B2C can reopen: horeca, cinemas, leisure parks, concert halls, theatres, congress centers, etc

  - **Sports, culture, leisure, religion and life moments**
    - There is no decision yet on the further potential changes and timing for phase 3. Various activities will be further examined, including but not limited to, youth camps, *outdoor facilities* (zoos, attraction parcs,…), musea group visits, smaller scale outdoor events, religions and 'morales laïques', sports competition, theaters, cinemas, …
- International travel: as epidemic conditions improve and converge at lower risk levels across the Schengen area, internal borders are likely to reopen gradually. Travelling into and out of the Schengen area is likely to remain problematic for countries where the epidemic is not under control.
- Decision on youth camps is expected to be done by end of May

4. Impact

a. Impact on the epidemic

With epidemiological modelling, the GEES has tried to forecast the impact of various partial reopening scenarios. There are many aspects of the virus that are still unknown, and any model is by definition wrong. Epidemiological scenario analyses are however useful to support developing a strategic vision. Models relying on rich demographic and social contact data including information on behavioural change were used for doing so.

More particularly, tracing and testing was found to be a key element enabling any measures of deconfinement to be taken. Without highly effective tracing and testing deconfinement strategy yields a substantial risk for a resurgence of the epidemic. Community contacts including those linked to B2C activities were found to be a potential driver for resurgence and should be kept well under control. Reopening schools in a partial way as outlined in this report poses manageable risks to avoid the epidemic to resurge. The full restart of the economy without sustained telework, a complete re-opening of schools and day care, or unlimited contacts in the community could rapidly trigger steep resurgence of the virus.

The epidemiological models used tend to suggest that phase 1 should be feasible and phase 2 critically depends on the manner it is implemented and the ability to sufficiently reduce the number of contacts and respect all other pre-conditions mentioned above.

b. Impact on the economy

This scenario would have the following impact on employment:

Phase 1	**Total # in telework (M)**	**Total # at the workplace (M)**	**Total active employees (M)**	**Total # unemployed/ inactive (M)**
Total # Employees (current best estimate)	1.5	1.5	3.1	1.8
Additional employees vs. current situation	0.2	0.5	0.7	-0.7
Total # Employees (Phase 1)	1.7	2.0	3.8	1.1
Additional employees %	13%	32%	22%	-38%

Phase 2	**Total # in telework (M)**	**Total # at the workplace (M)**	**Total active employees (M)**	**Total # unemployed/ inactive (M)**
Total # Employees (current best estimate)	1.5	1.5	3.1	1.8
Additional employees vs. current situation	0.3	1.0	1.3	-1.3
Total # Employees (Phase 2)	1.8	2.5	4.3	0.5
Additional employees %	18%	65%	41%	-70%

Compared to the current situation the number of total people working at the workplace would increase by 500,000 in phase 1 and an additional 500,000 in phase 2. Even in phase 2, a very significant number of ~1,8 mio employees would remain active through telework.

c. Impact on mobility

Mobility is a central part of the restart approach, to bring people back to school (teachers and other employees, pupils and students), to work, and to ensure essential public service mobility missions. Yet this needs to be done in a way that is compliant with public health aspects, considering proximity and contacts are a factor of contagion.

In normal times, public transport capacity during rush hour (7-9am) across all Public Transport Operators (PTOs) is estimated to be ~1,200k passengers of which ~80% is driven by home-work and home-school commute.

Confinement measures have reduced total demand for public transport during rush hour to 70-130k passengers. Implementation of the operating protocols (incl. physical distancing) reduce available capacity to 30-40% for trains vs 10-20% for metro, tram & busses. This means that rush hour public transport capacity will be limited to 200-310k passengers with current distancing rules.

Based on current assumptions, the phased restart looks possible in public transport for phase I): estimated rush hour demand of 110-180k passengers vs available capacity of 200-310k passengers. For a Phase II as the estimated demand for rush hour demand of 185-245k – potential for localized breaches of capacity in urban areas (e.g., STIB-MIVB network) for which solutions need to be looked for. In any case current physical distancing norms are incompatible with normal capacity demand and would need to be adjusted through other measures (e.g. masks, spreading starting hours for work / schools, etc.).

d. Impact on social aspects and wellbeing

There is a whole range of mental health and social issues that have acutely worsened during the lockdown and will remain during the transition into deconfinement. Every crisis is an opportunity to change what has to be changed for a more inclusive and sustainable society (e.g. sustainable development goals). Continuous monitoring of the evolution of the social crisis should be carried out throughout the exit phases.

Unfortunately, the given timeframe for the compilation of this plan did not allow in depth elaborations of this matter.

Nevertheless, to prevent a major social crisis, the deconfinement process should include attention to the following issues and anticipate a set of measures:

1. **Health and wellbeing at work during the exit-strategy**: protocols should be in place and respected, mechanisms of control should be in place. The control mechanisms to supervise the adherence to the workplace protocols must be efficient and in place and reinforced where needed.

2. **Work-life balance**: the conditions within which confinement is being lived are highly uneven as are also the possibilities of being able to go back to work or continue teleworking. The impossibility for parents to return to work or to combine effective teleworking in the presence of their children at home ask for supporting measures. In defining these measures, special attention should be put in

the way they are financially bearable for households with low income (e.g. a “corona” parental leave is not a bearable option for the working poor population, especially women).

3. **Acute increase of poverty during the lockdown which require urgent action:**
Income: the halt in the economy has created and will create new poor even when economy will restart gradually. Research estimates predict a rise from 16,4% (before the crisis) to 25% (with and after the crisis) of people living below the poverty line. A considerable part of the burden of this increase in poverty will be taken up by the CPAS/OCMW’s.

Given the difficulty of life for poor people exacerbated by the crisis, some ways of rapid cash relief (or other adequate mechanisms) are temporarily required for the most essential everyday needs.

Non take up: the phenomenon of **non-take-up** of rights must also be taken into account as the measures of confinement have come with an increase in difficulties in access to social rights and aids. In normal times, research estimates non take-up of the social integration income to be between 57 to 75%[1]. Measures have to ensure that rights and social aids are indeed allocated, as the deconfinment will be very gradual and have a long-term negative effect on conditions to assure take-up of rights (mobility is reduced, reception conditions are limited, etc).
Following suggestions should be considered:

- Encourage automatic rights allowance to social security tools and social protection mechanisms (i.e. consider temporarily suppressing the conditions for fulfilment enquiry for access to RIS/leefloon, AMU, etc to allow the system to function.).
- Strengthening of the first line of response, its actors and its organization (within the social/health sector); be it private or public

Food help: specific attention should also be given to the basic need of feeding oneself and one’s family. The confinement measures have weakened the offer guaranteed in usual time by the **food help sector**, while the demand for food help – which concerned already 450.000 people in Belgium before the crisis - has increased with the COVID-related confinement measures (and the increase of poverty). The functioning of our current food help system is threatened directly by the epidemic reality and the related exit strategy. It relies massively on voluntary assistance provided by elderly people (which are the most at risk for severe forms of the disease). It is partially organized within social restaurants which won’t reopen before phase III (at a later date yet to be determined) and relies on different sources of supply greatly disturbed today. For those reasons, the right for food should exists and be carried out through for example cash transfer or food vouchers given to all people in need (including people not in official systems).

4. **Access to health care for vulnerable people**

Health care coverage for all the population must be assured, with special attention to those falling out of the social security (eg: through extended and automated urgent medical help (DMH/AMU), special attention to prisoners and to asylum seekers/undocumented migrants – KCE reports 257 – 293 – 319). The virus may strongly impact groups with lower coverage and spread via those pockets. Medical coverage is one of the conditions of effective contact tracing. Access to healthcare for all vulnerable people will therefore also be key to keep the overall epidemic under control throughout society.

5. **Mental health during confinement/deconfinement (see also paragraph on Health)**

The confined life leads to conditions of stress, anxiety, tension, domestic violence, decompensation in all sorts of forms, which vary greatly depending on the "ease" in which the family lives

[1] Source: Service de lutte contre la pauvreté, la précarité et l’exclusion sociale.

Strengthening of the mental health first line of response (within the social/health sector) be it private or public, would be important.

Sufficient input from mental health experts will be required for the next phases of the deconfinement strategy.

5. Guiding principles underlying the proposed sequencing

a. General principles

Keep the virus under control: the overall aim of the proposed strategy is to gradually reopen society within the limits of what our health care system can bear. Taking into account low levels of immunity amongst the Belgian population (estimated at ca. 5%), it is not an option to let the virus spread freely with view to build herd immunity. It would inevitably push the reproduction rate of the virus above factor 1 again, leading to exponential increases in patients, which hospitals could not bear.

Balance medium term health, social and economic needs: Sequencing deconfinement measures inevitably implies trade-offs between conflicting interests. The GEES has tried to make a balanced proposal, taking social and societal interests, economic interests, the right to education and individual rights into account. It has tried to avoid that the sequencing proposed would benefit parts of the population only, although it is not possible in the early phases where deconfinement is by definition partial, to open all sectors of our society.

This being said, statistics demonstrate clearly that COVID-19 poses substantially higher health risks for elderly and people with pre-existing medical conditions. It therefore remains important that those groups are very strongly advised to stay isolated to protect themselves also after deconfinement has started. Other groups, such as working parents with young children (i.e. 32% of the working population) and people at risk of poverty (expected to increase from 20 to 25% of the population), should be given the necessary support during deconfinement (as pointed out in paragraph 4d).

As a general rule, the GEES has prioritized activities with low risk of virus spreading and activities that, with adjustments that can rapidly be implemented, have low risk of virus spreading. Some activities with very high risks, which cannot be mitigated, may be impossible for a longer period. The GEES has tried, and will continue to try, to give as much predictability as possible for such activities. However, it should be clearly understood that, as so many factors remain unknown today, medium term perspectives are highly uncertain.

Furthermore, the GEES has prioritized, where possible, lifting those confinement measures which have a high negative impact on people's mental health.

Avoid chaos and uncertainty: The GEES firmly holds the view that deconfinement measures must be announced in a timely manner, and rolled-out in an organised manner in close cooperation with the sectors concerned. Workers, employers, customers, shop owners, public transport companies, etc must know how to act responsibly in various situations. Communication, clear protocols or equivalent national guidelines, and effective mechanisms to ensure compliance must be in place before launching the first phase of deconfinement. In sequencing deconfinement measures, the GEES has prioritized sectors/area for which behavioural rules are easy to explain, protocols or national guidelines can rapidly be put in place and compliance can more easily be assured.

Look at correlations school-work-public transport: Whilst the GEES is very conscious of the fact that restarting economic activities without (fully) reopening of the schools puts extra burden on parents, the model does not support full school and economy reopening. The GEES underlines that, as more parents will return to work in phase 1, schools must be ready to receive more children of working parents and socially or mentally fragile families. Further increased capacity will be needed in phase 2. For this reason also, the GEES has given priority to reopening/upscaling of day care services and it aims to clarify as soon as possible if and how summer camps can be organized in July and August.

As regards public transport, the GEES estimates that no major bottlenecks will exist for phase I if masks or equivalent mouth/nose coverage are compulsory and 50% seat occupancy and 1-meter physical

distancing for standing passengers. Nevertheless, clear protocols must be in place before the launch of phase I, so that public transport operators and passengers know how to behave responsibly. Careful monitoring will be needed before moving to phase II, which will put a bigger strain on public transport, in particular if teleworking is not maintained at the highest possible level. Flanking measures may be needed to stimulate alternative means of transport (foot, bike, cars, private busses …) and/or to manage congestion during peak hours.

International

With the help of FOD Buitenlandse Zaken, the GEES has actively collected information on exit strategies in other countries. It has studied international publications, such as the opinion of Leopoldina in Germany, and has been in contact with homologue experts in France and the Netherlands. Whereas each country puts its own accents and timing for the start of deconfinement varies in function of the epidemiologic situation (the Netherlands and Germany are overall a bit ahead of Belgium in terms of deconfinement, whereas France trails somewhat behind), the sequencing proposed by the GEES is in broad terms aligned with the strategies of other countries, in particular other European countries. Some countries have announced faster deconfinement phases but also do not face the exact same situation (e.g. significantly lower share of ICU capacity used in Germany and Austria).

The March outbreak has clearly been fueled by imports of the coronavirus through people returning from carnival holidays abroad. To avoid similar flare ups, restrictions on international travel can only gradually be removed, as epidemic conditions converge at lower risk levels across countries. It is important that deconfinement measures with cross-border effects, such are reopening of the horeca and tourism sectors, are well coordinated in particular with neighboring countries.

b. Economy (profit and non-profit)

The GEES is conscious of the fact that the sequencing of reopening economic activities has very direct implications for many people (entrepreneurs, workers, customers, people in precarious situations).

As discussions around the reopening of DIY-shops demonstrated, it is not always easy to justify precisely why certain shops/businesses can reopen earlier than others. Nevertheless, it is unavoidable to sequence the reopening of the economy in phases, and therefore **uneasy choices have to be mad**e. As we can only increase the number of contacts in society gradually, this means shops which individually present a similar risk profile, may not be able to open at the same time.

Grosso modo, the GEES has used the following criteria. It is an overall assessment taking all factors into account, rather than one or more specific criteria that have been decisive:

- sectors which have partially been open in phase 0, which have practical experience already with applying physical distancing and other protective measures;
- sectors for which protocols are agreed between social partners
- sectors providing essential support to vulnerable groups;
- sectors supporting the production of masks
- sectors enabling people and companies to meet essential needs (eg renting, buying or selling private and professional real estate)
- the number of workers concerned and impact on public transport;
- the absence of direct contact with customers, except for goods and services which fulfil important social and societal needs (eg physical access to social and mental health services, sale and repair of means of transport, textile shops in view of home-made mask production)
- value chains: where possible support opening up integrated value chains

- contribution to GDP and exposure to international competition. To be noted that industry and services represent 64% of GDP;
- level-playing-field within Belgium (e.g. retail construction material, single market stall selling food)

c. Healthcare and social sectors

The COVID-19 epidemic has set the Belgian Health care system completely upside down, the entire structure has been reshaped in a short time period: GP-care has become pre-triage, second line COVID/non-COVID care and non-essential (non-urgent, non-necessary) health care has been placed on hold. Homes for elderly and other collective care homes have become highly vulnerable places.
COVID-19 has proven also to be a difficult-to-understand disease to diagnose and to manage, with lots of diagnostic aspects, high risk for quick spread into health care, and a lot of uncertainties among health care workers.
In the meantime, the care for non-COVID-patients has been reduced to a minimum, with 3 kinds of missed appointments: (1) non-essential care appointments, (2) essential care appointments, (3) those who were severely ill at home but too afraid to seek care or not getting hold of the care they need. The latter 2 are particularly worrisome and have led to increased morbidity and mortality.

With regards to **the health care system**, the GEES see the following priorities:

- Manage health care structures to get out of the COVID first wave while minimizing mortality, morbidity and impact on health care workers – until date there are still about 1000 patients in ICU-beds across the country. Continued provision of the necessary protective materials; disposables and drugs is essential, next to specific plans for health care workers' health (see below)
- Prepare the health care system for oscillations/possible new waves as long as there is no widespread population immunity. Hence some kind of permanent surge capacity will need to be organized in the hospitals (with a description of the maximum capacity that reasonably and safely can be reached).
    - An interfederal Surge Capacity-comité for Primary and Outpatient care was set up at the start of the epidemic and includes key-stakeholders from first line services. This comité will explore further how the first line services can be resumed in the presence of pre-triage and schakelzorgcentra. Close collaboration with the work field and between authorities at the federal and regional level is necessary.
    - An interfederal Comité Hospital & Transport Surge Capacity with the involvement of stakeholders (representative organizations of the hospital sector) has been set up from the beginning of the epidemic to organize and regulate the distribution and burden of patient in the Belgian hospitals and to organize medical transport. The comité is actually developing a plan to guarantee sufficient buffer for COVID-19 patients (e.g. 25% of all ICU beds + an additional 25% surge capacity) while gradually elective and non-elective care could be resumed. This is a very delicate balance however, as sufficient buffer will be absolutely necessary in case of flare-ups of the epidemic

With regards to **patient care**:

- Take care of the 'rebound impact' (collateral damage) of the COVID-epidemic on health care for non-COVID patients
    - A working group has been set up with key-stakeholders from first and second line care and emergency departments, to start an awareness campaign & reach out to those patients who need essential care and are not getting it. The campaign will be preceded by informing the health care professionals about safely treating these patients within essential care. It needs to receive priority.

   - Next, a plan should be made on how to gradually restart elective care (consultations, daghospitalisation, hospitalization, surgery, procedures,…), extra- and intramuros. awareness campaign & reach out. An advice has been requested by the Ministry of Health to the councils for the regulation of health professions on definition of 'elective', 'urgent', 'necessary' and modalities of resuming activities. As for the hospital sector has been done by the Comité Hopsital & Transport Surge Capacity, a process still needs to be set up for first line providers – independent professionals, groups and services – on how to resume activities.
- As the COVID-epidemic is not yet over, much more need to be learned about clinical care and prompt diagnosis. More extensive testing and tracing will allow to obtain a better impression of the ongoing epidemic in the community as well as in the health care structures. After discharge, close follow-up of post-COVID-disease at home is required to understand the long-term disease burden.
- The COVID-epidemic and confinement period has brought along also an increase in mental illness across the population as well as among health and social workers for requires particular attention, care and follow-up. Existing plans for the expansion of mental health care should be promoted and expanded. Exchange and coordination between the regions and the federal level is firmly recommended, e.g. through the Interministerial Conference on Public Health.

With regards to **health care and social workers**

- Health care and social workers have worked in very stressful circumstances, in new teams, with suboptimal protection and not prepared for the task. This has generated exhaustion and fear among many. Arrangements need to be made to allow health care staff and social workers a period of rest and decompression, as well as a longer-term positive perspective on working conditions.
- Permanent adequate provision of PPE, disposables, medication,…, training and quality improvement are required for long term epidemic preparedness
- Particular attention needs to be given to the follow up of staff health related to COVID-19 (in particular provision of low-threshold PCR-testing and serotesting at a later stage) as well as staff health.

d. Education

The possible restart of schools during deconfinement has several dimensions: societal (pedagogical), social/wellbeing, economical. The organization of education is a regional competency, with a broad group of stakeholders to consult (policy makers, administration, federations, unions, teachers' and parents' associations,…).

A wide range of educational activities are offered for a wide range of ages (e.g. kindergarden to adults), abilities and with a wide range of activities. All these different educational types have very different contexts and realities in terms of introducing physical distancing and other preventive measures.
Multiple discussions with educational authorities in all three communities reveal important concerns on delays in learning, in particular for those students with previous learning disabilities. On the other hand, fear and anxiety about schools to re-open without sufficient preparation is also sensed among teachers and parents. Taken together there is a strong motivation among educational policy makers to restart (viva) classes in one way or another, in order to restore connection with all students, to catch up with the learning plan and to close the school year properly.
In the first phases of the deconfinement, given the delicate balance between the need for restarting pedagogical classes in a safe environment with respect to physical distancing, choices are made towards:

- those classes/students most in need of viva classes (e.g. graduation years, professional education)
- the age groups with least impact on the epidemiological curve (e.g. young children, who have on average also younger parents)
- reorganization of classes which maximally allow physical distancing, e.g. teaching small groups in 'epidemiological silo's'. This would allow contact tracing in case of illness also to be feasible in contrast with large groups which would generate many more contacts.
- educational authorities have started with translating physical distancing into the reality at school, though more in depth discussion is still ongoing e.g. regarding the use of masks by teachers and/or students, the organization of exams etc.
- the GEES has offered a generic guideline which can subsequently be translated into the local reality at the different school systems (see Back-up document 3)

Discussions with universities and high schools are ongoing at the time of writing.

e. Sports, culture, leisure and life moments

The GEES has based its proposal for sequencing on the following criteria:

- Health risk: In phase 1, the GEES proposes to lift restrictions for activities with low risk (ie limited number of people) and which can be exercised with respect of physical distancing. Gradually, certain activities with larger number of participants can be considered for opening under certain conditions, in particular when these activities are outdoor and/or allows fluent circulation of people.
- Social implications: the GEES proposes to prioritise activities with a high social or psychological impact, with a particular attention for youth for whom social contacts with friends are particularly determining. It is too early to decide on summer camps, but outdoor trainings for groups sports in clubs can restart under certain conditions.
- Impact on individual rights: the confinement measures restrict in an unprecedented way core individual rights of the population: freedom of movement, freedom of gathering, freedom of religion, property rights. The GEES is very conscious of this fact and proposes that restrictions are kept only for as long as necessary for public health reasons, and to the extent that they are proportionate. In making its assessment, the GEES takes into account that the simultaneous exercise of individual rights may lead to congestion of public spaces and thereby cause public health risks. The GEES considers that no discrimination must be made in who can and cannot exercise their individual rights. However, as the corona-virus objectively causes higher risks to certain groups in the population, in particular the elderly (> 65 years old) and those with pre-existing health conditions, the GEES considers that it should be systematically underlined in the Government's communications that people belonging to those groups take substantially higher health risks than the general population when taking part in certain activities.
- Clusters: the GEES recommends that the population is sensibilised to limit physical contacts to small groups of always the same people ("clustering") as part of the "new normal". In the initial phases of deconfinement, restrictions should be kept to help people adjust to this new normal (eg limitations on number of participants in private gatherings) but over time these restrictions should be phased out.
- Compliance: more than in other area (work, school, public transport,…) the degree of compliance with guidelines concerning the private sphere will depend on the conviction of people that they are in their own best interest and for the health of their loved ones. New cultural norms (eg no handshake, stay home when you don't feel well,…) will help reducing risks. Sustained communication will be crucial to promote these. During the initial phases, close monitoring of

general compliance and robust engagement with individuals/groups who do not comply will be needed.

- Subsidiarity as regards the control of public spaces: the GEES considers that local authorities are particularly well placed to modulate and enforce the rules in this area taking into account the specific local context (eg the risk of overcrowding public spaces). It must be ensured that local authorities, in exercising these tasks, act in the public interest and with due respect to fundamental rights.

6. Pre-requisites to be in place before deconfinement can be started

The WHO guidelines have to be followed and have been detailed in this report.

1. **Disease transmission is under control.**
2. **Health systems are able to "detect, test, isolate and treat every case and trace every contact".**
3. **Hot spot risks are minimized in vulnerable places, such as nursing homes**
4. **Schools, workplaces and other essential places have established preventive measures**
5. **The risk of importing new cases "can be managed"**.
6. **Communities are fully educated, engaged and empowered to live under a new normal.**

The GEES also describes critical pre-requisites for this strategy to function: **Maximal continued physical distancing for any contacts.** Everyone should keep 1,5 m distance to anyone else but his household living in the same place. Where this is exceptionally not possible (e.g. at work, in public transport) equivalent protection measures specified in protocols and guidelines must be respected.

1. **Continue stringent hand and coughing/sneezing hygiene**
2. **Generalized availability and correct use of masks/equivalent coverings** in any populous environment (disposable comfort mask or re-usable cotton), including public transports, shops, busy streets…
3. **Generalized and continued availability of medical equipment** necessary to treat patients and protect health care workers.
4. **Strict definition and follow-up of protocols and national guidelines:** respect the general guidelines as published at the Sciensano website (https://covid-19.sciensano.be/nl/) and at www.info-coronavirus.be, detailed for various sectors, school or sports environments
5. **Capacity of minimally 25,000 viral PCR tests per day,** to be able to do necessary testsoffer testing for anyone with symptoms, for a subset of the direct contacts of positive cases, and to maintain a sufficient test capacity in the hospitals, the elderly homes and other high-risk settings and of anyone with symptoms and their direct contacts. Viral tests will go hand in hand with contact tracing in our strategy to control flare-up'**s**
6. **Extensive contact tracing through a force of 2000 trained people** that either remotely or on-site contact confirmed cases and follow up with their contacts
7. **Control mechanisms** of the respect of workplace protocols which must be reinforced at short notice (preventive medicine specialists, labour and health inspections,…)
8. **Follow-up and control mechanisms** of adherence to quarantine of confirmed or highly likely cases – to be further developed in the coming 10 days
9. **Clarify liability and insurance questions**: contractual and non-contractual liabilities
10. **Avoid disincentives to work** combined with measures to support working parents
11. **Clear consistent communication**

7. Dynamic management of the epidemic and measures if flare ups happen

Despite all precautionary measures, it is very likely flare-ups larger than individual cases will happen. It will be critical to monitor and map real time sources of infection, to be able to assess the need for new country-wide, regional or site-based re-confinement measures. Fast and radical actions will be needed, leveraging as much as possible early indicators like symptoms monitored by GPs and test results.

Practically, the GEES recommends to monitor both early indicators (such as flu-like symptoms or COVID-suspicions monitored by GPs and test results), the evolution of confirmed COVID-19 cases and late indicators (such as 7 -day growth in number of hospitalized cases and ICU capacity used for COVID 19 on a daily basis).

Decisions to move to a next phase should be taken about 1 week before the envisioned start of the next phase.

The actual impact of phase 1 and phase 2 deconfinement on the epidemic might only be fully visible after the start of phase 2. Other factors might also influence the evolution of the epidemic. It is therefore certainly possible that during phase 2, part or all of the relaxation of confinement measures may need to be dialed back – and in an emergency also measures of phase 1.

In terms of time line this would mean:

- National Security Council April 24th
- Potential Launch of Phase 1 May 4th
- Review whether conditions are met for Phase 2 - May 8th or May 11th
- Potential launch of Phase 2 whether all conditions are met – May 18th
- Ongoing assessment on a daily basis with weekly (or faster if needed) reporting to the Kern

8. Communication approach

Communication is a critical enabler to an orchestrated restart

- **Provide clarity:** Explain the *what* and *why* of what can be done or not and *how* we will implement, e.g., which sectors can restart, why have we made this choice and how do will ensure a safe restart through the right operating protocols (both day to day life and economic)
- **Ensure coordination:** Onboard all level of government, economic, health & social stakeholder across the country
- **Restore public confidence:** Ensure that the fact-based recommendation approach is translated in fact-based communication

A coordination mechanism between the various working groups including GEES & INFOCEL is a must

- GEES has aligned with INFOCEL and defined the following interaction process:
- **Daily updates**: Daily updates by email from INFOCEL to entire GEES group on key topics emerging from the monitoring of public perception and opinion in the press, social media and communication channels
- **Ad hoc check-in**: Ad hoc check-ins to discuss (1) input (INFOCEL insights based on public sentiment including concerns, etc.) and (2) output (key messages discussed by GEES to be communicated to the public by INFOCEL)
- **Weekly sessions**: Discuss overall GEES 'direction of travel' and implications for the key messages and audiences to be reached by INFOCEL

There is an urgent need for sequenced communication across 6 topics over the coming months. GEES Communication needs to be a true 'enabler' at the service of the 'restart' workstreams (General medical services, Culture, sport, entertainment and life moments, Economic sectors, Education, Public transport & mobility). In order to serve in an effective way, we will actively work with the respective workstream leads to identify & integrate all relevant workstream milestones in an integrated communication plan.

Communication needs will be phased over the next months, including

- **Prior to restart (i.e., next 10 days):** Prepare population & workforce for restart to covers "how to" guidance on elements of both public & professional life (e.g., how to behave in a store, public transport, etc.)
- **Phase I**: Issue guidance on how to contribute to contact investigation to secure a safe restart for the whole population, practical considerations, etc.
- **Between Phase I & II**: Inform on details of the proposed (B2B, B2C) sector restart including roll out of detailed 'how to' materials per sector (e.g., how to safely operate a retail store, how to enforce respect for the rules through posters & other materials that induce peer pressure)
- **Summer**: Remind the operating protocols in public life / insist on continued discipline, prepare for the 'back to school' measures, inform on details of the further sector restart in horeca, culture and leisure sectors, etc.

- **September**: Prepare for increased risk of virus resurgence during autumn & winter months, etc.

Next 10 days are critical to prepare the population for restart – urgent need to operationalise & resource large communication campaign

- GEES calls upon all stakeholders to rapidly operationalise (e.g., urgently hire an agency) & resource (e.g., make all financial & other resources available) a large communication campaign to prepare the population in a very practical way for the restart. We need to cover 'restart topics' with "how to" guidance on elements of both public & professional life:

- "**How to" communication on 'new normal' protocols**: Urgent need to 'educate' population on how to operate in a safe way based on the 'new normal' operating protocols, both in their social and public lives

- **Sector-specific protocols and guidelines**: Need to onboard employees per respective sector on the operating protocols relevant to their operations

- It is essential that the required resources to support such a campaign are made available by as soon as possible in order to be able to roll it out as soon as possible and before April 27.

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In the short term, the governments will need to ensure following actions are being implemented

1) Ensure testing scale up plans to 25k viral PCR test (and beyond)
2) Contact investigation taskforce: 2,000 FTEs, technological support/tablets, applications, training platform / delivery, funding
3) Support by regional/federal governments to be "provider of last resort" for masks/coverings; enabling mask availability by May 4 th , change of Min. Decree regarding use of masks and other protective equipment outside of health services
4) Likely need for consultation with social partners on implications for working parents
5) Ensure protocols endorsement
6) Communication campaigns both to (i) population, aiming at restoring confidence and optimism & explaining how to live and behave responsibly with Corona and (ii) employers, to get ready for protocols implementation
7) Key data reporting from GPs, contact identification, … quasi in real time to support restart decisions
8) Clarify modus operandi towards restart (who is responsible for what at what level), including coordination with all stakeholders
9) Transpose phase 1 into an updated Ministerial Decree

Back-up 1: Guidelines for individuals

The population needs to continue to adhere to guidance, particularly with regards to hygiene, distancing and masks. It is essential that all communication, operating protocols and other guidance that is issued covers the following four elements

- **Practice good hygiene**
  - Wash your hands with soap and water or use hand sanitizer, especially after touching frequently used items or surfaces
  - Avoid touching your face
  - Sneeze or cough into a tissue, or the inside of your elbow
  - Disinfect frequently used items and surfaces as much as possible
- **Maintain physical distancing and use face masks**
  - Maintain 1.5 m physical distancing when possible
  - Use disposable or reusable face masks (or equivalent, e.g., a scarf) while in public
  - Use of a face mask or equivalent using public tranport due to increased risk of not being able to consistently respect physical distancing
- **Stay home when you are not feeling well**
  - Do not go to work or school (suggested daily temperature check)
  - Contact and follow the advice of your medical provider when you are not feeling well
- Adhere to the highest safely measures when you are part of a risk group (e.g., age, pre-existing condition)

Back up 2: Guidelines for employers

- **Limit contact to the minimum**
  - Continue to strongly encourage tele-working
  - Minimize business travel to strictly necessary
  - Restrict common areas (e.g., canteens)
- **Develop & implement safety protocols** based on physical distancing, PPE, temperature checks, disinfection of common areas, use of face masks when physical distancing is not possible
- **Monitor indicative symptoms & support workforce where needed**

Back-up 3: School guidelines

General

The general principle is to minimize the risk of transmission in the school context by applying physical distancing, hand hygiene and mouth masks. Children or staff presenting clinical symptoms should stay at home, as well as children and staff belong to high-risk groups (these will be defined in due course). For those children, education should be provided through distance learning.

On masks and equipment

All pupils > 12 y of age and staff **should wear mask or equivalent mouth/nose coverage** throughout the day (artisanal or disposable comfort masks provided that they are replaced according to guidelines). The use of FFP2 masks is not recommended. Maintenance staff and health care workers should wear gloves in addition.

On hand hygiene

Hand washing (water and soap or with hand alcohol gel) should be applied by all pupils and staff on entering the school, entering the classroom (after play time), after toilet visit, after coughing or sneezing, after operating distributors machine, and before leaving schools.

Class organization

Within the class, education should be organized within classes of maximum 10 pupils, with a minimum of 4 m2 per pupil and an additional 8m2 per teacher. Chairs and table should be set-up such as to maximize the distance between tables, preferably close to the walls. The places in the classroom should be fixed. No practical (chemistry/physics/biology) involving movement and/or close interaction between pupils will be organized. The physical education lesson can be maintained but should be adapted to maintain physical distancing, with higher distances if the effort results in stronger respiration. A particular attention should be given to a higher than usual ventilation of the classes, either with artificial systems (specific instructions will be given for ventilation systems) or through the windows, and outdoor classrooms is recommended.

School organization

Preparatory meetings with staff should be held as much as possible using video conferencing. In preparation for the reopening, staff can be physically invited to the school before the reopening. Contacts with parents should be maintained using video conferencing and non-essential meetings should be canceled.

School entry, exit, play times, refectory should be all organized in a way that allows the maintenance of an area of > 1.5 m per pupil (or an area of $7m^2$). This could be organized through longer entry/exit time and alternate play and refectory times.

No hot meal should be served at the cantine. Cold lunch should be preferred and taken in class. The organization meetings between staff should preferably be held outdoor or in settings allowing a minimum of $4m^2$ per staff member.

Toilets

The access to toilets should be limited to the number of sinks, and these should be equipped with soap and disposable paper wipes. Posters should be put in the sanitary to remind pupils and staff to flush the toilet with lid closed.

Cleaning

Classes should be cleaned (tables, machines, everything that can be touched with the hands) after each day and after each use by other group of students. Sanitary facilities should be checked and possibly cleaned 2 times per day.

First aid/sick pupil or staff and general health

Parents of pupils showing symptoms should be immediately contacted to come and pick up their kid. The child and its contacts need to be tested.

A specific room should be dedicated for sick pupils should be equipped with a digital thermometer that can work at a distance, gloves and mouth masks for the person accompanying the pupils while waiting for the parents. The room should be large and ideally well ventilated. Arrangements should be made with the psycho-medical centers so that pupils showing signs of mental distress could be identified, taken care of, and oriented toward professional help in partnership with the parents.

Back-up 4: Contact investigation and active case finding

Active case finding of infectious cases consists in implementing interventions aiming to diagnose patients that would otherwise not present spontaneously for a test or that would present late during the course of their disease. In the context of the COVID-19 outbreak, these interventions should allow to prevent large chains of transmission in the community, which inevitably result in an increase in the number of people hospitalized.

Three types of interventions are required an should be implemented:

(1) **Systematic screening procedures** in well identified high risk communities (hospitals, nursing homes, prisons, camps, …) should be implemented.

(2) **Pro-active identification** of not yet identified high risk areas or communities, followed by targeted prevention and/or screening interventions.

(3) **Contact tracing** of contacts of new symptomatic patients suspected or diagnosed outside the two interventions above, typically following a consultation to the general practitioner. **Self-confinement** and **testing** strategies should include all contacts, with an increased attention for symptomatic cases and asymptomatic cases with a higher risk for (a) generating large outbreaks if carriers of the virus (health workers, social workers, …) or (b) evolving towards a more severe form of the disease if effectively infected (elderly people, comorbidities, …)

Implementing contact tracing and active case finding in general will significantly reduce the chance of virus resurgence and should be considered as critical for the gradual reduction of confinement measures. It is a proven way to immediately contain new roots of virus outbreaks, and certainly to prevent these new outbreaks to evolve to a large and less controllable scale.

Therefore, **the GEES recommends to deploy contact tracing at the required capacity as of the next phase of the exit strategy**, assuming May 4th, 2020. In parallel, systematic screening procedures should be maintained and strategies to better identify hotspots of transmission outside the well-defined high-risk groups should be reinforced.

Back-up 5: Testing

Until today only symptomatic patients requiring medical hospital care and specific high-risk groups have been eligible for testing, partly due to limited testing capacity.

Since the start of the outbreak, the overall testing capacity has increased and is expected to continue increasing significantly in the coming weeks. A particular attention should be given to the best usage of these available and evolving resources, considering their central utility in the outbreak response.

The latest indications for testing available on the Sciensano website (version 22/4/2020) are in this sense insufficient as they do not allow performing a test for people presenting symptoms at the community level, which is the seedbed of the transmission chains that will occur when re-opening the society.

Going forward, the GEES sees the need to increase tests to the following categories, in order of priority:

1. Clinically suspected Covid-19 infections at the community level
2. Active case finding interventions
3. Systematic screenings in high risk settings e.g., hospitals, nursing homes
4. Systematic screenings as targeted response for local outbreaks e.g., in a specific neighbourhood, specific communities

We consider a daily capacity of **25k PCR** (and eventually 35k serology tests) as of May 4th under the assumptions of 1000 Covid-19 infections per day, 10 contacts to trace via active case finding per Covid-19 case per day and 50% of the contacts requiring a PCR test, 100% a serology test. We nevertheless recommend **implementing and scaling-up as soon as possible**, and before May 4th, particularly for community-based testing (allowing GPs to prescribe tests among suspects and re-opening triage centres) in order to avoid any delay associated with the logistical requirements which inevitably will take a minimum of 10 days.

Number of symptomatic Covid-19 infections predicted	1000		Number deifned by epidemiologists
Description	**PCR**	**Serology**	**Comment**
1. Active case finding			
Number of contacts per symptomatic Covid-19 infection predicted	*10*	*10*	*Number defined by the level of confinement*
% of contacts eligible for test	*50%*	*100%*	*Only close contacts require PCR*
Number of tests among contacts	5000	10000	Total number of contacts eligible for test
2. Number of clinically suspected Covid-19 infections	10000	10000	To be 10 times higher than the number of cases due to aspecific clinical symptoms
3. Systematic screenings for local outbreak reponse	5000	5000	Oriented based on local epidemiological evolution
4. Systematic screenings in high risk settings	5000	10000	Hospitals, prisons, nursing homes
Total tests required	**25000**	**35000**	

Minimal daily testing capacity needs

Besides the total capacity, it is important that test results are completed within 24 hours to avoid contact tracing on much higher numbers of suspected cases that did not receive the test results within 24 hours.

The PCR testing rhythm now increased in the week of April 13th and April 20th, in line with the growing lab capacity for PCR-testing. On April 21st, we now have a PCR testing capacity of 20k (>6k in clinical labs, 2k in overflow university labs, 12k in the federal lab platform). The federal platform will increase to 15k test capacity end of April and 20 k test capacity mid-May. It is necessary to mobilize private laboratories at this stage in order to avoid a 2k shortage of test capacity between May 4th and May 15th. These capacity numbers include reagents and other material needs. Serology test capacity do not have the same constraints as PCR test capacity and should be less complex to implement. Decision to use serology on a systematic basis should be made with all parties, considering the limitations associated with the interpretation of these tests and their epidemiological value.

Immediate next steps to secure the required testing capacity are:

- Accelerate the capacity ramp of the national capacity by making sure all laboratory capacity is relieved from constraints related to restrictive testing criteria. Clinical laboratories, federal platform labs and academic platforms should be jointly mobilized and reach 25k by May 4th
- Ensure that laboratories can perform and communicate results within 24 hours

Back up 6: Masks

Citizens decrease the risks of infecting other citizens when wearing a mask. Wearing a mask does not protect against getting infected by others because a mask, by design, does not filter or block very small particles in the air that may be transmitted by coughs, sneezes, or certain medical procedures. In the confinement phase, wearing a mask is less relevant as you can respect physical distancing. In the next phase of the exit strategy, an increasing number of citizens will likely to be exposed to close contact again in specific situations (public transport, some work situations, shops, …).

The GEES therefore strongly encourages to wear masks in the following situations, regardless if you are COVID-positive or not:

- In public areas, wearing masks where you cannot control physical distancing e.g., crowded places
- At the workplace, wearing masks when the employee cannot work remotely and cannot control physical distancing e.g., on a production line with positions less than 1.5 m apart.
- In schools, wearing masks for all teachers and students, except youngest students i.e., students younger than 12 years old
- When using public transport, wearing mask or equivalent mouth/nose coverings at all times
- In the healthcare sector, to follow the guidelines as communicated by the Federal and Regional departments of Public Health.

The GEES recommends two types of masks:

- Disposable surgical mask, i.e. the user throws away the disposable surgical mask at the end of the day.
- Reusable cotton mask 100% cotton-based masks that can be regularly washed in a washing machine.(like washing whites). The GEES does not recommend to use the micro-wave to “disinfect’ a mask. Citizens can go to the following websites to make their own reusable masks with expert-approved procedure: Maakjemondmasker.be (Dutch), Faitesvotremasquebuccal.be (French), Makefacemasks.com (English). Children will mostly need to use reusable masks (with clear markings of front and rear side), given the lack of size adjusted disposable masks.

One should avoid promoting or providing FFP2 masks to citizens to avoid a public perception that surgical masks are of inferior quality and that citizens need FFP2 masks to protect one another.

To reduce contamination risks when wearing a mask, people should avoid touching their face and to wash their hands when they have touched the mask and when they have taken off the mask.

Needs and sourcing strategy

On the mid- to long-term, surgical masks are likely to become a commodity. As soon as the market dynamics of a commodity will come into play, the market will become self-regulating.

However, in the next phase of the exit-strategy the recommendations above will lead to an immediate shortage without government-controlled sourcing. As of phase 1, without re-usable masks up to more than 35 mio disposable masks may be required per week, of which 10 mio for professional use (outside of health services). The use of re-usable masks by 20-40-60% of the population could reduce these needs proportionally.

All channels should be activated now for sourcing and production simultaneously i.e.,

1) *Sourcing through the federal crisis task force*. The federal crisis task force gained experience in vetting suppliers, organising transport and quality control. In addition, central sourcing reduces the risk of artificial price increases.
2) *Sourcing through Comeos*, representing Belgian commerce and services, who have an estimated 30 m surgical masks ordered for their stores and commercial outlets
3) Organised *local production* coordinated
4) *Encouraging citizens* to produce their own reusable cotton masks

Repackaging and distribution channels

Repacking and distribution will be important element to get the masks to right people:

- The surgical mask supplied by the federal crisis task force and the local production volumes are send to the healthcare industry (current urgent flow to ensure supply) and to traditional repackaging and logistics companies
- These repackaging and logistics companies distribute to companies, government institutions, traditional and online retail channels, and vending machine service providers.
- As mentioned above, Comeos organizes the distribution to its members stores and commercial outlets
- The Belgian population can purchase masks through traditional and online retail channels and vending machines (e.g., at the entrance of public transport). Potential manual distribution in public transport stations might be needed in case the vending machines create queues and delays
- Food banks and other social organizations can supply underprivileged citizens

There is no recommendation to distribute surgical masks directly to the Belgian citizens through bPost because the federal government does not know household size for each address. However, mayors of certain cities (e.g. Leuven) are contemplating this strategy to distribute a cotton mask to each inhabitant of their city.

Schools should not purchase masks but parents of the students should purchase (reusable or not) masks individually.

Resulting immediate action include

a. Revise the ministerial decree of March 23rd, 2020 about the sales stop of personal protective equipment (PPE) through retail channels except pharmacies to allow retail channels to sell masks again.
b. Source additional masks to avoid shortage in early stages as of May 4th
c. Ensure massive reconditioning facilities are set up to repackage in packages of 5-10 -20 masks
d. Align with various distribution outlets for distribution
e. Communicated clearly as of April 24th on the future need for masks and encourage companies to source
f. Fulfil its role as employer and ensure masks are available for people in public administration where it is needed in the workplace