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1 **Ten considerations for effectively managing the COVID-19 transition**

2

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69 **Abstract**

70 Governments around the world have implemented measures to manage the transmission of coronavirus  
71 disease 2019 (COVID-19). While the majority of these measures are proving effective, they have a high  
72 social and economic cost, and response strategies are being adjusted. The World Health Organization  
73 (WHO) recommends that communities should have a voice, be informed and engaged and participate in  
74 this transition phase. We propose ten considerations to support this principle: (1) implement a phased  
75 approach to a ‘new normal’; (2) balance individual rights with the social good; (3) prioritise people at  
76 highest risk of negative consequences; (4) provide special support for healthcare workers and caring staff;  
77 (5) build, strengthen and maintain trust; (6) enlist existing social norms and foster healthy new norms; (7)  
78 increase resilience and self-efficacy; (8) use clear and positive language; (9) anticipate and manage  
79 misinformation and (10) engage with media outlets. The transition phase should also be informed by real-  
80 time data according to which governmental responses should be updated.

81 The rapid escalation and global spread of coronavirus disease 2019 (COVID-19) has prompted  
82 governments to implement policies and measures to manage virus transmission, which has given health  
83 systems time to prepare and mitigate the impact of the pandemic. While the majority of these measures  
84 are proving effective, they have a high social, psychological<sup>1</sup> and economic cost and are, therefore, not  
85 sustainable. Some countries and smaller jurisdictions are entering a phase of *transition* during which a  
86 ‘de-escalation of global actions may occur, and reduction in response activities or movement towards  
87 recovery actions by countries may be appropriate, according to their own risk assessments’<sup>2</sup> (p. 14). This  
88 transition has challenges. Until a vaccine or effective treatment becomes available, public behaviour and  
89 adherence to national and sub-national response strategies—notably social and physical distancing  
90 measures (SPDM)—will continue to be key measures for controlling the virus. One of the six key criteria  
91 that the World Health Organization (WHO) Regional Office for Europe<sup>3</sup> have defined for the transition is  
92 that communities should have a voice and be aware of and engaged in the transition process. We aim to  
93 substantiate this principle with available evidence and expert advice.

#### 94 95 **Unwanted scenarios**

96 At worst, a poorly timed and badly managed transition threatens the gains that each nation has  
97 collectively achieved—potentially with high social and economic costs<sup>4-6</sup> (5: preprint without peer-  
98 review). Historical evidence from the 1918 influenza pandemic shows that a second wave of infection  
99 can follow the removal of SPDM and lockdowns<sup>7,8</sup>. Each country’s government can apply lessons learnt  
100 from experience and analyse the current situation to anticipate potential unwanted scenarios and plan  
101 mitigation measures. These scenarios are likely to vary depending on cultural context. However, in  
102 general, the following scenarios and situations should be considered.

#### 103 104 *A continuum of reactions*

105 At one end of the continuum of public responses to the pandemic is a decline in feelings of fear and  
106 threat. A lack of perceived risk (e.g. due to declining cases or psychological adjustment to the new  
107 situation) can cause decreased adherence to measures<sup>9</sup> (preprint with internal peer-review) such as SPDM.  
108 Moreover, people’s desire to reduce loneliness as soon as possible after a period of prolonged enforced  
109 isolation may be strong, and the loosening of response measures might seem like standing in front of a  
110 rich buffet after a diet or period of fasting<sup>10</sup> (preprint without peer-review). Just as we might be tempted to  
111 binge eat, our craving to socialise may grow with each day of the pandemic. At the extreme end of the  
112 continuum of reactions, distrust of authorities, conspiracy thinking or reactance (anger due to restrictions)  
113 may lead to social movements against SPDM norms and policies and a rise in pro-social closeness and  
114 interaction. These reactions may be underpinned by messages that question the appropriateness of

115 government pandemic measures, which can increase distrust among broader segments of the population.  
116 This scenario is not dissimilar to events and patterns related to vaccination<sup>11-13</sup>. In addition, specific  
117 population groups may lack the capability to continue adhering to restrictions and recommendations.  
118 These groups may include youth, people with anxiety and other mental health disorders, people who lack  
119 social support structures, financially disadvantaged groups, the homeless, indigenous populations, mobile  
120 populations, people with chronic illness, people experiencing abuse or domestic violence, people living in  
121 long-term care facilities and the persons who care for them and healthcare workers. People with lower  
122 health literacy may face additional difficulties when navigating these challenges<sup>14</sup>. Conversely, some  
123 people may be overly cautious due to fear and worry<sup>15</sup> and may continue to over-implement restrictions<sup>16</sup>,  
124 avoid supportive social interactions and delay seeing health care providers for potentially life-saving  
125 measures, such as vaccinations or check-ups.

126

### 127 ***Uncertainty and lack of clarity***

128 As response strategies are continuously adjusted, it is likely that debates in the political and public  
129 spheres related to unresolved dilemmas or the appropriateness of the implemented measures will increase.  
130 How measures are implemented can fluctuate between what scholars refer to as societal tightness (e.g.  
131 having strict rules and punishing deviance) and societal looseness (e.g. having more permissive rules and  
132 lax punishments)<sup>17,18</sup> (18: preprint without peer-review). Moreover, the transition process is likely to be  
133 bidirectional and to require continuous adjustment<sup>3</sup>, and predictability will be challenging due to  
134 uncertainty regarding the evolution of the outbreak. People will need to navigate these adjustments and  
135 the lack of predictability, as well as complex and ambiguous messages (e.g. see some friends but not too  
136 many friends) and possibly competing demands from the social and cultural environment regarding social  
137 interaction<sup>19,20</sup>. Collectively, these situations may result in individuals developing idiosyncratic  
138 interpretations of restrictions as a coping strategy<sup>21</sup>.

139

### 140 ***Stigma and discrimination***

141 Disease can evoke fear and motivate people to separate themselves from infected individuals by  
142 stigmatising them<sup>22-24</sup>. Examples include the stigmatization of gay men as an early response to AIDS<sup>25</sup>  
143 and of ‘Typhoid Mary’ (Mary Mallon) in the early twentieth century. The latter was apprehended by  
144 authorities in Manhattan for spreading typhoid via her work as a cook, which caused many deaths<sup>24</sup>. In the  
145 current situation, certain population groups (e.g. health workers or certain ethnic groups) in some  
146 countries may be perceived and branded as virus transmitters<sup>26,27</sup>. COVID-19 may also become associated  
147 with unhygienic or careless practices. This thinking could increase the mental distress and anxiety of  
148 people who are infected<sup>28</sup> (preprint without peer-review) and reduce compliance with regard to testing

149 and engaging in the contact tracing process<sup>29</sup>. Moreover, individuals who are at higher risk of severe  
150 illness (and their families) may be advised to continue strict compliance with restrictions (e.g. working  
151 from home). These individuals may be exposed to new forms of stigma, blame or discrimination as  
152 societal expectations shift, especially in contexts where legal terminology is unclear.

153

#### 154 **Ten considerations**

155 Avoiding these potential unwanted scenarios calls for careful planning and consideration of the  
156 perspectives and engagement of populations<sup>3</sup> and should be informed by evidence and expert advice from  
157 the social and behavioural sciences and medical humanities. To support a key WHO criterion for the  
158 transition (that communities should have a voice, be informed, engaged and participate), we propose ten  
159 considerations for governments (Figure 1). Consideration 1 relates to the central idea that communities  
160 must be aware that there will be no going back to normal but a stepwise approach to a ‘new normal’. The  
161 other nine considerations relate to giving communities a voice (Considerations 2 to 4), engaging them in  
162 the transition (Considerations 5 to 7) and informing them (Considerations 8 to 10)<sup>3</sup>. These considerations  
163 are intended to support authorities in tailoring response strategies that will be accepted by the population  
164 and priority target groups and that are likely to be effective<sup>3,11,30,31</sup>.

165

166 To gather existing evidence and experiences of previous crises and brainstorm how this information could  
167 support the transition phase, the first authors convened a group of experts, who reflect a diversity of  
168 academic disciplines, domain expertise and familiarity with infectious diseases in general and COVID-19  
169 in particular. This brainstorming was conducted online over three days. The first authors synthesised the  
170 longlist of relevant issues into a shortlist, which was commented on by the full group in a shared  
171 document. When a consensus was reached regarding the number of considerations and their respective  
172 scope, the first authors drafted the sections and the experts added evidence and relevant references. The  
173 entire group reviewed the final version. Thus, the resulting ten considerations, which are presented in  
174 Figure 1 and explained with examples in Table 1, are based on expert advice and available evidence.  
175 We suggest that, where possible, each consideration be monitored, informed and qualified using real-time  
176 empirical evidence (sometimes referred to as ‘behavioural insights’). This could be achieved via  
177 population surveys<sup>32</sup>, media and social media monitoring, ethnographic studies, COVID-19 hotline  
178 monitoring and rapid assessment of specific population groups. While the following considerations have  
179 been devised for COVID-19, they may also be helpful for addressing future unexpected events.

180

#### 181 **Consideration 1**

182 *Implement a phased approach to a new normal*

183 At the centre of transition management is the assumption that an immediate return to normal will not be  
184 possible. Instead, the transition process will take place in accordance with a phased approach whereby  
185 society, systems and services are gradually re-opened, potentially in new forms. Each phase may involve  
186 adjustments to restrictions and potential re-employment of previous stricter measures. During this  
187 complex process, if people think that they are or soon will be returning to normal, their actions may  
188 hasten the onset of a second wave of the outbreak<sup>4</sup>. Insights on how to mitigate this and maximise the  
189 effectiveness of a phased approach to a new normal can be gained from studies that investigate how  
190 people acquire new habits. These include studies on adjusting social norms in new student  
191 populations<sup>33,34</sup>, evaluating procedures and aids for prisoners returning to society<sup>35</sup>, developing  
192 pedagogical steps for small children who learn to stay in kindergarten<sup>36</sup> and normalising behaviours for  
193 people with eating disorders<sup>37</sup>. Different as they are, these studies all employ a step-by-step approach to  
194 practising new behaviours in old environments whereby successfully acquiring habits is a function of  
195 repetition<sup>38-40</sup>. In each case, the transition process is iterative. It involves detailed planning, setting goals  
196 for each stage and stabilising, recapping and monitoring progress<sup>39</sup> and is underpinned by clear  
197 communication. The COVID-19 transition process involves defining and communicating specific phases  
198 in advance, while also accounting for the uncertainty of the outbreak evolution; preparing people for  
199 planned adjustments to the response strategy; and transparently communicating what is known, what is  
200 not known, and the criteria applied when making decisions.

201

## 202 **Consideration 2**

### 203 ***Balance individual rights with the social good***

204 The pandemic has prompted governments to temporarily introduce restrictions that infringe on individual  
205 rights, such as freedom of movement, freedom of assembly and the right to practise religion in groups.  
206 Public health approaches are often utilitarian in essence, which means that they maximise the overall  
207 benefit for the population<sup>41</sup>. Willingness to act for the benefit of society is subject to cultural differences  
208 and is more prominent in collectivist countries than in individualistic countries, where maximising  
209 individual benefit is prioritised<sup>42,43</sup>. These differences can also affect the level of acceptance of measures  
210 and make it difficult to predict acceptance of a strategy in multiple regions or countries (e.g. wearing  
211 masks to protect others may be well accepted in some Asian countries, but this does not necessarily  
212 predict high willingness to wear masks in European countries). Difficult questions can also arise  
213 regarding how to balance utilitarian values conducive to public health with respect for individual rights,  
214 equity and personal dignity. For example, in certain limited cases, involuntary quarantine might be a  
215 legitimate public health option<sup>44-46</sup>. However, efforts to protect public health should respect fundamental  
216 rights, such as freedom of speech, privacy, due process of law, freedom from discrimination and freedom



217 of religion. Restrictions that are not regarded as justified may also jeopardise public support for the  
218 pandemic response strategy and trust in authorities<sup>47</sup>. Challenging cases, such as people exercising  
219 freedom of speech to spread falsehoods that harm public health, may arise. Responses to these challenges  
220 may vary from country to country. However, in general, the continued adjustment of the response  
221 strategy, including decisions on which measures to adjust, lift or re-employ, should be maximally  
222 respectful of rights and the foundational interest of human dignity  
223 (<https://www.thehastingscenter.org/briefingbook/pandemic/>). Empirical evidence can inform this  
224 decision-making by enabling authorities to understand norms and values, ensure the acceptability of  
225 implemented and planned measures with respect to both individual and societal gains and detect shifts in  
226 acceptance or barriers to measures<sup>32,48</sup>.

227

### 228 **Consideration 3**

#### 229 ***Prioritise people at highest risk of negative consequences***

230 The greatest negative impact of COVID-19 is felt amongst people who experience disadvantage,  
231 especially poor and underserved groups<sup>49</sup> (see also  
232 <https://www.un.org/development/desa/dspd/2020/04/social-impact-of-covid-19>). Evidence from other  
233 infectious diseases contexts shows that socio-economic, equality-related disadvantages increase the risk  
234 of negative psychological, mental and physical health, social, and economic consequences<sup>50-52</sup>. It can be  
235 assumed that groups who suffer these consequences will also encounter difficulties in adhering to  
236 recommended behaviours in the long term. Therefore, mitigating the negative consequences for these  
237 groups will result in individual as well as collective gain. Surveys and rapid assessments can help identify  
238 priority groups who are likely to suffer the most. National response strategies could consider basic needs,  
239 such as access to food, safe housing, health care, social care and employment and an understanding and  
240 acknowledgement of the barriers faced by these different groups. Structural interventions can help support  
241 recommended behaviours<sup>51,53,54</sup>. For instance, a strategy for a staged return to work could consider a  
242 return to work for people who are essential for the maintenance of the system<sup>55</sup> (preprint without peer-  
243 review) or who face the least risk. Such a strategy could also include a needs assessment for new  
244 measures to be implemented to prevent or alleviate negative repercussions for those who cannot return to  
245 work, such as individuals and the families of individuals who are in COVID-19 risk groups. Working  
246 closely with unions, worker collectives and organisations that serve people at the margins can help ensure  
247 that the transition is structural.

248

249

250

251 **Consideration 4**

252 ***Provide special support for healthcare and caring staff***

253 Many healthcare workers were already under pressure before the pandemic for a variety of structural,  
254 professional and personal reasons<sup>56</sup>, and the current situation adds to this pressure. In the transition phase,  
255 special concern for those who take care of high-risk groups, including people who work in health care and  
256 public health, essential service workers and people who work in long-term care facilities, may be  
257 necessary. Special training, guidelines and support services may be needed. Healthcare workers and  
258 caring staff will need to continue protecting themselves from virus exposure and are likely to need further  
259 emotional and psychological support to deal with the loss of colleagues or family members or post-  
260 traumatic stress. Surveys and rapid assessments of healthcare and caring staff can provide insights into  
261 their needs and how to respond to these needs<sup>57</sup>. Access to workplace or home-based webinars<sup>58</sup> and the  
262 development of structured information delivery during handovers and in-service meetings can support this  
263 important group. This support could be combined with financial and symbolic rewards and public  
264 recognition<sup>59,60</sup>.

266 **Consideration 5**

267 ***Build, strengthen, and maintain trust***

268 By their nature, pandemics create inconsistency and uncertainty of a temporal, spatial and normative  
269 nature<sup>61</sup>. Science changes rapidly, and decisions may be tailored to certain contexts and be based on many  
270 considerations. This can produce inconsistencies between the risk of viral transmission and the  
271 restrictions that exist. Trust in institutions (i.e. perceptions of them as competent, honest and  
272 benevolent<sup>11,47</sup>) influences risk perceptions<sup>62</sup>, helps people manage complexity and is crucial for  
273 legitimising decisions made by authorities<sup>63-65</sup>. A strong sense of public trust is critical for harnessing  
274 public cooperation and achieving the high rates of behaviour adherence necessary for pandemic  
275 management. Therefore, actions and communication should aim to maintain or increase trust<sup>66</sup>.  
276 Transparent communication of what is known, what is not known, and what efforts are being taken to  
277 learn more can contribute to building a sense of trust<sup>67-69</sup>. Knowing the rationale for decisions makes it  
278 easier for people to internalise them into mechanisms of intrinsic motivation<sup>70</sup>, so scientific advice to  
279 governments should be transparent and not subject to political or government influence. Stakeholder  
280 coordination also contributes to trust as it generates consistency and reinforcement of messages<sup>67</sup>.  
281 Governments can obtain the support of individuals or groups who enjoy high levels of trust to  
282 communicate important messages or to reach more population groups in culturally and linguistically  
283 diverse populations (e.g. religious leaders, former politicians and public figures from the arts, culture,  
284 sports). Moreover, robust democratic infrastructures for community voices and pathways for these voices

285 to be translated into decision-making can help to maintain trust<sup>71</sup>. Open access to relevant information  
286 expressed in culturally sensitive language can also contribute to a transparent system<sup>72</sup>. Community  
287 engagement can demonstrate that the population is being heard and that their views are being considered  
288 by decision-makers<sup>73,74</sup> and promote trust. Surveys and other opportunities to monitor and detect possible  
289 shifts in trust and understand how this may be related to new events or new restrictions can enable  
290 decision-makers to respond accordingly.

291

## 292 **Consideration 6**

### 293 *Enlist existing social norms and foster healthy new norms*

294 Prevailing social norms shape people's behaviours<sup>75,76</sup>. The rapid employment of risk-reduction strategies  
295 in many countries during the pandemic has been made possible by appealing to longstanding norms and,  
296 crucially, by creating new norms to support these strategies (e.g. not shaking hands and staying at home).  
297 Social norms can also be invoked to support a transition, incremental or otherwise. Historical evidence  
298 shows that norms can shift rapidly as a consequence of high-profile actions by authoritative  
299 institutions<sup>77,78</sup>. Once norms are established, they can be drawn upon for communication and to enforce  
300 social compliance. Emphasising the social norms of a target group (e.g. health care workers, young  
301 people, the elderly, newcomers, ethnic groups and religious communities<sup>79</sup>) can increase adherence to  
302 interventions and improve the effectiveness of communication measures<sup>30,80,81</sup>. Meta-analytic evidence  
303 also suggests that exposure to depictions of risky behaviour is positively correlated with risk-taking,  
304 including exposure to risk-positive cognition and attitudes<sup>82</sup>. Thus, messages that privilege examples of  
305 desired behaviours are likely to lead to higher adherence than those that emphasise punishment for  
306 perceived breaches<sup>83</sup>. When measures are adjusted or when they become more local, messages about what  
307 is acceptable and appropriate behaviour may become mixed. Even people who wish to abide by messages  
308 from public health authorities may feel pressure to comply with requests to violate the measures (and their  
309 private preferences) from others in their immediate environment<sup>20</sup>. Guidance on how to resist pressure to  
310 participate in large social gatherings and oppose pressure to violate social norms or expectations can be  
311 helpful (and can increase self-efficacy; see Consideration 7). Role models, influencers, religious leaders  
312 and others who are trusted or in the public eye can help to strengthen prevailing social norms and support  
313 new norms<sup>84</sup>. In connection with consolidating positive social norms, emphasising the existence of a  
314 broadly shared endeavour and social solidarity—a shared appreciation of interdependence among  
315 individuals in a society—and acknowledging that strict rules are useful in the context of high societal  
316 threats<sup>17,85</sup> can be useful during mass emergencies that require collective action<sup>86</sup>. Increasing people's  
317 sense of social empathy towards those at highest risk<sup>87</sup> (preprint without peer-review) could be helpful in  
318 the context of the COVID-19 transition phase for promoting pro-social actions, such as reducing crowds

319 and avoiding the hoarding of essential supplies (e.g. medical masks). Regular surveys and culturally  
320 sensitive studies can be employed to understand social norms and expectations related to COVID-19,  
321 detect shifts in these norms and possible new emerging issues (e.g. stigma, misperceptions and conspiracy  
322 theories) and leverage this insight to plan and communicate the most socially acceptable measures.  
323

## 324 **Consideration 7**

### 325 ***Increase resilience and self-efficacy***

326 Resilience has been defined as the ability to recover after a stressful period<sup>88</sup>. Higher levels of resilience  
327 among the public reduce the possible adverse effects of a crisis<sup>89</sup>. Conflicting information, competing  
328 social interests, internal motivational dynamics and threats to daily income and basic needs, such as food  
329 or shelter, are demanding for individuals and communities<sup>19</sup>. In addition to ensuring the fulfilment of  
330 basic needs, strengthening resilience<sup>90,91</sup> can be valuable for crisis management. Recommendations for  
331 strengthening resilience include accepting the inevitable (the pandemic has already had a substantial  
332 impact on our societies, which may be alleviated but is not likely to end in the near future.); focusing on  
333 positive gains (e.g. being able to see some friends again even if we cannot attend large parties); drawing  
334 attention to progress (e.g. identifying strategies that have been working); measuring and attending to  
335 people's day-to-day emotional states and well-being and improvements in public health; taking  
336 responsibility (e.g. acting where possible); understanding our limitations (making changes that are  
337 possible and accepting what is not changeable); reversing negative thoughts (focusing on learning rather  
338 than on mistakes); knowing our strengths (highlighting past successes as individuals and communities and  
339 strengthening people's sense of self-efficacy). In some settings, where basic needs are being met and  
340 appropriate resources are available, resilience training can be conducted using apps, online programs or  
341 large-scale media campaigns<sup>92,93</sup>.

342  
343 One response to fear caused by previously unimaginable adversity is to attempt to control the fear by  
344 denying disturbing information and taking actions that are not consistent with individual or collective  
345 interests<sup>94,95</sup>. Such responses can cause non-compliance with public health recommendations; however,  
346 they can be mitigated by emphasising *self-efficacy* (the belief that an action can be completed<sup>96</sup>) and  
347 *response efficacy* (the belief that an action can reduce a threat<sup>95,97</sup>). Explaining what should be done (e.g.  
348 regular handwashing with water and soap) and the reasons for doing it (e.g. soap breaks down fatty  
349 membranes to destroy viruses and bacteria) can promote response efficacy<sup>98</sup>. Making change as easy as  
350 possible so that people understand the actions they should take to protect themselves and providing  
351 feedback on these actions can increase self-efficacy<sup>99</sup>. It can also increase health literacy, which is the  
352 ability to acquire, understand and use health information. Given the high levels of complex, contradictory

353 and false information associated with this pandemic, health literacy is a critical issue, particularly for  
354 population groups who experience disadvantage<sup>14</sup>. Studies show that feeling able to protect oneself  
355 against COVID-19 and knowing about effective measures are predictors of protective behaviours<sup>97,100</sup>  
356 (100: preprint without peer-review). Strengthening self-efficacy and response efficacy in a manner that  
357 reaches people with low health literacy can empower people to control and take ownership of their actions  
358 and generate adherence to protective measures. Should it be necessary to reinstate such measures during  
359 future waves of infection, people with high self-efficacy and response efficacy may be more willing to  
360 resume such measures as they know the measures will protect them and they believe that they can adhere  
361 to the measures.

362

### 363 **Consideration 8**

#### 364 *Use clear and positive language*

365 Behavioural science emphasises the importance of ensuring clarity in language and reducing cognitive  
366 load<sup>101</sup>. If people find new guidance confusing or difficult to understand, they might ignore it. Complex  
367 guidance can create serious navigation problems. An emergency such as the COVID-19 pandemic is  
368 characterised by uncertainty and clear guidance is needed. However, such guidance is often based on  
369 uncertain evidence. Research has shown that acknowledging uncertainty does not undermine trust<sup>69</sup>.  
370 Furthermore, while a language of *crisis*, *panic* and *war* can increase risk awareness—which may be  
371 needed—it can also cause anxiety, incite selfish or competitive reactions and undermine people’s sense of  
372 collective support and care<sup>102</sup>. Hoarding behaviour, which has been seen in many countries, may be a  
373 consequence of this rhetoric<sup>103</sup>. Crisis language may also cause over-cautiousness among some people,  
374 who, consequently, may not seek primary care or provide social support to people who need it. By  
375 contrast, the use of gain-frame language to highlight the collective gains already achieved and the benefits  
376 that could still be achieved may create more ownership and foster compliance with behavioural rules<sup>104</sup>.  
377 Building communication strategies that balance risk perception with risk assessment is also key for  
378 aligning people’s perception of risk with scientific estimations of the risks<sup>103</sup>. Some research suggests that  
379 people are less willing to make sacrifices for others when the *benefits* are uncertain<sup>105</sup>, so the benefits of  
380 compliant behaviour should be made concrete and visible. Ownership of something makes it more  
381 valuable to an individual (the endowment effect<sup>106</sup>). Moreover, hedonic framing, which combines smaller  
382 losses (e.g. the inconvenience of wearing masks) with larger collective or individual gains (e.g. being able  
383 to see friends again), could increase public acceptance of ongoing restrictions<sup>107</sup>. Therefore, the aim  
384 should be to highlight the gains that can be made from engaging in target behaviours and activate the  
385 internal moral compass that renders personal rewards less important than benefits to others<sup>102,108</sup>.

386

387 **Consideration 9**

388 ***Anticipate and manage misinformation***

389 COVID-19 is the first global public health emergency to occur in the era of widespread use of social  
390 media, the Internet and smartphones. The WHO has acknowledged the existence of an ‘infodemic’ in  
391 addition to the pandemic. The term ‘infodemic’ refers to the availability of an overwhelming amount of  
392 information, which can create confusion regarding which, if any, sources are trustworthy<sup>109</sup>. Pre-  
393 emptively exposing people to techniques that are often employed for misinformation and warning people  
394 against misleading techniques can reduce their susceptibility to future falsehoods<sup>110,111</sup> (110: preprint  
395 without peer-review). This prebunking<sup>112-114</sup> (or cognitive inoculation<sup>115,116</sup>) activates resistance  
396 mechanisms in the public and empowers people to assess the reliability of information<sup>111</sup>. However, some  
397 misinformation cannot be foreseen. Therefore, debunking approaches<sup>117</sup>, which counter widespread myths  
398 and uncover why they are wrong<sup>118-120</sup>, are also needed when misinformation is disseminated. Cognitive  
399 inoculation may also be successful for priming the public for the transition phase. This involves  
400 foreseeing the likelihood of widespread misinformation, explaining how people can manage this situation,  
401 addressing and talking openly about the possible aversive effects of physical isolation, reassuring people  
402 that these aversive effects are reversible and exploring how they can be addressed and mitigated. Pre-  
403 empting future waves of the virus based on currently available evidence and clearly communicating the  
404 potential continuous adjustment of restrictive measures may lay the foundation for greater acceptance.  
405 Prebunking and debunking approaches (i.e. inoculating people against misinformation before spreads and  
406 correcting misinformation after it appears) will also be needed if and when a COVID-19 vaccine becomes  
407 available, as misinformation about this topic is likely to be disseminated.

408

409 **Consideration 10**

410 ***Engage with media outlets***

411 Studies have reported high levels of information-seeking during the COVID-19 pandemic<sup>121</sup> (preprint  
412 without peer-review). During previous outbreaks of other diseases, combined trust in both the government  
413 and the media has been associated with increased preventive behaviours, such as hand-washing<sup>122</sup>. One  
414 study revealed that social media information increased risk perception during an outbreak, while legacy  
415 media, such as national television and broadsheet papers, increased proactive preventive behaviour<sup>123</sup>. For  
416 governments, media outlets are important influencers and critical channels for reaching the public.  
417 Established news and online media outlets can alleviate discomfort during a crisis<sup>124</sup> (preprint without  
418 peer-review), showcase appropriate behaviours<sup>125</sup> and provide helpful perspectives from trusted figures  
419 (e.g. established social media influencers and medical professionals<sup>126-128</sup>). However, media consumption  
420 can also cause stress and anxiety and spread misinformation<sup>102</sup>. Since the media can play a critical role in

421 communicating and balancing information and influencing public sentiment and discussion during a  
422 public health crisis<sup>129,130</sup>, the WHO has developed guidance on how authorities can work with the  
423 media<sup>131,132</sup>. A combined approach that targets legacy platforms, audience-specific and local outlets and  
424 social media may be the most efficient<sup>133</sup>. Particular groups may use, trust or feel represented by certain  
425 media<sup>123</sup>—which can be critical in a potentially increasingly polarised debate<sup>134</sup>—and behavioural studies  
426 stress the impact of communicating behavioural norms at a local level<sup>125</sup>. Thus, governments can continue  
427 to proactively reach out to a variety of media during the transition while respecting their independence  
428 and highlighting their role and potential influence<sup>135</sup>. Even if measures have not been implemented,  
429 journalists and media can frame shared understandings and prime their audiences for the future using  
430 strategies such as introducing important terminology<sup>136</sup> (e.g. ‘new normal’, ‘gradual changes’,  
431 ‘adjustments’, ‘need for cooperation’). The following key messages may be employed: this is an  
432 unprecedented situation; there may be changes to the strategy as we learn more; this is a solvable  
433 situation; and greater restrictions may become necessary again in the event of a second or third wave.  
434 Journalists and the media can support the framing of the transition phase as an all-of-society approach and  
435 responsibly perform their important role by avoiding actions such as feeding confusion and blame and  
436 reporting inconsistent messages, controversies, rumours, misinformation and speculation<sup>137,138</sup>.

437

#### 438 **Inform and qualify action with evidence from behavioural and cultural research**

439 To effectively manage the transition phase, the considerations outlined above should be adapted to  
440 individual contexts<sup>139</sup>. Thus, the process should be informed by a situation analysis and current evidence  
441 from behavioural, social and cultural sciences applicable to the specific context (examples are provided in  
442 Table 1) and be supported by engagement with communities. Continued cultural adjustment of the  
443 response strategy fosters spaces for listening to the voices of diverse communities during the development  
444 of behavioural strategies and the creation of support processes for sustaining behaviours<sup>72,79,140,141</sup>. These  
445 data can help us understand how people are experiencing, interpreting, responding to and accepting the  
446 COVID-19 response and can inform the development of interventions and support the tailoring of  
447 measures to subgroups of the population.

448

#### 449 **Limitations**

450 Although we sought experts from different global regions and drew on research from around the globe,  
451 we are aware that all of the experts except one expert live in high-income countries. Inevitably, their  
452 fields of study and lived experiences have shaped the final report. Furthermore, some aspects may be  
453 missing from one scientific perspective and over-emphasised from another perspective. However, these  
454 limitations were weighed against the need to provide decision-makers with evidence in a very short time.

455 We also acknowledge that the considerations described in this paper are based on evidence from various  
456 sources of literature, some of which relates to outbreaks, crises and pandemic situations and some that is  
457 unrelated to these situations. The validity and reliability of the evidence from psychology (and other  
458 fields) may be challenged as some studies have not been replicated<sup>142,143</sup>. Moreover, most published  
459 research in the field of ‘behavioural insights’ originates in Western, educated, industrialised, rich and  
460 democratic countries<sup>144</sup>, which makes generalising the results to other contexts difficult<sup>145</sup>. These  
461 limitations have caused some scholars to argue that this type of science should not inform crisis  
462 response<sup>143,146</sup> (146: preprint without peer-review). In this paper, however, we propose complementing  
463 existing evidence (summarised here) with real-time data collected in specific situations and countries<sup>32</sup>.  
464 This combination helps to interpret the newly generated evidence based on existing evidence and to  
465 generate and select relevant questions and variables to perform ad-hoc crisis research. In no case should  
466 scientific evidence provide decision-makers with a false sense of certainty as all evidence is surrounded  
467 by the uncertainty inherent in every scientific process. However, the evidence will help guide thinking  
468 and decision-making in a systematic way.

469

#### 470 **Conclusion**

471 In sum, evidence from multiple sources allows us to better understand population perspectives, gauge  
472 emotional responses and subjective experiences, anticipate unwanted scenarios, introduce mitigation  
473 measures and plan for the most effective actions to improve public understanding and compliance.  
474 Understanding how the pandemic and the restrictions imposed are impacting people’s everyday lives,  
475 their social and mental health and their motivation and intentions to follow recommended practices is  
476 critical for the sustained success of the pandemic response during the transition<sup>3,31</sup> and will be a valuable  
477 source for ensuring our preparedness for future pandemics.

478

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483 affiliated.

484



485 **Figure captions**

486

487 **Figure 1: Ten considerations for effectively managing the COVID-19 transition.** *Note:* The  
488 considerations substantiate the WHO/Euro principle #6 ‘Communities have a voice, are informed,  
489 engaged and participate in the transition’<sup>3</sup> and were derived from an online expert consultation. The  
490 considerations do not imply a temporal sequence and are interrelated just as listening to communities,  
491 engaging with them and informing them are interlinked. The ten considerations are aimed at providing  
492 suggestions to governments. The awareness that there will be no going back to normal but a stepwise  
493 adaptation to a ‘new normal’ is in the centre of the transition process (#1). Giving communities a voice  
494 (#2-4), engaging them in the transition (#5-7), and informing them in the best possible way (#8-10)<sup>3</sup> can  
495 help effectively manage the transition.

496

497

498

499 **Table 1: Examples of how to enrich the ten considerations with real-time data and further evidence**  
 500 **and how to apply the evidence obtained to inform the transition phase**

Consideration	How behavioural and cultural research can be applied*	Action examples Action should always be informed by an analysis of the situation**
1) <b>Implement a phased approach to a ‘new normal’</b>	Conduct research to understand population acceptance and barriers to measures implemented or planned and employ this research in planning and communication	<ul style="list-style-type: none"> <li>● Plan a detailed transition: set goals for each phase with red, yellow and green signs for pandemic response adjustment scenarios and transparently communicate these goals</li> <li>● Anticipate unwanted scenarios based on social, behavioural and cultural literature and previous crises in the country and prepare prevention and mitigation measures for these scenarios</li> <li>● Provide tailored guidance to priority population groups as needed following segmentation</li> </ul>
2) <b>Balance individual rights with the social good</b>	Use evidence from regular surveys, hotline monitoring, social media monitoring and qualitative ethnographic studies to understand prevailing norms and values and acceptability of implemented and planned measures and to detect shifts in acceptance or barriers to measures and be guided by this evidence in planning	<ul style="list-style-type: none"> <li>● Use existing research to identify elements of culture and history, social norms, beliefs and values and gather multi-disciplinary expert panels to provide input and insight; panels could include anthropologists, historians, social scientists and cultural studies specialists</li> <li>● Focus messages on identified prevailing norms and values; for example, emphasise the substantial impact of measures on protecting the community, individual families and/or workers</li> <li>● Consider fundamental issues regarding the individual versus the social good, privacy and protection of individual rights</li> </ul>
3) <b>Prioritise people at highest risk of negative consequences</b>	Conduct research to understand implications for people at highest risk, their mental and physical health needs and possible emerging discrimination and stigma and apply this insight to inform action	<ul style="list-style-type: none"> <li>● Address basic needs and fundamental human rights, such as access to employment, education, housing, food and health care</li> <li>● Prioritise people who are most severely affected, either mentally, physically or financially</li> <li>● Ensure that prioritising certain groups will not increase stigma or discrimination and take action to prevent and/or decrease these effects</li> <li>● Coordinate closely and engage in reciprocal communication with traditional and social media outlets, influencers and mediators who work with these groups</li> </ul>
4) <b>Provide special support for healthcare and caring staff</b>	Conduct research to identify specific needs of healthcare and caring staff (e.g. related to working hours, childcare, stress and protective equipment) and respond to these needs	<ul style="list-style-type: none"> <li>● Express the gratitude of leadership and foster community support</li> <li>● Provide guidance on the rights and entitlements of healthcare and caring workers</li> <li>● Provide guidance on organising primary care and long-term care homes and supporting users in accessing them safely</li> <li>● Support working from home and video-conferencing where possible</li> <li>● Engage staff in protecting themselves and providing trusted public health advice to patients and the public</li> <li>● Start planning for inclusion of epidemic management basics and communication with patients in core curricula of medical/nursing schools</li> </ul>
5) <b>Build, strengthen, and maintain trust</b>	Conduct research to understand trust in specific institutions, spokespersons and influencers and to detect possible shifts in this area and how such shifts may be related to new events or new	<ul style="list-style-type: none"> <li>● Organise daily media briefings where trusted spokespersons, identified through population surveys, are clear, humble and empathetic and people feel part of the process instead of feeling as if they are being lectured</li> <li>● Explain how insights from population surveys are being considered as the voices of populations</li> </ul>

	restrictions; use this research to inform planning	<ul style="list-style-type: none"> <li>• Acknowledge uncertainty, be transparent about unanswered questions and balance the need for clarity with acknowledgement of uncertainty about the evolution of the outbreak</li> <li>• Respect all voices and respond to all questions</li> </ul>
<b>6) Enlist existing social norms and foster healthy new norms</b>	Conduct research to understand social norms and expectations related to COVID-19 and to detect shifts in these expectations and possible new emerging issues (e.g. stigma, misperceptions and conspiracy theories) and leverage this insight in communication and planning of the most socially acceptable measures	<ul style="list-style-type: none"> <li>• Ensure that risk communication and community engagement occur to establish that measures are both scientifically accurate and acceptable by people</li> <li>• Engage citizens by providing community leaders with opportunities to co-create transition plans</li> <li>• Engage grassroots activists, local communities, university students, and volunteers in measures such as psychosocial support, helplines, support for infected people, phone-based contact tracing and message development</li> <li>• Work with influencers to amplify messages about the transition aimed at different population groups</li> <li>• Engage influencers and community leaders in sharing guidance on how to cope with competing interests</li> <li>• Coordinate across sectors; activities could include working with the arts and culture sector to fund or support COVID19-specific arts activities</li> </ul>
<b>7) Increase resilience and self-efficacy</b>	Conduct research to understand the population's capability to continue to adhere to restrictions and recommendations, which may signal the need for adjustment to restrictions	<ul style="list-style-type: none"> <li>• Continue to focus on public health advice regarding COVID-19, including hand and respiratory hygiene, and adjust messages in accordance with transition phase stages</li> <li>• Produce proactive advice about the importance of self-care, stress management, healthy habits, social interactions and prioritising rest, sleep and exercise, taking into account diversity in health literacy</li> <li>• Communicate the availability of individual and family support (e.g. education and schooling support, return to work support and guidelines related to alcohol/substance use, tobacco, weight/sedentary time, nutrition, stress, and safely accessing primary care) provided at national level or by the WHO</li> <li>• Engage with and support communities and organisations who work in the areas of domestic violence, child protection, temporary home offers, social isolation and other areas</li> <li>• Strengthen coping strategies for navigating competing interests (e.g. guidance on how to respond to expectations of friends and family regarding social interactions)</li> </ul>
<b>8) Use clear and positive language</b>	Conduct research to understand general perceptions related to COVID-19 and trust in spokespersons and base strategies on these findings	<ul style="list-style-type: none"> <li>• Communicate clearly and focus on the benefits and gains</li> <li>• Seek to communicate risk based on scientific evidence to prevent both under- and over-cautiousness among the public</li> <li>• Avoid using war language (e.g. war against COVID-19, the frontline response), which may increase stigma and undermine people's sense of collective support and care and lead to individualistic behaviours such as hoarding</li> <li>• Positive wording may include progress, advance, community, cohesion, improve, perspective, reasonable, resourceful, optimistic and generous</li> <li>• Refer to 'people who have been infected with COVID-19' rather than 'cases'</li> </ul>
<b>9) Anticipate and manage mis-information</b>	Conduct research to identify general perceptions related to COVID-19 and misperceptions and myths	<ul style="list-style-type: none"> <li>• Anticipate unwanted scenarios and gain insights from social, behavioural and cultural literature, including lessons that can be learned from previous pandemics and crises in the country</li> <li>• Advise people that they are likely to receive misinformation and inform them where they can access trustworthy facts</li> </ul>

		<ul style="list-style-type: none"> <li>• Communicate proactively regarding potential future waves of transmission and what these scenarios might entail</li> </ul>
<b>10) Engage with media outlets</b>	Conduct research to understand and detect shifts in trust in spokespersons and the use of various media outlets within the population and sub-segments of the population; use this insight to plan interactions with the media	<ul style="list-style-type: none"> <li>• Proactively reach out to media outlets to engage them as partners in the response, respect their independence and highlight their role and potential influence</li> <li>• Use the power of the media to alleviate discomfort from the pandemic; appeal to the media to avoid feeding fear, stress, confusion, polarisation and stigmatisation</li> <li>• Appeal to the media to present authoritative information and avoid confusion with speculations and misinformation</li> </ul>

501 *Note:* The table provides examples and is not intended to be read as prescriptive guidance. The examples  
502 in columns 2 and 3 were generated by applying the considerations to potential country contexts. Input was  
503 suggested and preselected mainly by WHO/Euro staff and reviewed by all authors. \* Various  
504 opportunities to monitor and understand public sentiments, responses, behaviours and physical and  
505 mental health reactions to the pandemic can be drawn upon, such as regular behavioural insight  
506 surveys<sup>32,100,147-154</sup> (148-154: preprints of study protocols without peer review), (social) media  
507 monitoring<sup>155</sup>, COVID-19 hotline monitoring, qualitative ethnographic studies, rapid assessments of  
508 priority population groups, diary projects<sup>156</sup>, virtual interviews and group discussions, ‘big data’ such as  
509 individual location data (e.g. from mobile phones<sup>157,158</sup>), data on consumer trends and data on use of  
510 primary care. \*\* Examples of sources to be analysed include epidemiological, structural, cultural,  
511 financial, political, health systems capacity-related data.

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886 **Competing interests**

887 The authors declare no competing interests.

