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

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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 care 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 of 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[1] 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'[2] (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[3] 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   support this principle with available evidence and expert advice. Note that due to the available research

94   and experts involved in this work, the steps may be biased towards high-income, well-resourced

95   countries. Applying them to other contexts may need additional adaptation.

96

97   **Unwanted scenarios**

98   At worst, a poorly timed and badly managed transition threatens the gains that each nation has

99   collectively achieved—potentially with high social and economic costs[4]. Historical evidence from the

100   1918 influenza pandemic shows that a second wave of infection can follow the removal of SPDM and

101   lockdowns[5,6]. Each country's government can apply lessons learnt from experience and analyse the

102   current situation to anticipate potential unwanted scenarios and plan mitigation measures. These scenarios

103   are likely to vary depending on cultural context. However, in general, the following scenarios and

104   situations would be helpful to consider.

105

106   *A continuum of reactions*

107   While there is no empirical evidence for a 'continuum', one may imagine a potential continuum of public

108   responses to the pandemic. On one end may be a potential decline in feelings of fear and threat. Research

109   reported in a non-peer-reviewed preprint found that a lack of perceived risk (e.g. due to declining cases or

110   psychological adjustment to the new situation) can cause decreased adherence to measures[7] such as

111   SPDM. Moreover, people's desire to reduce loneliness as soon as possible after a period of prolonged

112   enforced isolation may be strong: research reported in a non-peer-reviewed preprint suggests that the

113   loosening of response measures might seem like standing in front of a rich buffet after a diet or period of

114   fasting[8]. Just as we might be tempted to binge eat, our craving to socialise may grow with each day of the

115   pandemic. At the other end of the continuum of reactions, distrust of authorities, conspiracy thinking or

116   reactance (anger due to restrictions) may lead to social movements against SPDM norms and policies and

117   a rise in pro-social closeness and interaction. These reactions may be underpinned by messages that

118   question the appropriateness of government pandemic measures, which can increase distrust among

119   broader segments of the population. This scenario is not dissimilar to events and patterns related to

120   vaccination[9–11]. In addition, specific population groups may lack the capability to continue adhering to

121   restrictions and recommendations. These groups may include youth, people with anxiety and other mental

122   health disorders, people who lack social support structures, financially disadvantaged groups, the

123   homeless, indigenous populations, mobile populations, people with chronic illness, people experiencing

124   abuse or domestic violence, people living in long-term care facilities and the persons who care for them

125   and healthcare workers. People with lower health literacy may face additional difficulties when

126   navigating these challenges[12]. Conversely, some people may be overly cautious due to fear and worry[13]

127   and may continue to over-implement restrictions[14], avoid supportive social interactions and delay seeing

128   health care providers for potentially life-saving measures, such as vaccinations or check-ups.

129

130   *Uncertainty and lack of clarity*

131   As response strategies are continuously adjusted, it is likely that debates in the political and public

132   spheres related to unresolved dilemmas or the appropriateness of the implemented measures will increase.

133   How measures are implemented can fluctuate between cultures characterized by societal tightness (e.g.

134   having strict rules and punishing deviance) versus societal looseness (e.g. having more permissive rules

135   and lax punishments)[15]. Moreover, the transition process is likely to be bidirectional and to require

136   continuous adjustment[3], and predictability will be challenging due to uncertainty regarding the evolution

137   of the outbreak. People will need to navigate these adjustments and the lack of predictability, as well as

138   complex and ambiguous messages (e.g. see some friends but not too many friends) and possibly

139   competing demands from the social and cultural environment regarding social interaction[16,17].

140   Collectively, these situations may result in individuals developing idiosyncratic interpretations of

141   restrictions as a coping strategy[18].

142

143   *Stigma and discrimination*

144   Disease can evoke fear and motivate people to separate themselves from infected individuals by

145   stigmatising them[19–21]. Examples include the stigmatization of gay men as an early response to AIDS[22]

146   and of 'Typhoid Mary' (Mary Mallon) in the early twentieth century. The latter was apprehended by

147   authorities in Manhattan for spreading typhoid via her work as a cook, which caused many deaths[21]. In the

148   current situation, certain population groups (e.g. health workers or certain ethnic groups) in some

149   countries may be perceived and branded as virus transmitters[23,24]. COVID-19 may also become associated

150   with unhygienic or careless practices. This thinking could increase the mental distress and anxiety of

151   people who are infected[25] (preprint without peer-review) and reduce compliance with regard to testing

152   and engaging in the contact tracing process[26]. Moreover, individuals who are at higher risk of severe

153   illness (and their families) may be advised to continue strict compliance with restrictions (e.g. working

154   from home). These individuals may be exposed to new forms of stigma, blame or discrimination as

155   societal expectations shift, especially in contexts where legal terminology is unclear.

156

157   **Ten considerations**

158   Avoiding these potential unwanted scenarios calls for careful planning and consideration of the

159   perspectives and engagement of populations[3] and should be informed by evidence and expert advice from

160   the social and behavioural sciences and medical humanities. To support a key WHO criterion for the

161   transition (that communities should have a voice, be informed, engaged and participate), we propose ten

162   considerations for governments (Figure 1).

163

164   To gather existing evidence and experiences of previous crises and brainstorm how this information could

165   support the transition phase, KBH and CB convened a group of experts, who reflect a diversity of

166   academic disciplines, domain expertise and familiarity with infectious diseases in general and COVID-19

167   in particular. This brainstorming was conducted online over three days. The first authors synthesised the

168   longlist of relevant issues into a shortlist, which was commented on by the full group in a shared

169   document. When a consensus was reached regarding the number of considerations and their respective

170   scope, the first authors drafted the sections and the experts added evidence and relevant references. The

171   entire group reviewed the final version. Thus, the resulting ten considerations, which are presented in

172   Figure 1 and explained with examples in Table 1, are based on expert advice and available evidence.

173

174   Consideration 1 relates to the central idea that communities must be aware that there will be no going

175   back to normal but a stepwise approach to a 'new normal'. The other nine considerations relate to giving

176   communities a voice (Considerations 2 to 4), engaging them in the transition (Considerations 5 to 7) and

177   informing them (Considerations 8 to 10)[3]. These considerations are intended to support authorities in

178   tailoring response strategies that will be accepted by the population and priority target groups and that are

179   likely to be effective[3,9,27,28].

180

181

182 We suggest that, where possible, each consideration be monitored, informed and qualified using real-time

183 empirical evidence. This could be achieved via population surveys[29], media and social media monitoring,

184 ethnographic studies, COVID-19 hotline monitoring and rapid assessment of specific population groups.

185 While the following considerations have been devised for COVID-19, they may also be helpful for

186 addressing future unexpected events.

187

188 **Consideration 1**

189 *Implement a phased approach to a new normal*

190 At the centre of transition management is the assumption that an immediate return to normal will not be

191 possible. Instead, the transition process will take place in accordance with a phased approach whereby

192 society, systems and services are gradually re-opened, potentially in new forms. Each phase may involve

193 adjustments to restrictions and potential re-employment of previous stricter measures. During this

194 complex process, if people think that they are or soon will be returning to normal, their actions may

195 hasten the onset of a second wave of the outbreak[4]. Empirical evidence on how to mitigate this and

196 maximise the effectiveness of a phased approach to a new normal can be gained from studies that

197 investigate how people acquire new habits. These include studies on adjusting social norms in new

198 student populations[30,31], evaluating procedures and aids for prisoners returning to society[32], developing

199 pedagogical steps for small children who learn to stay in kindergarten[33] and normalising behaviours for

200 people with eating disorders[34]. Different as they are, these studies all employ a step-by-step approach to

201 practising new behaviours in old environments whereby successfully acquiring habits is a function of

202 repetition[35–37]. In each case, the transition process is iterative. It involves detailed planning, setting goals

203 for each stage and stabilising, recapping and monitoring progress[36] and is underpinned by clear

204 communication. The COVID-19 transition process involves defining and communicating specific phases

205 in advance, while also accounting for the uncertainty of the outbreak evolution; preparing people for

206 planned adjustments to the response strategy; and transparently communicating what is known, what is

207 not known, and the criteria applied when making decisions.

208

209 **Consideration 2**

210 *Balance individual rights with the social good*

211 The pandemic has prompted governments to temporarily introduce restrictions that infringe on individual

212 rights, such as freedom of movement, freedom of assembly and the right to practise religion in groups.

213 Public health approaches are often utilitarian in essence, which means that they maximise the overall

214 benefit for the population[38]. Willingness to act for the benefit of society is subject to cultural differences

215 and is more prominent in collectivist countries than in individualistic countries, where maximising

7

216   individual benefit is prioritised[39]. These differences can also affect the level of acceptance of measures

217   and make it difficult to predict acceptance of a strategy in multiple regions or countries (e.g. wearing

218   masks to protect others may be well accepted in some Asian countries, but this does not necessarily

219   predict high willingness to wear masks in European countries). Difficult questions can also arise

220   regarding how to balance utilitarian values conducive to public health with respect for individual rights,

221   equity and personal dignity. For example, in certain limited cases, involuntary quarantine might be a

222   legitimate public health option[40–42]. However, efforts to protect public health should respect fundamental

223   rights, such as freedom of speech, privacy, due process of law, freedom from discrimination and freedom

224   of religion. Restrictions that are not regarded as justified may also jeopardise public support for the

225   pandemic response strategy and trust in authorities[43]. Challenging cases, such as people exercising

226   freedom of speech to spread falsehoods that harm public health, may arise. Responses to these challenges

227   may vary from country to country. However, in general, the continued adjustment of the response

228   strategy, including decisions on which measures to adjust, lift or re-employ, should be maximally

229   respectful of rights and the foundational interest of human dignity

230   (https://www.thehastingscenter.org/briefingbook/pandemic/). Empirical evidence can inform this

231   decision-making by enabling authorities to understand norms and values, ensure the acceptability of

232   implemented and planned measures with respect to both individual and societal gains and detect shifts in

233   acceptance or barriers to measures[29,44].

234

235   **Consideration 3**

236   *Prioritise people at highest risk of negative consequences*

237   The greatest negative impact of COVID-19 is felt amongst people who experience disadvantage,

238   especially poor and underserved groups[45] (see also

239   https://www.un.org/development/desa/dspd/2020/04/social-impact-of-covid-19). Evidence from other

240   infectious disease contexts shows that socio-economic, equality-related disadvantages increase the risk of

241   negative psychological, mental and physical health, social, and economic consequences[46–48]. It is

242   reasonable to assume that groups who suffer these consequences will also encounter difficulties in

243   adhering to recommended behaviours in the long term, Therefore, mitigating the negative consequences

244   for these groups will result in individual as well as collective gain. Surveys and rapid assessments can

245   help identify priority groups who are likely to suffer the most. National response strategies could consider

246   basic needs, such as access to food, safe housing, health care, social care and employment and an

247   understanding and acknowledgement of the barriers faced by these different groups. Structural

248   interventions can help support recommended behaviours[47,49,50]. For instance, unpublished research

249   reported in a non-peer reviewed preprint suggests that a strategy for a staged return to work could involve

250   return to work for people who are essential for the maintenance of the economic or health system[51] or

251   who face the least risk. Such a strategy could also include a needs assessment for new measures to be

252   implemented to prevent or alleviate negative repercussions for those who cannot return to work, such as

253   individuals and the families of individuals who are in COVID-19 risk groups. Working closely with

254   unions, worker collectives and organisations that serve people at the margins can help ensure that the

255   transition is structural.

256

257   **Consideration 4**

258   *Provide special support for healthcare and care staff*

259   Many healthcare workers were already under pressure before the pandemic for a variety of structural,

260   professional and personal reasons[52], and the current situation adds to this pressure. In the transition phase,

261   special concern for those who care for high-risk groups, including people who work in health care and

262   public health, essential service workers and people who work in long-term care facilities, may be

263   necessary. Special training, guidelines and support services may be needed. Healthcare workers and care

264   staff will need to continue protecting themselves from virus exposure and are likely to need further

265   emotional and psychological support to deal with the loss of colleagues or family members or post-

266   traumatic stress. Surveys and rapid assessments of healthcare and care staff can provide insights into their

267   needs and how to respond to these needs[53]. Access to workplace or home-based webinars[54] and the

268   development of structured information delivery during handovers and in-service meetings can support this

269   important group. This support could be combined with financial and symbolic rewards and public

270   recognition[55,56].

271

272   **Consideration 5**

273   *Build, strengthen, and maintain trust*

274   By their nature, pandemics create inconsistency and uncertainty of a temporal, spatial and normative

275   nature[57]. Science changes rapidly, and decisions may be tailored to certain contexts and be based on many

276   considerations. This can produce inconsistencies between the risk of viral transmission and the

277   restrictions that exist. Trust in institutions (i.e. perceptions of them as competent, honest and

278   benevolent[9,43]) influences risk perceptions[58], helps people manage complexity and is crucial for

279   legitimising decisions made by authorities[59–61]. A strong sense of public trust is critical for harnessing

280   public cooperation and achieving the high rates of behaviour adherence necessary for pandemic

281   management. Therefore, actions and communication should aim to maintain or increase trust[62].

282   Transparent communication of what is known, what is not known, and what efforts are being taken to

283   learn more can contribute to building a sense of trust[63–65]. Knowing the rationale for decisions makes it

284 easier for people to internalise them into mechanisms of intrinsic motivation[66], so scientific advice to

285 governments should be transparent and not subject to political or government influence. Stakeholder

286 coordination also contributes to trust as it generates consistency and reinforcement of messages[63].

287 Governments can obtain the support of individuals or groups who enjoy high levels of trust to

288 communicate important messages or to reach more population groups in culturally and linguistically

289 diverse populations (e.g. religious leaders, former politicians and public figures from the arts, culture,

290 sports). Moreover, robust democratic infrastructures for community voices and pathways for these voices

291 to be translated into decision-making can help to maintain trust[67]. Open access to relevant information

292 expressed in culturally sensitive language can also contribute to a transparent system[68]. Community

293 engagement can demonstrate that the population is being heard and that their views are being considered

294 by decision-makers[69,70] and promote trust. Surveys and other opportunities to monitor and detect possible

295 shifts in trust and understand how this may be related to new events or new restrictions can enable

296 decision-makers to respond accordingly.

297

298 **Consideration 6**

299 *Enlist existing social norms and foster healthy new norms*

300 Prevailing social norms shape people's behaviours[71,72]. The rapid employment of risk-reduction strategies

301 in many countries during the pandemic has been made possible by appealing to longstanding norms and,

302 crucially, by creating new norms to support these strategies (e.g. not shaking hands and staying at home).

303 Social norms can also be invoked to support a transition, incremental or otherwise. Historical evidence

304 shows that norms can shift rapidly as a consequence of high-profile actions by authoritative

305 institutions[73,74]. Once norms are established, they can be drawn upon for communication and to encourage

306 or enforce social compliance. Emphasising the social norms of a target group (e.g. health care workers,

307 young people, the elderly, newcomers, ethnic groups and religious communities[75]) can increase adherence

308 to interventions and improve the effectiveness of communication measures[27,76,77]. Meta-analytic evidence

309 also suggests that exposure to depictions of risky behaviour is positively correlated with risk-taking,

310 including exposure to risk-positive cognition and attitudes[78]. Thus, messages that privilege examples of

311 desired behaviours are likely to lead to higher adherence than those that emphasise punishment for

312 perceived breaches[79]. When measures are adjusted or when they become more local, messages about what

313 is acceptable and appropriate behaviour may become mixed. Even people who wish to abide by messages

314 from public health authorities may feel pressure to comply with requests to violate the measures (and their

315 private preferences) from others in their immediate environment[17]. Guidance on how to resist pressure to

316 participate in large social gatherings and oppose pressure to violate social norms or expectations can be

317 helpful (and can increase self-efficacy; see Consideration 7). Role models, influencers, religious leaders

318 and others who are trusted or in the public eye can help to strengthen prevailing social norms and support

319 new norms[80]. In connection with consolidating positive social norms, emphasising the existence of a

320 broadly shared endeavour and social solidarity—a shared appreciation of interdependence among

321 individuals in a society—and acknowledging that strict rules are useful in the context of high societal

322 threats[15,81] can be useful during mass emergencies that require collective action[82]. As suggested in the

323 conclusions of preliminary unpublished work[83], increasing people's sense of social empathy towards

324 those at highest risk could be helpful in the context of the COVID-19 transition phase for promoting pro-

325 social actions, such as reducing crowds and avoiding the hoarding of essential supplies (e.g. medical

326 masks). Regular surveys and culturally sensitive studies can be employed to understand social norms and

327 expectations related to COVID-19, detect shifts in these norms and possible new emerging issues (e.g.

328 stigma, misperceptions and conspiracy theories) and feed into planning and communicating the most

329 socially acceptable measures.

330

331 **Consideration 7**

332 *Increase resilience and self-efficacy*

333 Resilience has been defined as the ability to recover after a stressful period[84]. Higher levels of resilience

334 among the public reduce the possible adverse effects of a crisis[85]. The COVID-19 pandemic confronts

335 individuals with conflicting information, competing social interests, internal motivational dynamics,

336 threats daily incomes, and compromised the ability of individuals and communities to meet their basic

337 needs, such as food or shelter[16]. In addition to ensuring the fulfilment of basic needs, strengthening

338 resilience[86,87] can be valuable for crisis management. Recommendations for strengthening resilience

339 include accepting the inevitable (the pandemic has already had a substantial impact on our societies,

340 which may be alleviated but is not likely to end in the near future.); focusing on positive gains (e.g. being

341 able to see some friends again even if we cannot attend large parties); drawing attention to progress (e.g.

342 identifying strategies that have been working); measuring and attending to people's day-to-day emotional

343 states and well-being and improvements in public health; taking responsibility (e.g. acting where

344 possible); understanding our limitations (making changes that are possible and accepting what is not

345 changeable); reversing negative thoughts (focusing on learning rather than on mistakes); knowing our

346 strengths (highlighting past successes as individuals and communities and strengthening people's sense of

347 self-efficacy). In some settings, where basic needs are being met and appropriate resources are available,

348 resilience training can be conducted using apps, online programs or large-scale media campaigns[88,89].

349

350 One response to fear caused by previously unimaginable adversity is to attempt to control the fear by

351 denying disturbing information and taking actions that are not consistent with individual or collective

352   interests[90,91]. Such responses can cause non-compliance with public health recommendations; however,

353   they can be mitigated by emphasising self-efficacy (the belief that an action can be completed[92]) and

354   response efficacy (the belief that an action can reduce a threat[91,93]). Explaining what should be done (e.g.

355   regular handwashing with water and soap) and the reasons for doing it (e.g. soap breaks down fatty

356   membranes to destroy viruses and bacteria) can promote response efficacy[94]. Making change as easy as

357   possible so that people understand the actions they should take to protect themselves and providing

358   feedback on these actions can increase self-efficacy[95]. It can also increase health literacy, which is the

359   ability to acquire, understand and use health information. Given the high levels of complex, contradictory

360   and false information associated with this pandemic, health literacy is a critical issue, particularly for

361   population groups who experience disadvantage[12]. Studies show that feeling able to protect oneself

362   against COVID-19 and knowing about effective measures are predictors of protective behaviours[93].

363   Strengthening self-efficacy and response efficacy in a manner that reaches people with low health literacy

364   can empower people to control and take ownership of their actions and generate adherence to protective

365   measures. Should it be necessary to reinstate such measures during future waves of infection, people with

366   high self-efficacy and response efficacy may be more willing to resume such measures as they know the

367   measures will protect them and they believe that they can adhere to the measures.

368

369   **Consideration 8**

370   *Use of clear and positive language*

371   Behavioural science emphasises the importance of ensuring clarity in language and reducing cognitive

372   load[96]. If people find new guidance confusing or difficult to understand, they might ignore it. Complex

373   guidance can create serious navigation problems. An emergency such as the COVID-19 pandemic is

374   characterised by uncertainty and clear guidance is needed. However, such guidance is often based on

375   uncertain evidence. Research has shown that acknowledging uncertainty does not undermine trust[65].

376   Furthermore, while a language of crisis, panic and war can increase risk awareness—which may be

377   needed—it can also cause anxiety, incite selfish or competitive reactions and undermine people's sense of

378   collective support and care[97]. Hoarding behaviour, which has been seen in many countries, may be a

379   consequence of this rhetoric[98]. Crisis language may also cause over-cautiousness among some people,

380   who, consequently, may not seek primary care or provide social support to people who need it. By

381   contrast, the use of gain-frame language to highlight the collective gains already achieved and the benefits

382   that could still be achieved may create more ownership and foster compliance with behavioural rules[99].

383   Building communication strategies that balance risk perception with risk assessment is also key for

384   aligning people's perception of risk with scientific estimations of the risks[98]. Some research suggests that

385   people are less willing to make sacrifices for others when the benefits are uncertain[100], so the benefits of

386   compliant behaviour should be made concrete and visible. Ownership of something makes it more

387   valuable to an individual (the endowment effect[101]). Moreover, hedonic framing, which combines smaller

388   losses (e.g. the inconvenience of wearing masks) with larger collective or individual gains (e.g. being able

389   to see friends again), could increase public acceptance of ongoing restrictions[102]. Therefore, the aim

390   should be to highlight the gains that can be made from engaging in target behaviours and activate the

391   internal moral compass that renders personal rewards less important than benefits to others[97,103].

392

393   **Consideration 9**

394   *Anticipate and manage misinformation*

395   COVID-19 is the first global public health emergency to occur in the era of widespread use of social

396   media, the Internet and smartphones. The WHO has acknowledged the existence of an 'infodemic' in

397   addition to the pandemic. The term 'infodemic' refers to the availability of an overwhelming amount of

398   information, which can create confusion regarding which, if any, sources are trustworthy[104]. Pre-

399   emptively exposing people to techniques that are often employed for misinformation and warning people

400   against misleading techniques can reduce their susceptibility to future falsehoods[105]. This prebunking[106–

401   108] (or cognitive inoculation[109,110]) could activate resistance mechanisms in the public and empower

402   people to assess the reliability of information[105]. However, some misinformation cannot be foreseen.

403   Therefore, debunking approaches[111], which counter widespread myths and uncover why they are

404   wrong[112–114], are also needed when misinformation is disseminated. Cognitive inoculation may also be

405   useful for priming the public for the transition phase. This involves foreseeing the likelihood of

406   widespread misinformation, explaining how people can manage this situation, addressing and talking

407   openly about the possible aversive effects of physical isolation, reassuring people that these aversive

408   effects are reversible and exploring how they can be addressed and mitigated. Pre-empting future waves

409   of the virus based on currently available evidence and clearly communicating the potential continuous

410   adjustment of restrictive measures may lay the foundation for greater acceptance. Prebunking and

411   debunking approaches (i.e. inoculating people against misinformation before spreads and correcting

412   misinformation after it appears) will also be needed if and when a COVID-19 vaccine becomes available,

413   as misinformation about this topic is likely to be disseminated.

414

415   **Consideration 10**

416   *Engage with media outlets*

417   Non-peer-reviewed research has suggested that there are high levels of information-seeking during the

418   COVID-19 pandemic[115]. During previous outbreaks of other diseases, combined trust in both the

419   government and the media has been associated with increased preventive behaviours, such as hand-

420   washing[116]. One study revealed that social media information increased risk perception during an

421   outbreak, while legacy media, such as national television and broadsheet papers, increased proactive

422   preventive behaviour[117]. For governments, media outlets are important influencers and critical channels

423   for reaching the public. A non-peer-reviewed preprint has suggested that established news and online

424   media outlets may alleviate discomfort during a crisis[118]. Credible media outlets can also showcase

425   appropriate behaviours[119] and provide helpful perspectives from trusted figures (e.g. established social

426   media influencers and medical professionals[120–122]). However, media consumption can also cause stress

427   and anxiety and spread misinformation[97]. Since the media can play a critical role in communicating and

428   balancing information and influencing public sentiment and discussion during a public health crisis[123,124],

429   the WHO has developed guidance on how authorities can work with the media[125,126]. A combined

430   approach that targets legacy platforms, audience-specific and local outlets and social media may be the

431   most efficient[127]. Particular groups may use, trust or feel represented by certain media[117]—which can be

432   critical in a potentially increasingly polarised debate[128]—and behavioural studies stress the impact of

433   communicating behavioural norms at a local level[119]. Thus, governments can continue to proactively

434   reach out to a variety of media during the transition while respecting their independence and highlighting

435   their role and potential influence[129]. Even if measures have not been implemented, journalists and media

436   can frame shared understandings and prime their audiences for the future using strategies such as

437   introducing important terminology[130] (e.g. 'new normal', 'gradual changes', 'adjustments', 'need for

438   cooperation'). The following key messages may be employed: this is an unprecedented situation; there

439   may be changes to the strategy as we learn more; this is a solvable situation; and greater restrictions may

440   become necessary again in the event of a second or third wave. Journalists and the media can support the

441   framing of the transition phase as an all-of-society approach and responsibly perform their important role

442   by avoiding actions such as feeding confusion and blame and reporting inconsistent messages,

443   controversies, rumours, misinformation and speculation[131,132].

444

445   **Inform and qualify action with evidence from behavioural and cultural research**

446   To effectively manage the transition phase, the considerations outlined above need to be adapted to

447   individual contexts[133]. Thus, the process should be informed by a situation analysis and current evidence

448   from behavioural, social and cultural sciences applicable to the specific context (examples are provided in

449   Table 1) and be supported by engagement with communities. Continued cultural adjustment of the

450   response strategy fosters spaces for listening to the voices of diverse communities during the development

451   of behavioural strategies and the creation of support processes for sustaining behaviours[68,75,134,135]. These

452   data can help us understand how people are experiencing, interpreting, responding to and accepting the

453 COVID-19 response and can inform the development of interventions and support the tailoring of

454 measures to subgroups of the population.

455

456 **Limitations**

457 Although we sought experts from different global regions and drew on research from around the globe,

458 we are aware that all of the experts except one expert live in high-income countries. Inevitably, their

459 fields of study and lived experiences have shaped the final report. Furthermore, some aspects may be

460 missing from one scientific perspective and over-emphasised from another perspective. However, these

461 limitations were weighed against the need to provide decision-makers with evidence in a very short time.

462 We also acknowledge that the considerations described in this paper are based on evidence from various

463 sources of literature, some of which relates to outbreaks, crises and pandemic situations and some that is

464 unrelated to these situations. The validity and reliability of the evidence from many fields may be

465 challenged as some studies have not been replicated[136,137]. A substantial portion of the evidence also

466 originates in correlational studies, rather than Randomized Controlled Trials (and systematic reviews and

467 meta-analyses of high quality evidence). Moreover, most published research in the field of 'behavioural

468 science' originates in Western, educated, industrialised, rich and democratic countries[138], which makes

469 generalising the results to other contexts difficult[139]. These limitations have caused some scholars to argue

470 that this type of science should not inform crisis response[137]. In this paper, however, we propose

471 complementing existing evidence (summarised here) with real-time data collected in specific situations

472 and countries[29]. This combination helps to interpret the newly generated evidence based on existing

473 evidence and to generate and select relevant questions and variables to perform ad-hoc crisis research. In

474 no case should scientific evidence provide decision-makers with a false sense of certainty as all evidence

475 is surrounded by the uncertainty inherent in every scientific process. However, the evidence will help

476 guide thinking and decision-making in a systematic way.

477

478 **Conclusion**

479 In sum, evidence from multiple sources allows us to better understand population perspectives, gauge

480 emotional responses and subjective experiences, anticipate unwanted scenarios, introduce mitigation

481 measures and plan for the most effective actions to improve public understanding and compliance.

482 Understanding how the pandemic and the restrictions imposed are impacting people's everyday lives,

483 their social and mental health and their motivation and intentions to follow recommended practices is

484 critical for the sustained success of the pandemic response during the transition[3,28] and will be a valuable

485 source for ensuring our preparedness for future pandemics.

486

492

493 **Figure captions**
494
495 **Figure 1: Ten considerations for effectively managing the COVID-19 transition.** *Note:* The
496 considerations substantiate the WHO/Euro principle #6 'Communities have a voice, are informed,
497 engaged and participate in the transition'[3] and were derived from an online expert consultation. The
498 considerations do not imply a temporal sequence and are interrelated just as listening to communities,
499 engaging with them and informing them are interlinked. The ten considerations are aimed at providing
500 suggestions to governments. The awareness that there will be no going back to normal but a stepwise
501 adaptation to a 'new normal' is in the centre of the transition process (#1). Giving communities a voice
502 (#2-4), engaging them in the transition (#5-7), and informing them in the best possible way (#8-10)[3] can
503 help effectively manage the transition.
504
505
506

Table 1: Examples of how to enrich the ten considerations with real-time data and further evidence

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)	**Implement a phased approach to a 'new normal'**	Conduct research to understand population acceptance and barriers to measures implemented or planned and employ this research in planning and communication	● 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 ● 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 ● Provide tailored guidance to priority population groups as needed following segmentation
2)	**Balance individual rights with the social good**	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	● 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 scientific evidence; panels could include anthropologists, historians, social scientists and cultural studies specialists ● 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 ● Consider fundamental issues regarding the individual versus the social good, privacy and protection of individual rights
3)	**Prioritise people at highest risk of negative consequences**	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 to inform action	● Address basic needs and fundamental human rights, such as access to employment, education, housing, food and health care ● Prioritise people who are most severely affected, either mentally, physically or financially ● Ensure that prioritising certain groups will not increase stigma or discrimination and take action to prevent and/or decrease these effects ● Coordinate closely and engage in reciprocal communication with traditional and social media outlets, influencers and mediators who work with these groups
4)	**Provide special support for healthcare and caring staff**	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	● Express the gratitude of leadership and foster community support ● Provide guidance on the rights and entitlements of healthcare and caring workers ● Provide guidance on organising primary care and long-term care homes and supporting users in accessing them safely ● Support working from home and video-conferencing where possible ● Engage staff in protecting themselves and providing trusted public health advice to patients and the public ● Start planning for inclusion of epidemic management basics and communication with patients in core curricula of medical/nursing schools
5)	**Build, strengthen, and maintain trust**	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	● 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 ● Explain how evidence from population surveys are being considered as the voices of populations ● Acknowledge uncertainty, be transparent about unanswered

			restrictions; use this research to inform planning	● questions and balance the need for clarity with acknowledgement of uncertainty about the evolution of the outbreak ● Respect all voices and respond to all questions
6)	**Enlist existing social norms and foster healthy new norms**	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 evidence in communication and planning of the most socially acceptable measures	● Ensure that risk communication and community engagement occur to establish that measures are both scientifically accurate and acceptable by people ● Engage citizens by providing community leaders with opportunities to co-create transition plans ● 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 ● Work with influencers to amplify messages about the transition aimed at different population groups ● Engage influencers and community leaders in sharing guidance on how to cope with competing interests ● Coordinate across sectors; activities could include working with the arts and culture sector to fund or support COVID19-specific arts activities
7)	**Increase resilience and self-efficacy**	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	● Continue to focus on public health advice regarding COVID-19, including hand and respiratory hygiene, and adjust messages in accordance with transition phase stages ● 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 ● 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 ● 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 ● Strengthen coping strategies for navigating competing interests (e.g. guidance on how to respond to expectations of friends and family regarding social interactions)
8)	**Use clear and positive language**	Conduct research to understand general perceptions related to COVID-19 and trust in spokespersons and base strategies on these findings	● Communicate clearly and focus on the benefits and gains ● Seek to communicate risk based on scientific evidence to prevent both under- and over-cautiousness among the public ● 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 ● Positive wording may include progress, advance, community, cohesion, improve, perspective, reasonable, resourceful, optimistic and generous ● Refer to 'people who have been infected with COVID-19' rather than 'cases'
9)	**Anticipate and manage mis-information**	Conduct research to identify general perceptions related to COVID-19 and misperceptions and myths	● Anticipate unwanted scenarios and gain evidence from social, behavioural and cultural literature, including lessons that can be learned from previous pandemics and crises in the country ● Advise people that they are likely to receive misinformation and inform them where they can access trustworthy facts ● Communicate proactively regarding potential future waves of

			transmission and what these scenarios might entail
10) Engage with media outlets	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 to plan interactions with the media	●	Proactively reach out to media outlets to engage them as partners in the response, respect their independence and highlight their role and potential influence
		●	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
		●	Appeal to the media to present authoritative information and avoid confusion with speculations and misinformation

509 *Note*: The table provides examples and is not intended to be read as prescriptive guidance. The examples
510 in columns 2 and 3 were generated by applying the considerations to potential country contexts. Input was
511 suggested and preselected mainly by WHO/Euro staff and reviewed by all authors. * Various
512 opportunities to monitor and understand public sentiments, responses, behaviours and physical and
513 mental health reactions to the pandemic can be drawn upon, such as regular surveys[29,140–147] (141-147:
514 preprints of study protocols without peer review), (social) media monitoring[148], COVID-19 hotline
515 monitoring, qualitative ethnographic studies, rapid assessments of priority population groups, diary
516 projects[149], virtual interviews and group discussions, 'big data' such as individual location data (e.g. from
517 mobile phones[150,151]), data on consumer trends and data on use of primary care. ** Examples of sources to
518 be analysed include epidemiological, structural, cultural, financial, political, health systems capacity-
519 related data.
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874

875   **Competing interests**

876   The authors declare no competing interests.

#3 Prioritize individuals at highest risk of negative consequences

#2 Balance individual rights with the social good

#4 Provide special support for healthcare and care staff

Communities have a voice

Ten considerations for effectively managing the COVID-19 transition

#1 Implement a phased approach to the 'new normal'

Communities are informed

Communities are engaged and participatory

#8 Use of clear and positive language

#9 Anticipate and manage misinformation

#10 Engage with media outlets

#5 Build, strengthen, and maintain trust

#6 Enlist existing social norms, and foster healthy new norms

#7 Increase resilience and self-efficacy