STAG-IH views on community mask use
6 April 2020

Overall, STAG-IH is not against mask\(^1\) use in the community to prevent infection of others, primarily in these specific contexts:

- Active and widespread community transmission is occurring with high attack rates in the population; all other essential public health measures (e.g., surveillance and response, physical distancing, personal hygiene and social measures) are in place; and mask use is introduced, with instructions for use, as an additional layer of physical distancing to prevent transmission to others from persons who may be infected but not yet manifesting symptoms and to maintain functions of societies (e.g., activities in closed environments without efficient air exchanges such as commuting on public transportation and over-the-counter consultations in pharmacies). Decision makers should explicitly communicate to the public that people feeling unwell and/or symptomatic should stay home for self-isolation and that mask use alone or incorrect use of masks will not protect others from infection.
- All or several essential public health measures are impossible to be implemented, as in low-resource areas with high population density or uncontrolled situations such as conflicts or humanitarian crises.
- Masks are introduced as part of a transitional package from a ‘confinement’ or ‘stay-at-home’ order to demonstrate solidarity, community empowerment, understanding of the seriousness of the situation, symbolism of the whole personal hygiene package, mitigation of stigmatization, and other positive psychosocial benefits.

Note: Masking of vulnerable populations (e.g., the elderly; institutionalized persons) for infection prevention purposes is discussed elsewhere under ‘mask use in healthcare/institutional settings.’

The above three points are based on 1) the possible contribution of asymptomatic and presyndromic transmission, though to a much lesser extent compared to symptomatic transmission, and mask use as source control; and 2) an albeit weak scientific evidence base. STAG-IH therefore acknowledges some indication of the effectiveness of masks in preventing transmission from infected individuals to others in non-healthcare settings. Given the diverse features and properties of nonmedical face masks and other face coverings (e.g., scarves), any recommendations for their distribution or use should include a clear goal, rationale, and instructions for use and handling as a part of whole personal hygiene package.

\(^1\) The term “mask” is used here to include homemade or improvised masks, dust masks and surgical masks (also called “medical facemasks”).
If masks are recommended for the general public, the decision maker should:

- Clearly communicate the purpose of wearing a mask, explain what it may achieve and what it will not achieve, and insist on the fact that this is an additional measure to supplement the comprehensive control strategy.
- Inform/train people on when and how to use masks properly, i.e., wear, remove, clean, dispose.
- Consider the feasibility of use, supply/access issues, and social acceptance (of both wearing and not wearing different types of masks in different contexts).
- Continue gathering scientific data and evidence on the effectiveness of mask use (different types and makes as well as other face covers such as scarves) in non-healthcare settings. Evaluate the impact (positive, neutral or negative) of using masks in the general population (including behavioral and social sciences).

Answers to the questions posed by WHO

1. **What is the STAG-IH's view of the available evidence?**
   - There is some evidence showing the effectiveness of medical and face masks in preventing transmission from infected individuals to others in non-healthcare settings (Cochrane review, 2020). These studies were mostly done in household settings, and one study was conducted in student residences. There is no data on the role/effectiveness of cloth masks or other facial covers in preventing disease transmission in community settings.
   - A review summary of pre-symptomatic and asymptomatic cases provided by CDC concluded that the preponderance of evidence makes a strong case that pre-symptomatic or asymptomatic persons with SARS-CoV-2 contribute to the propagation of SARS-CoV-2 infection. One example is the data from Singapore suggesting that 6% of infections were from pre-symptomatic individuals (MMWR).
   - There are some early observations on the psychosocial impacts (e.g., stigmatization) of wearing vs not wearing masks in different settings. However, there are no quantitative or qualitative data on this issue, although anecdotal evidence is being recorded.

2. **What should be recommended for WHO regarding the use of masks in the absence of evidence?**
   - The primary role of masks (of any kind) in the community is to reduce exposure risk for others from infected persons in the pre-symptomatic period. Infections from such persons are not considered to be a major driver of the epidemic, but there are concerns that viral loads are highest during the early phase of the disease.
   - If, as a precautionary infection prevention measure, it is decided to use masks in community settings, instruction must be given detailing the make, use, donning and doffing procedures, cleaning, and disposal.
   - If mask use in public is considered as a part of a package of transition from ‘confinement’ or ‘stay-at-home’ orders, as far as it does not increase risk behaviors (e.g., non-
o compliance with handwashing and physical distancing) and negative consequences, consideration should be given to include it as an option.

- Communication on mask use requires attention to evolving policy development.
- Countries must take supply issues into consideration and ensure that community use of medical masks will not compromise supplies for medical use, particularly in resource-constrained situations. Healthcare workers should be provided with appropriate masks and eye shields -- not only frontline workers directly involved in COVID-19 patient care, but also all healthcare workers especially in situations where widespread community transmission is occurring.

3. Should WHO think about ‘considerations’ for medical mask use for certain (e.g., vulnerable) populations after confinement is lifted, based on the transmission scenario?

- Current evidence suggests that community use of masks does not protect the wearer from infection. Masks are useful in the general population only if they are used to protect others from droplets.
- If care givers are unable to physically distance themselves from the elderly because of providing care that requires physical contact, they should consider wearing a mask to protect the elderly from droplets the care giver might create by speaking or coughing.