STAG-IH supports mask\textsuperscript{1} use by the general public in the community to decrease the risk of infection, primarily in these 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 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 persons 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.

The above three points are based on 1) the possible contribution of asymptomatic and presyndromic transmission, although to a much lesser extent compared to symptomatic transmission [1,2,3,4]; 2) the possible missed recognition of persons with non-specific and/or mild symptoms on the date of onset or in early days of infection who continue to carry out their daily activities in the community [1,5,8]; 3) the important role of speech and other vocal activities such as singing for production of respiratory droplets [5,7,8]; and 4) the role of mask use as source control [7,9]. STAG-IH therefore acknowledges the effect 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 a comprehensive personal hygiene package.

\textsuperscript{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 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, social and psychological 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 (including 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 masks in preventing transmission from infected individuals to others in non-healthcare settings [9,10,11,12,13]. These studies were mostly done in household settings, Hajj tents and one study was conducted in student residences. There are no data on the role/effectiveness of cloth masks or other facial covers in preventing disease transmission in community settings. (Annex 1).
   - A review of pre-symptomatic and asymptomatic cases provided by U.S. CDC [4] supports the possibility of SARS-CoV-2 transmission from persons who are pre-symptomatic or asymptomatic and reinforces the value of measures that prevent the spread of SARS-CoV-2 by infected persons who may not exhibit illness despite being infectious. One example is the data from Singapore suggesting that 6% of infections were from pre-symptomatic individuals [3].
   - Given the rapid propagation of the pandemic and multiple reports of severe strains on health-care systems, and in the absence of effective vaccines and treatments, acceptance of masks has occurred rapidly in some countries: lower morbidity and mortality observed in Asian countries implied that wide-spread mask use may have a role. There have been some early observations on the behavioral and psychosocial impacts of wearing versus not wearing masks in different settings. Wearing a mask may convey a sense of agency and reduce anxiety as well as risk of infection when used responsibility and in conjunction with other public health measures (e.g. hand washing and physical distancing) [14,15].

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 a major driver of the pandemic, but there are concerns that viral loads are highest during the early phase of the disease.

- If it is decided to use masks in community settings as a precautionary infection prevention measure, information must be provided on make and use, including instructions on donning and doffing procedures, cleaning, and disposal.
- If mask use in public is considered as part of a package of transition from ‘confinement’ or ‘stay-at-home’ orders, consideration should be given to include it as an option – as long as it does not increase risk behaviors (e.g., non-compliance with handwashing and physical distancing) and other negative consequences.
- 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?

- When it is known that SARS-CoV-2 is circulating in the community, vulnerable individuals (e.g., the elderly) may wish to avoid crowded areas and consider wearing surgical/medical masks when physical distancing cannot be respected. When used correctly, medical/surgical masks prevent droplets from reaching nasal and oral mucosa. Other types of masks are likely to reduce exposure, although an evidence base is lacking. [13,16,17]
References:

[13] Eikenberry SE et al. To mask or not to mask: Modeling the potential for face mask use by the general public to curtail the COVID-19 pandemic. Infectious Disease Modelling 2020