

Wearing a mask to prevent viral respiratory infections in all circumstances (pandemic, epidemic, endemic) in healthcare activities

Open Urgent consultation 9757 validated by mail on 03/02/2023

At the urgent request of the Risk Management Group (RMG) and the Strategic Scientific Committee (SSC) of the Federal Public Service (FPS) Health, the Superior Health Council (SHC) proposes an urgent Open Consultation on the wearing of masks* in the context of the prevention of viral respiratory infections in all circumstances (pandemic, epidemic, endemic) within healthcare activities.

This Urgent Open Consultation is not a classic SHC advisory report and only engages the responsibility of the signatories of the document who have approved it by consensus and by email. It is not intended to be made public in its current state without following all the quality procedures of the SHC. A broader advisory report (SHC 9749: Comprehensive management of COVID-19 patients in health care institutions and common standard procedures for the prevention of severe acute respiratory infections - SARI) is underway and will include the main recommendations of this urgent document.

In order to ensure an optimal coordination of the Belgian recommendations to the Authorities and the professionals in the field, a consultation is set up between the SHC, experts from Sciensano, experts from the Risk Assessment Group (RAG) and experts from the SSC.

* In this document, when 'masks' are mentioned, surgical masks are meant. Filtering facepiece 2 (FFP2) masks are kept for the care of patients with suspected or proven aerogenic pathogens (COVID-19, tuberculosis, measles, etc.) and during aerosol-generating procedures.

Moreover as the debate on the FFP2 superiority for protection in Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV2)-transmission is still ongoing (Li et al., 2021 ; Jefferson et al., 2023).

1. Background

With the actual COVID-19 pandemic slowing down after 3 years, requests have been made by (health) care workers, patients and visitors for further relaxation of the obligation to systematically wear masks in health care settings, to homogenize rules among care settings and to streamline as much as possible with measures taken outside of the health care sector.

Systematic mask wearing during (health) care, together with other measures (screening, vaccination¹, ventilation², hand hygiene, etc³.) has helped significantly to reduce health care associated transmission and outbreaks of COVID-19 and other respiratory pathogens (Tirupathi et al., 2020 ; MacIntyre et al., 2020 ; Li et al., 2021 ; Schoberer et al., 2022 ; Gastaldi et al., 2021 ; Herstein et al., 2021). Until date, universal masking in health care settings is included in infection prevention and control recommendations at international (WHO, 2021) and national level⁴ in situations with high community transmission of SARSCoV-2.

On the other hand, the use of masks is often perceived as uncomfortable (Burgos-Blasco et al., 2023 ; Sahebi et al., 2022) and reduces non-verbal communication, hence potentially jeopardizes the quality of the contact between caregiver and patient (Ramdani et al., 2022). This is a particular problem with young children, persons with mental illness, persons with language problems, elderly, and during critical moments in the care process (Marler and Ditton, 2021 ; Cummings et al., 2022). Overall, more research is needed from well-designed studies both on the effectiveness and types of masks as on their side effects (Jefferson et al., 2023).

For these reasons, the SHC propose a new generic guideline for the use of masks, applicable in all (health) care settings and based on the overall risk for transmission and acquisition of SARI. This generic guideline is decoupled from more covid-19 waves and applicable to the overall respiratory risk for the patients and the health care personnel. This risk depends on:

- The evolution of the specific **Belgian epidemiology** and the **level of transmission**. Some SARI are seasonal but other less. The late autumn-winter is more critical for the health care system with the onset of some SARI approximatively during the same period.
- The presence of **respiratory symptoms**.
- The individual **vulnerability** and immunocompromised status (KRINKO, 2022).
- The **type of care** and the health personnel and health facilities **equipment** available ?

¹ <https://www.health.belgium.be/fr/vaccination>

² <https://www.health.belgium.be/fr/avis-9616-ventilation-et-la-transmission-de-sars-cov-2>

³ <https://www.health.belgium.be/fr/covid-19-0>

⁴ Advies gebruik persoonlijke beschermingsmiddelen (PBM) in beleidsniveau 1 van de epidemie. Advies HGR-FAGG-Sciensano-RAH. vergadering 24-02-2022 – gevalideerd door RMG 28-02-2022.

2. In which health care settings should this guideline apply?

- **Hospitals:** acute, rehabilitation, psychiatric, pediatric, etc.
- **Other (health) care collectivities:** long term care facilities, home for disabled persons, nursing homes, handicapped homes, etc.
- **Ambulatory health care:** private clinic or consultation with a general practitioner, specialist, dentist, pharmacy, home nursing, physiotherapist, psychologist, etc.
- **Medical transport and emergency intervention.**

These guidelines can be adjusted to the specific situation in the field and are left to the discretion of the care institutions depending on the type of patients and especially on the risk analysis specific to the hospital or care communities.

Given the particular challenges of 'finding the equilibrium between protection and quality of life', the implementation of these recommendations in the diverse long term care facilities may need to be discussed with the local responsible and locally relevant stakeholders e.g. HOST-teams.

For ambulatory care, medical transport and emergency intervention or in the absence of a risk analysis, these general guidelines should be applied everywhere in Belgium and in a uniform way to facilitate the understanding and the adherence of patients and caregivers to them.

As is already the case for hand hygiene, respiratory hygiene and cough etiquette⁵, use of antibiotics, vaccination, etc., a coordinated information and awareness campaign will be necessary for staff in care institutions, communities, outpatients, patients and the general population. The latter should be particularly focused at times of transition from one level to another.

3. To whom should this guideline apply?

- **Health care workers with direct patient contact:** medical, paramedical, maintenance, etc.
- **Other workers in health care settings without direct patient contact:** administrative, kitchen, technical department, laboratory, etc.
- **Patients**
- **Visitors**

⁵ <https://www.cdc.gov/flu/professionals/infectioncontrol/resphygiene.htm>

4. Epidemiological considerations

For Covid-19, 3 pandemic management levels have been defined in 2021:

- **Management level 1/yellow:** epidemiological situation under control. There is virus circulation but at a low level and with no impact on the healthcare system (first and second line).
- **Management level 2/orange:** increasing circulation with incipient pressure on the healthcare system; intervention is needed to reverse the trend again.
- **Management level 3/red:** very high virus circulation with a high risk of overloading the healthcare system.

The translation of the actual epidemiological situation into these levels are discussed on a regular basis at the RAG epidemiology meeting, and approved by the RMG.

During the winter of 2022-2023, with the decline of covid-19 the (re)-emergence of the respiratory syncytial virus (RSV), influenza and other respiratory viruses have been taken into account as well to determine recommendations of the management level, marking a gradual evolution towards an 'overall respiratory tract infection risk'. Other already existing parameters, **must be included as well** in the level of overall respiratory tract infection risk definition: the beginning of the influenza season, the RSV season, the Influenza-like Illness Monitoring (ILI-Monitoring⁶), etc. This way we could evolve from mere covid-19 levels to a more general respiratory risk levels. An integrated risk assessment based on weekly incidences of RSV/SARS-CoV-2/Influenza virus infections, 'acute respiratory infections' (ARI), 'influenza-like illness' (ILI) and 'severe acute respiratory infections' (SARI) by the RAG seems to be the most suited approach.

These levels will most likely continue to fluctuate along the seasons (spring-summer-early autumn versus late autumn-winter), which would be helpful to prepare the (health) care setting, but a more refined and clinically relevant threshold could be helpful to mark the transition from one level into another. For example with the launch of the 'Hitteplan' according to temperatures and ozon levels.

The combination of all these epidemiological indicators that exist for COVID-19, Influenza, RSV, ILIs, SARIs, etc. should be used to define thresholds for signaling the change from levels 1, 2 or 3 of these recommendations.

It is RAG's responsibility to define these combined epidemiological thresholds and then guide the decisions of the RMG and the Authorities on this and on the appropriate times to change levels.

⁶ Acute respiratory infections can be caused by many different germs (e.g. influenza virus, Respiratory Syncytial Virus (RSV), Mycoplasma pneumoniae, parainfluenza virus, adenovirus, human metapneumovirus, etc.). The disease is mainly transmitted by inhaling contaminated airborne droplets or particles.

5. Others considerations

- Systematic mask wearing during (health) care, has helped significantly to reduce health care associated transmission and outbreaks of covid-19 and other respiratory pathogens. However, **mask wearing is not a standalone preventive measure, always requires attention for hand hygiene, testing and isolation of infected cases, adequate air quality, vaccination of patients/visitors and health care workers and personnel** (WHO, 2021).
- **Specific settings merit extra attention and may need to be rethought**, such as waiting rooms (poor ventilation, crowding of people with symptoms, etc.).
- The use of masks during the “respiratory season” would imply **the permanent availability of sufficient stock of good quality masks**.

6. Mental and social considerations

Mask are frequently perceived as uncomfortable (Burgos-Blasco et al., 2023 ; Sahebi et al., 2022), create a barrier and reduce non-verbal communication, hence jeopardize the quality of the contact between caregiver and patient (Ramdani et al., 2022). This is a particular problem with young children, persons with mental illness, persons with language problems, elderly and during critical moments in the care process (Marler and Ditton, 2021 ; Cummings et al., 2022).

Therefore, it is important **to create an ‘on/off’ system** for their use, where during sufficient amount of time, masks **are not needed systematically, but to be reapplied** during the height of the respiratory season, while applying measures to mitigate the side effects of mask use for specific patient populations (Balestracci et al., 2022).

For persons living or residing in a long term (health) care facility, an equilibrium needs to be sought between protection of the vulnerable, prevention of transmission and outbreaks **and** well-being or respectful quality of life (Balestracci et al., 2022).

7. Considerations for the health care workers as part of a business continuity plan (Level 3)

- Local decision on the use of masks (and other Personal Protective Equipment - PPE) are taken by **'committees for prevention and protection at work'** and **'committee on hospital hygiene'**, hence in function of local risk assessments and implementation decisions.
- We suggest **to work with a risk based approach focusing on:** seasonal, vulnerable, symptoms. Priority should be given to those situations where people gather, where vulnerable people are, risk of coming into contact with infected persons.
- **Masks may be one of the measures to prevent sick leave among health care workers**, but only one element of infection prevention. Further investments in air quality and maintenance of vaccination status should be done as well. Apply preventive measures taking into account prevention hierarchy including : collective measures (such as ventilation, herd immunity, cleaning and disinfection procedures, etc.), PPE (masks, gloves, etc.), organizational measures (instructions and application hand hygiene, respiratory hygiene, cough etiquette, appropriate health surveillance with vaccination, etc.) and finally procedures to limit harm (isolation, etc.).
- When using continuous or universal masking at the workplace, **mitigating methods need to be sought** e.g. rehydration, sufficient 'air breaks' during the working day, teleworking, etc.
- More studies on impact **(epidemiological and social) of masks and other preventive measures** are needed.
- **Etc.**

8. Recommendations for patients and residents during care/contact

The aim of mask use in the (health)care setting is the prevention of all respiratory tract infections within the (health) care setting, in particular those with known important morbidity and mortality (e.g. COVID-19, influenza, RSV, etc.).

We propose to implement a revised version of the already existing measures to prevent respiratory tract infections within health care settings.

- **Not confined to COVID-19**, but also applicable during other respiratory epidemics: the beginning of the influenza season, the RSV season, the ILI-Monitoring⁷, etc.
- Depending on **the epidemic level** of the different respiratory pathogen.
- These guidelines can be adjusted to the specific situation in the field and are left to the discretion of the care institutions depending on the type of patients and especially on the risk analysis specific to the hospital or care communities. For ambulatory care, medical transport and emergency intervention or in the absence of a risk analysis, these general guidelines should be applied everywhere in Belgium and in a uniform way to facilitate the understanding and the adherence of patients and caregivers to them.
- **Regardless of vaccination status**. But, vaccination for covid and influenza remains highly recommended for Health Care Workers - HCW⁸ (SHC 9699, 2022 ; SHC 9671, 2021 ; SHC 9689, 2022).
- **2 phases**: ON/OFF (important to keep also an 'off' phase during summer, parts of spring and autumn, to avoid 'desensitization' towards Infection Prevention and Control (IPC) measures).
- **3 levels**: according to the global epidemiological risk assessment (see above).
- **For persons living or residing in a long term (health) care facility**, an equilibrium needs to be sought between protection of the vulnerable, prevention of transmission and outbreaks **and** well-being or respectful quality of life.
- As is already the case for hand hygiene, respiratory hygiene and cough etiquette, use of antibiotics, vaccination, etc., **a coordinated information and awareness campaign will be necessary** for staff in care institutions, communities, outpatients, patients and the general population. The latter should be particularly focused at times of transition from one level to another.

⁷ Acute respiratory infections can be caused by many different germs (e.g. influenza virus , Respiratory Syncytial Virus (RSV), Mycoplasma pneumoniae, parainfluenza virus, adenovirus, human metapneumovirus, etc.). The disease is mainly transmitted by inhaling contaminated airborne droplets or particles.

⁸ <https://www.health.belgium.be/fr/avis-9699-vaccination-grippe-saisonniere-saison-hivernale-2022-2023>
<https://www.health.belgium.be/fr/avis-9671-vaccination-obligatoire-pour-le-personnel-de-sante>
<https://www.health.belgium.be/fr/prise-de-position-9689-cst-et-vaccination-obligatoire-contre-la-covid-19>

PERMANENTLY, **also during OFF phases!** (to be considered as the new 'standard precautions')

1) **Standards precautions for all:** respiratory hygiene, cough etiquette, hand hygiene.

2) **Standards precautions for anyone (patient and workers) with symptoms of a respiratory infection:** should wear a mask, should apply standards precautions for all and should avoid going to health care institutions, if possible.

2) **Protective precautions for severely immunocompromised:** masks wearing and possibly isolation depending of the individual risk analysis (KRINKO, 2022).

Levels definition according to the thresholds of SARI determined by RAG for the RMG

➔ **Level 1** (under control, no active outbreaks): **PERMANENTLY, also during OFF phases!**

1) **Standards precautions for all:** respiratory hygiene, cough etiquette, hand hygiene.

2) **Standards precautions for anyone (patient and workers) with symptoms of a respiratory infection:** should wear a mask, should apply standards precautions for all and should avoid going to health care institutions, if possible.

2) **Protective precautions for severely immunocompromised:** masks wearing and possibly isolation depending of the individual risk analysis (KRINKO, 2022).

Isolation for severely immunocompromised depends of the individual risk analysis (KRINKO, 2022).

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9174886/>

For information: "The risk groups of immunosuppressed patients defined here are a dynamic (and to some extent pragmatic) guide introduced primarily for adaptation of the required hygiene measures. This allocation concept suggested by the KRINKO (2022) must not be confused with other clinical risk scores or stages of disease. The specific situation of individual patients and the corresponding risk of infection can change in the course of treatment. Individual patients can move between risk groups depending on their clinical treatment situation (e.g. induction vs. consolidation therapy, recurrence of leukaemia, preparation for and execution of stem cell transplantation after conventional treatment). This means that it may be necessary for doctors to amend the risk group in their risk analysis.

For information, the KRINKO recommends:

- Accommodating neutropenic patients in risk groups 1 and 2 in a single or twin room with ensuite sanitary facilities, but not larger units (three or more patients per room), and carefully observing basic hygiene measures. As paediatric haemato-oncology patients are regularly admitted with a parent (companion caregiver), their rooms should be large enough for a folding bed to be set up next to the bed without excessively obstructing their care (particularly at night) or creating additional transmission risks.

- Accommodating patients in risk group 3 in a single room with ensuite sanitary facilities and specific ventilation measures.

→ **Level 2** (increasing strain on the health care system, e.g. winter season, active outbreak): All precautions of level 1 PLUS:

3) **Mask wearing for all in all areas where patients may be present**, mask wearing (by personal and patient) **for all contacts between caregiver and patient or among patients out of his room**. For long term care facilities/nursing homes, masks not to worn when residents are together if they are no symptoms of respiratory infection (cf. WHO 'targeted masking').

→ **Level 3** (risk of overburdened health care system, business continuity problems): mask wearing **for all persons present in the health care setting**. **Everywhere and every time, in contact or not with patient!** (cf. WHO 'universal masking').

OFF	Level 1	<p>Under control, no active outbreaks</p> <p>To be considered as the new 'standard precautions'</p>	<p>PERMANENTLY (LEVELS 1,2 and 3) !</p> <ul style="list-style-type: none"> • Standards precautions for all: respiratory hygiene, cough etiquette, hand hygiene. • Standards precautions for anyone with symptoms of a respiratory infection: should <u>wear a mask</u>, should apply standards precautions and should avoid going to health care institutions, <u>if possible</u>. • Protective precautions for severely immunocompromised: Masks wearing, hand hygiene and possibly isolation depending of the individual risk analysis (KRINKO, 2022) for all interactions with severely immunocompromised patients.
ON	Level 2	<p>Increasing strain on the health care system', e.g. winter season, active outbreak</p> <p>Cf. WHO 'targeted masking'</p>	<ul style="list-style-type: none"> • Mask wearing for all in all areas where patients may be present. • Mask wearing for all direct interactions between caregiver/patient and between patients. • Mask wearing for all patients out of his room. <ul style="list-style-type: none"> - For rooms with more than one patient, cf. local risk analysis. - For long term care facilities/nursing homes, masks not to worn when residents are together if they are no symptoms of respiratory infection.
	Level 3	<p>risk of overburdened health care system, business continuity problems and plan, teleworking, etc.</p> <p>cf. WHO 'universal masking'</p>	<ul style="list-style-type: none"> • Mask wearing for all persons present in the health care setting. Everywhere and every time, in contact or not with patient ! <ul style="list-style-type: none"> - all workers, patients, visitors, etc.

Risk group 1 (moderate immunosuppression/-deficiency)

- Neutropenia $<0.5 \times 10^9/L$; ($<500/\mu L$) expected to last up to 10 days (comparable to leukopenia $<1 \times 10^9/L$; $<1,000/\mu L$)
- Up to three months after day 0 of autologous stem cell transplantation (the day the stem cells are returned to the patient)
- Decrease in CD4-positive T-helper cells to $<200/\mu L$ (caution: normal levels that are commensurate vary with age for children); up to three months after the intensive treatment phase of autologous stem cell transplantation.

Patients with more than one of the features of immunosuppression/-deficiency listed for risk group 1 are assigned to risk group 2.

Risk group 2 (severe immunosuppression/-deficiency)

- Neutropenia $<0.5 \times 10^9/L$; ($<500/\mu L$) for more than 10 days (comparable to leukopenia $<1 \times 10^9/L$; $<1,000/\mu L$)
- Severe aplastic anaemia or macrophage activation syndrome during intensive immunosuppressive therapy
- Up to 6 months after completion of the intensive treatment phase of allogeneic bone marrow or stem cell transplantation (important: severity of GVHD and intensity of ongoing iatrogenic immunosuppression)
- Acute inpatient treatment phase of autologous stem cell transplantation or after solid organ transplantation (until discharge).

Risk group 3 (very severe immunosuppression/-deficiency)

- Intensive treatment phase of allogeneic BMT/PBSCT (until engraftment=regeneration of granulopoiesis)
- Severe grade III or IV GVHD with intensive immunosuppression.

The decision to assign patients who have undergone allogeneic stem cell transplantation to group 3 is ultimately taken by their haemato-oncologists after a review of all findings.

9. Existing guidelines on the use of masks in the health care setting

CDC 2007 post SARS 'All who cough wear a mask'

CDC 2009 : [Respiratory Hygiene/Cough Etiquette in Healthcare Settings | CDC](#)

WHO 2021: [Infection prevention and control during health care when coronavirus disease \(COVID-19\) is suspected or confirmed \(who.int\)](#)

CDC: for general public: [Use and Care of Masks | CDC](#)

CDC for HCW: [Infection Control: Severe acute respiratory syndrome coronavirus 2 \(SARS-CoV-2\) | CDC](#)
Comparable difference between high and low covid circulation, with/without symptoms

KRINKO - Commission for Hospital Hygiene and Infection Prevention (KRINKO). Infection prevention requirements for the medical care of immunosuppressed patients: recommendations of the Commission for Hospital Hygiene and Infection Prevention (KRINKO) at the Robert Koch Institute. *GMS Hyg Infect Control*. 2022 Apr 13;17:Doc07. doi: 10.3205/dgkh000410. PMID: 35707229; PMCID: PMC9174886.

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11. Experts approving this Open Urgent Consultation

The following experts were involved in drawing up and endorsing this Open Consultation report during the meeting of 27/01/2023 and by mail. The working group was chaired by **Anne SIMON** and **Hilde JANSENS**. The preparations for this meeting were made by Mr. Jean-Jacques DUBOIS (Born in Mons on 08 May 1969 - Deceased in Sirault on 22 January 2023). The scientific secretarial duties were performed by Ms. Muriel BALTES and Mr. Fabrice PETERS.

BYL Baudouin	Hospital hygiene, epidemiology	Erasme
CORNELISSEN Laura	Epidemiology, obstetrics, gynecology	Sciensano
DEMAITER Guido	Nursing hospital hygienist	AZ Groeninge Kortrijk
GERARD Michèle	Hospital hygiene	CHU Saint-Pierre
JANSENS Hilde	Infection prevention and control, medical microbiology	UZA
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MELIN Pierrette	Clinical Biologist	U Liège
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SIMON Anne	Infection prevention and control	Groupe Jolimont
VAN LAETHEM Yves	Infectiology, Vaccinology, Travel medicine, HIV	CHU Saint-Pierre - Strategic Scientific Committee (SSC)
VELGHE Yves	Nursing hospital hygienist	CHU Brugmann
VLIEGHE Erika	General internal medicine, infectious diseases and tropical medicine	UZA - Strategic Scientific Committee (SSC)

The following administrations and/or ministerial cabinets were heard:

VAN DER BORGHT Stefaan	Adviser-Expert PHE SP - Public Health Emergencies	FPS Public Health RMG
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12. List of abbreviations

BMT	Bone Marrow Transplantation
CDC	Centers for Disease Control and Prevention - US
COVID-19	Coronavirus disease 2019
FFP2	Filtering facepiece 2
FPS	Federal Public Service - BE
GVHD	Graft-versus-host disease
HCW	Health Care Workers
ILI	Influenza-like Illness
IPC	Infection Prevention and Control
KRINKO	<i>Kommission für Krankenhaushygiene und Infektionsprävention</i> - DE
PBSCT	Peripheral Blood Stem Cell Transplantation
PPE	Personal Protective Equipment
RAG	Risk Assessment Group - BE
RMG	Risk Management Group – BE
RSV	Respiratory Syncytial Virus
SARI	Severe Acute Respiratory Infection
SARS-CoV2	Severe Acute Respiratory Syndrome Coronavirus 2
SHC	Superior Health Council - BE
SSC	Strategic Scientific Committee – BE
WHO	World Health Organization - INT