

Policy on the Isolation on arrival of persons travelling from affected areas

14 October 2021

Version 3.1

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Executive summary

- COVID-19 presents a significant threat to Ascension Island, and as such appropriate measures to combat this threat have been developed and implemented.
- An effective isolation and quarantine (isolation following arrival) policy is therefore necessary to safeguard against COVID-19 establishing itself within Ascension. This policy is applied to all persons arriving at Ascension who are considered by the Senior Medical Officer to be potential sources of COVID-19 infection.
- In recognition of local circumstances, such as the working nature of the island and the limitations of the facilities available within Ascension, a number of options for isolation have been developed. In order provide the Senior Medical Officer with suitable confidence in these protocols certain measures, such as testing during the isolation period, may be deployed in particular circumstances.

Background

The SARS Coronavirus type II (COVID-19) poses a serious risk to Ascension Island, its community and the limited medical resources available within the territory. As a result it is necessary for the Ascension Island Government (AIG) to ensure that adequate measures are in place to protect the island community from COVID-19 whilst that risk remains.

Issue

The SARS Coronavirus type II (COVID-19) is a highly contagious novel respiratory droplet spread infection in which transmission is most likely to occur amongst groups of individuals interacting without appropriate protective equipment (particularly facemasks and face coverings) within distances less than two metres for periods totalling 15 minutes or longer.

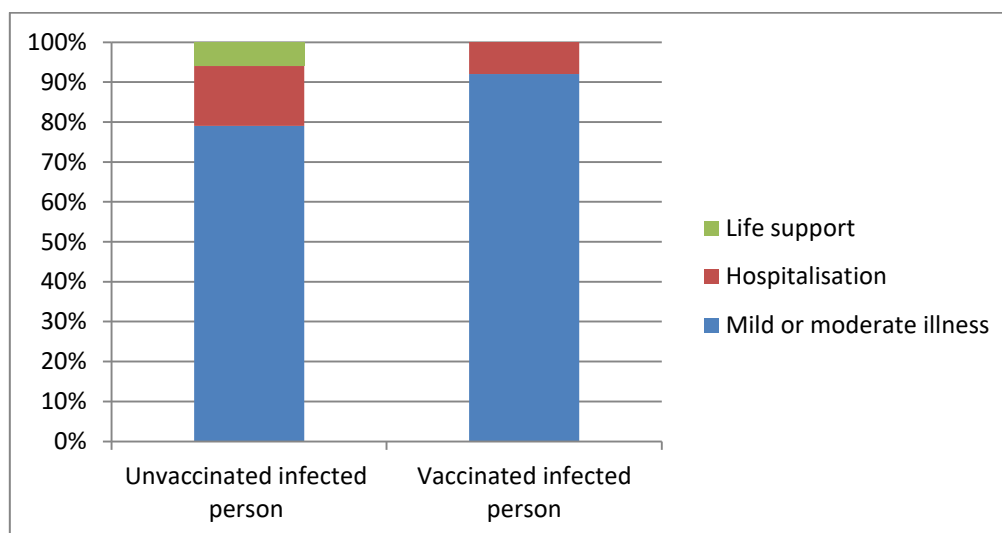
The known incubation period (from infection to clinical disease) in an unvaccinated person is between two to 14 days, with a mean incubation of four to seven days. In some studies as many as 40% of infected unvaccinated individuals may remain asymptomatic or only mildly symptomatic. Data is still emerging with regard to infection in fully vaccinated individuals but it is expected that symptomatic and contagious infection by the Delta variant of COVID-19 is reduced by up to 60% in fully vaccinated persons. The greatest risk of transmission from an infected individual occurs approximately 48-72 hours before the onset of illness, and continues until about 10 days after onset¹. If no protective measures are taken each infected

¹ [Wölfel R, Corman VM, Guggemos W, Seilmaier M, Zange S, Müller MA, et al. \(2020\). Virological assessment of hospitalized patients with COVID-2019. Nature 2020 May;581\(7809\):465-469. doi:10.1038/s41586-020-2196-x](#)

individual can be expected to infect up to five others², producing the exponentially explosive epidemics observed internationally.

On average, in unvaccinated persons around 80% of infected individuals have a mild or moderate illness, 15% are more seriously affected and require hospitalisation and oxygen therapy; whilst about half of these more seriously affected individuals become critically ill and require life support³.

On average, in vaccinated persons around 92% of infected individuals have a mild or moderate illness, with the rest requiring hospitalisations and oxygen therapy⁴. Further work is underway to establish what percentage of those infected ultimately become critically ill and require life support.



Even with widespread full vaccination within a population it is vital that measures are in place to safeguard the community. Of those vaccinated, only 80% on average will actually have protection against the virus, and vaccines have been proven to be less effective than this against some of the more recently emerging variants⁵. Whilst widespread full vaccination will reduce the chance of serious illness and death for most, infection can still occur (on average protection against serious illness is between approximately 60% and 90% when variation for variants and individual immune response are considered). Similar amounts of viral genetic material have been found in both vaccinated and unvaccinated persons amongst those infected with the Delta variant. Whilst severe illness is avoided for the majority of vaccinated persons, they remain capable of transmitting the virus to others, albeit for a shorter period of time when compared to unvaccinated individuals^{6,7}. As such, it remains important to recognise that the unique dynamic of the island (for instance ~50% of the population are served by messing facilities) means that viral spread can occur quickly and widely, so authorities need to take practical measures to safeguard against this.

Admission of any number of ill individuals to Georgetown Hospital poses a significant risk of onward transmission of COVID-19 to the limited number of available hospital staff, and

² <https://www.cdc.gov/coronavirus/2019-ncov/variants/delta-variant.html>

³ <https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200306-sitrep-46-covid-19.pdf>

⁴ PHE – Effectiveness of COVID-19 vaccines against hospital admission with the Delta (B.1.617.2) variant, <https://bit.ly/3gLdAFZ> - 14 June 2021

⁵ The AstraZeneca COVID-19 Vaccine is currently reported as providing a 62% level of protection against the Delta variant

⁶ <https://www.cdc.gov/coronavirus/2019-ncov/variants/delta-variant.html>

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https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1005517/Technical_Briefing_19.pdf

thence into the community. Due to the limitations of medical facilities and supplies in Ascension, any person admitted to Georgetown Hospital with a severe COVID-19 illness could only be managed for a limited period of time before requiring medical evacuation to another territory for substantive treatment.

The impact of sustained community-acquired cases within Ascension would be significant. The Hospital is staffed with two full-time doctors and eight nurses; it has capacity to care for up to 10 moderately ill patients, and two critically ill patients at any one time. In order to try to prevent the medical services and facilities being overwhelmed during community-established transmission, significant reactive public health mitigation measures would need to be observed, causing substantial disruption to individuals and organisations for a potentially prolonged period of time.

An effective compulsory isolation and quarantine (isolation following arrival) policy is therefore necessary to prevent unchecked direct transmission of COVID-19 to the island community, to protect the critically vulnerable hospital service from unnecessary risk of exposure and to allow the continued operation of island services and businesses.

Principles

COVID-19 public health measures should seek to ensure:

- the community is sufficiently safeguarded from unchecked direct transmission of COVID-19;
- community-acquired infection and spread is prevented from becoming established.

Decisions on the measures being applied should:

- be based on the best scientific evidence available at the time;
- be kept under constant review and be adapted in light of new scientific evidence that becomes available.

Advice received

Throughout the COVID-19 pandemic AIG has been in constant liaison with experts from The UK Health and Security Agency and a dedicated taskforce within The UK Health and Security Agency set up to support the Overseas Territories through this health crisis. This liaison has provided AIG with the opportunity to seek advice and guidance from some of the most highly qualified individuals in the world with access to the most up to date scientific understanding available. This advice has informed the approach taken by AIG to date, with ongoing refinement also informed by the advice and evidence provided by these colleagues.

The compulsory isolation of arrivals measures outlined below under [Application](#) are predicated on the following conditions being fulfilled:

- the level of full vaccination, considered to be two doses of a UK/EU/USA approved vaccine for a period of nine months after application of the second dose, of the eligible population is maintained at 80% or higher;

- no pockets of unvaccinated persons are considered to be present within the community;
- effective public health measures are in place to react to any outbreak as it is identified, such as contact tracing and precautionary isolation of known contacts.

Application

Pre-departure testing of arrivals

As travellers to Ascension pose a risk of introducing COVID-19 into Ascension, all travellers to Ascension will be required to produce a negative COVID-19 polymerase chain reaction (PCR) or molecular test result taken within three days of their scheduled departure time for Ascension, or where they are transiting St Helena within 72 hours of their scheduled departure time for St Helena. Evidence of the negative test should be provided prior to, or at, check-in at the point of departure. Evidence of a negative test result should also then be provided to an Immigration Officer and the Senior Medical Officer (SMO) prior to arrival, or upon demand.

Several Overseas Territories have reported that fully vaccinated persons, including arrivals, have tested positive with high Ct values of between 14 and 18, indicating high loads of viral RNA, despite being asymptomatic⁸. As such, the requirement for pre-departure testing will be applied to all travellers, regardless of vaccination status.

If arrivals are able to demonstrate that they have not travelled from an affected area within the last 14 days they will not be required to produce a pre-departure negative result from a COVID-19 PCR test taken within three days of their scheduled departure time for Ascension. However, a pre-departure negative result from a COVID-19 PCR test taken within three days of their last known point or port of departure may be considered when determining what isolation protocols that individual will be required to observe on arrival at Ascension.

Observation of compulsory isolation

In order to safeguard against the introduction of COVID-19 into the community, AIG is currently implementing a period of strict quarantine (compulsory isolation) on arrival which is usually for a period of up to 14 days. It is to be observed by all arrivals considered by the SMO to be potential sources of COVID-19 infection. This is in accordance with the provisions laid out in the Public Health (Coronavirus)(Temporary Provisions) Regulations 2020.

Given the opportunity for onward transmission from one person to another, the ideal is for each arrival to be individually isolated away from others. However, it is recognised that practically and logistically this cannot always be achieved (e.g. for family units containing parents and children, or because of a lack of suitable accommodation). As such, isolation should seek to ensure that the lowest number as can be logistically accommodated takes place, noting that the higher the number of persons isolating together, the greater the risk of transmission of any as yet unidentified COVID-19 within the group will be, as well as potential transmission beyond the group into the community after the isolation period ends (due to “slow burn” transmission). Noting that there is an increased risk of transmission in a

⁸ Confirmation provided by two OTs during PHE teleconference on 10 June 2021.

group isolation setting, it is not advisable for persons determined to be in a high-risk category for developing a severe illness as a result of contracting COVID-19 to undertake isolation in this form if avoidable.

Additionally, Georgetown Hospital currently has the ability to deploy COVID-19 testing using a Cepheid GeneXpert molecular test platform. As such, it is also possible to utilise the negative predictive power of this testing platform to establish the potential for infection in arrivals and those who are observing isolation measures. Due to the highly sensitive nature of the test, persons testing negative on arrival will be highly unlikely to be shedding virus and hence non-contagious at that point in time, regardless of their actual infective status subsequent to that point. Therefore in certain circumstances bespoke measures can be put in place to mitigate the chance of infection from someone travelling from an affected area in the same conveyance as someone travelling from an unaffected area, and in doing so accommodate a quarantine free, or reduced quarantine, travel corridor. The comprehensive policy and protocols to be observed for potential reductions or exemptions to compulsory isolation requirements through air travel corridors are detailed separately in the *Policy on HLE-ASI Reduced Length Compulsory Isolation*.

Current evidence indicates that placing an unvaccinated person in individual isolation for 10 days, with a test taking place at the beginning and the end of the isolation period, will result in an approximately <2% chance of a person infected with COVID-19 being released from quarantine without having already been identified. As such, a 10 day period of individual isolation following arrival, combined with testing, for an unvaccinated person offers a high-level of protection to the wider population.

Given the increase in risk of spread amongst a group observing isolation measures together, whether vaccinated or unvaccinated, it is necessary to deploy testing during the period of compulsory isolation in order to provide suitable assurances that no transmission of infection is taking place within those groups.

Whilst strictly observed isolation in and of itself provides a high-level of confidence that upon release an individual will pose little risk to the public, deploying testing prior to releasing a person from isolation provides additional assurance that they are not in fact infectious at the point of release, and also offers a final fail-safe to guard against an as yet unidentified failure in the system of protocols and procedures which may have undermined the efficacy of the system of compulsory isolation.

Therefore, all persons who undergo compulsory isolation will be subject to a testing regime based on the category of arrival they are considered to be.

Given different arrivals pose different levels of risk to the community based on their travel history and vaccination status, it is possible to implement a variety of compulsory isolation protocols depending on the category of individual in question. It should be noted that these are not strictly determined by scientific modelling alone, and consider factors such as the ability to practically accommodate the level of testing required to support the system effectively and the facilities in which the compulsory isolation has been observed.

The length of time each category of individual is required to observe compulsory isolation following arrival from an affected area is:

8 days	10 days	14 days
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Vaccinated person	x		
Vaccinated groups of four or fewer persons	x		
Unvaccinated person		x	
Unvaccinated, or mixed, groups of four or fewer persons		x	
Vaccinated groups of five or six persons		x	
Unvaccinated, or mixed, groups of more than four persons			x
Vaccinated, or mixed, groups of more than six persons			x

The rationale for the length of compulsory isolation applied to each category of individual is outlined in more detail below.

Definitions

For the purposes of compulsory isolation on arrival the following definitions apply:

A territory will be considered an **affected area** if it has been declared an infected area by the Administrator by notice under Regulation 2 of the Public Health (Coronavirus)(Temporary Provisions) Regulations 2020.

A person will be considered a **vaccinated person** if–

- the person has been vaccinated against COVID-19;
- in the case of a single-dose vaccine, the vaccine was administered at least four weeks prior to the person’s arrival at Ascension;
- in the case of a two-dose vaccine, the second dose was administered at least four weeks prior to the person’s arrival at Ascension;
- the vaccine was approved by the relevant UK/EU/USA regulatory authority on the date it was administered (or, in the case of a two-dose vaccine, on the date second dose was administered);
- they are a child aged 17 years or less observing compulsory isolation within a family unit, even if they are unvaccinated.

A vaccinated person will be considered to remain vaccinated for a period of nine months from the date on which they were vaccinated (or, in the case of a two-dose vaccine, from the date the second dose was administered).

A person who is not a vaccinated person will be considered an **unvaccinated person**; this includes—

- those who have received no doses of vaccine;
- in the case of a two-dose vaccine:
 - those who have received only the first dose, and

- those who received their second dose fewer than four weeks prior to their arrival at Ascension;
- those who cannot provide acceptable evidence that they meet the criteria for being determined a vaccinated person.

A **vaccinated group** is one in which everyone is considered to be a vaccinated person.

An **unvaccinated group**, or a **mixed group**, is any group which contains one or more unvaccinated persons.

However, an unvaccinated child observing compulsory isolation within a family unit will be considered as a vaccinated person for the purposes of observing compulsory isolation on arrival.

Treatment of children in the compulsory isolation process

Like adults, children and adolescents can be infected with COVID-19 and can pass the virus on to others. Whilst children are far less likely to develop a severe COVID-19 illness when compared to adults, they are more likely to develop an asymptomatic infection⁹. However, due to assumptions made regarding social factors it is possible to differentiate an unvaccinated child from an unvaccinated adult in the isolation of arrivals process.

Children within a family unit, even if unvaccinated, are very unlikely to pose a risk which is not equivalent to that of their parents. This is because children are not independent adults with independent travel and social histories, and as such their risk profile will likely be the same as their parents. As with all travellers, both they and their parents will have been subject to a testing regime during quarantine and prior to arrival at Ascension. All of those within the family unit will then be subject to a confirmatory exit test prior to being provided permission to end their period of isolation. Taken in combination, this therefore provides a high-level of confidence that no persons within that isolation unit will exit isolation with an active COVID-19 infection.

As adults within a family or bubble group isolation setting are more likely to have separate travel and social histories, the same principle cannot be applied to adult groups of mixed vaccinated and unvaccinated persons. As such a 10 day period is required to provide confidence that no persons within that isolation unit will exit isolation with an active COVID-19 infection.

Isolation of units of ≤4 persons

A person placed into compulsory isolation is placed under strict measures during their period of isolation, mandating no interaction take place with others outside of their isolation group which could lead to virus transmission and/or infection. As such, whilst the individual could have been infected or contaminated with COVID-19 prior to entering isolation they will not have the opportunity to either be infected or contaminated by others during their period of isolation or to infect or contaminate anyone else, except for those they are observing isolation with.

⁹ Davies NG, Klepac P, Liu Y, et al. Age-dependent effects in the transmission and control of COVID-19 epidemics. *Nat Med* 2020;26(8):1205-1211

Although the risk of transmission between individuals undergoing isolation together remains, given a household will have common travel history prior to arrival at Ascension, the risk is deemed to be lower than when compared to a bubble placed together for the purposes of observing compulsory group isolation who shared no common travel history prior to their arrival at Ascension. When testing is applied at two or more points during the isolation period the additional assumed risk dynamic within a bubble can be effectively mitigated.

However, as the risk of intra-group transmission remains in both categories of groups, it is important to monitor vigilantly these units for signs of potential COVID-19 infection.

Current evidence indicates that placing vaccinated persons in small isolation groups (either households or bubbles) of four or less persons for eight days, with a test taking place at the beginning and the end of the isolation period, will result in around a $\leq 2\%$ chance of a person infected with COVID-19 being released from quarantine without having already been identified¹⁰. An indicative period of compulsory isolation for someone in this category would therefore look as follows:

Test	Isolation	Test	Isolation					Test						
0	1	2	3	4	5	6	7	8	9	10	11	12	13	14

Current evidence indicates that placing unvaccinated persons, or vaccinated persons and unvaccinated persons, together in isolation groups of four or less (either households or bubbles) for 10 days provides an $\sim 10\%$ chance of a person infected with COVID-19 being released from quarantine without having already been identified. Applying a test at the beginning and a test at the end of the isolation period, spaced at least eight days apart, will result in a significant reduction in this, and is estimated to provide around a $\leq 2\%$ chance of a person infected with COVID-19 being released from quarantine without having already been identified.¹¹ An indicative period of compulsory isolation for someone in this category would therefore look as follows:

Test	Isolation	Test	Isolation							Test				
0	1	2	3	4	5	6	7	8	9	10	11	12	13	14

Isolation of vaccinated groups of five and six persons

Increasing the number of persons placed into a bubble for the purposes of observing compulsory isolation on arrival, or having a higher number of persons within a household, increases the risk of intra-group transmission. However, full vaccination greatly reduces the chances that an individual who has been exposed to, or contracted, COVID-19 will infect others. As such, when combined with a two test strategy vaccinated groups of five to six persons can observe a 10 day period of compulsory isolation.

Current evidence indicates that placing vaccinated persons in groups of five or six persons for 10 days, with a test taking place at the beginning and the end of the isolation period, will result in around a $\leq 2\%$ chance of a person infected with COVID-19 being released from quarantine without having already been identified. An indicative period of compulsory isolation for someone in this category would therefore look as follows:

Test	Isolation	Test	Isolation							Test				
0	1	2	3	4	5	6	7	8	9	10	11	12	13	14

¹⁰ Correspondence from PHE to Dr Bill Hardy (AIG) on 10 June 2021.

¹¹ Report of meeting between OTs and PHE provided by AIG SMO on 10 June 2021.

Isolation of unvaccinated or mixed groups of >4 persons and of vaccinated groups of >6 persons

As the number of persons in an isolation group increases, so does the risk of transmission of COVID-19 between those persons, particularly within a bubble containing unvaccinated persons. However, it is recognised that isolation of such persons in units of five or more may be necessary in certain situations, due to the logistics of accommodating arrivals required to observe compulsory isolation measures.

Given the increased risk of COVID-19 spread amongst a bubble containing unvaccinated persons and numbering five or more, or of a group containing vaccinated persons numbering six or more, a minimum of a two-test strategy is required¹², with further individual isolation implemented for anyone found to be infected. This is to ensure that the additional risk posed by this form of isolation is appropriately managed as the nature of bubble quarantine invalidates the eight to 10 day isolation periods applied to individuals and smaller groups.

As such it is necessary to test shortly after arrival, with further monitoring (and possible testing) during the isolation period, with an additional test 12 days following arrival. Assuming negative results are returned, the individuals within the bubble will be permitted to leave isolation after 14 days. Taken in combination, this provides around a $\leq 2\%$ chance of a person infected with COVID-19 being released from compulsory isolation following arrival without having been identified. An indicative period of compulsory isolation for someone in this category would therefore look as follows:

Test	Isolation	Test	Isolation									Test	Isolation	
0	1	2	3	4	5	6	7	8	9	10	11	12	13	14

Given the increased risk of transmission in a group isolation setting, it is not advisable for persons determined to be in a high-risk category for developing a severe illness as a result of contracting COVID-19 to undertake this form isolation if otherwise avoidable.

Testing during compulsory isolation following arrival

The timings for tests detailed above are indicative of what is the best available practice to provide the greatest level of assurance. However, they may be subject to change as a result of operational pressures or obstacles.

To provide the best possible baseline for determining the last point of potential COVID-19 exposure, where practical, samples for the first test following arrival will be taken at the point of arrival (e.g. at Wideawake Aerodrome). In the event that someone from that cohort later tests positive, this will provide assurance that infection occurred prior to their transit to the island in the conveyance shared with others, assuming all arrival tests were negative. Where it is not possible to collect samples at the point of arrival, these will be taken as early as practical following arrival, ideally within 48 hours (i.e. on or before day two of the isolation period).

Tests taken ahead of the last scheduled day of compulsory isolation for the purposes of release from quarantine should be taken no earlier than 14 hours prior to the scheduled time of release for those observing eight days of isolation, and no earlier than 24 hours prior to the scheduled time of release for those observing any other duration of isolation. This is to ensure that the results of that test provide an accurate assessment of the individuals COVID-19 status at the point of release from quarantine.

¹² Correspondence from PHE to Dr Bill Hardy (AIG) on 12 August 2020.

Samples may be collected by Georgetown Hospital staff, by staff from either the USAF or RAF medical centres or by other suitably trained individuals where appropriate. Tests will then be processed at Georgetown Hospital using a Cepheid GeneXpert molecular test platform, in line with established protocols and procedures agreed with experts in the UK Health and Security Agency.

Positive identification and management of COVID-19 cases

A case of COVID-19 will be confirmed if a positive PCR test result is returned from a sample taken from an individual. In the event that a positive case of COVID-19 is identified in a person undergoing compulsory isolation following arrival at Ascension (quarantine), it will be necessary to immediately place them into individual isolation separate from anyone else they may be observing compulsory isolation with. In some cases an immediate move to individual isolation might not be practical: whilst this is the best course of action from an epidemiological position, there may be instances where environmental factors prevent this from happening (e.g. a positive case in a child or a single parent with caring responsibilities).

As they pose a confirmed risk of infection to others, they will be tested regularly at the discretion of the SMO. Following two successive negative test results within a 72-hour period, an individual who was previously determined to be positive will be considered to be negative for COVID-19. If they have provided two non-infectious test results within a 72-hour period then, absent other factors, they will be treated the same as a convalescent COVID-19 individual arriving at Ascension and will have their isolation or restrictions brought to an end.

If an individual recovers from a confirmed case of COVID-19 whilst in Ascension, determined by providing two non-infectious test results within a 72-hour period then, absent other factors, they will be treated the same as a [convalescent COVID-19 individual](#) arriving at Ascension and will have their isolation or restrictions brought to an end. As the individual will no longer be infectious, and therefore will not pose a risk of infection or contamination to others, they may have their period of isolation ended without necessarily having fulfilled the period of isolation usually prescribed as per this policy.

Isolation of known contacts of COVID-19 cases

It is vital that an effective, comprehensive and robust contact tracing and isolation apparatus exists within the territory to effectively manage and address any signs of COVID-19 within Ascension as they appear. If a COVID-19 case is identified immediate contact tracing will take place, with close contacts that are identified as possible candidates for contagion directed to observe compulsory isolation for a period of time prescribed by the SMO.

The comprehensive policy and protocols to be observed for the isolation of known contacts of COVID-19 cases are detailed separately in the *Standard Operating Procedures for Contact Tracing*.

Interaction between those under isolation measures and other persons

Isolation measures are in place in order to protect the wider community from the threat of COVID-19. As such they must be strictly observed, noting all statistical modelling is predicated on this.

However, if appropriate mitigation measures are observed interaction may still take place between those in isolation and others. Appropriate distancing should always be observed,

with no direct contact between the parties or encroachment into the property under which isolation is taking place.

If it is necessary to enter a property currently being used for isolation in an emergency, agreed plans and procedures are to be strictly followed and appropriate PPE worn at all times and as advised by the SMO.

Co-isolation of arrivals with non-arrivals

Although some arrivals will arrive at Ascension as family units and enter into isolation together, or will be placed into group isolation where isolation in one's own home is not possible, others will arrive alone and are currently required to complete their isolation period alone. Given this can be for up to 14 days, if not more, this can have a detrimental impact on their health and wellbeing. Equally, certain island critical work is time critical and may require the skills of both a person present in Ascension and that of a person who has arrived within the last 14 days.

As such, in certain circumstances consideration may be given to co-isolating an arrival with a person already present in Ascension. However, accommodating an individual who has recently arrived from a territory affected by COVID-19 with an otherwise healthy person from a COVID-19 free territory is not without risks. The most notable of these is the risk of potential infection or contamination of an otherwise healthy person who enters isolation with the arrival. Therefore this will only be considered if the SMO determines the risks to be manageable and the individuals in question acknowledge that co-isolation takes place at their own risk.

In order to provide some level of reassurance, testing will need to be deployed on the person under isolation measures prior to any others joining them in isolation. In order to then manage the risk to the wider community the point at which the individuals in question enter isolation together and become a group for isolation purposes is the point at which the relevant isolation period will be considered to have begun. Any further testing during this time will be determined by the number of individuals considered to be in the isolation group. As an example, a 14 day isolation period would be undertaken as follows:

Isolation		Test	Isolation											Test	Isolation	
0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
			1	2	3	4	5	6	7	8	9	10	11	12	13	14

Restrictions Short of Compulsory Isolation

In recognition of the fact that Ascension is a working island, AIG has made special provision within the isolation protocols to permit individuals to undertake certain island critical activities during the period when they would otherwise be subject to compulsory isolation. Such instances are considered exceptional, are risk assessed and are considered on a case-by-case basis. It should be noted that these measures are only considered for healthy individuals, and under these circumstances isolation is still observed with any permitted activities taking place in isolation from the wider community, and with appropriate mitigations in place to prevent infection or contamination from occurring.

Exceptional circumstances

It may be the case that under certain exceptional circumstances the release of persons under isolation measures ahead of the completion of their relevant isolation periods is considered (e.g. medical emergency, release of a critical emergency worker, etc.).

Such instances will need to be considered on a case-by-case basis and will be evaluated in liaison with experts from Public Health England, ensuring that any COVID-19 risk resulting from the exceptional circumstances is managed as effectively as possible based on the facilities and apparatus available.

Potential reduction or exemption to compulsory isolation requirements through air travel corridors

Where a territory remains free of community established COVID-19, the threat posed by travellers from such places is significantly reduced. Although risk remains if these travellers share a conveyance with other passengers or crew travelling from an affected area, a decision to reduce the length of compulsory isolation, or to remove the requirement, can take account of the following principles:

1. The change to the compulsory isolation requirement does not increase the risk to the wider community from COVID-19;
2. The process of managing arrivals remains robust, observing agreed protocols to mitigate effectively the potential risk from COVID-19 in a precautionary way, until the SMO is satisfied that no COVID-19 infection or contamination is likely to have occurred in transit.

The comprehensive policy and protocols to be observed for potential reductions or exemptions to compulsory isolation requirements through air travel corridors are detailed separately in the *Policy on HLE-ASI Reduced Length Compulsory Isolation*.

Convalescent COVID-19 Individuals

It is understood that recovery from a previous infection provides an individual with a high level of immunity against COVID-19 for at least a limited period following their recovery and in particular during the period immediately after recovery. This is based on the current understanding of cross-immunity and susceptibility to reinfection with regard to known variants¹³. Therefore, if an individual is able to provide documented evidence which satisfies the SMO that they have recently recovered from a previous infection then, absent other factors, that individual is unlikely to be considered to pose a risk of passing on the virus to others. In that case, the requirement for that individual to isolate, or to continue to isolate, may be removed without undermining the effectiveness of the overall system of managing arrivals to the territory.¹⁴

An individual who is able to provide such evidence which satisfies the SMO will be considered a “convalescent COVID-19 individual”. AIG defines a “convalescent COVID-19 individual” as: **an individual who has recovered from a previous COVID-19 infection where the most recently documented confirmation of infection is a PCR test result based on a sample taken not more than 28 days before the individual’s arrival in Ascension.**

¹³ Correspondence between Dr Nick Gent (PHE) and Dr Bill Hardy (AIG) on 30 August 2021

¹⁴ Correspondence between Dr Nick Gent (PHE) and Dr Bill Hardy (AIG) on 07 September 2021

For the purpose of this definition, an individual will be considered to have “recovered from a previous COVID-19 infection” if they return both: (a) a negative pre-departure PCR test result (i.e. within 72 hours of scheduled departure for Ascension), and (b) a negative PCR test result on arrival at Ascension.

The comprehensive policy and protocols to be observed with regard to Convalescent COVID-19 individuals are detailed separately in the *Policy on Treatment of Convalescent Persons within the Compulsory Isolation Model in Ascension*.

Considerations for further adaptations

Maintenance of community vaccination levels and status

Based on current evidence and understanding of the efficacy of approved COVID-19 vaccines against known variants, it is estimated that the percentage of full vaccination coverage in a population required to ensure the breakdown of COVID-19 transmission chains is ~88%¹⁵. At this level it is expected that the rate of infection will be less than one. Whilst this should be aimed for, recognising that it will be very difficult to achieve and sustain this level of vaccination coverage, as noted a minimum of 80% full vaccination amongst eligible individuals is required¹⁶.

Ongoing program of vaccination

Present evidence suggests that full vaccination from approved vaccines provides a good immune response that lasts for at least six months, and likely longer in many persons who are not otherwise considered vulnerable to a severe COVID-19 illness¹⁷. As such those that have already been fully vaccinated will need to be provided with additional vaccinations within six to nine months of their second dose, where possible, to ensure that community vaccination rates remain at a level considered to be necessary for the current entry control measures to be effective.

Full vaccination as a requirement of entry to Ascension

Were full vaccination to be applied as a condition of entry it would ensure that the percentage of fully vaccinated individuals within the community remains at a certain level, or even improves, even if those currently within the community depart the territory.

Vaccination of those aged 12 to 17 years old

Amongst populations with widespread full vaccination status, where younger age groups have not been vaccinated they tend to be responsible for a significant proportion of transmission¹⁸. Persons aged 17 years and younger represent approximately 10% of the territory’s population¹⁹ and as such pose a potential bridge for transmission between vaccinated persons, as well as the rest of the community.

¹⁵ PHE UKOTs-Crown Dependencies SARS-CoV-2 Teleconference Meeting Note 10/06/2021 and 11/06/2021

¹⁶ PHE UKOTs-Crown Dependencies SARS-CoV-2 Teleconference Meeting Note 10/06/2021 and 11/06/2021

¹⁷ N. Doria-Rose *et al.* *N. Engl. J. Med.* <https://doi.org/f5c6>; 2021

¹⁸ PHE UKOTs-Crown Dependencies SARS-CoV-2 Teleconference Meeting Note 10/06/2021 and 11/06/2021

¹⁹ AIG population statistics 31 March 2021 (101 of a total population of 1023)

Vaccination of this cohort, or as high of a proportion of this cohort as possible, is therefore desirable. At present several vaccines have been approved for use on the proportion of this age group aged 12 years and older, and evidence suggests that widespread vaccination of these age groups impacts patterns of transmission²⁰. If access to these vaccines could be secured, it would provide an opportunity to further increase the vaccination coverage within the population and further challenge the potential for virus transmission.

Reactive capacity

Ensuring authorities have the capacity and capability to respond effectively to any observed community outbreak will be pivotal to further adaptations, and in particular any potential relaxation, of compulsory isolation measures for arrivals.

Ability to deploy mass community testing

Whilst the PCR platform remains the most effective testing regimen in detecting COVID-19 in an individual, it is relatively labour intensive, and therefore slow, to collect and process large numbers of tests at once. As such, rapid COVID-19 tests performed by handheld devices could provide opportunities to quickly respond to observed community outbreaks and as such influence wider COVID-19 measures.

Although non peer-reviewed, a recent study has estimated that the most sensitive antigen lateral-flow devices could have the potential to detect up to four in five COVID-19 cases that have the potential to lead to an infected contact²¹. This is based on the current understanding of Ct values and the estimated infectivity of those values.

If confirmed evidence becomes available as to the effectiveness of rapid handheld tests in detecting cases that could lead to an infected contact, it could provide additional confidence in the ability to manage any observed outbreaks, and as such could support potential future adaptations to the compulsory isolation of arrivals model in Ascension.

In order to be able to deploy this form of testing effectively, such as over several weeks to targeted sections of the territory's population, a significant reserve of test kits would need to be secured and held. If this were possible however, it would bolster the reactive capability of authorities to respond to community cases and transmission.

Conclusion

The measures presently in place have been informed by the current understanding of COVID-19 and the circumstances specific to Ascension Island. AIGs approach to managing the threat posed by COVID-19 remains under constant review and may be subject to change as the understanding of the virus evolves, the resources available to manage the threat of COVID-19 changes and/or the advice and evidence received from expert colleagues in The UK Health and Security Agency is adapted.

²⁰ https://www.cdc.gov/coronavirus/2019-ncov/science/science-briefs/transmission_k_12_schools.html

²¹ L. Y. W. Lee *et al.* Preprint at medRxiv <https://doi.org/f5jic>; 2021