



Adviesaanvraag

Vraagsteller	OCC
Datum van adviesaanvraag	07/12/2020
Onderwerp	Contactberoepen
Vraag	<ul style="list-style-type: none">- Kunnen de niet-medische contactberoepen opnieuw opstarten? Wat met kappers?- Wat zou de impact zijn van het heropstarten van contactberoepen?
Reden	<ul style="list-style-type: none">- Veel scepticisme over wetenschappelijke onderbouwing van oorspronkelijk advies tot sluiting- Door sector werd veel in veiligheid geïnvesteerd die nu niet kan renderen (op een economisch cruciaal moment), belangrijke financiële moeilijkheden- Geen perspectief, geen indicatie van wanneer deze sector terug kan opstarten

Adviesverstrekking t.a.v. het Overlegcomité van 18 december 2020

Datum van adviesverstrekking	15/12/2020
Dit advies werd opgesteld en goedgekeurd door	De volgende leden van de expertgroep beheerstrategie: Isabelle Aujoulat, Philippe Beutels, Steven Callens, Bénédicte Delaere, Mathias Dewatripont, Frédéric Fripiat, Lode Godderis, Niel Hens, Yves Kreins, Tinne Lernout, Romain Mahieu, Christelle Meuris, Geert Molenberghs, Céline Nieuwenhuys, Michel Thieren, Pierre Van Damme, Steven Van Gucht, Yves Van Laethem, Marc Van Ranst, Dimitri Van der Linden, Maarten Vansteenkiste, Erika Vlieghe, Dirk Wildemeersch



1. Recommendation and rationale

We **advise not to restart non-medical contact professions at this moment** in time for the following reasons:

1. Society motivational perspective: urgent need for clarity and consistency

The principle of the management strategy has been announced to the public; it has repeatedly been mentioned that the actual increasing figures do not allow further relaxations for commercial sectors. Disregarding this principle might confuse people and harm the credibility of the policy makers. This in turn could result in less adherence to the rules.

2. The precarious epidemiological situation and lack of buffer in the healthcare sector to absorb a new wave of COVID-19 cases

The current indicators (14-days cumulative incidence of new infections, daily number of new hospitalisations) are far above the thresholds set to change from the lockdown stage to a control stage, where relaxation measures can be planned. More worrisome, the trend of new infections is stabilising or even increasing in some parts of the country. Details are given in a separate epidemiological report. Given the many cases within the healthcare workforce as well as the stretch they have been in since March, the healthcare workforce (and in particular the hospital staff and nursing home staff) does not have sufficient capacity to handle and absorb a third COVID-19-wave of even higher magnitude than the preceding two.

In addition, the healthcare sector will also be a crucial partner to co-organise the mass-vaccination from the beginning of 2021 onwards, which means there might be less capacity for COVID-19 and other care.

3. Activities within contact professions assessed as 'medium to high infection risk' for COVID-19 transmission

Risks are associated with proximity, conversations, contact duration, inconsistent mask use¹, ventilation and aerosolization... Details are given in *section 2 ('Risk assessment and evidence')*. Taken together, the type of encounter within contact professions seems to hold more risks on viral transmission than brief on-distance encounters in shops. The sector took appreciated preventive measures, which are likely to reduce the risk, but given the specificity of contact occupations and the general epidemiological circumstances, insufficient to reduce the risk to an acceptable level. Therefore, it is not deemed ethical to re-open at this stage of viral transmission.

4. Available published evidence from Belgian RSZ data as well as international published literature

Whereas the international evidence on the risks of occupational COVID-19 in non-medical contact professions is limited at the moment, the proportion of confirmed COVID-19 positive cases are considerably higher among hairdressers and beauty-workers than other professions (*see section 2.2.2*).

¹Bundgaard, H., Bundgaard, J. S., Raaschou-Pedersen, D. E. T., von Buchwald, C., Todsén, T., Norsk, J. B., Pries-Heje, M. M., Vissing, C. R., Nielsen, P. B., Winsløw, U. C., Fogh, K., Hasselbalch, R., Kristensen, J. H., Ringgaard, A., Porsborg Andersen, M., Goecke, N. B., Trebbien, R., Skovgaard, K., Benfield, T., ... Iversen, K. (2020). Effectiveness of Adding a Mask Recommendation to Other Public Health Measures to Prevent SARS-CoV-2 Infection in Danish Mask Wearers. *Annals of Internal Medicine*. <https://doi.org/10.7326/m20-6817>



5. Socio-economic perspective

The demand to restart activities is mainly driven by the economic needs of this professional group, and not by a low risk assessment. However, the risk of fuelling a third wave by reopening a sector with a higher than average estimated professional risk may hurt the economy more profoundly. In addition, within the sector, the opinions are divided upon resuming activities. As shown by a survey among the 'Union belge des esthéticiennes', there is also a considerable concern among the workers, and a wish to only reopen in more epidemiologically stable times. Furthermore, due to a long period of closure and with the holidays coming up, a proportion of the hairdressers are scared of being overwhelmed by demand. Epidemiologically, this high demand means that prevalence could be high.

Nevertheless, the sector requires sufficient financial support and a clear perspective (i.e. able to resume activities when the epidemiological situation allows), especially since it is a sector which has almost no option to adapt itself to a lockdown situation (unlike e.g. restaurants which can organise takeout). Even though reopening the sector should not be done now, preparations could be taken in the meantime, with strengthened protocols, and training on correct handling masks/shields, attention for ventilation and dealing with difficult situations (e.g. clients not wanting to keep their mask on or to wait outside) ...

2. Risk assessment, available evidence and critical appraisal

2.1. Risk assessment

- a. Non-medical contact professions include by definition professional activities which require **close physical contact with clients for aesthetic and wellbeing reasons**, i.e. hairdressing, make-up and grime, non-medical manicure and pedicure, application of tattoos and piercings, massage/wellness and beauty-salons...
- b. The performed activities within the non-medical contact professions are per definition **high risk**, which means (according to Belgian classification):
 - i. A situation in which at least two people are inside at a distance of less than 1.5 m for longer than 15 minutes, and at least one of them is not wearing a mask; OR
 - ii. A situation in which at least two people have direct physical contact.
- c. **Mask wearing is sometimes not possible or done** during activities of contact professions (e.g. for visagists, barbers, hairdressers, massage...), but even when worn correctly, masks are only part of a comprehensive set of measures, including physical distancing, according to advice of the WHO (01/12/2020). Furthermore, according to ECDC², face masks provide partial protection against the transmission of SARS-CoV-2, but the effect may be lower when the face mask is not worn properly at all times (which is often the case when used by a public not trained to correct use)¹.
- d. Hairdressers are hypothesised to specifically carry a great risk, since they are not only close to a person's face but using **hair dryers could contribute to** further spread of possible infected particles across the room.

² <https://www.ecdc.europa.eu/sites/default/files/documents/covid-19-contact-tracing-public-health-management-third-update.pdf>



- e. Activities typically occur in relatively small (treatment) rooms where adequate **ventilation is not always ensured**, especially in winter.
- f. Several of the aforementioned treatments and activities require a considerable amount of time (e.g. hair staining, massages) which may lead to client and worker prolonged **exposure**.
- g. During encounters with contact professions, there are typically (**prolonged**) **conversations** between two people with close physical contact (with talking being associated with increased risk of aerosol production). Contacts with conversations hold an intrinsically higher risk to the production and transmission of aerosols than silent contacts.
- h. Clientele includes **large numbers of high-risk groups for severe COVID-19**, e.g. elderly people.
- i. Although such treatments often contribute to the well-being of people, this benefit does not outweigh the epidemiological risk that comes with it.

2.2. Available evidence

2.2.1. General

There have been few published empirical studies on SARS-CoV-2 acquisition through contacts made with non-medical professionals.

At the beginning of the crisis, a risk assessment was mainly made on the basis of physical proximity and contact with infections at work (*see figure 1 below*). This is because SARS-CoV-2 spreads among the population through close human contact. This risk assessment seemed to correspond fairly well with reality. The first cases of occupational risk from COVID-19 occurred in the tourism industry. A lockdown quickly followed, after which, at the start of the first wave, especially essential workers, such as healthcare providers, were at greater risk of COVID-19. This was also confirmed by a study by the European Center for Disease Control³ which examined the number of clusters per sector during the first wave of fifteen European countries and the United Kingdom and a Norwegian study⁴.

Barbers, hairdressers, hair stylists, and cosmetologists rank between health professionals, professions with a high physical proximity.

³ <https://www.ecdc.europa.eu/en/publications-data/covid-19-clusters-and-outbreaks-occupational-settings-eueea-and-uk>

⁴ <https://www.medrxiv.org/content/10.1101/2020.10.29.20220426v1>

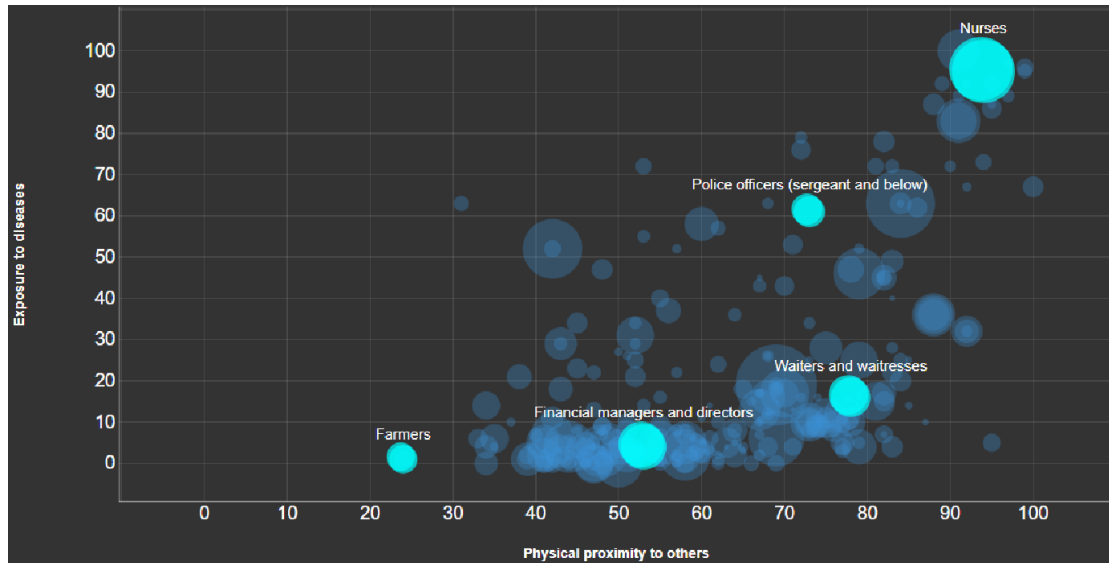


Figure 1. Classification of at-risk jobs according to physical distance from others and exposure to infection risks at work (<https://autonomy.work/portfolio/jari/>).

2.2.2. Belgian data

A recent analysis of data provided by RSZ-ONSS allows to associate certain professions with the proportion of positive cases. The data shows that rate of infection is higher among hairdressers and workers in beauty-salons, as compared to the average of all sectors⁵.

Please note that there is no information in this data about where the person was infected: workplace, home or elsewhere. It just concerns data about the proportion of infections among persons registered with a certain profession, regardless of the place and context in which they got infected. Additionally, since the link of the cases is only identified at the level of the company, no information is available on the job description of the index case (e.g. administrative work), the exact location (e.g. secondary site or telework) or the activity (e.g. absence of the worker because the shop is closed).

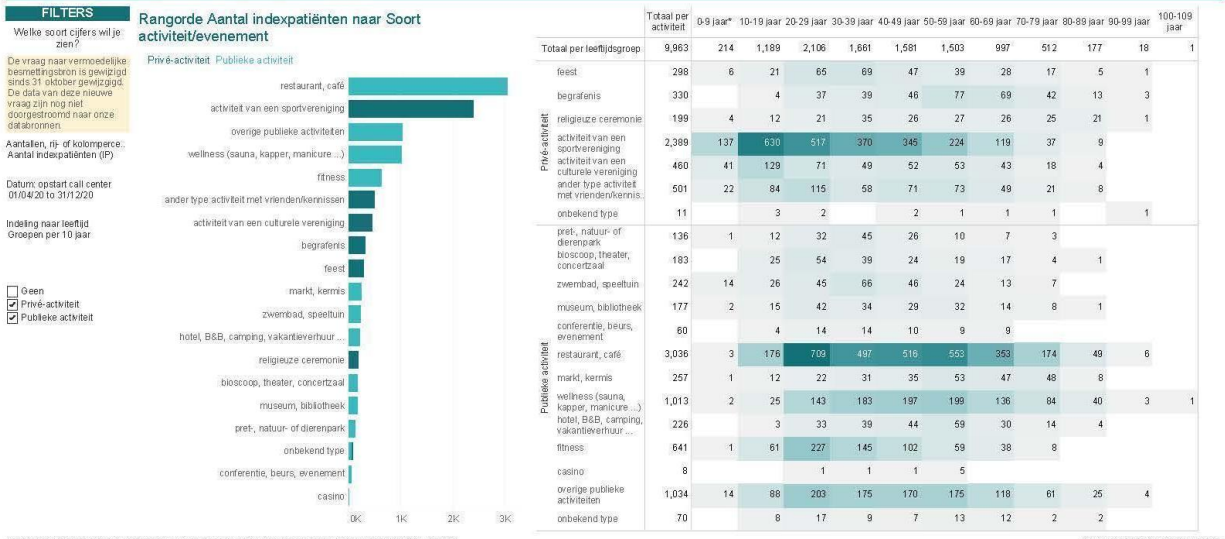
Data from the Flemish contact tracing (*figure 2*) also shows that a large portion of index cases come from wellness (sauna, hairdresser, manicure...). In the age category 60 years and above, the relative contribution is even higher.

⁵ The analysis is based on data from aggregated output tables containing incidences per sector. This is obtained by linking positive COVID-19 cases and multiple workplace-related databases. This database does not include information about self-employed workers. In some sectors, that may represent a large proportion of the workers. Each company is classified by sectors of its main activity (as attributed by the RSZ-ONSS) which are identified by the NACE code. This standard code defines workplaces into 21 main sectors and then in subcategories for which the specificity depends on the chosen granularity (which can have up to 943 subcategories). However, although some companies may be active in more than one sector, only one NACE number associated with the main activity is used in the analysis.



Naar menu
rapporten

Samenkomsten: Soort activiteit/evenement
Aantal indexpatiënten (IP) voor 14/10-12/12



Rangorde toont aantal meldingen of aantal indexpatiënten (meer dan 1 melding per indexpatiënt mogelijk). Tabel per leeftijd en locatie toont aantal meldingen of indexpatiënten (per cel en in totaal). Omdat 1 persoon meer dan 1 locatie kan bezoeken is het totaal bovenaan niet exact de som van alle rijen. * 0-6 jaargen worden niet vaak getest

Figure 2: Data from Flemish contact tracing.

2.2.3. International findings

As mentioned before, there have been few published empirical studies, with inconsistent results, on SARS-CoV-2 acquisition through contacts made with non-medical professionals. The following studies thus have to be interpreted with care.

1. Singapore: role of close physical proximity and verbal interaction as risk factor for transmission.

On Tek Ng et al. SARS-CoV-2 seroprevalence and transmission risk factors among high-risk close contacts: a retrospective cohort study. Lancet Infect Dis S1473-3099(20)30833-1 [https://doi.org/10.1016/S1473-3099\(20\)30833-1](https://doi.org/10.1016/S1473-3099(20)30833-1).

Close physical proximity and increased duration of verbal interaction were found to be independent risk factors for SARS-CoV-2 transmission among both household and non-household contacts. Mask wearing was not significant in the univariable analysis, but as with many current studies, some questions about the validity can be raised due to methodological limitations.



Table 1: Univariable and multivariable analysis of risk factors for acquisition of COVID-19 among non-household (work and social) contacts (Tek Ng et al. (2020)).

	Cases (n=53)	Controls (n=611)	Univariable analysis		Multivariable analysis	
			Odds ratio (95% CI)	p value	Odds ratio (95% CI)	p value
Longest duration that a COVID-19 case spoke to individual						
Individual was not spoken to by a COVID-19 case	13 (24.5%)	281 (46.0%)	Ref	--	Ref	--
COVID-19 case spoke for <30 min	19 (35.9%)	196 (32.1%)	2.10 (1.01-4.34)	0.047	2.50 (1.15-5.44)	0.021
COVID-19 case spoke for ≥30 min	21 (39.6%)	134 (21.9%)	3.39 (1.65-6.97)	0.0009	2.67 (1.21-5.88)	0.015
Mask worn by COVID-19 case or cases						
COVID-19 case or cases did not wear a mask during all contact episodes	45 (84.9%)	548 (89.7%)	Ref	--	--	--
COVID-19 case or cases wore a mask during all contact episodes	8 (15.1%)	63 (10.3%)	1.55 (0.70-3.43)	0.28	Not included†	--
Mask worn by individual						
Individual did not wear a mask during all contact episodes	47 (88.7%)	564 (92.3%)	Ref	--	--	--
Individual wore a mask during all contact episodes	6 (11.3%)	47 (7.7%)	1.53 (0.62-3.77)	0.35	Not included†	--

2. US: transmission among hairdressers

Absence of Apparent Transmission of SARS-CoV-2 from Two Stylists After Exposure at a Hair Salon with a Universal Face Covering Policy — Springfield, Missouri, May 2020
Weekly / July 17, 2020 / 69(28);930-932. https://www-cdc.gov.vdicp.health.fgov.be/mmwr/volumes/69/wr/mm6928e2.htm?s_cid=mm6928e2_w

Among 139 clients exposed to two symptomatic hair stylists with confirmed COVID-19 while both the stylists and the clients wore face masks, no symptomatic secondary cases were reported; among 67 clients tested for SARS-CoV-2, all test results were negative. Adherence to the community's and company's face-covering policy likely mitigated spread of SARS-CoV-2. Although there were no transmissions detected in this study, there are important limitations⁶ that prevent a conclusion from being drawn.

3. Norway: occupational risk of COVID-19 in the 1st vs 2nd wave of infection

Karin Magnusson, Karin Nygård, Line Vold, Kjetil Telle, Norwegian Institute of Health
medRxiv preprint doi: <https://doi.org/10.1101/2020.10.29.20220426>

In a study of 3 553 407 persons aged 20-70 years, the relationship between their profession and the risk for acquiring COVID-19 during the first and second epidemic waves was assessed. While medical contact

⁶ First, whereas the health department monitored all exposed clients for signs and symptoms of COVID-19, and no clients developed symptoms, **only a subset was tested**; thus, asymptomatic clients could have been missed. Similarly, with a viral incubation period of 2–14 days, any **COVID-19 PCR tests obtained from clients too early in their course of infection** could return false-negative results. To help mitigate this possibility, all exposed clients were offered testing on day 5 and were contacted daily to monitor for symptoms until day 14. Second, although the health department obtained supplementary data, **no information** was collected regarding underlying medical conditions or **use of other personal protective measures**, such as gloves and hand hygiene, which could have influenced risk for infection. Third, **viral shedding is at its highest during the 2 to 3 days before symptom onset; any clients who interacted with the stylists before they became symptomatic were not recruited for contact tracing**. Finally, the **mode of interaction between stylist and client might have limited the potential for exposure to the virus**. Services at salon A were limited to haircuts, facial hair trimmings, and perms. Most stylists cut hair while clients are facing away from them, which might have also limited transmission.



professions and people working in the public transport sector seemed to be professionally most at risk during the first wave (which included more restrictions for other professions), workers in the catering and travel sectors appear to be relatively more at risk.

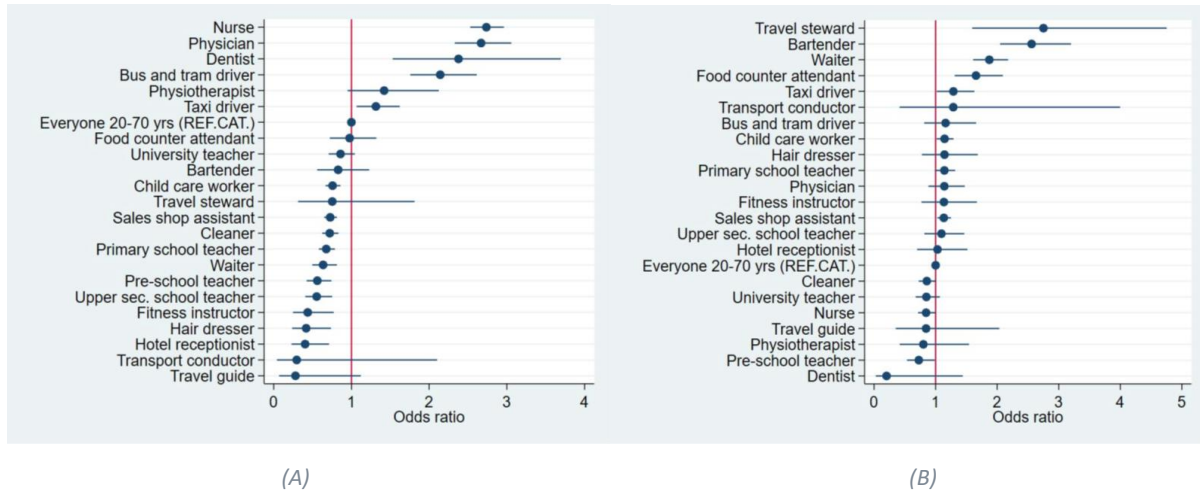


Figure 3: Odds ratios for different professions during first wave (A) and second wave (B) of COVID-19.

The number of confirmed COVID-19 cases among hairdressers was higher during the second wave than during the first.

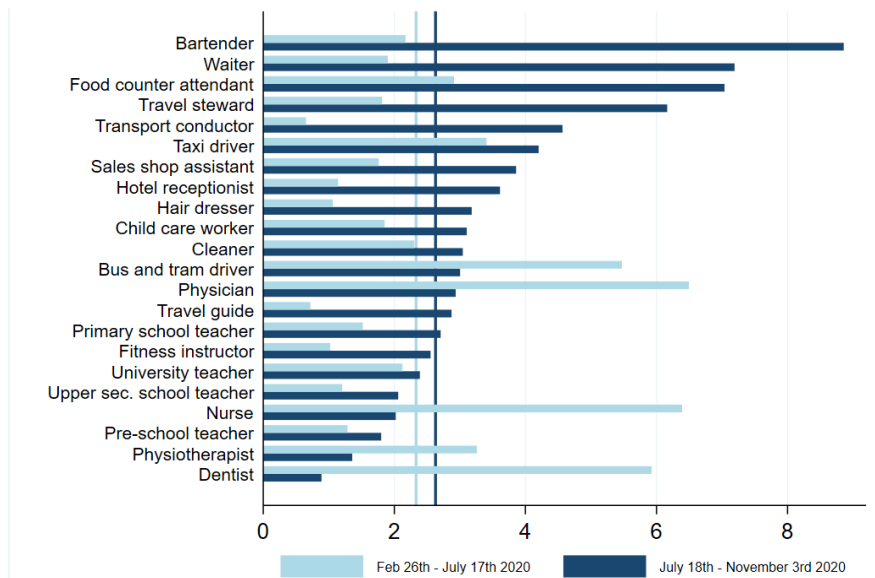


Figure 4: The number of confirmed COVID-19 cases per 1000 working employees in different occupations in Norway, before and after July 18th 2020. Vertical lines represent the proportion of confirmed cases for everyone in their working age (20-70), for the two periods.

2.3. Critical appraisal of available evidence

As mentioned above, the base and type of evidence available is limited, but absence of evidence is not equal to evidence of absence – as we learned the hard way with asbestos and tobacco-related diseases



decennia ago. In addition, the evidence from methodologically sound studies is very scarce and only gradually becoming available. This should not be of surprise, given that COVID-19 is a new disease and evidence is only gradually collected and published. Nevertheless, assessments as input for base public health decisions have to be made in the meantime, based on theoretical risk assessments, extrapolations from earlier knowledge and the precautionary principles.

The evidence base used for non-pharmaceutical interventions is by definition different from e.g. the evidence base required before a specific pharmaceutical intervention (e.g. vaccination campaign) is started. The latter is much less standardisable and (societal) interventions come per definition in a combined package.

With vaccines, one can use the 'gold standard' of evidence, i.e. randomised control trials (RCTs). For confinement measures during an epidemic, we do not always have the possibility, mainly due to time, resource or ethical constraints to conduct RCTs. This is not unique to the COVID-19 epidemic, also many other public health interventions have been introduced without the back-up of an RCT but with a significant load of circumstantial evidence. For instance, RCTs on the risk of smoking, drinking alcohol or eating fast food have also not been carried out so far. This means we have to obtain information more indirectly and settle for less certainty.

However, there is by now ample evidence from both virology and epidemiology that increasing the number of contacts in society causes more infections, hospitalisations and deaths, and the more so the more intimate or exuberant their social interaction, the smaller their distance, the poorer the mask protection, the longer the contact duration, and the poorer the ventilation. This means that scientific evidence does allow for a ranking of activities in terms of sanitary risks; going to a shop is less risky than going to the hairdresser (where social distancing is by definition impossible).

A better knowledge of occupational risks can provide an important source of information for more targeted and fine-tuned restrictions on certain activities in certain sectors in order to prevent the spread of the virus or, even better, to take preventive measures. In fact, one would need to do source-tracing to really know if and how the virus spreads through work and how the (lockdown) measures affect it. However, currently available studies on occupational transmission that often show no clear sign of higher contamination rates have many limitations, of which an important one is lack of data quality. Therefore, we recommend starting up a sectorial workgroup (represented: employers, employees and prevention advisors) in order to co-create preventive measures, assess its impact, follow-up and correct when necessary.

2.4. International considerations

Some of our neighbouring countries had been relaxing their measures while the number of daily new cases was still relatively high. It can only be observed that most of them are again tightening measures, in some cases quite severely (e.g. Germany and the Netherlands), in an attempt to hold or reclaim control over the virus spread. Note that these tightening measures almost systematically include the occupational contact sector and that contact professions are thus rarely escaping any stringency tightening policy.

The effect of seasonality is likely contributing to the resurgence in the whole of Europe. In winter periods, people spend more time indoors, where viruses can transmit more easily.



3. Providing perspective

This advice will be re-evaluated when the rate of new cases and hospitalisations decline and ICU occupancy rates continue to fall and when revised protocols are provided.