


REVIEW

A rapid review of measures to support people in isolation or quarantine during the Covid-19 pandemic and the effectiveness of such measures

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Summary

This rapid review aimed to identify measures available to support those in isolation or quarantine during the coronavirus disease 2019 (Covid-19) pandemic, and determine their effectiveness in improving adherence to these recommendations and or reducing transmission. The rapid review consisted of two elements, the first was a review of guidance published by national and international agencies relating to measures to support those in isolation (due to case status) or quarantine (due to close contact status) during the Covid-19 pandemic. Five categories of support measures were identified in the international guidance, they were: Psychological, addiction and safety supports, Essential supplies, Financial aid, Information provision and Enforcement. The second element was a rapid literature review of the effectiveness of measures used to support individuals in isolation or quarantine during any pandemic or epidemic setting, due to respiratory pathogens. A systematic search of published peer-reviewed articles and nonpeer-reviewed pre-prints was undertaken from 1 January 2000 to 26 January 2021. Two Australian publications met the inclusion criteria, both based on data from a survey undertaken during the 2009 H1N1 pandemic. The first reported that 55% of households were fully compliant with quarantine recommendations, and that there was increased compliance reported in households that understood what they were meant to do compared with those who reported that they did not (odds ratio [OR]: 2.27, 95% confidence interval [CI]: 1.35–3.80). The second reported that access to paid sick and or carer's leave did not predict compliance with quarantine recommendations (OR: 2.07, 95% CI: 0.82–5.23). Neither reported on reduction in transmission.

Abbreviations: Covid-19, coronavirus disease 2019; ECDC, European Centre for Disease Prevention and Control; MERS, Middle East respiratory syndrome; PPE, personal protective equipment; SARS-CoV-2, severe acute respiratory syndrome coronavirus 2; WHO, World Health Organisation.

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KEYWORDS

Covid-19, isolation, quarantine, respiratory pathogens, SARS-CoV-2, supports

1 | BACKGROUND

On 11 March 2020, the World Health Organisation (WHO) declared the coronavirus disease 2019 (Covid-19) outbreak a global pandemic. As of 16 March 2021, there have been almost 120 million cases and over 2.5 million deaths from laboratory-confirmed cases of Covid-19 worldwide.¹ In the context of the overall public health response to Covid-19, effective management of cases and their contacts is key to reducing the spread of Covid-19. In regard to cases, that is, those with confirmed or suspected Covid-19 infection, isolation is the term used to describe their separation from those who are not infected. Quarantine is the term used to describe separation of those exposed or potentially exposed to severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) from others, as a precautionary measure because they may have the disease.^{2,3} Measures to support individuals in isolation and quarantine should be considered to improve compliance with the recommendations.⁴ As such, the aim of this rapid review was to (1) identify the measures being taken internationally to support compliance with isolation and quarantine recommendations during the Covid-19 pandemic (a review of international guidance) and (2) to determine the effectiveness of such measures during pandemics or epidemics involving respiratory pathogens (a review of primary research studies) on compliance and reduction in spread of infection.

2 | METHODS

A detailed summary of the methods used in this rapid review is provided in the protocol,⁵ which is in accordance with Cochrane rapid review methodology guidance.⁶

In short, official national and international agency websites from a predefined list were searched for measures implemented to support those in isolation or quarantine during the Covid-19 pandemic. Supports identified were then categorised by theme. Following a scoping exercise, it was evident that there was a lack of evidence relating to the effectiveness of measures implemented to support those in isolation or quarantine during the Covid-19 pandemic. Therefore, evidence of the effectiveness of measures implemented to support those in isolation or quarantine relating to other respiratory pathogens (e.g., SARS-CoV and Middle East respiratory syndrome [MERS]) from an epidemic or pandemic situation from 2000 to 2021 were included. A systematic search of published peer-reviewed articles and nonpeer-reviewed preprints was undertaken from 1 January 2000 up to 26 January 2021; no language restrictions were applied. All potentially eligible papers were exported to Covidence (www.covidence.org) and titles/abstracts and full texts were single screened for relevance based on the inclusion/exclusion criteria

outlined in the protocol. Data extraction and quality appraisal of included studies was completed by a single reviewer and checked by a second reviewer; the Joanna Briggs Institute checklist for analytical cross sectional studies was used for quality appraisal of included studies.⁷

3 | RESULTS

3.1 | International review

In total, guidance from the European Centre for Disease Prevention and Control (ECDC), WHO and official national and international agency and or government websites from 19 countries, relating to measures to support those in isolation or quarantine, were included in this review. The findings were summarised into five main categories of support measures. Table 1 provides a summary of the measures found to support individuals who are in isolation or quarantine during the Covid-19 pandemic.

3.2 | Psychological, addiction and safety support measures

Psychological support measures were identified in 18 of the 19 countries reviewed; this included mental health support, addiction support as well as support for victims of violence (domestic and or child abuse). This support is available to those isolating, quarantining, or those affected by restrictions in general. Available support was varied and included information leaflets, helplines, online appointments or video conferences with counsellors or psychologists. The information on websites did not specify if organisations were government funded, whether there was a fee for those using the service, nor did they specify which organisations existed before the Covid-19 pandemic.

In line with recommendations from the ECDC⁸ and the WHO,^{9,10} agency and or government websites for Austria,¹¹ Australia,^{12–15} Belgium,¹⁶ Canada,^{17,18} Denmark,¹⁹ England,^{20,21} Finland,^{22–25} France,^{26,27} the Netherlands,^{28,29} New Zealand,^{30,31} Norway,³² Scotland³³ and Switzerland³⁴ have listed resources for mental health support, addiction support and or support for victims of violence. Typically, the support offered is in the form of online information portals and information sheets, as well as helplines and online counselling services. Official agency and or government websites for Wales³⁵ and Singapore³⁶ have listed resources for mental health and victims of violence. Ireland^{37,38} has resources for mental health support and addiction support, and Iceland³⁹ and Northern Ireland⁴⁰ listed resources for mental health support (see Table 1).

TABLE 1 Summary of the measures to support those in isolation and quarantine identified in the review of international guidance

Support measures available	Psychological, addiction and safety supports			Essential supplies			Information			Financial		Enforcement			
	Mental health	Addiction	Safety	Medicines	Food	Accommodation	Provision of care	PPE	Helpline	Website	Apps	Assistance payment	Certificate	Monitoring	Fines and or prison term
Countries															
Austria	✓	✓	✓	✓	✓			✓	✓	✓		✓			F (US\$2177)
Australia	✓	✓	✓	✓		✓ ^a		✓	✓	✓	✓	✓		✓	F ^a , P ^a
Belgium	✓	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓	✓	F ^a
Canada	✓ ^a	✓ ^a	✓ ^a	✓	✓	✓ ^a		✓	✓	✓		✓			F ^a
Denmark	✓	✓	✓			✓		✓	✓	✓		✓			F (US\$1506)
England	✓	✓	✓	✓	✓		✓	✓	✓	✓		✓			
Finland	✓	✓	✓	✓	✓			✓	✓	✓		✓		✓	
France	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓		✓	
Iceland	✓			✓	✓	✓		✓	✓	✓		✓	✓		F (US\$1832)
Ireland	✓	✓		✓	✓	✓		✓	✓	✓		✓	✓		
Netherlands	✓	✓	✓	✓	✓	✓		✓	✓	✓		✓			
New Zealand	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓			F, P (US\$2841)
Northern Ireland	✓			✓				✓	✓	✓		✓			F (US\$301)
Norway	✓	✓	✓					✓	✓	✓	✓	✓			F, P
Scotland	✓	✓	✓	✓	✓			✓	✓	✓		✓			F (US\$723)
Singapore	✓	✓	✓					✓	✓	✓		✓			F, P
Sweden								✓	✓	✓		✓	✓		
Switzerland	✓	✓	✓	✓	✓			✓	✓	✓		✓	✓		F (US\$8881)
Wales	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓			F (US\$753)
International agencies															
ECDC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
WHO	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	

Abbreviations: ECDC, European Centre for Disease Prevention and Control; F, fines; P, prison term; PPE, personal protective equipment; WHO, World Health Organisation.

^aRegional variation.

It should be noted that while official national and international agency and or government websites may not have listed specific support measures available during the Covid-19 pandemic, this does not mean that support is not available. For example, in Ireland, support for victims of domestic abuse continues to be made available through organisations such as Safe Ireland which existed pre-Covid-19.⁴¹

3.3 | Essential needs support measures

Guidance from the ECDC^{8,42} and WHO⁹ highlights the importance of ensuring that individuals who are isolating or quarantining have access to daily essential needs. This encompasses access to medicines, food, accommodation, provision of care (including healthcare and childcare) and personal protective equipment (PPE); the ECDC recommend that medical face masks are used by everyone in households where there are people with symptoms of Covid-19 or confirmed Covid-19.⁴² Information on support in relation to an individual's essential needs was available in 16 of the 19 countries reviewed.^{12,15,19,20,28,31,35,40,43-56} The level of support identified ranged from extremely comprehensive support covering all essential needs (i.e., medicines, food, accommodation, provision of care and PPE) to covering fewer of these needs; see Table 1. Specific supports may not always be identified on government websites, but that does not necessarily mean they are not available. For example, in Singapore isolation of cases and quarantine of close contacts must be completed in purpose-built isolation centres where all essential needs, including psychological support, are met.⁵⁷

3.4 | Information

The WHO recommend that national communication strategies equip the public with comprehensive information about Covid-19.⁵⁸ All countries reviewed provided some form of information support for those isolating or quarantining.^{11,12,14-19,21,24,27,28,30,33,35,36,38,54,59-72} In addition to specific information to support those required to isolate or quarantine, information sources typically provided comprehensive information regarding a wide range of Covid-19 related issues. The most common form of information support available could be accessed via helplines or websites; some countries (Australia,^{12,15} France,⁶⁸ New Zealand³⁰ and Wales³⁵) also provided information through mobile phone applications (see Table 1).

3.5 | Financial support measures

All countries reviewed provided details of financial support available to those who are isolating or quarantining.^{13,28,36,40,45,50,51,65,73-90} Some countries provide individuals with a certificate informing them of their need to isolate or quarantine; which enabled them to access available financial supports. The payments varied between countries

and were typically a fixed amount rather than a percentage of the individual's salary (see Table 1).

3.6 | Enforcement

Of the 19 countries reviewed, only Australia,⁵⁵ Belgium⁹¹ and France⁸⁹ reported monitoring those who should be isolating or quarantining (subject to regional variation). Austria,⁴⁶ Australia,^{14,55,92-94} Belgium,^{86,95} Canada,⁵¹ England,²¹ Iceland,⁹⁶ New Zealand,⁹⁷ Northern Ireland,⁹⁸ Norway,⁹⁹ Scotland,¹⁰⁰ Singapore,¹⁰¹ Switzerland¹⁰² and Wales¹⁰³ report the use of fines and or prison terms (Australia,^{14,93,94} New Zealand,⁹⁷ Norway⁹⁹ and Singapore¹⁰¹) for noncompliance to the regulations. The fine imposed varies by country and in some cases by state or province (namely, Australia, Belgium and Canada) (see Table 1).

3.7 | Rapid literature review

Across the databases searched, the collective search up until 20 January 2021 resulted in 1343 citations; the search strategy included terms for other respiratory pathogens (e.g., SARS-CoV and MERS) during an epidemic or pandemic situation from 2000 to 2021. Following removal of duplicates 1301 citations were screened for relevance, with 158 full-texts assessed for eligibility and 156 subsequently excluded. See Figure 1 for a PRISMA flow diagram of the studies included in this review. Accordingly, after full review of the inclusion criteria, two publications were identified for inclusion based on one study.

Both publications, by Kavanagh et al.,^{104,105} were conducted in the school setting in Australia and used the same dataset, but reported on different measures implemented to support isolation and quarantine. These publications reported data from one study with each publication reporting on different measures of support. Survey data were collected in November and December 2009. The data collected related to quarantine recommendations implemented from 22 May 2009 to 2 June 2009 during the 2009 H1N1 pandemic. Voluntary home quarantine of cases and close contacts was the main intervention used to limit transmission of (H1N1)pdm09 flu virus during the initial response to the outbreak of the disease in Australia. The trigger for closure of mainstream schools was two or more confirmed cases in separate classes.^{104,105}

The findings published in 2011,¹⁰⁵ reported on compliance with restrictive measures as a result of information on quarantine having been provided. Data were included from 297 families; 49% of respondents' children were under 12 years old, 54% of respondents were male and 17% had a confirmed case of (H1N1)pdm09 flu virus in their household.¹⁰⁵ Overall, 90% (166/297) of participants understood what they were meant to do during the quarantine period. This proportion was significantly higher in households with cases than in households with contacts only (98%, 95% confidence interval [CI]: 93%–99% vs. 88%, 95% CI: 84%–91%, $p < 0.001$). Nearly 90% of

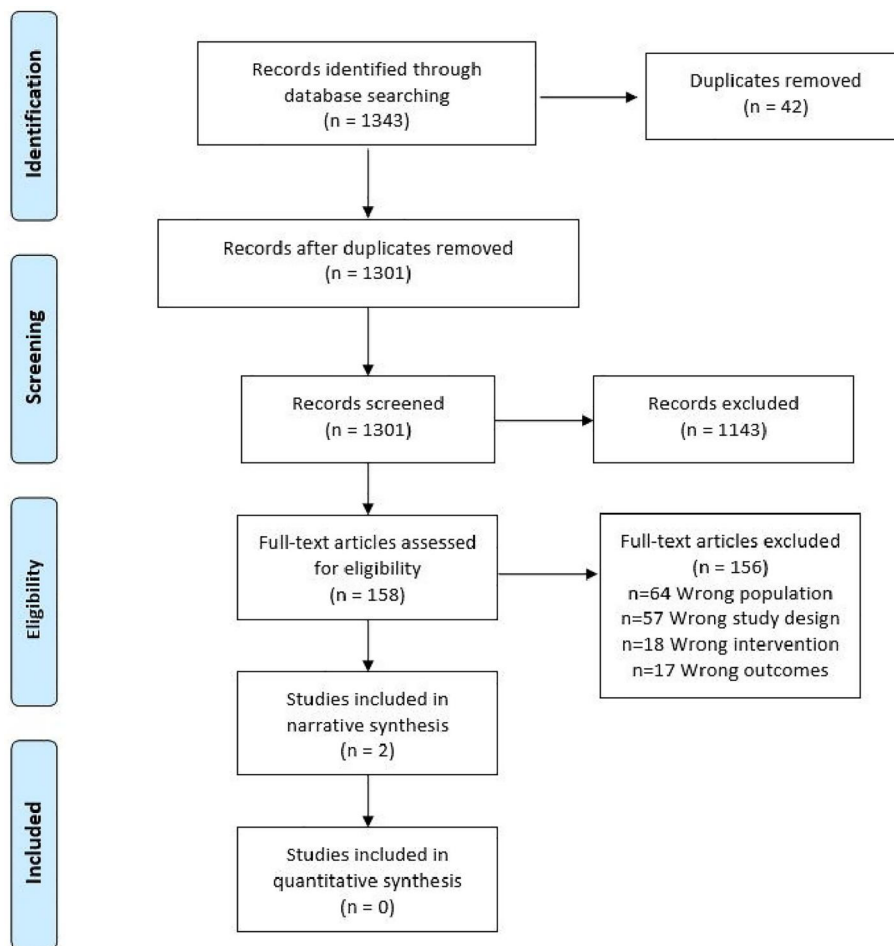


FIGURE 1 PRISMA flow diagram of included publications

parents received information about quarantine from the school and 63% obtained information from the health department. The next most common information source was the media (44%). Overall, most families used multiple sources of information; only one household reported that they did not use any sources. Regarding the source of information used, 24% used one source, 32% used two, and 44% used three or more sources of information.¹⁰⁵ Approximately two-thirds of participants reported that they found the information from the health department, schools and health service providers useful or extremely useful, whereas only 38% gave media sources this rating. Full compliance with quarantine recommendations within their household was reported by 55% of all participants. Compliance was higher in the households that reported understanding what they were meant to do during the quarantine period compared with those who did not (55% vs. 35%, odds ratio [OR] 2.27, 95% CI: 1.35–3.80).¹⁰⁵

The findings published in 2012,¹⁰⁴ reported on the compliance with restrictive measures as a result of access to paid sick leave or paid leave to look after quarantined children. Data from 133 households were used, all of whom included a resident parent that was employed during the quarantine period. At the time of data collection, 6% of respondents had a confirmed case of (H1N1)pdm09 flu virus in their

household. A larger proportion of households with access to leave had a parent who took time off work to care for a child (58% [47/81] vs. 42% [22/52]). Half of all households were fully compliant with quarantine recommendations. Compared to households without access to sick leave or leave to look after quarantined children, households with access to leave appeared more likely to have all quarantined members stay at home for most of the time on all days during the quarantine period (88% compared with 75%) (OR: 2.07, 95% CI: 0.82–5.23, $p = 0.12$ after adjustment for parental structure and parental education).¹⁰⁴ In terms of the relationship between taking time off and quarantine compliance (independent of access to leave), quarantined members of households in which a parent took time off work were less likely to make trips to populated public spaces during the quarantine period (97% vs. 84%) and these households were more likely to have all quarantined members stay at home for most of the time on all days during the quarantine period (88% vs. 77%).¹⁰⁴ After adjustment for parental education and parental structure of households, taking time off work was associated with over double the odds of staying at home on all days (OR: 2.47, 95% CI: 1.17–5.22, $p = 0.02$) and seven times the odds of not making trips outside the home (OR: 7.20, 95% CI: 1.42–36.51, $p = 0.02$). Taking time off work was not, however, associated with full compliance.¹⁰⁴

3.8 | Quality appraisal

The study included in this review consisted of two publications reporting on different measures of support. The publications were deemed to be of very low quality and a number of issues were identified. The study^{104,105} was an observational cross-sectional study. Therefore, it is particularly vulnerable to biases (e.g., recall bias) and may not incorporate important confounding factors. In the 2011 publication,¹⁰⁵ it was unclear whether the exposure (i.e., information on quarantine) was measured in a valid and reliable way. In the 2012 publication,¹⁰⁴ no demographic data were presented for the study population. In both publications,^{104,105} it was unclear if outcomes (i.e., compliance with recommendations and reduction in spread of infection) were measured in a valid and reliable way.

4 | DISCUSSION

4.1 | Overview of international review

This rapid review comprised two parts, the first was a review of international guidance which identified five broad categories of measures that are available to support those who are in isolation or quarantine. The ECDC and WHO identify a range of supports necessary to improve compliance with isolation and quarantine. While all countries reviewed provide some degree of support, these appear to differ in intensity. For example, some countries primarily target their supports at vulnerable individuals or those who are ordinarily dependent on state-aid. In general, support is provided either by a mixture of state agencies or by charitable bodies who have been provided with state support to fund their activities; many countries are leveraging off existing support services rather than establishing de novo services for Covid-19. Most services appear reactive, with the requirement for the individual to seek assistance, but some are proactively targeting individuals known to be medically or financially vulnerable. In addition to using supportive measures to encourage compliance to isolation and quarantine recommendations, punitive measures were also identified; these included monitoring of cases and contacts as well as fines and or prison terms for breaching the regulations.

As noted, all 19 of the countries included in this review provided financial assistance and 12 of the 19 countries provided suitable accommodation. The need to work for financial reasons has been identified as one of the most widely cited reasons in the research as to why people do not isolate appropriately, particularly in those of lower socioeconomic status. Lack of suitable accommodation and essential supplies has also been identified as a common barrier for people to self-isolate.¹⁰⁶ While many countries have reduced the length of isolation required for cases in an effort to improve compliance, the evidence of improved compliance is mixed. In a review by Webster et al.,¹⁰⁷ the authors reported that reduced length of isolation or quarantine did not affect compliance with recommendations during the H1N1 pandemic in Australia. Evidence of the

effectiveness of monitoring compliance with the regulations and penalties for noncompliance is mixed and largely dependent on the culture within which the measures are implemented.¹⁰⁶ In general, individualism and independence is encouraged in Western culture, whereas in Asian cultures there is greater emphasis on collectiveness and interdependency.¹⁰⁸ Furthermore, research has highlighted differences in terms of more strict social norms in countries like China, Japan and Singapore compared with Italy and the United States, whereby there is punishment for breaking regulations.¹⁰⁹ As such, individuals may be more compliant compared with those in 'looser', western cultures.¹⁰⁸

Overview of evidence summary on the effectiveness of measures to support isolation or quarantine on compliance and reduction in spread of infection.

The second element of this rapid review was a review of literature on the effectiveness of measures to support those in isolation or quarantine, that is, increased compliance with recommendations and reduced spread of infection. The lack of evidence identified in this review was echoed in a report by the National Academies of Sciences, Engineering, and Medicine published in July 2020. It included a mixed-methods review of implementing quarantine (including isolation and or quarantine) to reduce or stop the spread of a contagious disease.¹¹⁰ The authors used quantitative evidence from research studies to determine the effectiveness of strategies to improve compliance with quarantine recommendations.¹¹⁰ The evidence predated the Covid-19 pandemic, and included other infectious diseases, such as SARS-CoV, MERS, Ebola, smallpox and measles and concluded that compliance with quarantine recommendations can vary by culture, disease and socioeconomic status. Furthermore, identified evidence provided low certainty evidence that such strategies (e.g., risk communication and messaging and access to employment leave) improve compliance with quarantine recommendations.¹¹⁰

4.2 | Additional considerations

Others reviews identified did not report on the effectiveness (i.e., compliance with regulations and reduction in spread of infection) of measures to support those in isolation or quarantine. However, they provided an insight into the measures that study participants perceived to be of support during isolation and quarantine. DiGiovanni et al.¹¹¹ conducted a mixture of structured and unstructured interviews as well as focus groups with over 1700 residents of the Greater Toronto Area who were affected by the public health measures implemented to control the SARS pandemic in 2003; participants included the general public, government officials, healthcare workers and students. The authors identified a number of factors that impeded compliance with the recommendations. The overriding theme was fear of loss of income, especially in those who were not convinced that their quarantine was necessary. The absence of monitoring (that authorities claimed would be enforced) invited noncompliance, as did lack of support with obtaining essential items

(e.g., food). Inconsistency in information provision or in the application of recommendations between jurisdictions created confusion and lack of confidence even among those who intended to comply. Stress and stigma associated with quarantine was also cited as a reason for noncompliance.¹¹¹ Similarly, in a review by Webster et al.,¹⁰⁷ published in March 2020, the most common factors that were associated with increased compliance with isolation recommendations during an infectious disease outbreak were related to improved knowledge about the disease and purpose and benefit of isolation, as well as the provision of adequate essential supplies and financial support.¹⁰⁷

The psychological impact of imposed isolation is well cited in the research literature. In a review by Brooks et al.,¹¹² the negative psychological effects of isolation included posttraumatic stress symptoms, confusion and anger. Such effects were compounded by extended durations of isolation, fears of infection, frustration, boredom, inadequate supplies, lack of information, financial pressures and stigma.¹¹² The authors concluded that if isolation is indicated, the duration of isolation should not be any longer than necessary, and that adequate information and supplies should be provided.¹¹² In the same way that the provision of adequate, factual information is important in empowering individuals to adhere to isolation recommendations, warning people about misinformation and providing them with counterarguments against false information and conspiracy theories is equally important.¹¹³ As highlighted previously, evidence on the effectiveness of penalties for lack of compliance with the regulations is lacking. Instead, people should be made aware of the practical and emotional support that is available to them throughout this time and the benefits of isolation for themselves and society as a whole should be outlined.¹¹⁴ As such, promoting solidarity and altruism through community engagement, outreach initiatives and collaboration on communication strategies is vital in ensuring compliance.¹¹⁵

In addition to the provision of measures to support those in isolation (e.g., adequate essential supplies and financial support) there is a need to effectively communicate the existence of such support measures to help individuals feel prepared should they need to isolate. Some countries provide this information through Web applications (apps) that utilise conditional logic. Such apps enable people to identify the social and financial supports that are both available and applicable to their specific situation. Research shows that individuals cope better with changes in lifestyle when they plan for said changes; this has also been shown to enable better compliance with public health guidance.¹¹⁶ In a study conducted in Ireland, researchers hypothesised that, individuals would have increased confidence in their ability to isolate if they used an online tool (or decision aids) to help them make a plan and develop a routine for isolation.¹¹⁷ The study, which was uncontrolled, conducted in April 2020 ($n = 500$ individuals), tested three interventions to help individuals first decide whether they need to isolate, second be confident in their ability to isolate should they need to and third manage a household in which an individual needs to isolate.¹¹⁷ The authors reported that the behaviourally informed decision aids were

associated with statistically significant, positive outcomes and can be used to support isolation during the Covid-19 pandemic. As such, the findings from the study have been incorporated into social media campaigns in Ireland.¹¹⁷

In July 2020, a follow-up study was conducted in 1000 individuals living in Ireland; the aim of which was to understand an individual's willingness to isolate.¹¹⁸ The results showed that less than 40% of individuals with one of the main Covid-19 symptoms (fever, cough, shortness of breath, change and or loss of taste and or smell) would isolate immediately and 50% would contact their GP.¹¹⁸ The factors that independently increased the likelihood of isolating immediately were being female, having a degree and being an Irish national.¹¹⁸ In the same sample, there was a lack of awareness around how to access a Covid-19 test, and that such tests were available free of charge.¹¹⁹ Researchers recommended that test and trace staff should be utilised to direct individuals to available resources should they have to isolate or quarantine. Likewise, human resources departments should also be utilised to direct employees to available resources should they need to isolate or quarantine.¹¹⁹

This review has a number of limitations. First, although official national and international agency and or government websites were reviewed to identify measures to support those in isolation or quarantine, there is a possibility that some measures may be in place, but are not documented on the websites reviewed. Second, this review did not evaluate if there was a relationship between the range and or intensity of measures offered and the burden of disease experienced in that country. Third, this review is limited by the type of review conducted for the effectiveness element of the question (i.e., a 'rapid literature review'). This was limited by the time constraints associated with the review, and the biases considered likely to be present in the primary research studies included.

5 | CONCLUSION

This rapid review identified five categories of measures available to support individuals in isolation or quarantine. At a country level, there appears to be variation in the range and intensity of supports offered, the mechanisms by which the supports are offered, whether support is proactive or reactive, and if supports are universal or preferentially targeted at vulnerable groups.

Measures to support individuals in isolation or quarantine aim to reduce spread of infection by improving compliance with recommendations and or regulations. At the time of writing there is a paucity of evidence from primary research studies relating to the effectiveness of these measures either in increasing compliance or in reducing spread of infection. No data were identified relating to the effectiveness of measures on official national and international agency and or government websites. Data from qualitative and decision support studies report that improved knowledge about the disease and purpose of the recommendations, as well as the provision of adequate essential supplies and financial support are perceived as being of most importance by individuals, to support them in isolation

or quarantine. In addition, signposting to available resources is key to helping individuals plan for isolation and be confident in their ability to do so effectively.

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CONFLICTS OF INTERESTS

The authors declare that there are no conflict of interests.

AUTHOR CONTRIBUTIONS

Karen Cardwell, Sinéad M. O'Neill, Barrie Tyner, Natasha Broderick and Kirsty O'Brien scoped the question, constructed the systematic search, screened titles/abstracts and full-texts and completed the data extraction and quality appraisal. Karen Cardwell wrote the manuscript. All authors reviewed and contributed to the writing of the manuscript.

DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no new data were created or analysed in this study.

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