

DIAGNOSTIC REPORT

DIAGNOSIS ON **BIOSAFETY PROTOCOLS** IN THE TOURISM SECTOR OF **LATIN AMERICA AND THE CARIBBEAN**

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SUMMARY

Tourism is a key sector for generating GDP, jobs, exports and investments for the Latin America and the Caribbean (LAC) Region¹; nevertheless, it is also one of the economic sectors most affected by the SARS-CoV-2 pandemic as a result of mobility restrictions and the shutdown of activity.

Even with the vaccination process underway in many countries, the emergence of new variants, the successive waves of outbreaks, the mistrust among the population concerning the side effects of vaccines, the difficulty in the supply and logistics of vaccines and the short-term impossibility of achieving herd immunity, among others, call for updated protection measures to regain the trust of tourist visitors and reactivate the sector.

This diagnosis is oriented to restore tourism activity in Latin America and the Caribbean (LAC), considering:

- i. the adequation of biosafety protocols to prevent SARS-CoV-2 in the tourism sector, and
- ii. the identification of the suitable management framework for these protocols to lay the groundwork for a speedy and effective response to future health crises.

First, an analysis was carried out on the adequacy of existing biosafety tourism protocols. For this purpose, over 150 documents of different scope and ownership (public/private, international/national/regional/subregional) were revised. In addition, nearly 500 users in 23 countries took part in surveys and a focus group was created. After analyzing the information collected, gaps were detected, concluding that:

- **LAC Region has extensively developed protocols for COVID-19, but there is a lack of consistency in the measures defined and in their specification level, which has a negative impact on the user's perception of safety and, therefore, must be corrected.**

¹ It accounted for USD 357.8 billion of GDP and nearly 20 million jobs for the region as a whole in 2019 (World Travel and Tourism Council -WTTC-, Travel and Tourism Economic Impact, Latin America and Caribbean)

- **In LAC protocols, it can be seen that coverage is higher in those points identified by health experts as having a greater risk of contagion (Risk Nodes - RN)** compared to protocol coverage in other regions. Even so, the study carried out concludes that some subsectors have greater coverage than others: accommodation protocols stand out for having the highest level of coverage out, followed by restaurants and beaches. Local transport, ports and airports have the lowest levels of coverage. The risk nodes with lowest coverage by LAC protocols in general are those related to operational-support processes (waste management and use of shared cleaning equipment), in addition to the informal economy and relative humidity. **It is therefore advisable to cover the risk nodes for which the study shows that no response is provided.**
- Likewise, after a year of pandemic and with the rollout and consolidation of the vaccination process, **it is observed that the risk is not static; therefore, adapting measures to each circumstance, taking into account its variability, should be considered.** This, coupled with the **emergence of new scientific evidence that consider aerosol particles as a key transmission mode, calls for an updating of the protocols.**

Secondly, the management framework of these protocols in terms of implementation, communication and control was revised to ensure its effectiveness. For this purpose, 43 interviews were conducted with different stakeholders of the value chain at the destination (authorities, service providers, consumer associations), as well as with health experts. The following conclusions were reached:

- On the one hand, there are **conditioning factors** that **influence the effectiveness of and compliance** with the protocols and that should be considered when defining the management framework, such as the **degree of the binding nature** of the protocol and the **contribution of the different public-private stakeholders** at the destination.
- On the other, the **absence of measures related to implementation, communication and control generates distrust, confusion, and perceived improvisation and lack of coordination** among users. It is necessary to make an effort in this matter to regain their trust and reactivate tourism activity, especially regarding **communication, on the one hand, so as to align perceived and real risk among users;** and on the other hand, regarding **control measures**, as it is observed that **in general, they do not exist** or, they have been defined but not implemented. Although there is no “ideal” control system, the results of the research point to systems based on self-assessment, public-private partnerships and other cost-effective measures that allow for effective monitoring. Finally, there is also a **lack of definition** in terms of **contingency plans** to be deployed by tourism organizations in case of need.

Adapting current biosafety protocols for the tourism sector based on the **above conclusions** and considering the **lessons learned** is a fundamental and necessary step in the race for the safe reactivation of the activity and the preparation of countries for future health crises.

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1. INTRODUCTION AND OBJECTIVES

Tourism is a **key sector for generating GDP**, jobs, exports and investments for Latin America and the Caribbean (LAC), reaching in 2019 a total of 220 million international tourist arrivals, USD 338.207 million in tourism-generated income in the region¹, USD 357.8 billion of GDP and nearly 20 million jobs for the entire region². However, after almost a decade of strong growth, tourism is one of the economic sectors most affected by the COVID-19 pandemic, as a consequence of the associated travel and mobility restrictions³.

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Tourism is a key sector for generating GDP in Latin America and the Caribbean.



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According to data from the World Tourism Organization (UNWTO), in 2020 tourism suffered its **biggest crisis** to date after an unprecedented health, social and economic emergency triggered by the COVID-19 pandemic. International tourist arrivals (overnight visitors) fell 74% in 2020 compared to the previous year due to widespread travel restrictions and the huge drop in demand, and in Latin America and the Caribbean, there was a drop of 69%. According to estimates from the World Travel and Tourism Council (WTTC), the impact of COVID-19 in 2020 on tourism employment and GDP in LAC has been devastating: 1.7 million tourism jobs have been lost in the Caribbean (-61%) and 7.4 million in Latin America (-44%). Tourism's contribution to GDP in the Caribbean has fallen by USD 36 billion (-62%) and in Latin American, by USD 131 billion (-44%)⁴. In addition, the strategic nature of tourism is related to its multiplier effect on other productive activities, as the indirect and induced impact of tourism is three times greater than its direct contribution to the Latin American economy, and more than double in the case of the Caribbean. The slowdown in tourism activity caused by COVID-19 thus generates a significant **negative carry-over effect on other sectors** of the region's economy.

¹ UNWTO World Tourism Barometer and Statistical Annex, Volume 18, Issue 1, January 2020 available in <https://www.e-unwto.org/toc/wtobarometereng/18/1>

² World Travel and Tourism Council (WTTC), Travel and Tourism Economic Impact, Latin America and Caribbean

³ UNWTO Reports on Travel Restrictions available in <https://www.unwto.org/covid-19-travel-restrictions>

⁴ WTTC, Latin America and Caribbean recovery scenarios, November 2020

2021 has kicked off with some uncertainty. According to the International Monetary Fund (IMF, 2021) the forecast for global economic growth (GDP) is 5.5%, and for the LAC Region, 4.1% this year and 2.9% for 2022, calling for the need for close international cooperation to control the pandemic globally. The slow recovery confirmed by tourism industry indicators (UNWTO, 2020) is due to this uncertain scenario characterized by slow vaccination rollouts, continuing outbreaks and infections, new restrictions on mobility and low confidence levels. This suggests that tourism will not return to pre-pandemic levels until at least 2023 (UNWTO, 2020a). These changing circumstances have defined a new scenario of “perceived risk” that requires responses from destinations and tourism companies, so that they provide solutions that increase real and perceived levels of safety. This response must be coordinated between countries to ensure harmonized protocols (World Tourism Crisis Committee, UNWTO Executive Council, 2021)⁵ and it is still a priority for tourism⁶. It is indisputable that the **approval of vaccines and the start of their rollout** have been a very important step in the fight against the pandemic; however, the associated procurement, distribution and logistics, and the maintenance of efficacy against new variants of the virus put a damper on immediate optimism.

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The approval of vaccines and the start of **their rollout** have been a very important step in the fight against the **pandemic**.

anywhere

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⁵ The Global Tourism Crisis Committee of the World Tourism Organization (UNWTO), unwto.org/news/global-tourism-crisis-committee-meets-again-to-explore-safe-travel-in-age-of-vaccines.

⁶ UNWTO Global Guidelines to Restart Tourism (May 2020) available in <https://webunwto.s3.eu-west-1.amazonaws.com/s3fs-public/2020-05/UNWTO-Global-Guidelines-to-Restart-Tourism.pdf>

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Under these circumstances, the **biosafety protocols** implemented in the tourism sector continue to be a **key factor in guaranteeing** travelers and tourism workers the **highest standards of safety**. This need has given rise to the report's **main objective**, which is to **carry out a diagnosis of the adequacy of current biosafety protocols in the tourism sector** (focusing on accommodation, restaurants, local transport, beaches, airports and ports) **to generate tourism areas and services that are safe and are perceived as safe by visitors**. Based on this diagnosis, **regional recommendations** will be made for the LAC Region that will include the minimum specifications to be considered in any biosafety protocols for the aforementioned tourism subsectors and areas.

This diagnosis will produce a "photo" of the contents of current protocols based on the **systematic analysis of biosafety measures** included therein, as well as the review of the **implementation, control and communication mechanisms** established to apply these protocols. It is important to emphasize that the aim is not to replace the efforts made by the countries of the LAC Region, but to complement and recognize these efforts from a different perspective, providing a framework to assess, through comparative benchmarking, the safety measures that should be considered in each subsector and tourism area analyzed.

2. METHODOLOGY

The following steps were taken to prepare the diagnosis necessary to address, subsequently, the regional recommendations:

2.1. Contagion risk maps

First of all, contagion risk maps were drawn up for each tourism subsector and area covered by this project, i.e. accommodation, restaurants, local transport, beaches, ports and airports. In these maps, the main potential SARS-CoV-2 contagion points were graphically represented. To identify these points, **the customer's itinerary was cross-checked with the possible virus transmission modes** (contact with contaminated surfaces, droplets and aerosols). These **points of confluence were referred to as transmission risk nodes (RN)** and were **validated** by a team of public health experts and contagion-prevention specialists.

These maps have been created to illustrate where efforts need to be focused through measures to minimize the contagion risk. These maps have facilitated the analysis of the different protocols in order to check whether they include the main RN identified.



Biosafety protocols continue to be a **key factor** in guaranteeing travelers and tourism workers the highest possible standards of **safety**.



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>Transmission modes of SARS-CoV-2

The SARS-CoV-2 can spread through the following modes:

Figure 1. Transmission modes of SARS-CoV-2



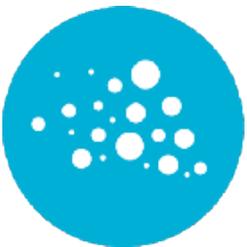
Transmission through contact with contaminated surfaces:

This occurs when a person touches objects or surfaces contaminated by secretions from infected people and then touches the mucous membranes of their mouth, nose or eyes.



Transmission through respiratory droplets:

Expelled when the infected person coughs, sneezes, speaks or sings, they follow semi-ballistic trajectories reaching distances up to two meters.



Airborne transmission through aerosols:

Produced by droplets of 5 microns or less that can remain suspended in the air for varying lengths of time and travel over 2 meters. These aerosols can be generated by the evaporation of larger droplets, either with the outgoing projection or transported by air currents (which can be inhaled). Poor ventilation fuels transmission by aerosols.

It should be noted that at the beginning of the pandemic, biosafety protocols primarily focused on contagion risks through contaminated surfaces and droplets (recognized transmission modes at the time), so the measures included in most of the protocols analyzed aim to reduce the spread of the virus mainly through these two transmission modes. **However, the appearance of new research⁷ that focuses on aerosol transmission as the primary route of contagion calls for a review and updating of the measures to be considered.**

In any case, in this diagnostic report, the risk nodes (RN) are maintained regarding the contact with surfaces applying the **precautionary principle** and in line with the recommendation of experts, who consider this transmission mode as possible, although less relevant.

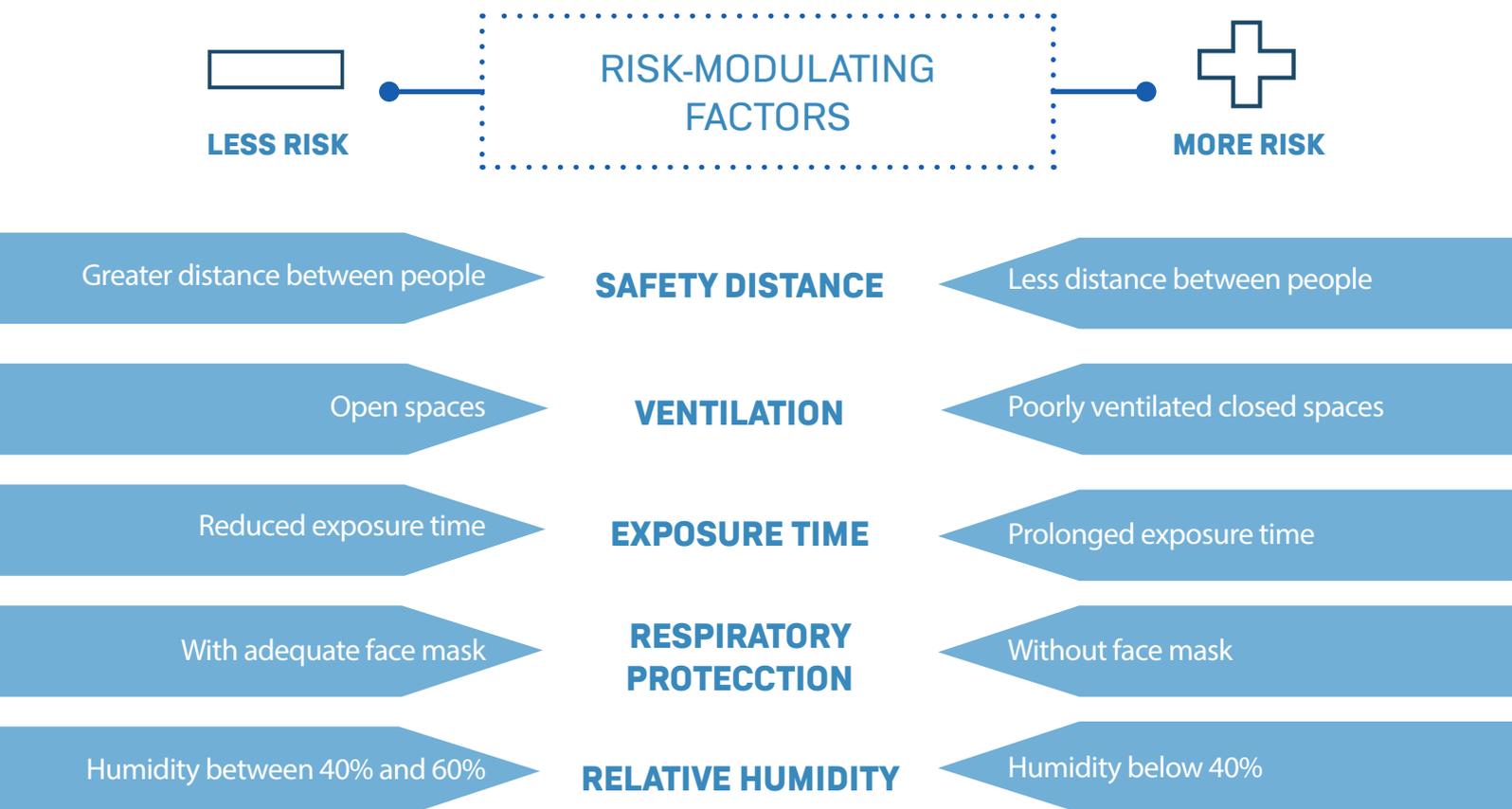
⁷ [https://www.thelancet.com/journals/laninf/article/PIIS1473-3099\(20\)30561-2/fulltext](https://www.thelancet.com/journals/laninf/article/PIIS1473-3099(20)30561-2/fulltext)

> Risk-modulating factors

It is important to highlight that **risk is not static** and it varies depending on a number of **factors** that, combined, lead to an increase or decrease:

- (i) **safety distance** (greater distance between people, less risk of contagion);
- (ii) **ventilation** (greater ventilation, less risk of contagion);
- (iii) **exposure time** (longer exposure time, more risk of contagion);
- (iv) **respiratory protection** (the use of appropriate respiratory protection reduces the risk of contagion);
- (v) **relative humidity** (below 40%, more risk of contagion).

Figure 2. Risk variability according to modulating factors



Thus, as described above, a coffee shop, for example, where safety distances can be respected, with an outdoor terrace, where people spend a short time (15 minutes) and wear face masks while not consuming has a lower risk of contagion than a busy restaurant (where keeping a safe distance is impossible), which is closed in and poorly ventilated, and where people stay for a couple of hours and do not wear face masks. Furthermore, in places where relative humidity is low, aerosol generation rises, increasing the risk of contagion.

In addition to the above, current scientific evidence considers that the risk of transmission of SARS-CoV-2 **increases when people speak, sing or shout** (Figure 2). In contrast, it is reduced if people avoid talking. In fact, recommendations are starting to be made in public transport in some cities⁸, encouraging passengers to avoid talking and not answer phone calls during the journey. Finally, some experts suggest that **intense physical activity** could also be a factor that contributes to increased risk of contagion.

This variability in the risk of contagion, which is not generally provided for in the protocols analyzed, influences the biosafety measures to be applied in each situation and context, depending on the combination of variables in each case. Therefore, it is important, in addition to considering the biosafety measures of each RN, to include in the protocols the need to assess the transmission risk depending on the abovementioned variables when implementing biosafety measures.

Table 1. Risk of SARS-CoV-2 transmission from asymptomatic people

Number of people and group activity	Low occupancy			High occupancy		
	Outdoors	Well-ventilated indoors	Poorly ventilated indoors	Outdoors	Well-ventilated indoors	Poorly ventilated indoors
Wearing face mask, contact for a short time						
Avoid talking	Low	Low	Low	Low	Low	Average
Talking	Low	Low	Low	Low	Low	Average
Shouting, singing	Low	Low	Average	Average	Average	High
Wearing face mask, contact for a long time						
Avoid talking	Low	Low	Average	Low	Average	High
Talking	Low	Low	Average	Average	Average	High
Shouting, singing	Low	Average	High	Average	High	High
Not wearing face mask, contact for a short time						
Avoid talking	Low	Low	Average	Average	Average	High
Talking	Low	Average	Average	Average	High	High
Shouting, singing	Average	Average	High	High	High	High
Not wearing face mask, contact for a long time						
Avoid talking	Low	Average	High	Average	High	High
Talking	Average	Average	High	High	High	High
Shouting, singing	Average	High	High	High	High	High

Transmission risk	Low	Average	High
Source: Nicholas R. Jones et al. (2020) ⁹			

⁸ A destination where this recommendation has already been issued is Barcelona, Spain: <https://www.euronews.com/2021/01/22/the-silence-of-the-trams-barcelona-commuters-told-not-to-talk-to-avoid-spreading-coronavir>

⁹ Jones NR, Qureshi ZU, Temple RJ, Larwood JRP, Greenhalgh T, Bourouiba L. Two metres or one: what is the evidence for physical distancing in covid-19? BMJ. 2020 Aug 25;370:m3223. 10.1136/bmj.m3223. PMID: 32843355.

2.2. Sources of information used

2.2.1. Secondary sources: biosafety protocols

Once the RN were identified in the corresponding risk maps, the secondary sources were revised with two objectives:

Objective 1. Assess to what level (high-medium-low) current protocols cover the RN identified and the measures necessary to reduce the transmission risk in these RN;

Objective 2. Assess to what level (high-medium-low) the protocols include implementation mechanisms, communication and control for its adequate application.

A total of **123 protocols**, recommendations and guidelines of **LAC** and **other parts of the world**, both **public and private, national and regional in scope, were revised**. The protocols correspond specifically to the subsectors of **accommodation (36), restaurants (24), local transport (11)** and neuralgic tourist areas such as **beaches (13), airports (17) and ports (10)**. The subsectors were chosen because they have the highest concentration of tourism MSMEs and, in the case of neuralgic tourist areas, the largest volumes of tourist flows. In addition, 24 general guidelines and action frameworks were revised.

The documents revised covered the following geographical areas:

- **LAC Region:** Argentina, Brazil, Chile, Colombia, Costa Rica, Jamaica, Mexico Panama, Peru, Dominican Republic.
- **Other regions:** Australia, Spain, Hong Kong (China), Israel, New Zealand, Portugal, Seychelles.

Additionally, the following models were studied: Caribbean Public Health Agency (CARPHA), Brazilian Micro and Small Business Support Service (SEBRAE), Pacific Asia Travel Association (PATA), World Travel and Tourism Council (WTTC), International Civil Aviation Organization (ICAO) and World Health Organization (WHO).

It should be noted that the aim was to represent all the geographical areas of the LAC Region, considering both the countries most dependent on tourism and those with most international tourists, bearing in mind that the review of protocols would be completed with the inputs obtained from interviews, online surveys, webinars and focus groups.

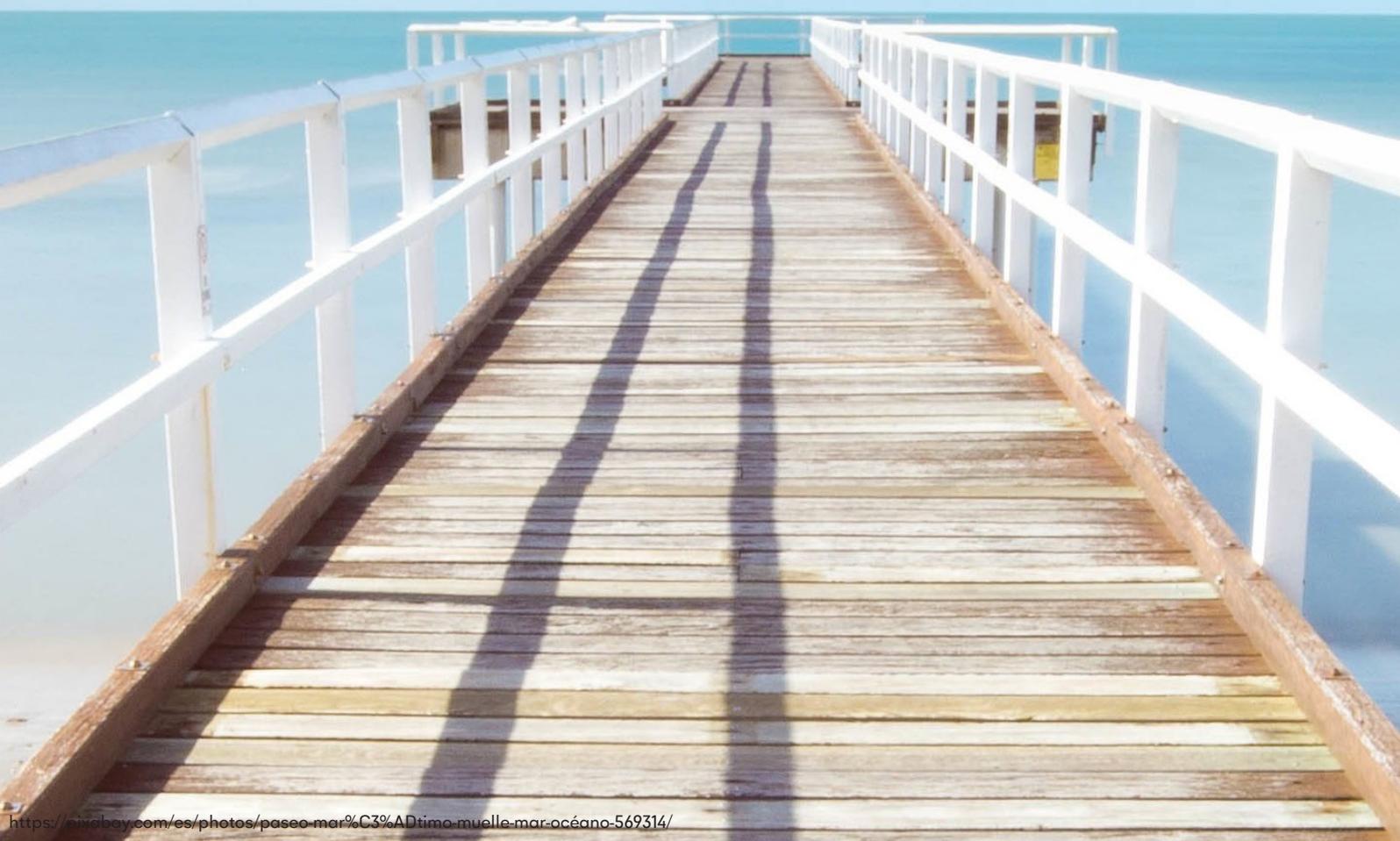
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Risk is not static and it varies depending on a number of factors that, combined, lead to an increase or decrease.



<https://www.shutterstock.com/es/image-photo/asian-female-tourist-wearing-mask-using-1741455509>

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With regard to the protocols analyzed, it is worth highlighting some details detected during the analysis that affect the level of coverage of the RN:

- **Specificity of the protocols analyzed:** the tourism subsectors covered by this analysis have their **own protocols** (accommodation, restaurants and local transport). Nevertheless, the accommodation protocols have been more widely developed and have served as a base to define measures on others subsectors. In addition, there are cross-sectoral protocols, not necessarily related to tourism activity, but that have an impact on it. These **cross-sectoral protocols** define guidelines for "**closed spaces**", "**open spaces**" or "**leisure venues**" applicable to beaches. This cross-sectoral approach means that the protocols include more general measures and do not consider the RN specific to each type of subsector, leaving some critical points uncovered.
- **Scope of the protocols analyzed:** the scope varies depending on the subsector:



Tourist accommodation:

The vast majority of the protocols analyzed provide for biosafety measures for accommodation in general, without specifying their type or classification, given that the customer's itinerary and the RN are basically the same.

Only in some cases is the type of accommodation specified: hotels (categorized and not categorized), apartment hotels, hostels, rural accommodation and campsites. The analysis carried out has considered all the typologies and classifications of accommodation in the selected protocols/countries.



Restaurants:

The protocols analyzed in this subsector cover practically all kinds of food establishments—including restaurants, coffee shops, pubs and take-away services, home delivery and other analogical services—although they do not specify differentiated measures for one or the other, except in the case of take-away and delivery services, the demand for which has increased substantially during the pandemic.



Beaches:

Most protocols included in this study are specific to beaches, although in some cases general protocols for outdoor or recreational areas have been analyzed, as mentioned above.



Local transport:

The protocols analyzed establish guidelines for operators of passenger land transport terminals, as well as for infrastructure managers, concessionaires, etc., and apply to vehicles such as tour buses, public transport, rental vehicles and shuttles operated by hotels, among others. The analysis includes vehicles and transport terminals.



Airports:

The protocols revised include national protocols and, to a lesser extent, protocols drafted by concession companies or airport managers (public access) that have subsequently been approved by the country's health authorities. These ad hoc protocols, based on general guidelines issued by the authorities, are more specific in terms of the coverage of the RN. Some protocols of the countries studied refer to the ICAO guidelines. Cases have even been found in which there are no national protocols and the authorities refer directly to the ICAO protocols. It is also common for protocols to refer to guidelines issued by the WHO or by health, civil aviation, transport or migration authorities. Finally, a significant part of the protocols (both in the region and outside) focus on migratory aspects (requirements to enter the country, quarantines, etc.) or on the management of cases with symptoms associated with COVID-19—these are cross-sectoral measures and do not cover specific RN.



Ports:

The protocols identified and revised include cruise ports, marinas and tourism docks (sea, river and lake), in some cases privately managed or under concession. Fewer countries have specific biosafety protocols for ports, and those that do refer to general measures, not necessarily covering RN, as is the case for airports. Finally, it is worth mentioning that **tourism activity** in many of the ports of the region **has not yet been resumed**; the protocols have therefore not been widely implemented.

2.2.2. Primary sources of information: interviews, surveys and a focus group

The information analyzed in the secondary sources was complemented by holding **interviews, online surveys and a focus group**. This primary-source analysis had three objectives:

Objective 1.

Study **issues not covered in the protocols** but that could be useful in carrying out future regional recommendations in terms of **implementation, communication and control of protocols**, both by tourism service providers and public decision makers (at the destination and/or country level).

Objective 2.

Compare the level of safety perceived by the end user¹⁰ with the results of analysis of the protocols on the level of coverage (high-medium-low) of the RN.

Objective 3.

Detect aspects related to **implementation, communication and control** included in the protocols and carried out in the countries of the LAC Region.

> Interviews

Forty-three semi-structured interviews¹¹ were held with stakeholders in the area of study (tourism authorities, health experts, tourism service providers, consumer associations and end users) to detect the main **practices in place for implementation, communication and control** of the protocols in the different countries/destinations analyzed. Thus, the interviews provided information on best practices, identifying the main obstacles perceived by the sector when it comes to effectively implementing biosafety measures. The stakeholders selected included authorities from the countries whose protocols were being analyzed, but also from other countries and private sector stakeholders from the different geographic areas of LAC. Special focus was placed on those geographic areas with the greatest number of international travelers and also on those most tourism-dependent. Stakeholders were also selected from the private sector in the different countries, as well as from national, regional and local authorities.

¹⁰ Throughout this report, users or end users are tourist visitors and potential passengers of the subsectors and areas analyzed who use these services at the tourism destination.

¹¹ Colombian Civil Aviation Authority; Airports of Peru; Alianza Sodis; AMResorts; European Association for the Coordination of Consumer Representation (ANEC); Municipality of Aracatí (Brazil); The Colombia Restaurant Association (ACODRES); Hotels, Restaurants, Bars & Cafés in Europe (HOTREC); Hotels, Restaurants and Casinos Association of Peru (AHORA); Panama Tourism Authority (ATP); Municipality of Maceió (Brazil); Caribe Hospitality; Casa Andina Hoteles; Tourism Training Center (CENFOTUR); National Land Transport Council of Peru; Consumidores Argentinos; National Association of Consumers and Users of Chile (CONADECUS); Cruise Lines International Association (CLIA); Decameron; Despegar.com; Hotel and Gastronomy Business Federation of Argentina (FEHGRA); GHL Hoteles; Grupo Punta Cana; Hilton Hotels; Hoteles Libertador; Costa Rica Tourism Board (ICT); Keteka; Meliá Hotels International; Ministry of Foreign Trade and Tourism of Peru; Ministry of Tourism of Argentina; Ministry of Tourism of Belize; Ministry of Tourism of Brazil; Ministry of Tourism of Paraguay; Ministry of Tourism and Aviation of the Bahamas; Organization of Brazilian World Heritage Cities; Municipality of Salvador de Bahía; Municipality of Santa Marta; Mexican Secretary of Tourism; Chilean National Tourism Board (SERNATUR); National Union of Consumers and Users of the Republic of Panama (UNCUREPA).

> Online surveys

The opinions of end users of the subsectors and tourism areas being studied were collected to find out their level of perception of the safety of each RN. The online survey was completed by 467 participants of 23 nationalities from the LAC Region.

> Focus group

In addition, a focus group (end users, consumers of subsector services under study and neuralgic tourist areas) was created where seven people from Argentina, Chile, Colombia, Mexico, Peru, Dominican Republic and the USA participated, and whose opinions made it possible to conclude the analysis of the RN coverage in the protocols.

> Webinar workshops

Five workshops were held in which tourism authorities and tourism service providers from the LAC Region participated. The script prepared for these workshops covered questions on the gaps identified during the protocol review phase so that, in each of the groups, those gaps that were perceived as most relevant were selected.

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Current protocols were revised and interviews, surveys, focus groups and webinar workshops were held.



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2.3. Analysis process

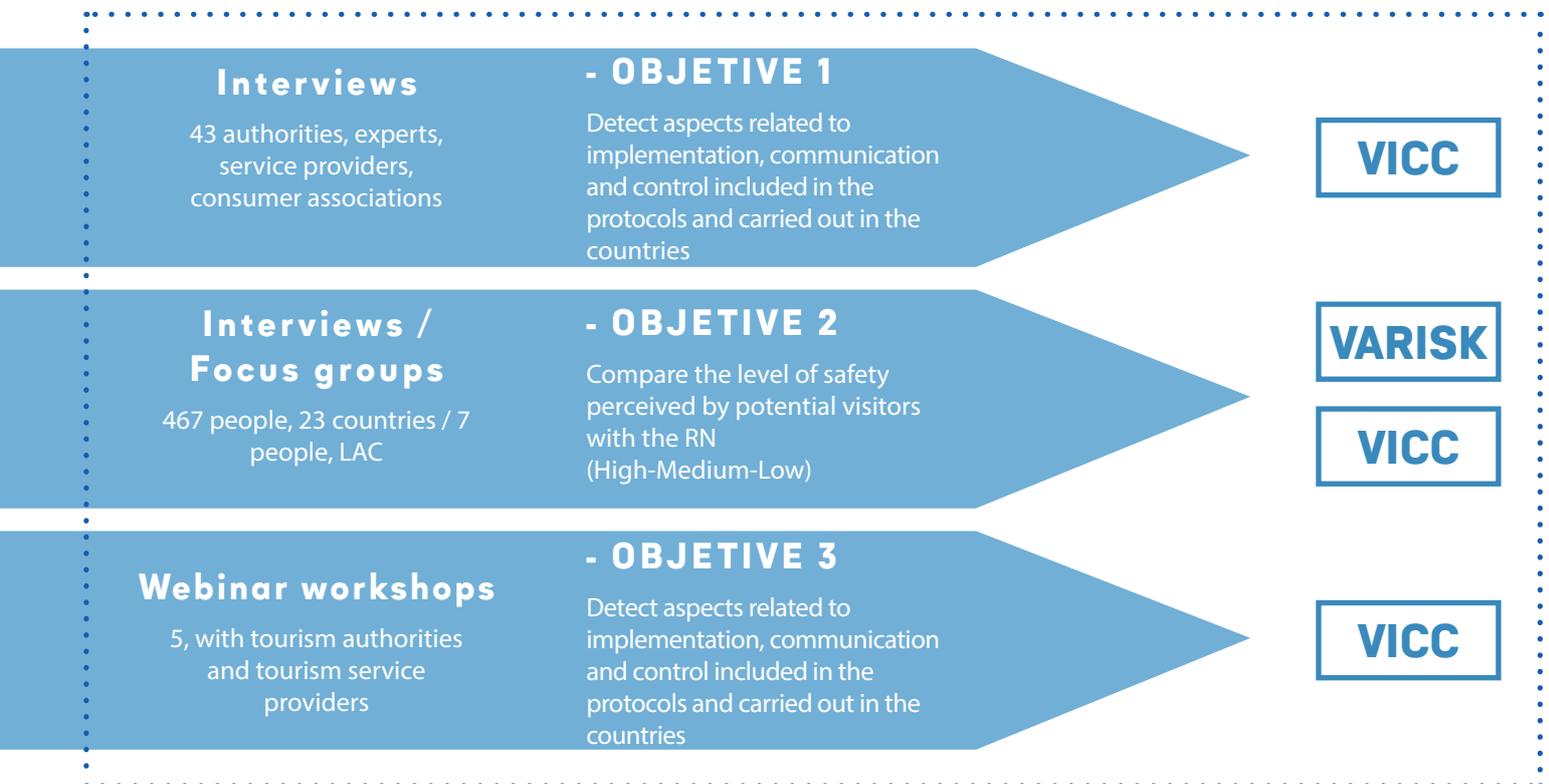
2.3.1. Determination of critical variables for protocol management

Based on the various sources and the information collected, two types of critical management variables were identified as relevant for studying the adequacy of current protocols and identifying subsequent key recommendations:

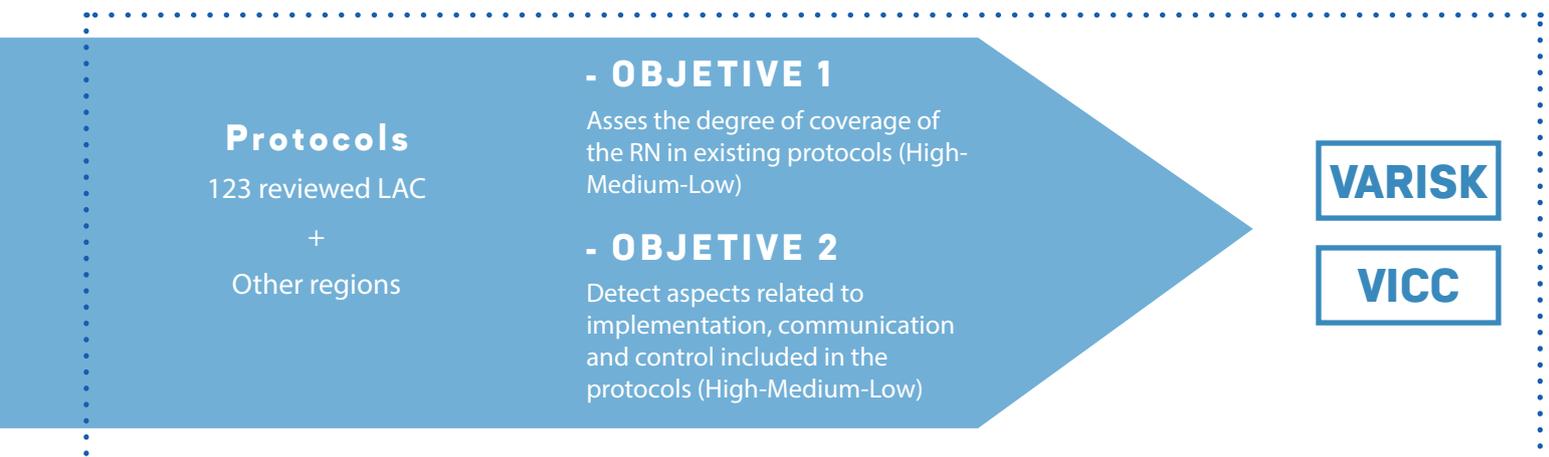
- Variables related to the Management of Risk Nodes: VARISK
- Implementation, Communication and Control Variables of the protocols (internal in tourism organizations and cross-sectoral for destinations): VICC

Figure 3. Information collected and determination of critical management variables

PRIMARY SOURCES OF INFORMATION



SECONDARY SOURCES OF INFORMATION



VARISK Variables

The VARISK variables coincide with the RN identified on the risk maps, and, depending on each subsector and tourism area analyzed, are as follows:



Accommodation VARISK:

- Check-in and check-out: (i) Check-in; (ii) Key / card delivery; (iii) Payment.
- Stay: (i) Use of lifts; (ii) Use of common areas; (iii) Rooms; (iv) Catering service.
- Ventilation: (i) indoor spaces.
- Relative humidity: (i) relative humidity.
- Operational-support processes: (i) Use of shared cleaning equipment among staff; (ii) Staff common areas (changing rooms, canteen and toilets); (iii) Supplier management; (iv) Waste management.



Restaurant VARISK:

- Welcoming and seating clients: (i) Preparation of the space; (ii) Allocation; (iii) Assembly / disassembly.
- Taking orders: (i) Menu; (ii) Order.
- Service: (i) Bar service; (ii) Table service; (iii) Take-away, Delivery; (iv) Toilets.
- Billing/Exit: (i) Payment.
- Kitchen: (i) Menu preparation.
- Ventilation: (i) Indoor spaces.
- Relative humidity: (i) Relative humidity.
- Operational-support processes: (i) Use of shared cleaning equipment among staff; (ii) Staff common areas (changing rooms, canteen and toilets); (iii) Supplier management; (iv) Waste management.



VARISK variables were analyzed based on the systematic review of protocols and contrasted with the level of safety perceived by end users.



<https://pixabay.com/es/photos/cocina-trabajo-restaurante-cocinar-731351/>



Local transport VARISK:

- Terminal: (i) Customer service area; (ii) Ticket sales area; (iii) Waiting areas.
- Vehicle: (i) Boarding; (ii) Luggage handling; (iii) Disembarking; (iv) Inside the vehicle.
- Ventilation: (i) Indoor spaces and inside the vehicle.
- Relative humidity: (i) Relative humidity.
- Operational-support processes: i) Use of shared cleaning equipment among staff; (ii) Staff common areas (changing rooms, canteen and toilets); (iii) Supplier management; (iv) Waste management.
- Informal economy¹².



Beaches VARISK:

- Access: (i) Influx of users (capacity control); (ii) Parking.
- Sand area: (i) Play/recreational area; (ii) Access walkways; (iii) Toilets and changing rooms; (iv) Showers and footbaths; (v) User/rest areas; (vi) Concessionary businesses (restaurants, kiosks, activities); (vii) Rescue/first aid service; (viii) Informal economy.
- Wet area: (i) Seashore; (ii) Swimming area.
- Relative humidity: (i) Relative humidity.
- Operational-support processes: i) Use of shared cleaning equipment among staff; (ii) Waste management.



Port and airports VARISK¹³:

- Access to terminal: (i) Access; (ii) Baggage trolleys.
- Check-in area: (i) Check-in/document verification; (ii) Baggage handling; (iii) Automatic check-in.
- Inspection and control process: (i) Scanner/trays; (ii) Control/Customs.
- Departures terminal: (i) Vending machines; (ii) Toilets; (iii) Commercial area; (iv) Catering services (v) Waiting area; (vi) Recreational area; (vii) Smoking area.
- Boarding/disembarking: (i) Boarding/disembarking process; (ii) Shuttle bus; (iii) Access/exit walkways.
- Baggage claim: (i) Baggage handling by staff; (ii) Baggage claim.
- Ventilation: (i) Indoor spaces.

¹² The informal economy is defined as unauthorized vendors (tours, food and beverages, clothing), touts, parking lot attendants, etc. In the case of ports and airports, the informal economy is not always present within the main infrastructure, but may take the form of unlicensed taxis/vehicles at exits, unauthorized vending, etc.

¹³ The VARISK variables in ports and airports coincide as the itinerary of the customer (passenger) and the service provision in these spaces are the same.

- Relative humidity: (i) Relative humidity.
- Operational-support processes: i) Use of shared cleaning equipment among staff; (ii) Staff common areas (changing rooms, canteen and toilets); (iii) Supplier management; (iv) Waste management.
- Informal economy.

The VARISK variables were analyzed based on the systematic review of protocols and contrasted with the level of safety perceived by end users [3.1].

VICC Variables

In addition, variables **common to all the subsectors and tourist spaces were identified in relation to the implementation, communication and control of the protocols.** These variables were analyzed from two perspectives:

- **From the perspective of internal application in tourist establishments (I)**, by considering the extent to which these variables are covered in the protocols of the tourism organizations of the subsectors and spaces analyzed.
- **From the perspective of cross-sectoral application to all destinations (C)**, considering the extent to which these variables are covered in the mechanisms implemented in all tourism value chains.

The identification of the VICC variables **was based on the primary sources and research questions** developed by the diagnostic team:

Table 2. VICC Variables

VICC Implementation Variables	
Staff training	
I	Do the protocols provide staff training to effectively implement biosafety measures?
C	At the destination, have there been any training initiatives for the public and/or private sector on biosafety promoted by authorities and/or other stakeholders?
Coordination with rest of private sector	
I	Do the protocols provide for coordination mechanisms with other private sector organizations so they can work more closely together?
C	At the destination, have private-private coordination mechanisms been defined?
Coordination with authorities (health, safety, etc.)	
I	Do the protocols provide for coordination mechanisms with authorities for the effective implementation of biosafety measures?
C	At the destination, have public-private coordination mechanisms been defined?
Management of contagion: risk variability	
I	Do the protocols provide for the facilities to perform risk assessment according to their specific conditions in order to adequately implement the measures?
C	Not applicable

VICC Communication Variables

Internal communication of the measures

I	Do the protocols provide, by any means, information to employees regarding the biosafety measures to be complied with in the establishments and neuralgic tourist areas?
C	At the destination, are effective communication measures in place to ensure information reaches employees throughout the organization? Have good communication practices been shared with the employees in the different organizations at the destination?

External communication

I	Do the protocols provide, by any means, information to employees regarding the biosafety measures to be complied with in the establishments and neuralgic tourist areas?
C	At the destination, have effective communication measures been established with the different stakeholders of the value chain (public-public, private-public, private-private)?

VICC Control Variables

Supervision of compliance of measures

I	Do the protocols indicate internal control measures that establishments must implement in order to monitor the effectiveness of the biosafety measures?
C	At the destination, are there control mechanisms in place on the effectiveness of biosafety measures? What entities are in charge? How is this control implemented?

Updating of the protocols

I	Do the protocols provide for the updating of measures, contingency plans and information in response to identified needs or new information?
C	Have the competent entities updated the protocols published since the beginning of the pandemic? What mechanisms are in place to ensure their updating? Are the results of new scientific research or the existing difficulties in putting the measures into practice systematically considered?

Monitoring of staff health

I	Do the protocols indicate internal control measures that establishments should implement to monitor the health of employees?
C	Not applicable.

Contingency plans (management of positive cases or symptomatic users)

I	In the destinations, have contingency mechanisms been considered for the detection of positive or symptomatic cases?
C	In the destinations, have contingency mechanisms been considered for the detection of positive or symptomatic cases?

Contingency plans (management of positive cases or symptomatic employees)

I	In the destinations, have contingency mechanisms been considered for the detection of positive or symptomatic cases?
C	Not applicable

2.3.2. Analysis of the protocols on the level of coverage of VARISK and VICC variables

The results of the systematic analysis of the level of coverage of VARISK and VICC variables in the protocols were color-coded as shown in the RN Coverage Range table. When the variable being analyzed was covered by less than 75% of the revised protocols (low or medium level of coverage), it was identified as a WEAKNESS. When the variable was covered by 75% or more of the revised protocols, it was identified as a STRENGTH.

Table 3. Coverage Range

Variable covered in > 75% of the protocols	HIGH
Variable covered by 50 to 75% of the protocols	MEDIUM
Variable covered by < 50% of the protocols	LOW

In the case of VARISK variables, the **analysis of the level of coverage was complemented** with survey results and focus groups with end users to contrast their **perceived safety** concerning the coverage of the RN in the protocols revised and to observe whether gaps occur.

In the case of the VICC variables, the analysis was also supplemented by interviews with experts, service providers and authorities in order to detect aspects related to the **implementation, communication and control carried out in the different countries.**

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The level of coverage of VARISK and VICC variables in the protocols was analyzed.



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DIAGNOSIS ON
BIOSAFETY PROTOCOLS
IN LATIN AMERICA AND
THE CARIBBEAN



3. RESULTS

3.1. VARIABLES RELATED TO THE MANAGEMENT OF RISK NODES (VARISK) AND USER PERCEPTION

A. TOURISM SUBSECTORS (tourist accommodation, restaurants and local transport)

The protocols of these tourism subsectors have been the most widely developed by both countries and international organizations, primarily accommodation protocols.

It has been shown that the level of coverage of the RN identified is similar within the same subsector, both at LAC level and in the total of the revised protocols. In the few RN for which the level of coverage differs, it is observed that the LAC protocols present a better result in the three subsectors analyzed. The accommodation subsector presents a HIGH level of coverage, the restaurants subsector MEDIUM-HIGH and the local transport subsector, MEDIUM-LOW.

The revised protocols include measures for the different processes through which the company interacts with users and for the support of such operations. In this regard, it is these support processes that present a lower level of coverage compared to the RN.

The accommodation and restaurant subsectors are those perceived by users as being the safest, although in the case of restaurants, perceived safety does not coincide with the real risk of many of these spaces according to the risk-modulating variables identified (especially concerning closed spaces in which diners chat without respiratory protection equipment and at close range). This leads us to believe that communication about risk, transmission modes, etc., is not entirely effective. In turn, local transport protocols are those that obtain a lower level of coverage and also in which users feel least safe, so work needs to be done to improve the coverage of the RN through specific measures.

The following are the findings of the analysis of the revised protocols on tourist accommodation, restaurants and local transport.

“

The accommodation **protocols** have been the most widely developed.

<https://pixabay.com/es/photos/cama-dormitorio-habitación-de-hotel-4416515/>

H

3.1.1. TOURIST ACCOMMODATION

The following figure and table show the coverage of the RN from the review of protocols for the tourism accommodation subsector.

Figure 3. RN in accommodation and level of coverage in LAC



The coverage of the RN in the accommodation protocols is **HIGH**. The results obtained in the overall assessment of protocols and in the LAC assessment are similar, although with a significantly better result in the LAC protocols for check-in and check-out processes.

> Strengths:

In LAC, the revised accommodation protocols mostly cover the RN identified in the contagion risk maps, achieving **HIGH** coverage [given that they are covered by more than 75% of the documents revised]. Regarding operational-support processes, the use of cleaning elements shared by the staff and **supplier management** are the best considered variables (**HIGH** coverage).

> Weaknesses:

Sector protocols only record RN with low coverage in the case of relative humidity; however, in customer operations in LAC, **key/card delivery** is the least-covered aspect as it is not specifically mentioned (although in many cases it is recommended to avoid sharing items between staff and guests and general safety measures are established in the check-in process). In terms of operational-support processes, **staff common areas** (such as changing rooms, canteens and toilets), as well as **waste management**, are the areas least included in the documents revised. Measures in response to the previous RN in the protocols should be strengthened.

> User perception:

51% of users perceive accommodation as unsafe, being the areas with the highest coverage of the RN, so it is important to improve communication of protocols, in addition to improving the worst-served RN.

Table 4. Level of coverage of the RN in the ACCOMMODATION protocols

Risk nodes		Covered in revised protocols	
		Total protocols ¹⁴	LAC countries
Check-in and check-out	Check-in	Green	Green
	Key/card delivery	Yellow	Yellow
	Payment	Yellow	Green
Stay	Use of lifts	Green	Green
	Use of common areas	Green	Green
	Rooms	Green	Green
	Catering areas	Green	Green
Ventilation	Ventilation: indoor spaces	Green	Green
Relative humidity	Relative humidity	Red	Red
Operational-support processes	Use of shared cleaning equipment	Green	Green
	Staff common areas (changing rooms, canteen and toilets)	Yellow	Yellow
	Supplier management	Yellow	Green
	Waste management	Yellow	Yellow

¹⁴ The total number of revised protocols includes revised protocols from LAC, other regions and international organizations.



3.1.2. RESTAURANTS

The levels of coverage of the restaurant protocols on VARISK variables are shown in the following figure and table.

Figure 4. RN in restaurants and level of coverage in LAC



The coverage of the RN in the restaurant protocols is **MEDIUM-HIGH**. The overall assessment of protocols and the LAC evaluation produce similar results, except for the case of preparing menus, managing suppliers and staff common areas, whose results improve significantly in the protocols of the LAC Region.

> Strengths:

The aspects best dealt with (in more than 75% of the revised documents) are **allocating clients**, taking orders (**menus**), service (**at table, take-away/delivery and customer toilets**) and **paying and exit**. In the operational-support processes, the **HIGH** coverage of the measures regarding the **use of shared cleaning equipment** stands out. In addition, in the case of LAC protocols, the **preparation of menus** in the kitchen and the **management of suppliers** are added to the above variables.

> Weaknesses:

In the revised restaurant protocols, there is room for improvement, especially in operational-support processes, where the **staff common areas** (changing rooms, canteens and toilets) obtain a **MEDIUM**

level of coverage in the case of LAC. **Waste management**, on the other hand, is addressed in less than 50% of the documents revised (**LOW** coverage) both in all the protocols and in the LAC protocols. In the case of customer operations, the least covered RN (**MEDIUM** coverage) include **taking orders and bar service**; although bar service is not a generalized practice throughout the LAC Region, it is important to consider it for those establishments that do provide this service. In addition, the inclusion of measures related to ventilation, both in the protocols overall and in the case of LAC, is an aspect that could be improved, even more so considering the type of spaces in which these services are provided (closed, with poor **ventilation** at times, with users not wearing face masks and interacting socially—talking). Ultimately, measures in response to the previous RN in the protocols should be strengthened.

> User perception:

Restaurants is the subsector perceived by users as **the safest (50% of respondents perceive a HIGH safety level)**, even if these are spaces that, due to their characteristics (people not wearing face masks, sometimes in closed spaces, with poor ventilation, etc.), may involve a greater risk. However, 37% of users state they perceive a medium safety level, and 13% perceive a low level. That is, up to 50% of users perceive these spaces as unsafe. This leads to the conclusion that, on the one hand, RN coverage must be strengthened, as indicated in the previous point. On the other hand, and to the extent that a high percentage of users perceive a high level of safety in these services, it is necessary to strengthen communication, aligning the work of health experts and tourism authorities, so that the perceived risk does not differ from actual risk.

Table 5. Level of coverage of the RNs in the RESTAURANTS protocols

Risk nodes		Covered in revised protocols	
		Total protocols ¹⁵	LAC Countries
Welcoming and seating clients	Preparation of the space		
	Allocation		
	Assembly / disassembly		
Taking orders	Menu		
	Order		
Service	Bar service		
	Table service		
	Take-away/delivery		
	Toilets		
Billing/Exit	Payment		
Kitchen	Menu preparation		
Ventilation	Indoor spaces		
Relative humidity	Relative humidity		
Operational-support processes	Use of shared cleaning equipment		
	Staff common areas (changing rooms, canteen and toilets)		
	Supplier management		
	Waste management		

¹⁵ The total number of revised protocols includes revised protocols from LAC, other regions and international organizations.



3.1.3. LOCAL TRANSPORT

The levels of coverage of the protocols on VARISK variables are shown in the following figure and table.

Figure 5. RN in local transport and level of coverage in LAC



The RN coverage by the protocols of this sector is **MEDIUM-LOW**, lower than for accommodation and restaurant protocols. The overall assessment of protocols and the LAC evaluation produce similar results, except for the case of ticket sales points and baggage handling, where LAC performs better.

> Strengths:

Local transport protocols mainly cover aspects related to **boarding** and the **vehicle's interior**, providing measures for both passengers and staff (especially drivers).

> Weaknesses:

In the overall study of protocols, the RN with **LOW** level of coverage are **ticket sales points, waiting areas, baggage handling**, as well as the possible **informal economy**, a variable in which the interviewees agree that this is an issue that needs to be worked on. Specifically for the protocols discussed in **LAC**, the results for ticket sales points and baggage handling slightly improve to **MEDIUM** coverage. The rest of the variables analyzed obtain in all cases a **MEDIUM** level of coverage, so there is room for improvement. Measures in response to the previous RN in the protocols should be strengthened.

> User perception:

In general, the users surveyed perceive the use of local transport to have a **LOW** level of safety. 84% of users perceive these spaces as unsafe. In fact, of those analyzed, it is the subsector perceived as the least safe. The vehicle's interior stands out—perceived by users as unsafe (54% of users perceive MEDIUM and HIGH risk) in contrast to the high coverage of this RN in the revised protocols. Strengthening measures in response to weak RN represents an opportunity to restore user trust.

Table 6. Level of coverage of the RN in the LOCAL TRANSPORT protocols

Risk nodes		Covered in revised protocols	
		Total protocols ¹⁶	LAC countries
Terminal	Customer service area	Yellow	Yellow
	Ticket sales area	Red	Yellow
	Waiting area	Red	Red
Vehicle	Boarding	Green	Green
	Baggage handling	Red	Yellow
	Disembarking	Yellow	Yellow
	Inside the vehicle	Green	Green
Ventilation	Indoors and inside the vehicle	Yellow	Yellow
Relative humidity	Relative humidity	Red	Red
Operational-support processes	Use of shared cleaning equipment	Yellow	Yellow
	Staff common areas (changing rooms, canteen and toilets)	Yellow	Yellow
	Supplier management	Yellow	Yellow
	Waste management	Yellow	Yellow
Informal economy		Red	Red

¹⁶ The total number of revised protocols includes revised protocols from LAC, other regions and international organizations.

B. NEURALGIC TOURIST AREAS (beaches, airports and ports)

In general, it is observed that RN coverage in the revised protocols is lower in these spaces than in the subsectors described above, with beaches having the highest RN coverage (medium) and ports obtaining the lowest coverage (medium-low).

Although the beach protocols generally identify the different RN, the same does not apply to many of the protocols analyzed for ports and airports, which frequently focus on measures related to the control of tourism flows and criteria for access/admission to the destination, as well as contingency plans in the event of detecting infected visitors or employees (see VICC results) and not so much regarding the current RN in each area. As in the analyzed subsectors, operational-support processes (where the customer is not directly involved) record the lowest coverage. Regarding LAC results versus overall results, the results are generally similar in the types of spaces being compared.

Users perceive a greater contagion risk in ports and airports, identifying them as a challenge for the tourism sector's reactivation, as these are entry points to destinations. It is therefore necessary to review the specific RN measures and include them in the protocols.



3.1.4. BEACHES

The levels of coverage of the protocols on VARISK variables are shown in the following figure and table.

Figure 6. RN in beaches and level of coverage in LAC



The coverage of the RN in the accommodation protocols is **MEDIUM**. The overall assessment of protocols and the LAC evaluation produce similar results, except for the case of play and recreational areas, where coverage is lower in LAC.

> Strengths:

Coverage in beach protocols is **HIGH** regarding **access** and **rest areas (loungers and umbrellas)**. The play or recreational area is also covered in the overall assessment of the protocols (although not in those of LAC). This greater coverage in countries outside the region may be due to the fact that, according to sources consulted, LAC beaches are less frequently provided with this type of services, and, when they are, they are not included in the protocols if they are not directly under the control of the managing body of the beach. Regarding operational-support processes, **waste management** coverage is **HIGH** in all cases, contrasting with other subsectors (accommodation, restaurants, local transport), in which it obtains a lower level of coverage. This high coverage may be due to the fact that there are many beaches that already make a great effort in terms of waste management and, **with this framework already in place**, the management of user waste from COVID-19 (face masks), is nothing new.

> Weaknesses:

The RN with **LOW** coverage are **parking facilities and access walkways**. In turn, **toilets and dressing rooms, showers and footbaths, concessionary businesses, rescue/first aid services** (although there are many beaches that do not have this service) and the **wet area** record **MEDIUM** coverage, as is the case of the **informal economy**, so there is room for improvement. In the case of operational-support processes, the **use of shared cleaning equipment** is present in less than half of the protocols revised (**LOW** coverage). Measures in response to the previous RN in the protocols should be strengthened.

> User perception:

The risk perceived by surveyed users is **HIGH**. Up to 70% of users perceive these spaces as unsafe. Especially noteworthy is the risk they perceive in the sand and bathing areas due to the crowded conditions, despite being outdoor spaces. Indeed, the control of tourism flows on the beaches is the greatest challenge faced by its managers—who have resorted directly to closing areas on many occasions as a preventive measure. This is because the necessary **control mechanisms** are not in place to supervise these access flows. Likewise, the closure of some beaches has had, far from alleviating the problem, a collateral effect, as user flows have moved to other open beaches in nearby municipalities, increasing crowding and contagion risk.

The above results show the need to reinforce the coverage of the RN as indicated in the previous section, which will result in the improvement of the user's perception regarding the level of safety on the beaches. These measures must be accompanied by a similar communication effort.

Table 7. Level of coverage of the RN in the BEACH protocols

Risk nodes		Covered in revised protocols	
		Total protocols ¹⁷	LAC countries
Accesses	Influx of users (capacity control)		
	Parking		
Sand area	Play/recreational area		
	Access walkways		
	Toilets and dressing rooms		
	Showers and footbaths		
	User/rest areas		
	Concessionary businesses (restaurants, kiosks, activities)		
	Informal economy		
	Rescue/first aid services		
Wet area	Seashore		
	Swimming area		
Relative humidity	Relative humidity		
Operational-support processes	Use of shared cleaning equipment		
	Waste management		

3.1.5. AIRPORTS AND PORTS

In the results of both tourism areas, it should be considered that the study sample of protocols outside LAC is very small in the case of airports and non-existent in the case of ports, because the countries/models selected in the analyzed sample do not have them.

In the case of airports, the protocols of the countries analyzed do not include general and detailed measures in response to the RN identified, although they focus on more strategic and cross-sectoral aspects such as conditions of entry and exit from the country/destination during the pandemic. On the other hand, the measures in response to the RN are included in the protocols of the International Civil Aviation Organization (ICAO), provisions dictated as a framework to be considered by the countries in the exercise of their powers, for the definition of their own protocols.

¹⁷ The total number of revised protocols includes revised protocols from LAC and other regions as no beach protocols from international organizations have been identified.



AIRPORTS

The levels of coverage of the protocols on VARISK variables for airports are shown in the following figure and table.

Figure 7. RN in airports and level of coverage in LAC



The variables determined by the RN¹⁸ identified in these tourism areas present a **MEDIUM-LOW** level of coverage, similar in the overall results and the LAC results, being slightly higher in the latter. However, some of the protocols explicitly refer to the ICAO recommendations, which would cover practically all the RN; therefore, there are gaps between the protocols and the recommendations that need to be addressed. It is noteworthy that ICAO does not include a RN related to operational-support processes (use of shared cleaning equipment), nor does it address the informal economy issue in airports/ports that would be worth considering in the protocols.

¹⁸ Similar risk maps have been considered for ports and airports, as both subsectors share the traveler itinerary and therefore, risk nodes.

> Strengths:

The aspects with **HIGH** coverage in the airport protocols of **LAC** are those related to **accesses, check-in or document verification in the check-in/automatic check-in area, the boarding/disembarking process**, including the **shuttle bus**, and **toilets and ventilation**.

> Weaknesses:

In LAC, the RN least addressed (**LOW** coverage) are those related to **baggage handling by staff during baggage claim, scanner/trays** at the checkpoints, as well as spaces and equipment at the departure terminal (**vending machines, catering services, recreational and smoking area**). As in some countries smoking is not allowed in airports and in which it is not usual to find recreational areas for children, etc.—this may be the reason why these two variables are poorly covered. Regarding operational-support processes, the **use of shared cleaning equipment** among staff and supplier management are the least addressed variables (**LOW** coverage). On the other hand, once again, the **informal economy** also has a low level of coverage. This may be due to the fact that the informal economy in these infrastructures usually takes place in the exit area and, therefore, outside the facilities (although not always). The rest of the RN in **LAC** have **MEDIUM** coverage. In the case of the ICAO protocol, only the use of shared cleaning equipment (operational-support processes) is not covered. Measures in response to the previous RN in the protocols should be strengthened.



RN analysis reveals **strengths and weaknesses** in the protocols.

<https://pixabay.com/es/photos/corona-covid-19-máscara-5086496/>

> User perception:

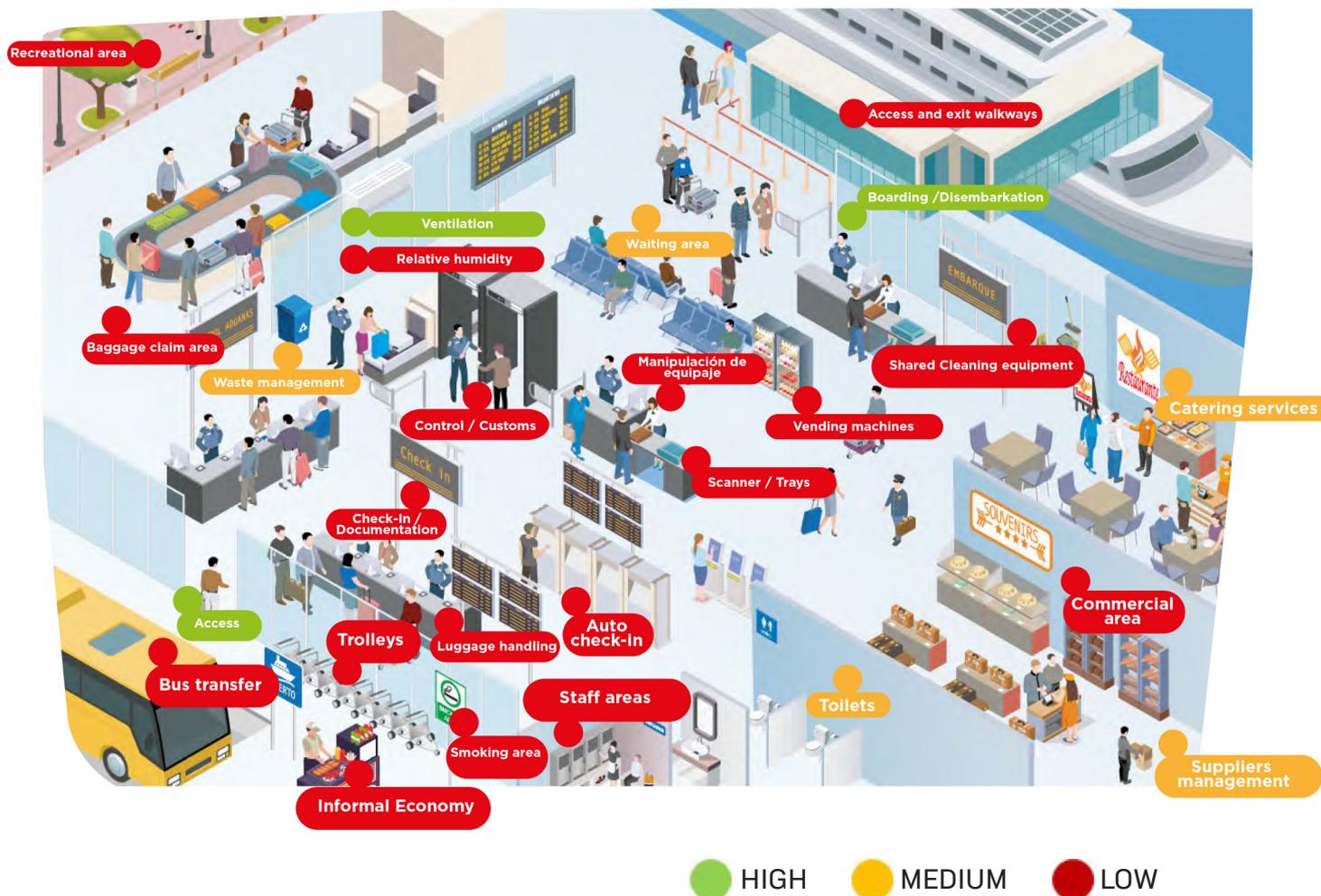
The perceived level of safety by users at airports is **MEDIUM-LOW**. 73% of users perceive these spaces as unsafe. There are also communication problems in specific cases in which the protocols are better than perceived: for example, the case of boarding/disembarking processes for which 20% of users perceived safety is LOW due to crowded conditions, in contrast to the high coverage of this RN in LAC protocols. This suggests that communication requires special attention.



PORTS

Figure 8 shows the location of the RN with their coverage levels (VARISK), which are referenced in Table 8 together with airports, because both spaces have the same passenger itinerary, as explained above.

Figure 8. RN in ports and level of coverage in LAC



It is observed that this tourism area presents a MEDIUM-LOW coverage level. As mentioned, in this case, 100% of the protocols included in the analysis correspond to the LAC Region.

> Strengths:

The aspects with **HIGH** coverage in LAC port protocols are those related to access, and the boarding/disembarking process. In addition, ventilation in closed spaces is addressed in more than 75% of the revised LAC protocols (HIGH coverage).

> Weaknesses:

In LAC, the RN least covered (**LOW** coverage) are **baggage trolleys**, the whole process of **check-in, inspection and control, baggage claim, shuttle bus, boarding/disembarking access and exit gateways**, as well as spaces in the departure terminal (**vending machines, shopping area, recreation and smoking area**). The assessments made at airports concerning the coverage of the recreational and smoking areas can be extrapolated to ports. Regarding operational-support processes, the use of shared cleaning equipment among staff and **staff common areas** are the least covered variables (**LOW** coverage). The other RN have **MEDIUM** coverage in LAC port protocols.

> User perception:

The perceived safety level by users in ports is **MEDIUM-LOW**. 73% of users perceive these spaces as unsafe. The check-in area presents the highest percentage of users who perceive a medium and high risk (almost 50%) and is, in addition, a weakness in terms of its level of coverage in the protocols. In general, almost 90% of the RN identified in ports are not properly covered in the protocols. It is necessary to consider the coverage of all RN in the protocol review to restore the user's trust, improving their perceived safety. To this end, it will also be necessary to strengthen communication about the measures.



It is necessary to consider the **coverage of all RN** in the protocol review.

Table 8. Level of coverage of the RN in the AIRPORT and PORT protocols

Risk nodes		Covered in revised protocols			
		Airports			Ports ¹⁹
		Total protocols ²⁰	LAC Countries	OACI	LAC Countries
Accesses	Accesses				
	Baggage trolleys				
Check-in area	Check-in/document verification				
	Baggage handling				
	Automatic check-in				
Inspection and control	Scanner/trays				
	Control/Customs				
Departures terminal	Vending machines				
	Toilets				
	Commercial area				
	Catering services				
	Waiting area				
	Recreational area				
	Smoking area				
Boarding/disembarking	Boarding/disembarking process				
	Shuttle bus				
	Access/exit walkways				
Baggage claim	Baggage handling by staff				
	Baggage claim area				
Ventilation	Indoor spaces				
Relative humidity	Relative humidity				
Operational-support processes	Use of shared cleaning equipment				
	Staff common areas (changing rooms, canteen and toilets)				
	Supplier management				
	Waste management				
Informal economy					

¹⁹ In the analysis of ports, only LAC is considered as there is no study sample of those from outside the region.

²⁰ The total number of revised protocols includes revised protocols from LAC, other regions and international organizations.

3.2. IMPLEMENTATION, COMMUNICATION AND CONTROL VARIABLES (VICC)

In order to carry out this study and complete the analysis of the content of the protocols, interviews have been conducted to provide qualitative information on the processes of implementation, communication and control of the protocols by the countries. The following sections integrate the main insights gained after almost 80 hours of recording. This information, although not in the protocols, completes their analysis and is essential when designing, reviewing and updating both the protocols and their management framework based on practices and solutions that have been proven valid and effective.

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The **interviews** carried out complete the analysis of the **protocols**.



<https://www.shutterstock.com/es/image-photo/tourist-woman-face-mask-reading-map-1812404401>

3.2.1. IMPLEMENTATION

The variables analyzed have been: (i) Staff training; (ii) Coordination with the rest of the private sector in the destination; (iii) Coordination with health authorities and others; (iv) Management of risk variability.

Table 9. Coverage of implementation variables in the protocols

IMPLEMENTATION OF VICC VARIABLES		Included in revised protocols					
		Accommodation	Restaurants	Local transport	Beaches	Airports	Ports
Staff training	T ²¹	Green	Green	Yellow	Yellow	Green	Grey
	L ²²	Green	Green	Yellow	Yellow	Green	Red
Coordination with the rest of the private sector in the destination	T	Red	Red	Red	Yellow	Red	Grey
	L	Red	Red	Red	Green	Red	Red
Coordination with authorities (health, safety, etc.)	T	Green	Yellow	Green	Green	Green	Grey
	L	Green	Green	Green	Green	Green	Yellow
Management of risk variability	T	Red	Red	Red	Red	Red	Grey
	L	Red	Red	Red	Red	Red	Red

HIGH	MEDIUM	LOW	No protocols have been analyzed of ports outside the LAC Region
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²¹ T: Total

²² L: LAC

In the table we observe that the level of coverage of the implementation variables varies depending on the subsector and space analyzed, with variables with a high level of coverage and variables with little or no level of coverage.

> Strengths:

In LAC protocols, the highest degrees of coverage (**HIGH**) are observed in the **staff training** for service providers (accommodation, restaurants and airports). Staff training is one of the most highly valued aspects and what both internal organizations and tourism authorities at the destination level have opted for. Likewise, **coordination with authorities** is largely addressed in the protocols, especially with regard to the health authorities, in the implementation of contingency plans. Specifically for **beaches**, coordination not only with the authorities but also with other **agents at the destination** is included, which is logical in coastal destinations where beaches are the main tourism resource.

> Weaknesses:

In LAC protocols, weaknesses are reflected in the **coordination measures with the rest of the private sector in the destination** (**LOW** coverage), except on beaches, as well as the **staff training** in ports.

On the other hand, management of **risk variability is not generally covered in the protocols for any subsector or area**. Except in a few specific cases, the protocols do not propose a framework for managing measures according to the current risk in a given circumstance. This means that they quickly become outdated and do not adapt to new scenarios and needs.

Regarding factors that modulate contagion risk, and therefore affect this variability, are referred to in the protocols in different depths, so in some cases the risk-reduction measures are insufficient:

Safety distance

It is the risk variability factor that most affects all the protocols revised, although there is a discrepancy between the specified safety distances, which vary between 1 and 2 meters [droplets expelled when speaking, singing, laughing, etc. can reach up to 2 meters].

Ventilation

Ventilation is addressed in part of the protocols both in the LAC Region and in international protocols, as indicated in the coverage level tables. However, the measures related to ventilation are unevenly detailed. At times, they refer only to a certain type of space and time (for example, rooms to be cleaned after the guest checks out). On other occasions, "adequate ventilation" or "maximizing it" is mentioned. In other cases, emphasis is placed on the advisability of natural ventilation and, in very few, on the need for mechanical ventilation equipment to renew a sufficient amount of air, avoiding its recirculation. Only in two cases have specific references to air filtration been detected. Emphasis needs to be placed not only on ventilation, but also on improving air quality and how this can be done.

Exposure time

The protocols do not expressly mention this risk-modulating factor. However, it is indirectly inferred that many of the protocols include specific measures to reduce exposure by employees and users to the virus (intrinsically related to the reduction of contact with other people), for example, with prior reservation systems, preferential attention for vulnerable people, promotion of online check-in, etc. It is advisable to emphasize in the protocols the importance of reducing exposure time in contexts of possible contagion through a more instructive approach.

Use of face mask

The use of a face mask is included in most protocols (and where not, reference is made to the applicable legal framework). Except in isolated cases, the protocols do not determine the type of face mask to be worn. When the type is specified, surgical and/or fabric masks are referred to. In some cases, reference is made to Personal Protective Equipment (PPE) in general. The protocols recommend both users and employees wear face masks. It is observed that it is necessary to include the different mask options available, their level of protection in each case and other recommendations associated with their use.

Relative humidity

This risk-modulating factor is not generally included in the protocols, except in one case in where it is indicated that it should be kept below 70%, which does not seem entirely adequate (contagion risk is favored by relative humidity below 40%). In some particular cases, the aim is to maintain an ambient temperature of between 21°-23°C, which could affect the relative humidity keeping it in the recommended 40-60% range, although it is not clear in these protocols if this is the ultimate goal of measure.

“

Formalized and systematic communication prepares for **future emergencies.**



<https://pixabay.com/es/photos/covid-19-coronavirus-cuarentena-5070666/>

> Qualitative analysis (key stakeholders and user perception):

In general, users have stated that they perceive differences in the implementation of measures in the various tourism organizations and a lack of coordination, not only within the same subsector (for example, restaurants or accommodation) but also between one destination and another, which generates mistrust in the use of tourism services and when traveling. In fact, it is observed that:

- Internally, **each tourism organization**, depending on the protocol that has been adopted, **has established its own internal management mechanisms to implement the measures**.
- At the destination level, **authorities, unions and tourism sector stakeholders** have also established **different implementation mechanisms**. This has meant that the **results obtained** with respect to the efficacy of the protocols and their validity have also **differed from those obtained in some destinations**.

On the other hand, the different models in relation to **differing degrees of participation by key stakeholders, levels of representativeness, as well as control mechanisms** and making said measures binding also contribute to a **low level of standardization, which results in the depreciation** of the work carried out for the protection of visitors and staff.

Based on the above and in order to regain the trust of users and reboot the recovery of tourism activity, **a harmonization of these management mechanisms is necessary from the protocols themselves, both internally and throughout the destinations**.

3.2.2. COMMUNICATION

Structured, speedy, formalized and systematic communication is a key tool for the adoption of the protocols, their management and the cross-sectoral involvement of all stakeholders at the destinations: internal communication in tourism organizations has been an aspect widely outlined in the protocols analyzed, both for the customer and for the employee, allowing the implementation of biosafety measures and their monitoring. On the other hand, **external communication** aims to publicize the protocols and generate trust in the end user of the tourism service (potential visitor). Likewise, it **coordinates key stakeholders at the destination**, and this second objective of external communication is not met by the protocols analyzed. However, **inter-and intra-sectoral communication of all stakeholders (public, private, etc.) and at different levels (subnational, national, supranational), considering all the competent authorities (health, work, transport, tourism, etc.) has been key in drafting the protocols and in the adoption phase by tourism service providers**. In the first phase of the pandemic, this communication was speedy and cooperative, in many cases using unofficial channels that, nevertheless, were effective with regard to their intended purpose. Months after the outbreak of the pandemic, however, **there is a risk that structures, models and coordinated initiatives that have been effective will be abandoned**. For this reason, the **formalization and systematization of these communication mechanisms** is necessary for a **fast and coordinated response** by the different key stakeholders in **future emergency situations**.

The variables analyzed in the protocol review have been: (i) Internal communication of the measures (to staff and users); (ii) External communication (to the destination and other private and public agents).

Table 10. Coverage of communication variables in the protocols

VICC COMMUNICATION VARIABLES		Included in revised protocols					
		Accommodation	Restaurants	Local transport	Beaches	Airports	Ports
Internal communication of the measures (to staff, users)	T ²³	High	Medium	High	Medium	High	Grey
	L ²⁴	Medium	Medium	Medium	Medium	Medium	High
External communication (to the destination, other private and public agents)	T	Medium	Medium	High	Medium	High	Grey
	L	Medium	Medium	High	Medium	Medium	Medium

HIGH	MEDIUM	LOW	No protocols have been analyzed of ports outside the LAC region
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Unlike the analysis carried out for other variables, in terms of communication, the analysis of the LAC protocols obtained a lower coverage of the variables than the overall analysis, which includes protocols from other regions.

> Strengths:

For LAC, the **variable for the internal communication of the measures** has a **HIGH** coverage level only for the **port** protocols. This variable obtains better results in the analysis of all the protocols, especially regarding accommodation, local transport and airports. According to the **external communication**, there is a **HIGH** level of coverage only for **local transport** protocols.

²³ T: Total

²⁴ L: LAC

> Weaknesses:

In general, the **internal communication of the measures** has a **MEDIUM** level of coverage for all subsectors and areas (except ports), although the beach protocols are almost failing in this variable (only 50% of the protocols include specific internal communication measures). **External communication**, which is covered in less than 75% of the protocols analyzed, fails to produce better results.

> Qualitative analysis (key stakeholders and user perception):

In the study carried out, it is observed that users perceive greater safety when the applicable measures are communicated in each subsector or space. In this regard, users report a lack of communication (both at the time of “consuming” tourism services and before). **In addition, the communication available does not necessarily meet its objective** (regarding end users, publicizing the protocols for their adoption and follow-up in order to build trust). In fact, users state that in most cases the information they receive is **disparate**, and dependent on the subsector, space or destination. In addition, the information is dispersed through **different sources**, with **unclear updates**. The **scattering** of information makes it difficult for the user to receive complete and updated information at all times, which again **causes confusion and distrust**. This, added to prevailing uncertainty already surrounding this pandemic (for example, regarding mobility restrictions), further slows down the recovery of the sector even more. In this regard, it is necessary to **work on the standardization of the internal management mechanisms of the protocols, which will result in a more harmonized communication** and, therefore, will spread the message more effectively.

In turn, and at the destination level, **the different competent entities need to be able to efficiently manage varied and variable information, formalizing speedy, coordinated communication channels in which all key stakeholders are considered**, and that can be effective in managing future health crises.

Finally, the information available, both internal and external, must be easily **accessible and understandable to the target audience, and be up-to-date and adapted to the circumstances** at all times.

“

The scattering of **information** leads to confusion and distrust among users.



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3.2.3. CONTROL

The following variables were analyzed in the review of protocols to assess the degree of follow-up and control: (i) Internal supervision of compliance with the measures; (ii) Protocols update; (iii) Health control of staff; (iv) Contingency plans - management of positive or symptomatic user cases; (v) Contingency plans - management of positive or symptomatic staff cases.

Table 11. Coverage of control variables in the protocols

VICC CONTROL VARIABLES		Included in revised protocols					
		Accommodation	Restaurants	Local transport	Beaches	Airports	Ports
Internal supervision of compliance with measures	T ²⁵						
	L ²⁶						
Protocols update	T						
	L						
Health control of staff	T						
	L						
Contingency plans (management of positive or symptomatic users cases)	T						
	L						
Contingency plans (management of positive or symptomatic staff cases)	T						
	L						

HIGH	MEDIUM	LOW	No protocols have been analyzed of ports outside the LAC Region
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²⁵ T: Total

²⁶ L: LAC

Updating of protocols, as well as control and **follow-up activities on compliance with them are weaknesses** found in practically all the documents revised, even though they are especially relevant for their validity and effectiveness.

First, and regarding the **updating of the protocols**, it should be noted that both the management mechanisms of the protocols as well as their approach and content must be updated periodically to ensure their effectiveness and validity throughout this pandemic. Although protocols were quickly defined by most of the stakeholders involved, **most of these documents have not been updated since they were first published**. In this regard, health experts emphasize the need to **update protocols, especially those developed at the beginning of the health crisis**, when measures in response to the risk of contagion focused mainly on contact with contaminated surfaces and droplets, and given that **months later, aerosol transmission has gained weight, as has been referred to in various articles and scientific studies, including those of the prestigious journal Nature²⁷ or The Lancet²⁸**. In addition, during the protocol study, it became evident that **risk was treated statically**, when in fact the risk of SARS-CoV-2 contagion is clearly variable, as explained at the beginning of the document. The static treatment of risk can be understood in a context of emergency and urgency for the definition of measures at a time of uncertainty, changing information and lack of data. However, months later, it is necessary for the protocols to include **contagion risk variability factors** when defining biosafety measures, so they can be **adapted to the evolution of the pandemic**.

On the other hand, **claiming something we do not control or measure is a fact generates distrust and devalues the efforts made. As a result, there has been a gap between the communication of safe destinations—which has been widely used to reactivate tourist arrivals—and control over the proper implementation of biosafety measures, over which no control has been established. In general, the communication and control approach to destination safety should be revised.**

From the administration perspective, work has been done in most of the cases analyzed—and especially in destinations with a greater number of international tourists—in communicating the status of "**Safe destination**". This has been coordinated with the stakeholders of the value chain, sometimes relying on trade and tourism promotion offices abroad, embassies and promotional campaigns at origin and at the destination itself (for example, at airports). To this effect, both the administrations and the tourism trade have made use of **seals to try to reinforce the image of the destination**.

In this regard, and as indicated by the interviewees, it is observed that the initiatives to transmit safety and promote traveler confidence are **multiple and disparate**. This, together with the **different methods of control** concerning this type of safe destination (with varying degrees of exhaustiveness depending on the model), has generated **inconsistencies with respect to compliance with measures and, therefore, distrust in the end user, leading to communication policies failing to meet their intended goals**. Likewise, the **aggregation of seals and recognitions** (sub-sectoral, regional, local, private, public, etc.), with different scope and focus, has devalued the work done in the area of compliance assurance in the eyes of the consumer. Added to this is the impossibility of ensuring that a destination, environment, establishment, etc., can be a "safe destination" or "COVID-19-free" destination.

²⁷ <https://www.nature.com/articles/d41586-020-02058-1>

²⁸ [https://doi.org/10.1016/S2213-2600\(20\)30514-2](https://doi.org/10.1016/S2213-2600(20)30514-2)

In this regard, it is important to emphasize that the seals of approval guarantee the user that the biosafety protocols are complied with—which contributes to reducing the spread of the virus and restoring user trust—but it is necessary to rethink the communication approach of these seals to avoid misleading people. **Positive discrimination** from **seals of approval** is useful for the end user and for the reactivating tourism, but only if there are effective control measures in place and adequate communication is carried out.

> Strengths:

In LAC, the establishment of mechanisms for **internal supervision of compliance with the measures** has a **HIGH** level of coverage in the restaurants subsector. This result makes sense, insofar as restaurants have their own self-monitoring mechanisms as part of the Hazard Analysis and Critical Control Point (HACCP) system, with frameworks in place on which to implement the new biosafety measures (for example, they already have cleaning and disinfection plans as part of the self-monitoring plans). On the other hand, given that many of the accommodation protocols do not include catering measures (and refer directly to the corresponding protocol), the lower level of coverage of this variable for this subsector can be understood.

Health control of staff in most subsectors and spaces is seen as a strength with a **HIGH** level of coverage, except on beaches, which is explained below. In turn, the **management of positive or symptomatic user cases** and to a lesser degree, **of employees**, also has a **HIGH** level of coverage in the protocols concerning accommodation, local transport, airports and ports (accommodation and local transport in the case of employees). It is important to note here that this case management falls within the framework of the management of **contingency plans** in organizations, in coordination with destination stakeholders (for example, health authorities). It should be noted that protocols including contingency plans for the detection of positive cases, or symptoms compatible with the disease, cover only basic issues related to the isolation of the sick person and notifying the health authorities. While it is true that the health authorities have the competence to establish the procedures to be followed in each case from the health point of view, **there is a lack of established minimum recommendations** prior to intervention by the health services, and even after they have intervened (for example, to define the protocol staff need to follow in terms of communication, prevention, etc.). It can be seen that there is a need to **expand the scope and detail of contingency plans** where the tourism organization is concerned—taking into account coordination (for example, with the destination's health authorities and insurance companies), communication (for example, defining the commercial policy of a tourist accommodation if a guest is isolated in a room), control (for example, monitoring staff health) and RN (for example, cleaning and disinfecting the quarantine area).

“

It is essential to have **contingency plans** and avoid improvisation.



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> Weaknesses:

In LAC, the **internal supervision of compliance with measures** implemented obtains the **LOWEST** level of coverage in local transport and beaches, and slightly higher in accommodation, airports and ports (**MEDIUM**). The **management of positive or symptomatic cases** also has a **MEDIUM** level of coverage in restaurants, beaches, airports and ports for employees, and in restaurants and beaches for users. **Health control of staff** is also covered to a lesser extent in the case of **beaches**. In general, beach protocols do not have much impact on staff protection measures, and this may be due to the fact that the workers found on the beaches are generally employees of the concession companies or subcontractors of the managing body (on public beaches). For private beaches, these aspects can be left out of the protocols as it is understood that they are already included in other protocols, such as accommodations, which are responsible for cleaning and maintaining them at some destinations. The vast majority of employees of the managing entity will be located in the offices of the municipality, and this may be the reason why the inclusion of this variable has not been considered. In any case, and in the specific case of beaches, it seems reasonable to include in the protocols a requirement for coordination between the managing entity and the concessionaires of the services in these areas. In turn, the **MEDIUM** level of coverage of the variable relative to **contingency plan for users in restaurants and beaches** is due to the low probability of detecting and confirming a positive case during service in a catering facility and to the unavailability of staff to monitor the health status of users during their stay on the beach (cases have been occasionally detected at the entrances). Finally, the variable with the lowest level of coverage is the **updating of protocols**, especially at beaches, airports and ports, obtaining a **LOW** level of coverage.

> Qualitative analysis (key stakeholders and user perception):

Users perceive the existence of mixed measures implemented in different organizations, so they **conclude that adequate control measures are not being applied**. Internally, within the organization itself, this generally coincides with the result of the analysis of the level of coverage of the variable "internal supervision of compliance with measures", **which suggests that supervision mechanisms (self-monitoring) should be defined in the protocols themselves, as requested by users²⁹**. **Control measures related to the management of positive or symptomatic cases** of employees or users are observed to be disparate; most protocols do not outline how to act in this situation, but rather refer to the health authorities. This has the disadvantage that **in many cases nobody knows how to act in the establishment or space until the health authorities intervene. In order to avoid improvisation in the application of the contingency plan** (for example, regarding the commercial policy in rooms occupied by infected clients, regarding the provision of antigen tests or PCRs by the organization for its employees, regarding the quarantine policy for close contact employees, etc.), **it is necessary to outline at least the basic framework for action** (which will be accompanied by the health authorities' decisions in force) **and communicate it duly to employees and users**.

²⁹ Both in the focus group carried out and in answers to the questionnaires, this is one of the aspects most reported by end users.

At the destination level, the control mechanisms vary from one model to another—in those cases in which an **on-site control** (via **inspection visits**) is carried out, compliance with biosafety measures is monitored either by **subnational or national health authorities**, or **tourism authorities and/or the police**. Although sources consulted generally state that there are control mechanisms in place, the fact is that **no data are available on the results of this supervision**, which leads us to believe that the control mechanisms have not been implemented or have not been effective. On the other hand, in **models based on third-party certification**, expert evaluators are available for risk management in the tourism sector and supervisions are carried out every six or twelve months, depending on the model. There are also **private models managed by tourism associations that establish the type of control activities to be carried out**. Finally, at some destinations, **monitoring committees** have been created, **made up of the different** (public) **authorities** responsible for supervising organizations in the destination (tourist and non-tourist). In turn, **control models based on self-monitoring** involve the submission (usually) of certain documentation (for example, a self-assessment or check list on compliance with the measures), attendance at training sessions or records of implementation and control of the protocols (for example, statement on the absence of positive cases in the establishment in the 30 days prior to the responsible declaration, cleaning records, minutes of the constitution of a health and safety management committee, etc.). Some models have established that this declaration must be updated 12 months after it was first presented, while for others nothing is indicated in this regard.

The disparity and level of demand in the control models and associated recognitions (seals or other types of visual image) arising from the different systems listed above does not help to build trust, but rather to devalue the strictest and most controlled schemes, invalidating the positive discrimination of those organizations that implement biosafety measures effectively and maintain them over time. In this regard, it is necessary to review the validity and effectiveness of the control mechanisms implemented in the destinations, as well as the associated seals of approval and certificates.

Finally, it is striking that the interviewees state that **control is observed to be more effective when it is carried out by entities with a smaller geographical scope** (for example, local entities), **which should be considered in monitoring and control strategies.**

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The **control model disparity** does not contribute to building trust.



<https://pixabay.com/es/photos/test-tube-covid-19-mask-mascarilla-5065426/>

DIAGNOSIS ON
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IN LATIN AMERICA AND
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4. CHALLENGES

From the results of the analysis previously carried out, a series of challenges arise that need to be addressed:

CHALLENGE 1. Given that the risk of contagion from the SARS-CoV-2 virus will remain with us longer than we expected, **current biosafety protocols to prevent the spread of COVID-19 for the tourism sector must be updated** taking into account lessons learned, as well as the result of new research on the transmission and behavior of the virus.

The review of biosafety protocols to prevent the spread of COVID-19 must:

D.1.1. Include mechanisms to assess the contagion risk based on different modulating factors, which will adapt the measures to be implemented to the different circumstances and evolution of the pandemic, taking into account the results of said assessment. The **risk variability approach** overcomes the idea that it is always static, and contributes to mitigating the transmission of the virus. Therefore, it cannot be ignored that a protocol must mitigate risk through **assessment and management of contagion risk. It is necessary to consider this aspect in current protocols, updating them in such a way as to take into account these risk-modulating factors.**

D.1.2. Harmonize the biosafety measures and their level of granularity in relation to each RN, in order to facilitate their implementation and build user trust. This is especially important in **ports and airports**, which in many cases do not affect the RN and present unequal levels of coverage. Similarly, in the **local transport subsector**, in which its users perceive a medium-low level of safety, it is necessary to review the biosafety measures defined in response to the RN. In turn, it should be remembered that **specific protocols** are more effective against the risk of contagion by establishing specific measures in response to RN.

“

Current **tourism protocols** for biosafety measures in response to COVID-19 **must be updated.**

D.1.3. Include measures in response to RN that have been identified as relevant and that the protocols analyzed do not adequately cover. The following stand out, for example:

- **operational-support processes**, with special emphasis on everything related to **protection of employees, including those who are part of concessionaires and subcontractors** that operate in the tourism establishment or space and with which internal coordination mechanisms must be established (D.1.4). In this regard, it is important to have the opinion of the workers in the drafting of protocols.
- **the informal economy** in local transport, beaches, ports and airports, which constitutes an important risk node and, if properly managed, could represent a first step towards the formalization of this sector, as has already been observed in some destinations.
- **natural aeration and/or ventilation** to reduce the risk of contagion by aerosols, **the main transmission mode**. Although ventilation is referred to in some protocols, recommendations, which vary in detail, are not always complete and adequate.
- the definition or outlining of the **contingency plans for the detection of positive and symptomatic cases** among users or employees, as well as associated aspects that have an impact on the user and that are not under the responsibility of the health authorities (commercial policy to be applied by the organization, designated isolation area, protocol to be followed with workers who have come into contact with the infected person, etc.).

D.1.4. Include internal management mechanisms and self-monitoring on measures implemented for tourism organizations. The lack of specific internal management measures in the protocols themselves aimed at the implementation and control of their effectiveness has led to difficulties in their adoption and different levels of compliance, generating an image of lack of coordination in the tourism sector. The definition of **internal management and self-monitoring** mechanisms will contribute to the standardization of the practical application of the protocols and to the professionalization of the tourism sector, representing a **step towards the establishment of internal management systems in organizations**.

CHALLENGE 2. Measures must be defined for the management of the implementation, communication and control of the protocols. The aim is to standardize these processes, convey a clear message of confidence to the user and establish permanent structures that will enable future health crises to be dealt with in a speedy and effective manner, based on the lessons learned.

The measures that should be highlighted include the following:

D.2.1. The collaborative approach and the participation of all key stakeholders of the value chain at the destination (public and private) in the processes of creation, implementation (D.2.4., D.3.1.), communication (D.2.2., D.2.3.) and control (D.2.6.). This approach promotes the dissemination of these initiatives and their endorsement by tourism service providers. In addition, it considers the different RN in the protocols from different points of view (employees, visitors), which also favors their **integral approach**. This integrated approach can be reinforced with the participation of **labor authorities** and **consumers**, through their **associations**. The collaborative approach **increases the value of the protocols, as it contributes towards the development of a more consistent and homogeneous perception by the users**.

D.2.2. The establishment of **mechanisms for updating information and communication** for users. Research has shown that having higher levels of information improves levels of trust; however, this communication should focus on the RN [D.1.2], as there is a **gap between the risk of actual contagion and the perception of that risk by the user** in some of the subsectors and spaces analyzed. In this regard, the **work of health experts and tourism authorities should be aligned**, strengthening collaboration for a coordinated and effective message.

D.2.3. The establishment of **coordinated, speedy communication channels and structures between the stakeholders of the value chain at the tourist destination** (public-public, private-public, private-private). This will facilitate, on one hand, the building of an image of a safe destination (both for tourists and residents) by encouraging the involvement of the stakeholders of the value chain at the destination and, on the other hand, the quick response to possible health emergencies—for example, regarding the implementation and monitoring of **contingency plans** in tourist establishments [D.1.3].

D.2.4. Training in the tourism sector to raise awareness of the measures to be implemented, to achieve their understanding, to comprehend their benefits, and to facilitate their implementation and their **maintenance over time**. In this regard, mass, free and open digital training has been efficient in a pandemic context and has fostered **digital know-how** throughout the tourism sector. This path, which arose at a time of need and emergency, can be seen as an **opportunity** whose synergies can be exploited in the immediate future to improve the sector's professional skills.

D.2.5. The definition and implementation of effective, systematic, and cost-effective control mechanisms that ensure compliance with measures, promote affirmative action and generate user confidence, contributing to the reactivation of the activity. Control over compliance with measures has turned out to be the “Achilles heel” of the implementation process of biosafety protocols in the tourism sector due to the scarcity of resources available for this purpose. As a result, there has been a gap between the communication of safe destinations, which has been widely used to reactivate tourist arrivals, and control over the proper implementation of biosafety measures, over which no control has been established. **In this regard, real control systems must be designed that add value to both the service provider and the end user, and that will allow the destination to improve users’ perceived safety, with the consequent economic reactivation. This mechanism, or combination of mechanisms, must be adapted to the nature of the destination.** Thus, the lack of resources for the control of measures must be countered through **public-private cooperation formulas for control and monitoring, use of digital media, self-monitoring by the service provider and on-site inspections** (by the competent and/or delegated entities), and with a **comprehensive approach to destinations**, so that the measures are established in such a way that they make sense and are **consistent** throughout the value chain. The right **combination of the above factors** will strengthen the destination and its tourism sector, improve user confidence and contribute to tourism reactivation. Likewise, value should be placed on the work of those tourism organizations that are committed to **real, verified compliance** with the protocols, providing advantages and benefits as a form of **positive discrimination**—for example, through **seals of approval** (without making the mistake of devaluing these seals by failing to implement effective control mechanisms).

D.2.6. The availability of **performance indicators** that provide data on the evolution of the designed biosafety assurance schemes, so that the **best decisions can be made** on the implementation, management and control of the protocols. Although few destinations had specific data on protocol management, adequate management is not understood without quantitative information on how well the biosafety protocols are working.

CHALLENGE 3. The enforcement of the protocols and their convergence with the current legal framework (occupational health, food hygiene, safety) need to be promoted as a basis for the establishment of biosafety measures and their management framework.

D.3.1. It is necessary to **facilitate harmonisation and self-control** of measures, searching for points of convergence with the current legal framework. This will improve user perception and the recovery of confidence. It is worth considering that the binding nature of the protocols presents an important challenge—ensuring that they can be adapted to all types of companies, regardless of their size, level of professionalism, type of services offered, infrastructures or location.

D.3.2. The existence of a prior legal framework convergent with some of the measures detailed in the protocols reinforces the idea that the **co-creation** is essential to identify not only the key stakeholders that should be part of this process, but also the **points of convergence on which to build measures** [e.g. occupational safety standards, food hygiene, etc.].

“

Permanent structures are required for the **implementation, communication and control** of the protocols.



<https://pixabay.com/es/photos/senior-ancianos-personas-pareja-3336451/>

D.3.3. In addition, the use of the **current regulatory framework** as a basis for the construction of a new framework (in this case, in response to COVID19) makes it possible to **speed up the construction and implementation** of measures, which is essential in a health emergency context. This, in turn, **emphasizes and reinforces the legal framework**, which is a stimulus for the sector to adapt to it. Likewise, it represents another step in the **development and professionalization of the sector**, and **consolidates its management framework in the face of future health crises, preparing and strengthening it**.

“

From the analysis carried out, a series of challenges arise to **reactivate tourism** and prepare for future health crises.

<https://www.shutterstock.com/es/image-photo/doctor-wearing-protective-mask-against-coronavirus-1681869925>

5. NEXT STEPS

The completion of this diagnosis is the **beginning of the construction phase of the minimum recommendations** to be considered in any **biosafety protocols** in the tourism sector, **considering**, on the one hand, **the content that must be revised and updated based on the previous conclusions**; and on the other hand, **defining implementation, communication and control mechanisms** of the protocols that ensure their standardization, effectiveness, relevance and validity, with a view to **restoring user trust and reactivating tourism activity**.



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