REPUBLIC OF SOUTH SUDAN

The National Taskforce on COVID-19

South Sudan National Guidelines on COVID-19

Prepared by: The Medical Advisory Panel

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Foreword:

South Sudan confirmed its first case of COVID-19 on April 5th 2020; since that time; the cases continued to increase exponentially to the extent that the fragile health capacity of our nascent nation was almost overwhelmed by the surge of the novel corona virus pandemic and the other health related ailments were unfortunately brought to a standstill condition. The High Level Taskforce on COVID-19 was established by the leadership of South Sudan in an anticipation to curb this health catastrophe as early as March 23rd 2020, when most of the neighboring countries reported cases of COVID19 in their territories. The HLTF was chaired by the President of the Republic **H.E Salva Kiir Mayardit** and deputized by the First Vice President **H.E. Dr. Riek Machar Teny** with membership of high ranking national ministers and senior government officials.

The HLTF on COVID-19 was re-structured and replaced by the National Taskforce on COVID-19 under the chairmanship of **H.E Hussien Abdelbagi Akol** the Vice President for Service delivery Cluster, deputized by the national minister for health **Honorable Elizabeth Acuei Yol** and membership of undersecretaries, senior army, police and security officers as well as civil society organizations representative. The Chairman of the NTF established the Medical Advisory Panel (MAP) on July 2nd 2020 with clear terms of reference which are:

1- To advise the National taskforce with medical and scientific based advisees on COVID-19 responses;
2- To review and endorse COVID-19 related protocols and guidelines;
3- To provide feedback on COVID-19 prevention and control measures and recommend action points;
4- To evaluate the current working groups and recommend reforms if deemed necessary;
5- To advise the National Taskforce on COVID on submissions made by health partners and any other international stakeholder;
6- To advise the National Taskforce on COVID-19 related medical and diagnostic products;
7- To advise the National Taskforce on COVID-19 on any other arising matter in relation to COVID-19; and
8- To provide strategic analysis and guidance on health issues of National Concern.

The membership of the Medical Advisory Panel (MAP) is drawn from different specialized medical and health institutions of South Sudan as follows:

S/No.	Name of Representative	Institution	Position
1	Dr. Fredrick K Tawad	College of physicians and surgeons	Chairman
2.	Dr. Pawil Arop Yor	Juba Teaching Hospital Representative	Deputy Chairperson
3.	Dr. Akway Cham	School of Medicine, Juba University	Secretary
4.	Dr. Kenneth Lado Lino	School of Medicine, Juba University	Secretariat
5.	Dr. Moses Hassan Ayat	School of Medicine, Juba University	Secretariat
6.	Dr. Ajak Makor	SSPDF Defense Health Service	Spokesman
7.	Dr. Simon Gore	General Medical Council	Member
8.	Dr. Changkel Banak Riak	National Public Health Laboratory	Member
9.	Mr. Peter Aguek	Drugs and Food Control Authority	Member
10.	Mr. Ahmed Ismail Jula	Public Health Specialist	Member
11.	Dr. Kajomsuk Abdalla	Chest Physicians Representative	Member
12.	Dr. Atong Ayuel Longar	Psychiatrists Representative	Member
13.	Dr. Joseph Makuur Gai	Anesthesiologists Representative	Member
14	Dr. Dr. Justin Bruno	Pediatricians Representatives	Member
15.	Dr. Anthony Lupai	Obstetrics & Gynecologist Representatives	Member
16	Dr. Moses Maror	Obstetrics & Gynecologist Representatives	Member
17	Dr. Akram Gabriel	Forensic Medicine Specialist	Member
18	Dr. Dario Kuron	Surgical Society Representative	Member
19	Ms. Anna Martin	Nursery and Midwifery representative	Member
20	Dr. Oromo Francis	Private Health Practitioners Representatives	Member

We; in the NTF are confident that the right way to fight COVID19 is through collective efforts where every individual in the society is a stake holder and the role of the government is to provide leadership and guidance.

Let us strive to grab this opportunity to improve on the general health infrastructure starting with consolidating and empowering our health personnel to overcome COVID19 Pandemic as well as any other health related challenges in our country.

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H.E. Husien Abdelbagi Akol

Vice President for Service Delivery Cluster

Chairman, National Taskforce on COVID-19

Dr. Fredrick Khamis Tawad

President of CPS & Chairman of the

Medical Advisory Panel (MAP)

Background on COVID-19 Pandemic:

COVID-19 is caused by a novel SARS-COV-2 which is a beta corona virus. It is transmitted by respiratory droplets, direct contact with infected patients or contaminated objects.

The incubation period for COVID-19 is 5-6 days up to 14 days.

Most people develop mild (40%), moderate (40%), severe (15%) requiring O_2 support, and critical (5%) requiring mechanical ventilation.

Risk factors for severe disease include:

- Smoking
- Old age
- Underlying chronic medical conditions such as: Hypertension, Diabetes Miletus, lung; heart and kidney diseases and cancer

Presentation in children and infant: it present with mild diseases, however, 23% of children present with multi-organs failure due to pre-existing lung and heart diseases.

COVID-19 patients are classified as follows:

a. Clinical criteria: Any person with at least one of the following symptoms:
    - Cough
    - Fever
    - Shortness of breath
    - Sudden onset of loss of smell (anosmia) or loss of taste (ageusia/ dysgeusia).
b. **Diagnostic imaging criteria**: Radiological evidence showing lesions compatible with COVID-19
c. **Laboratory criteria**: Detection of SARS-CoV-2 nucleic acid in a clinical specimen
d. **Epidemiological criteria**: At least one of the following two epidemiological links:

- Close contact with a confirmed COVID-19 case in the 14 days prior to onset of symptoms.

- Having been a resident or a staff member, in the 14 days prior to onset of symptoms, in a residential institution for vulnerable people where on-going COVID-19 transmission has been confirmed.

Case classification:

1. Possible case: Any person meeting the clinical criteria
2. Probable case: Any person meeting the clinical criteria with an epidemiological link OR any person meeting the diagnostic criteria
3. Confirmed case: Any person meeting the laboratory criteria.

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The Medical Advisory Panel (MAP) has developed the following twelve protocols that were adopted by the National Taskforce (NTF) as the South Sudan National Guidelines for COVID-19.

The First Protocol: Guidelines for COVID-19 Laboratory Testing Strategy"[1]":

Diagnostic testing for COVID-19 is an integral strategic preparedness and response plan.

COVID-19 testing has two important functions:

- To confirm diagnosis and
- Assist in management of patients with COVID-19.

The MOH plans to rapidly scale up diagnostic testing across all the 10 states. It is understandable that the targeted prioritization for COVID-19 testing will change based on the phase of the outbreak.

- Guidance on covid-19 laboratory testing strategy/ prioritization:

❑ Testing must be rationalized with aim of early identification of cases.

❑ Priority should be given to the detection and protection of the vulnerable patients and health care workers.

❑ Results of testing of specific populations can give a rough estimate of the size an outbreak.

- ❑ The current national testing guidelines cast the net wider and continuing to increase testing.

Recommended prioritizations for targeted testing in South Sudan:

1. All suspect cases (particularly >50 years and those vulnerable to severe disease)
2. Non-COVID-19 (hospitalized patients), who show symptoms
3. Symptomatic health care workers (managing COVID-19)
4. The first symptomatic individuals in closed/congregate facilities (POCs, refugee camps, health facilities, prisons)
5. All contacts (if further prioritization is needed then those at risk of poorer outcomes i.e. >50 years, vulnerable to severe disease)
6. Discharge indication

The following table shows the different types of approved laboratory tests for suspected COVID-19 cases in South Sudan:

Type of Test/ Strategy	**Time to Results**	**Indications/Uses/ Advantages**	**Disadvantages**
RT-PCR	4 hours, reliable and confirmatory results	COVID-19 Case definition:	High turnaround time & High operational cost
GeneXPert Platforms	High turnover 45 minutes per test	Its equitable and reliable	Use Cartridge for GenXepert SARS-COV-19 in Country and region
RDTS for SAR-COV-2 screening and diagnosis	10-30 minutes	Determine asymptomatic COVID-19 cases	Antibody tests (IgM & IgG) are not suitable for the diagnosis of a clinically suspected case.

South Sudan Testing Options for COVID-19:

First Option: SARS COV-2 real-time RT-PCR for Diagnosis and confirmatory test of SARS-COV2: Real-time RT-PCR is a gold standard Test recommended by the WHO as the first-line for laboratory diagnosis for clinically suspected COVID-19 cases.

Second Option: Utilization of Diagnostic Capacity of GeneXpert Platforms to diagnosis SARS-COV-2 in States and County hospitals: GeneXpert platform is an existing diagnostic capacity in South Sudan as Global fund support for HIV and TB control programs.

Third Options 3: Rapid Diagnostics tests (RDTs) for Screening and diagnosis of community transmission of COVID -19: SARS-COV-2 Rapid Diagnostic Tests (RDTs) for screening and diagnosis of asymptomatic populations and travelers screening as it give a timely results within 10-30 minutes and expand the testing capacity per day.

The Second Protocol: Guidelines on Case Management of COVID-19"[2]":

Mild COVID-19: When there is no viral pneumonia or hypoxemia, the case is managed as follows:

- Isolation
- Test for endemic diseases in the area
- Symptomatic treatment with antipyretics, adequate nutrition, appropriate rehydration, close monitoring of patient with risk factors for severe disease, no antibiotics or therapeutic or prophylactic

Moderate COVID-19: When the case present with pneumonia with SPO_2 > 90%, then the management is as follows:

- No hospitalization
- Isolation is mandatory
- No antibiotic unless there is a clinical suspicion of bacterial infection
- Empirical treatment of children and older age with antibiotic for possible pneumonia

Severe COVID-19:

Adolescent and adult: The case present with severe pneumonia with SPO_2 < 90% or respiratory rate > 30 b/m.

Child present with clinical signs of pneumonia (cough or difficulty in breathing) + at least one of the following: Central cyanosis or SpO2 < 90%; severe respiratory distress; general danger sign:

inability to breastfeed or drink, lethargy or unconsciousness, or convulsions. Fast breathing (in breaths/min): < 2 months: ≥ 60; 2–11 months: ≥ 50; 1–5 years: ≥ 40

- Children and adult should receive O_2
- Manage RDS and septic shock
- Prevention and mange complications

Treatment Plans:

a. **Asymptomatic case**: Management consists of medical observation and monitoring of any expected symptoms.
b. **Moderate case:** Management consists of the following steps;

- Paracetamol tabs 1gm TDS
- Aspirin 75mg OD x 10 days
- Zinc Sulphate 20mg OD x10 days
- Vitamin C 400mg TDS x 10 days
- Azithromycin 500mg OD x 3 days
- Treat any underlying medical conditions

c. **Severe case:** Management consists of the following steps;

- Paracetamol tabs 1gm TDS
- Aspirin 75mg OD x 10 days
- Zinc sulphate 20mg OD x 10 days
- Vitamin c 400mg TDS x 10 days
- Azithromycin 500mg OD x 3 days
- Dexamethasone 4mg per oral as follows:
- 8mg loading dose
- 4 mg OD x10 days
- Nasal oxygen ventilation
- Treatment of any underlying medical conditions

d. **Critical case:** Management consists of the following steps;

- Paracetamol tabs 1gm TDS
- Aspirin 75mg OD x 10 days
- Zinc sulphate 20mg OD x 10 days

- Vitamin c 400mg TDS x 10 days
- Azithromycin 500mg OD x 3 days
- Dexamethasone 4mg per IM as follows:
- 8mg loading dose
- 4 mg OD x10 days
- Endotracheal oxygen ventilation
- Treatment of any underlying medical conditions

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The Third Protocol: Guidelines on Home care for COVID-19 Cases"[3]":

Purpose of the Guidance:

The aim of this protocol is to guide public health and infection prevention control professionals, health facility managers, health workers and other trained community – based providers when addressing issues related to home care for patients with suspected or confirmed COVID-19.

It is critical to ensure that caregivers have appropriate training and guidance on how to care for patients as well as how to minimize the risk of infection.

Decision to care for COVID-19 at home:

Hem care may be considered for an adult or child with confirmed or suspected COVID-19 when inpatient care is unavailable or unsafe as well for patients who have been discharged from hospital to continue management at home in necessary conditions.

The decision as to whether to isolate and care for an infected person at home depends on the following three factors:

1. Clinical evaluation of the COVID-19 patient
2. Evaluation of the home setting, and
3. The ability to monitor the clinical evolution of a person with COVID-19 at home.

According to the above evaluation, patients who are asymptomatic or those with mild or moderate disease without risk factors for poor outcome may not require hospitalization and could be suitable for home isolation and care.

Advices for health workers providing care in a private home:

1. Strict maintaining of IPC measures for health workers
2. Follow the guidelines on the clinical considerations for home-based care of patients with mild or moderate COVID-19 as detailed in the protocol.
3. Releasing COVID-19 patients from isolation at home:
    a. For asymptomatic patients; 10 days after testing positive.
    b. COVID-19 patients who receive home – based care or have been discharged from hospital should remain in isolation for a minimum of 10 days after symptom onset plus at least 3 additional days without symptoms especially fever and cough.
    c. Health workers need to establish a means of communicating with the caregivers of individuals with COVID-19 for the duration of the isolation period.
4. Management of contacts: Any person who has been exposed to a probable or confirmed case during the 2 days before and 14 days after the onset of symptoms, should be quarantined at home and monitor their health for 14 days from the last day of possible contact with the infected person.

Infection Prevention and Control for Caregivers providing care at home:

Caregivers, household members and individuals with probable or confirmed COVID-19 should receive guidance from trained health workers on how to adhere to the general IPC measures as well as the following specific ones:

1. Limit the patient's movement around the house and minimize shared spaces such as the kitchen and bathroom and keep them well ventilated and properly cleaned.
2. Household members should avoid entering the room where the patient is located and if it is not possible, then they should maintain a distance of at least 1 meter from the patient.
3. Limit the number of caregivers. Ideally; assign one person who is in good health and has no underlying chronic conditions.
4. Visitors should not be allowed in the home until the person has completely recovered, shows no signs or symptoms of COVID-19 and has been released from isolation.
5. Perform regular hand hygiene according to the WHO 5 moments.
6. A medical mask should be provided to the patient, must be worn as much as possible and should practice a rigorous respiratory etiquette.

7. Materials used to cover the mouth and nose should be discarded or cleaned appropriately after use.
8. Caregivers should wear a medical mask that covers their mouth and nose when they are in the patient's room.
9. Avoid direct contact with the patient's body fluid particularly oral or respiratory secretions.
10. Gloves and protective clothing such as plastic aprons should be used when cleaning surfaces or handling clothing or linen soiled with body fluids. Depending on the context; wear either utility or single – use gloves.
11. Clean and disinfect surfaces that are frequently touched in the room where the patient is being cared for, such as bedframes, tables and other bedroom furniture at least once daily.
12. Use dedicated linen and eating utensils for the patient; these items should be cleaned with soap and water after use and may be re-sued as needed.
13. Place contaminated linen in a laundry bag. Do not shake soiled laundry and avoid contaminated materials coming into contact with skin and clothes.
14. Clean the patient's clothes, bed linen and towels using regular laundry soap and water or machine wash at 60 – 90 ^{0}C with common household detergent and dry thoroughly.
15. After use, utility gloves should be cleaned with soap and water and decontaminated with 0.1% sodium hypochlorite solution. Perform hand hygiene after before putting and after removing gloves.
16. Waste generated at home while caring for COVID-19 patients during the recovery period should be packed in strong bags and closed completely before disposal and eventual collection by municipal waste service. If such a service does not exist, waste may be buried because burning is the least preferred option due to its harmful effect to human health and exacerbation of environmental pollution.
17. Avoid sharing contaminated items from the patient's immediate environment such as toothbrushes, cigarette, towels and bed linen and avoid any other forms of exposure to the patient.

The Fourth Protocol: Guidelines on Clinical Discharge from COVID-19 Isolation Centers"[4]:

This protocol is based on the revised WHO scientific briefing on the Criteria for Releasing COVID-19 Patients from Isolation which was released on June 17 June 2020. It considers the clinical condition and the time lapse instead of the PCR testing policy.

A. **The medical decision on discharging a COVID19 patient from an isolation center depends on the followings:**

1. The patient is not in any need of an ICU service especially oxygen ventilation or;
2. No any possibility of a clinical deterioration of the patient's condition.

The patient must be advised to continue following the quarantine measures at home for 14 days since being symptoms free. No PCR test will be required after the completion of this period.

B. The medical decision on discharging a COVID19 patient with mild or moderate symptoms from his/her self-isolation depends on the followings:

1. Fever free without antipyretics and improved respiratory symptoms such as cough and shortness of breath for at least 3 consecutive days and;
2. Completing 14 days since the beginning of symptoms.

No PCR test will be required after the completion of this period.

C. The medical decision on discharging a laboratory confirmed case of COVID 19 without symptoms from his/her self-isolation depends on the followings:

1. Lapse of 14 days since the first day of the laboratory test.

No PCR test will be required after the completion of this period.

N.B: Positive cases may still demonstrating positive results for a prolonged period but this doesn't indicate that they are infectious.

The Fifth Protocol: Guidelines on Safe Burial of COVID-19 Cases"[5]":

Criteria for team activation:

- Notification of possible COVID-19 death to Rapid Respond Team (RRT).
- National/state RRT investigators are activated.
- RRT or the case management partner to ensure sample to be taken. If not Team Leaders should be informed.
- Death notification and burial forms are issued by the authorized person in the RRT.
- Location of the burial site is identified.
- Incident manager or local authorities responsible for the dead body management authorize the team deployment.

Settings of COVID-19 Suspected or Confirmed Deaths:

Community death of a suspected or confirmed case of COVID-19

- Community members shall call the RRT – 6666.
- RRT shall collect a sample from the body to be sent to the laboratory for further testing / confirmation.
- The body should be prepared for burial as soon as possible (should not exceed 24 hours from death to the actual burial) under the strict supervision of the RRT or designated trained teams.
- **Embalming is not recommended to avoid excessive manipulation of the body.**
- In contexts where mortuary services are not standard or reliably available, or where it is usual for ill people to die at their home, families and traditional burial attendants can be equipped and educated to bury people under the supervision in accordance with the present SOPs.
- Any person (e.g. family member, religious leader) preparing the deceased (e.g. washing, cleaning or dressing the body, tidying hair, trimming nails or shaving) in a community setting should wear the following basic PPEs:

- Medical mask.
- Water resistant gown.
- Gloves.
- Eye protection.

- The burial can be done by the community members under the supervision/technical guidance of the RRT or designated trained teams either within the community (including home) or a designated burial site of the family's choice as long as the grave is marked properly.

Health facility death of a suspected or confirmed case of COVID-19:

- The medical personnel shall call the RRT– 6666.
- If the deceased is a confirmed case of COVID-19 then the body handling and burial will follow in compliance with the standard operating procedures.
- If the case is not confirmed but suspected and a sample not collected the RRT collects a sample from the body (to be sent to the laboratory for testing/confirmation), while the body is taken to the mortuary and kept until the lab result is issued.
- The sample should be prioritized in order to get the result within 24 hours.
- If the result is negative the usual burial procedures should apply.
- If the result is positive, the family shall be informed to either to come and collect the dead body for immediate burial (after IPC measures have been put in place) or immediate body handling and burial procedures shall be followed before the 24-hour-delay is over.

Death of an unidentified person suspected or confirmed case of COVID 19:

- Call the police forensics department who will collaborate with the RRT or other relevant authority to verify the body (identification).
- RRT shall collect a sample from the body (to be sent to the laboratory for testing/confirmation), while the body is taken to the mortuary and kept until the lab result is issued.

- The sample should be prioritized to get the result within 24 hours.
- If the result is negative the usual burial procedures should apply.
- If the result is positive, immediate burial procedures shall be followed after proper documentation is ensured. The documentation of unidentified dead bodies should be kept in a secure place (filling cabinet) to allow further verification with requests coming from families looking for their missing relatives.

Death of a suspected or confirmed case of COVID-19 in PoC:

Death at the community level (household level);

- Relatives of the deceased, key community members (including block/zone/sector leaders) and/or designated body management committees shall notify the designated agency conducting dead body management at the site (i.e. camp management agency).
- Designated agency shall coordinate for the burial of the body to be done as soon as possible and not exceed the 24-hour threshold.
- Embalming is not recommended to avoid excessive manipulation of the body.
- In contexts where mortuary services are not standard or reliably available, or where it is usual for ill people to die at home, families and traditional burial attendants can be equipped and educated to bury people under the proper supervision.
- The body handling team should handle suspect and confirmed deaths in the same manner to ensure the staff protection.
- Designated dead body management agency (camp management agency) shall contact case management team to collect the COVID-19 sample from the dead. Camp management agencies should ensure case management teams are briefed, prepared and equipped to carry out sample collection from dead persons. The sample should be taken to a laboratory for processing.
- **Note: burials should not wait for the test results. Burials should be conducted within 24 hours. If the test result is positive, contact tracing should be initiated.**

- Burials should be facilitated in the pre-identified burial site. **No designated site is required for suspected or confirmed COVID-19 cases; the same burial site used for common deaths can be used (usually located in close proximity to the PoC sites).**

Deaths at health facilities located within the PoC sites

- Death in the PoC health facility should follow the aforementioned health facility procedures.
- The body must be buried immediately following the recommended protection level of PPE and by using the usual burial site located outside of PoCs.

Should there be a morgue (holding area) available on-site in the PoC:

- The health actor in charge of health facility inside the POC shall transfer the dead body from the health facility to the morgue in the site.
- The health actor shall notify the designated dead body management agency (i.e. camp management agency) to arrange pick-up of the dead body from the morgue.
- Designated dead body management agency shall provide transportation of the dead body from the morgue to the burial site.

Should there be no morgue available on-site in the PoC:

- The health actor in charge of the health facility shall prepare the dead body and notify the designated dead body management agency.
- Designated dead body management agency shall arrange for collection and transportation of the dead body to the burial site.

Dead Body Management during partial or total lockdown scenarios in the PoC sites:

- Designated dead body management agencies should follow the same aforementioned procedures.
- Designated dead body management agencies shall ensure a dedicated vehicle, trained staff and protective equipment is available during this scenario to carry out burials.

Deaths of PoC populations occurred at critical care centers, health facilities and IDU:

- Should cases be referred to facilities located outside of the PoC sites and result in death, actor managing the treatment center must inform the PoC designated dead body management agency. It will ensure that the information is duly communicated to the relatives of the deceased.
- Body handling to be carried out by the actor managing the facility following the standard procedures.
- Prearrangements shall be made between the PoC designated dead body management agency and the actor managing the facility to identify the following procedures:
  - Transportation of the dead body from the facility to the burial site;
  - Threshold of time, in hours, during which the dead body will be kept at the facility.

Dead body of unconfirmed/unidentified cause/s coming from abroad:

The relevant legal procedures should be followed, and the dead body should be managed as a suspect COVID-19 case in order to ensure maximum protection of the personnel and family members involved in handling the body (with mandatory autopsy carried out).

Dead body of confirmed case of COVID-19 coming from abroad:

- The body to be prepared for burial as soon as possible within the time limit not exceeding 24 hours; embalming is not recommended avoiding excessive manipulation of the body.

General procedures:

12 steps for management of COVID-19 Cases:

Twelve steps have been identified describing the different phases burial teams have to follow in order to ensure safe and dignified burials, starting from the moment when the respective team arrives to the village up to their return to the hospital or team headquarters after burial and disinfection procedures being completed. These steps are based on tested experiences from previous infectious disease outbreaks and fatalities. The handling of human remains should be

kept to a minimum. Cultural and religious concerns must be always taken into account. Only trained personnel should be allowed to handle the remains during the outbreak.

It is worth noting that the burial process is very sensitive for the families of the deceased and their communities and as such can represent the source of resistance or even an open conflict. Before starting any procedure, the family must be fully informed about the dignified burial process and their religious and personal rights in order to show respect for the deceased.

The formal agreement of the family should be received prior to the burial.

No team activities / burial should begin until family agreement has been obtained.

Steps for safe and dignified burial:

Step 1: Prior to departure: Team composition and preparation of disinfectants

Step 2: Assemble all necessary equipment

Step 3: Arrival at deceased patient home: prepare burial with family and evaluate risks

Step 4: Put on all Personal Protective Equipment (PPE)

Step 5: Placement of the body in the body bag

Step 6: Placement of the body bag in a coffin where culturally appropriate

Step 7: Sanitize family's environment

Step 8: Remove PPE, manage waste and perform hand hygiene

Step 9: Transport the coffin or the body bag to the cemetery

Step 10: Burial at the cemetery: place coffin or body bag into the grave.

Step 11: Burial at the cemetery: engaging community.

Step 12: Return to the hospital or team headquarters.

The Sixth Protocol: Guidelines on Reopening of Institutions of Higher Education"[6]":

Background:

This protocol is an extract from the American CDC guidelines called "Consideration for Institutes of Higher Education" which was published on May 30th 2020. It is based on decline in the documented cases of COVID19, because the more an individual interacts with others and the longer that interaction, the higher the risk of COVID-19 spread.

The risk of COVID-19 spread increases in Institution of Higher Education non-residential (campus) and residential (housing) settings because of the interaction of huge number of individuals in a confined place.

The followings are the guiding principles in decision making to reopen institutions of higher education:

I. Institutions of Higher Education General Settings:

Lowest Risk: Faculty and students engage in virtual – only learning options including all activities and events.

Moderate Risk: Small in-person classes including activities and events. Individuals remained spaced at least 6 feet apart and do not share objects (e.g. hybrid virtual and in-person class structures or staggered/ rotated scheduling to accommodate smaller class sizes).

Highest Risk: Full – sized in-person classes, activities and events. Students are not spaced apart, share classroom materials or supplies and mix between classes and activities.

II. Institutions of Higher Education Accommodation and Housing Settings:

Lowest Risk: Residence halls/boarding is closed where feasible.

Moderate Risk: Residence halls are open at lower capacity and shared spaces are closed (e.g. kitchens, common areas).

Highest Risk: Residence halls are open at full capacity including shared spaces (e.g. kitchens, common areas).

III. Promoting behaviors that reduce COVID-19 spread:

1. Staying home or self – isolating when appropriate
2. Reinforcing hand hygiene and respiratory etiquette
3. Cloth face mask coverings
4. Provision of adequate food supplies
5. Provision of awareness signs and messages

IV. Maintaining Healthy Environments:

1. Maintain campus cleaning and disinfection
2. Discourage shared objects
3. Ensure ventilation systems operate properly and increase circulation of outdoor air as much as possible.
4. Maintain safe water systems
5. Install physical barriers and guides
6. Close shared spaces
7. Maintain take away food services

V. Maintain Healthy Operations:

1. Protections for students, faculty and staff from COVID- 19
2. Be aware of existing regulatory awareness messages
3. Control gatherings
4. Encourage telework and virtual meetings
5. Limit travel and transit/ visiting staff
6. Designate a COVID-19 point of contact.
7. Participation in national response efforts
8. Put in place proper communication systems.

VI. Toilets:

1. Toilets inside or linked to campuses and staff compounds should be kept open and carefully managed to reduce the risk of transmission of COVID-19.
2. Make hand sanitizer available on entry to toilets where safe and practical, and ensure suitable hand-washing facilities including running water and liquid soap and suitable options for drying are available.
3. Communal towels should be removed and replaced with single use paper towels.

4. Keep the facilities well ventilated, for example by fixing doors open where appropriate and safe to do so.
5. Putting up a visible cleaning schedule that is kept up to date and visible.
6. Providing more waste facilities and more frequent refuse collection.

VII. General Cleaning:

1. All surfaces, especially those most frequently touched such as door handles and rails, should be regularly cleaned using standard cleaning products.
2. Sufficient time needs to be allowed for this cleaning to take place, particularly before reopening for the first time.
3. Frequently used objects, surfaces or spaces, including for example doorways between outside and inside spaces should be given particular attention when cleaning.

VIII. Face coverings and masks:

1. Face coverings are currently mandatory on public transport, shops and in other public places of gatherings.
2. People are encouraged to wear face coverings in enclosed public spaces where there are people they do not normally meet, such as offices, classes and places of worship.

IX. Prepare for when someone gets sick:

1. Prepare testing centers
2. Prepare isolation centers
3. Provide ambulances for medical evacuation

X. Prepare for a second wave:

1. Get ready for an early detection of a new outbreak
2. Be prepared for an immediate closure
3. Maintain communication with the national taskforce

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Check List on Reopening of Institutions of Higher Education

1. Institutions of Higher Education General Settings:

Lowest Risk	Moderate Risk	Highest Risk

2. Institutions of Higher Education Housing and Accommodation Settings:

Lowest Risk	Moderate Risk	Highest Risk

3. Promoting behaviors that reduce COVID-19 spread:

S/No.	Activity	Yes	No	Not Sure
1.	When necessary; staying home or self-isolation is reinforced			
2.	Hand hygiene and respiratory etiquette is reinforced			
3.	Cloth face mask coverings is observed			
4.	Take-away food supplies are availed			
5.	Awareness signs and messages are provided			

4. Maintaining Healthy Environments:

S/No.	Activity	Yes	No	Not Sure
1.	Campus cleaning and disinfection is maintained			
2.	Shared objects are discouraged			
3.	Ventilation systems operate properly			
4.	Safe water systems is maintained			
5.	Physical barriers and guidelines are installed			
6.	Shared spaces are closed			

5. Maintaining Healthy Operations:

S/No.	Activity	Yes	No	Not Sure
1.	Regulatory awareness messages are displayed			
2.	Gatherings are controlled			
4.	Telework and virtual meetings are encouraged			
5.	Traveling and transit/ visiting staff are limited			
6.	A COVID-19 focal point of contact is designated			
7.	The institution is participating in the national response efforts			

8.	Proper communication system with the National Taskforce available			

6. **General Hygiene:**

S/No.	Activity	Yes	No	Not Sure
1.	Hand sanitizers/washing facilities are provided at the entrances			
2.	Awareness signs and posters are available.			

7. Toilets:

S/No.	Activity	Yes	No	Not Sure
1.	Toilets are carefully and regularly cleaned			
2.	Hand sanitizers are available on entry to toilets			
3.	Communal towels are replaced with single use paper towels			
4.	Toilets are well ventilated			
5.	A visible cleaning schedule of the toilet is put in place			
6.	Waste facilities and refuse collection are provided.			

8. Face coverings and masks:

S/No.	Activity	Yes	No	Not Sure
1.	Face coverings/ masks are worn in closed spaces			

9. Preparedness for when someone gets sick:

S/NO.	**Activity**	Yes	No	Not Sure
1.	Testing centers are available			
2.	Isolation centers are prepared			
3.	Ambulances for medical evacuation are provided			

10. Preparedness for a second wave:

S/NO.	Activity	Yes	No	Not Sure
1.	Institution is ready for an early detection of a new outbreak			
2.	Institution is prepared for an immediate closure			
3.	Institution is maintaining communication with the national taskforce			

11. Enforcement:

S/No.	Activity	Yes	No	Not Sure
1.	Measures enforcement personnel are identified			

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The Seventh Protocol: Guidelines on Reopening of Places of Worship"7":

I. Background:

This protocol is extracted from the guidance for the safe use of places of worship during COVID19 Pandemic published by the UK Government on July 4th 2020.

II. Purpose of this protocol:

This guidance is designed to assist places of worship to prepare to open for a broad range of worship activities. The guidance sets out how this can be done in a manner that is COVID-19 secure and in line with social distancing guidelines, in order to minimize the risk of exposure to infection.

III. Definition:

Place of worship includes a confined or enclosed space within buildings or outdoors which is used for religious ceremonies such, collective prayer and worship or similar gatherings such as churches and mosques etc.

IV. Introduction:

The entire world is currently experiencing a public health emergency as a result of the Coronavirus (COVID-19) pandemic. The transmission of COVID-19 occurs mainly through

respiratory droplets generated by coughing and sneezing, and through contact with contaminated surfaces. Places of worship play an important role in providing spiritual leadership for many individuals and in bringing communities and generations together. However, their communal nature also makes them places that are particularly vulnerable to the spread of COVID-19. Consideration should be given to how fair and equal access can safely be provided for all users to be able to undertake faith practices within a place of worship.

This guidance for places of worship has been drafted on the basis of the scientific evidence available and will be updated as necessary as more data becomes available on this novel virus.

V. Preparing the building for use:

In order to ensure that those who are attending the place of worship are able to adhere to the Protocol on reopening places of worship; the setting of places of worship should ensure the followings:

1. Maintaining the distance of 2 meters between every person except between two members of the same household.
2. Maintain proper open ventilation.
3. The necessary actions to mitigate any risks identified in the risk assessment are in place.
4. Avoid congregating in confined spaces.
5. Identifying entry and exit points and a one way system within the building
6. Closing off unused areas.
7. Preparedness for an adverse eventuality.

VI. Permitted use for places of worship:

1. Private prayer by individual or household members not more than 30 individuals.
2. Remote services through broadcasting.
3. Marriage ceremonies attended by a congregation not more than 30 individuals.
4. Funeral services for not more than 30 individuals.
5. Provision of voluntary services.
6. Meetings or small gatherings.

VII. Adapting practices to reduce the spread of infection:

Religious leaders should adopt this guidance and seek to include additional changes that could be made to their religious rituals that usually involve close contact and shared items between individuals.

Places of worship and faith communities should adapt religious services, especially where ceremonies would otherwise have taken place over a number of hours or days, to ensure the safety of those present and minimize spread of infection.

1. It is advised that the ceremonies and services should be concluded in the shortest reasonable time.
2. Once completed, participants should be encouraged to move on promptly, to minimize the risk of contact and spread of infection.
3. If appropriate, you should reconfigure spaces to enable worshippers to be seated rather than standing which reduces the risk of contact.
4. Worshippers should limit their interactions with anyone they are not attending the Place of Worship with, i.e. if they are attending a communal service with one other household, wherever possible they should try not to engage in conversation with anyone outside of this group.
5. It is recommended that, where possible, places of worship continue to stream worship or other events to avoid large gatherings and to continue to reach those individuals who are self-isolating or particularly vulnerable to COVID-19.
6. Individuals should be prevented from touching or kissing objects that are handled communally. Barriers and/or clear signage should be put in place where necessary to avoid this taking place.
7. Individuals should also avoid touching property belonging to others such as shoes which, if removed, should be placed and collected by their owner while adhering to social distancing principles.
8. Reusable and communal resources such as prayer mats, service sheets, religious texts or devotional material should be removed from use. Single use alternatives should be provided as long as they are removed and disposed of by the worshipper.
9. Items owned by the individual to aid worship such as a prayer mat or religious text, can be brought in but should be removed again by the worshipper.

10. In circumstances where worshippers cannot bring their own books, places of worship should keep a selection of clean books for individuals to use.
11. Clean books should be quarantined for 48 hours since their previous use and should be quarantined for 48 hours again after use. Items which cannot be easily cleaned should also be subject to the 48 hour quarantine after use.

VIII. Food and Drink:

1. Where food or drink 'consumables' are essential to the act of worship, they can be used, however the sharing of food should be avoided, as should the use of communal vessels.
2. If it is necessary to handle consumables as a part of a faith practice, those giving and receiving food items should wash their hands thoroughly before and after consumption, or wear gloves.
3. The person distributing the consumable should release it, into the hand only, in such a way to avoid any contact between them and those receiving it, or wear gloves. If accidental contact does occur, both people should cleanse their hands immediately.
4. Other actions taken to reduce the risk of transmission should also be considered, for example, foodstuffs should be pre-wrapped, and a system should be in place to prevent individuals from coming into contact with consumables and any dishes other than their own.
5. Hospitality spaces within a place of worship, such as cafes, are permitted to open but should be limited to table-service, social distancing should be observed, and with minimal staff and customer contact.

IX. Singing, chanting and the use of musical instruments:

1. Worshipers are advised only to play musical instruments that are not blown into. Organs can be played for faith practices, as well as general maintenance, but should be cleaned thoroughly before and after use.
2. Speaking, singing and chanting should not happen across uncovered consumables. Instead consumables should be securely covered, and prior to the receptacle being opened, it should be cleaned, hands should be washed or gloves worn.

X. Weddings and other life cycle events:

1. It is strongly advised that only essential aspects of the ceremonies take place at this time.

2. No food or drink should be consumed as a part of the event unless required for the purposes of solemnization.
3. Weddings should have no more than 30 people present.
4. Other life cycle ceremonies should also have no more than 30 people present, unless the event is part of a routine communal worship service.
5. Worshippers should maintain social distancing.
6. Large wedding receptions or parties should not take place after life cycle events.
7. If anyone is considering arranging an event for more than 30 people in a public outdoor space they should liaise with those responsible for the open space in question to ensure that the event can be staged in a safe way, which includes undertaking a risk assessment that considers security.

XI. Use of water:

1. Any pre-requisite washing/ablution rituals should not be done at the place of worship but carried out prior to arrival.
2. In rare circumstances where it is necessary, washing facilities within the place of worship should be used in line with social distancing guidelines and hygiene measures applied.
3. People should not wash the body parts of others.
4. Where rituals or ceremonies require water to be applied to the body, small volumes can be splashed onto the body, but full immersion should be avoided.
5. Others present should move out of range of any potential splashing.
6. Where an infant is involved a parent/guardian or other member of the infant's regular household should hold the infant.
7. All individuals involved should thoroughly wash their hands before and after and ensure good hygiene.

XII. Cash donations:

1. Where possible faith leaders should discourage cash donations and continue to use online or contactless giving and resources.
2. Where this is not an option, cash should be collected in a receptacle that is set in one place and handled by one individual, as opposed to being passed around.
3. Regular cleaning and hygiene should be maintained, and gloves worn to handle cash offerings where giving continues.

XIII. Young people and children attending places of worship:

1. Young children should be supervised by the parent or guardian. They should wash hands thoroughly for 20 seconds with running water and soap and dry them thoroughly or use hand sanitizer ensuring that all parts of the hands are covered.
2. Places of worship can help remind children and young people, and their parents and guardians; of the important actions they should take during the COVID-19 outbreak to help prevent the spread of the virus.
3. Any shared facilities for children, such as play corners, soft furnishings, soft toys and toys that are hard to clean, should be removed and/or put out of use.
4. Outdoor playgrounds are permitted to open where venue managers risk assess that it is safe to do so.
5. Particular attention should be paid to cleaning frequently touched surfaces by children and those that are at child height.

XIV. Social distancing:

1. Remember that social distancing measures are actions to reduce social interaction between people in order to minimize the opportunity for transmission of COVID-19.
2. Queue management is important so the flow of groups in and out of the premises can be carefully controlled in a socially distanced way, reducing the risk of congestion or contact. Considerations should be made for how to manage those waiting outside a place of worship, including the introduction of socially distanced queuing systems.
3. All religious practices should be carried out such that adherence to social distancing can be maintained between individuals from different households.
4. Those leading the worship reminding congregants of the importance of social distancing and hygiene.
5. Introducing a one-way flow in and out of the premises with appropriate floor markings or signage, with restrictions on accessing non-essential areas. At the end of worship, this could include worshippers leaving one row at a time, in order to prevent crowding at entry or exit points.
6. Multiple entry points could be opened, and clear signposting or assistance could be offered to guide worshippers and to avoid congestion.

7. Staggering arrival and departure times will reduce the flow at exits and entrances as well as reduce any impacts on public transport. Venues could also consider introducing a booking system to help facilitate this. You may want to consider how prioritization could be given to people who may have a specific need or requirement.
8. Using screens, barriers or alternative rooms and spaces to separate worshippers.
9. Any changes to entrances, exits and queues should take into account reasonable adjustments to accommodate those who need them, such as worshippers with physical disabilities.
10. Introducing a booking system to help with managing numbers, particularly for services where demand will be high.
11. Venue managers advertising set days or times when places of worship are open solely for those particularly vulnerable to COVID-19, such as those over 70 or clinically vulnerable.
12. Leading worship in different spaces of the place of worship to limit the number of people in any one location - while avoiding risk of crowding at entry/exit points.
13. Where social distancing cannot be maintained, extra attention needs to be paid to cleaning and hygiene to reduce the risk of transmission. Consider how well ventilated the venue is and improve this where possible, for example by fixing doors open where appropriate.
14. Following the guidance on hand hygiene:
15. Wash your hands more often than usual, for 20 seconds using soap and water or hand sanitizer, particularly after coughing, sneezing and blowing your nose, or after being in public areas.
16. When you cough or sneeze, cover your mouth and nose with a tissue, or the crook of your sleeved arm (not your hands) if you don't have a tissue, and throw the tissue away hygienically immediately afterwards. Then wash your hands thoroughly for at least 20 seconds using soap and water or hand sanitizer if hand washing facilities are not available.
17. The above advice on social distancing also applies when travelling to and from a place of worship.

XV. People who are symptomatic:

1. Anyone showing symptoms of COVID-19 such as a new continuous cough, a high temperature or a loss of, or change in, their normal sense of taste or smell; should not

attend the place of worship due to the risk that they pose to others; they should self-isolate at home immediately with other members of their household.

XVI. General Hygiene:

1. On entering and leaving a place of worship, everyone, including staff, should be asked to wash their hands thoroughly for at least 20 seconds using soap and water or to use hand sanitizer if hand washing facilities are not available.
2. There should be signs and posters to build awareness of good hand-washing technique, the need to increase hand-washing frequency, avoid touching your face and to cough or sneeze into a tissue which is binned safely or into the crook of your sleeved arm if a tissue is not available.
3. Provide hand sanitizer in multiple locations in addition to toilet facilities.

XVII. Toilets:

7. Toilets inside or linked to places of worship should be kept open and carefully managed to reduce the risk of transmission of COVID-19.
8. Make hand sanitizer available on entry to toilets where safe and practical, and ensure suitable hand-washing facilities including running water and liquid soap and suitable options for drying are available.
9. Communal towels should be removed and replaced with single use paper towels.
10. Keep the facilities well ventilated, for example by fixing doors open where appropriate and safe to do so.
11. Putting up a visible cleaning schedule that is kept up to date and visible.
12. Providing more waste facilities and more frequent refuse collection.

XVIII. General Cleaning:

4. All surfaces, especially those most frequently touched such as door handles and rails, should be regularly cleaned using standard cleaning products.
5. Sufficient time needs to be allowed for this cleaning to take place, particularly before reopening for the first time.
6. Frequently used objects, surfaces or spaces, including for example doorways between outside and inside spaces should be given particular attention when cleaning.

XIX. Face coverings and masks:

3. Face coverings are currently mandatory on public transport, shops and in other public places of gatherings.
4. People are encouraged to wear face coverings in enclosed public spaces where there are people they do not normally meet, such as a place of worship.

XX. Protecting the vulnerable:

1. There should be a particular focus on protecting people who are clinically vulnerable and more likely to develop severe illness.
2. Certain groups of people may be at increased risk of severe disease from COVID-19, including people who are aged 70 or older, regardless of medical conditions.
3. Individuals who fall within this group are advised to stay at home as much as possible and, if they do go out, to take particular care to minimize contact with others outside of their household.

XXI. Risk assessment for protective security - factors to consider:

1. A risk assessment that considers protective security should be conducted in addition to, or as part of, any health and safety/ fire safety or other broader assessment of the hazards and threats to the people in and around the place of worship as a result of changes made to how that place of worship functions.

XXII. Staff, security officers/ volunteers and stewarding:

1. It is vital for staff to remain vigilant and act on potential security threats including terrorism and wider criminality.
2. Continue to ensure that awareness of security threats is raised alongside health and safety risks through staff briefings.
3. Whilst stewards, and in some cases security officers, may be focused on managing people and queues for COVID-19 safety reasons, they should continue to remain vigilant for and report any suspicious activity as soon as possible.
4. Consider having separate stewarding for managing social distancing and health and safety aspects, and for security as this will allow proper due attention to be given to keeping the site safe from threats.
5. Ensure there is a good communication system in place to inform people of any incident.

XXIII. Enforcement:

1. It is important to be aware of the enforcement provisions, as is the case for other sectors.

2. Identify responsible individuals who are not taking action to comply with the relevant public health guidance to control public health who will consider taking a range of actions to improve control of risks.

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Check List on Reopening of Places of Worship:

1. Preparing the place of worship for reopening:

S/No.	Activity	Yes	No	Not Sure
1.	Risk assessment of the place is done			
2.	Distance of 2 meters is maintained between individuals			
3.	Proper open ventilation is maintained in the building			
4.	Congregating in confined places is avoided			
5.	Entry and exit points are identified within the building			
6.	Unused areas are closed off			
7.	Preparedness for an adverse eventuality is maintained.			

2. Promoting behaviors that reduce COVID-19 spread:

S/No.	Activity	Yes	No	Not Sure
1.	Staying home or self-isolating when appropriate is reinforced			
2.	Hand hygiene and respiratory etiquette is reinforced			
3.	Cloth face mask covering is observed			
4.	Communal food and drinks are discouraged			
5.	Awareness signs and messages are provided			

3. Maintaining Healthy Environments:

S/No.	Activity	Yes	No	Not Sure
1.	General cleaning and disinfection is maintained			
2.	Shared objects are discouraged			
3.	Ventilation systems operate properly			

4.	Safe water systems is maintained			
5.	Physical barriers and guidelines are installed			
6.	Shared spaces are closed			
7.	Instruments, books and podiums are disinfected regularly			

4. Maintaining Healthy Operations:

S/No.	Activity	Yes	No	Not Sure
1.	Clergy and congregation are protected from COVID- 19			
2.	Regulatory awareness messages are displayed			
3.	Gatherings are controlled			
4.	Telework and virtual meetings are encouraged			
5.	Visiting and transit clergy are limited			
6.	A COVID-19 focal-point of contact is designated.			
7.	Participation in national response efforts is maintained			
8.	Proper communication systems is put in place			

5. Toilets:

S/No.	Activity	Yes	No	Not Sure
1.	Toilets are carefully and regularly cleaned			
2.	Hand sanitizers are available on entry to toilets			
3.	Communal towels are replaced with single use paper towels			
4.	Toilets are well ventilated			
5.	A visible cleaning schedule of the toilet is put in place			
6.	Waste facilities and refuse collection are provided.			

6. Face coverings and masks:

S/No.	Activity	Yes	No	Not Sure
1.	Face coverings/ masks are worn in closed spaces			

7. **Preparedness for when someone gets sick:**

S/NO.	Activity	Yes	No	Not Sure
1.	Testing centers are prepared			
2.	Isolation centers are prepared			
3.	Ambulances for medical evacuation are provided			

8. **Preparedness for a second wave:**

S/NO.	Activity	Yes	No	Not Sure
1.	Institution is ready for an early detection of a new outbreak			
2.	Institution is prepared for an immediate closure			
3.	Institution is maintaining communication with the national taskforce			

9. **Enforcement:**

S/No.	Activity	Yes	No	Not Sure
1.	Measures enforcement personnel are identified			

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The Eighth Protocol: Guidelines for Healthcare Personnel Prevention and Control"7":

Background

As healthcare facilities begin to relax restrictions on healthcare services provided to patients in accordance with guidance from national taskforce, there are precautions that should remain in place as a part of the ongoing response to the COVID-19 pandemic.

These recommendations have been organized into the following two sections:

- Recommended infection prevention and control (IPC) practices for routine healthcare delivery during the pandemic.
- Recommended (IPC) practices when caring for a patient with suspected or confirmed SARS-CoV-2 infection

Definitions:

- **Healthcare Personnel (HCP):** HCP refers to all paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or infectious materials, including body substances such as blood, tissue and body fluids; contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air.
- **Source Control:** Use of cloth face coverings or facemasks to cover a person's mouth and nose to prevent spread of respiratory secretions when they are talking, sneezing, or coughing. Facemasks and cloth face coverings should not be placed on children under age 2, anyone who has trouble breathing, or anyone who is unconscious, incapacitated, or otherwise unable to remove the mask without assistance.
- **Cloth faces covering:** Textile covers that are intended for source control.
- **Facemask:** Facemasks are PPE and are often referred to as surgical masks or procedure masks. Use facemasks according to product labeling and local, state, and federal requirements.
- **Respirator:** A respirator is a personal protective device that is worn on the face, covers at least the nose and mouth, and is used to reduce the wearer's risk of inhaling hazardous airborne particles including dust particles and infectious agents, gases, or vapors.
- **Substantial community transmission:** Large scale community transmission, including communal settings such as schools and workplaces.
- **Minimal to moderate community transmission:** Sustained transmission with high likelihood or confirmed exposure within communal settings and potential for rapid increase in cases.
- **No to minimal community transmission:** Evidence of isolated cases or limited community transmission, case investigations underway; no evidence of exposure in large communal setting.

1. Recommended routine infection prevention and control (IPC) practices during the COVID-19 pandemic:

The MAP recommends using additional infection prevention and control practices during the COVID-19 pandemic, along with the standard practices recommended as a part of routine healthcare delivery to all patients.

These additional practices include:

a. **Implement Nurse -Directed Triage Protocols: Patients** should put on cloth face covering before entering the health facility.

b. **Screen and Triage Everyone Entering a Healthcare Facility for Signs and Symptoms of COVID-19 by:**

- Limit and monitor points of entry to the facility.
- Consider establishing screening stations outside the facility to screen individuals before they enter
- Screen everyone (patients, HCP, visitors) entering the healthcare facility for symptoms consistent with COVID-19 or exposure to others with SARS-CoV-2 infection and ensure they are practicing source control.
    - Actively take their temperature and document absence of symptoms consistent with COVID-19. Fever is either measured temperature ≥100.0°F or subjective fever.
    - Ask them if they have been advised to self-quarantine because of exposure to someone with SARS-CoV-2 infection.
- Properly manage anyone with symptoms of COVID-19 or who has been advised to self-quarantine:
    - HCP should return home and should notify emergency services personnel to arrange for further evaluation.
    - Visitors should be restricted from entering the facility.
    - Patients should be isolated in an examination room with the door closed.

- If an examination room is not immediately available, such patients should not wait among other patients seeking care.

c. **Re-evaluate admitted patients for signs and symptoms of COVID-19:**

All fevers and symptoms consistent with COVID-19 among admitted patients should be properly managed and evaluated.

d. **Implement Universal Source Control Measures:**

Source control refers to use of cloth face coverings or facemasks to cover a person's mouth and nose to prevent spread of respiratory secretions when they are talking, sneezing, or coughing.

- HCP should wear a facemask at all times while they are in the healthcare facility, **including in break rooms or other spaces where they might encounter co-workers**.
- Educate patients, visitors, and HCP about the importance of performing hand hygiene immediately before and after any contact with their facemask or cloth face covering.

e. **Encourage Physical Distancing:**

- Limiting visitors to the facility to those essential for the patient's physical or emotional well-being and care.
- Scheduling appointments to limit the number of patients in waiting rooms.
- Arranging seating in waiting rooms so patients can sit at least 2m apart.
- Modifying in-person group healthcare activities by implementing virtual methods or scheduling smaller in-person group sessions while having patients sit at least 2m apart.
- Reminding HCP that the potential for exposure to SARS-CoV-2 is not limited to direct patient care interactions.
- Emphasizing the importance of source control and physical distancing in non-patient care areas.
- Providing family meeting areas where all individuals (e.g., visitors, HCP) can remain at least 2m apart from each other.

- Designating areas for HCP to take breaks, eat, and drink that allow them to remain at least 2m apart from each other, especially when they must be unmasked.

f. **Implement Universal Use of Personal Protective Equipment:**

- HCP working in facilities located in areas with moderate to substantial community transmission are more likely to encounter asymptomatic or pre-symptomatic patients with SARS-CoV-2 infection, hence; they should:
    - Wear eye protection in addition to their facemask to ensure the eyes, nose, and mouth are all protected from exposure to respiratory secretions during patient care encounters.
    - Wear an N95 or equivalent respirator instead of a facemask for procedures that might pose higher risk for transmission if the patient has COVID-19.
- For HCP working in areas with minimal to no community transmission, universal use of a facemask for source control is recommended.

g. Consider Performing Targeted SARS-CoV-2 Testing of Patients without Signs or Symptoms of COVID-19.

h. Consider if elective procedures, surgeries, and non-urgent outpatient visits should be postponed in certain circumstances.

i. Optimize the use of engineering controls to reduce or eliminate exposures by shielding HCP and other patients from infected individuals.

Examples of engineering controls include:

- Physical barriers and dedicated pathways to guide symptomatic patients through triage areas.
- Remote triage facilities for patient intake areas.
- If climate permits, outdoor assessment and triage stations for patients with respiratory symptoms.
- Vacuum shrouds for surgical procedures likely to generate aerosols.

    - Reassess the use of open bay recovery areas.
- Explore options to improve indoor air quality in all shared spaces.

j. Create a Process to Respond to SARS-CoV-2 Exposures among HCP and others, the plan should address the following:

- Who is responsible for identifying contacts and notifying potentially exposed individuals?
- How will such notifications occur?
- What actions and follow-up are recommended for those who were exposed?
- Contact tracing should be carried out in a way that protects the confidentiality of affected individuals and is consistent with applicable laws and regulations.
- Healthcare facilities must be prepared for potential staffing shortages and have plans and processes in place to mitigate these, including providing resources to assist HCP with anxiety and stress.

2. Recommended infection prevention and control (IPC) practices when caring for a patient with suspected or confirmed SARS-CoV-2 infection:

- Establish Reporting within and between Healthcare Facilities and to Public Health Authorities

- Implement mechanisms and policies that promote situational awareness for facility staff including infection control, healthcare epidemiology, facility leadership, occupational health, clinical laboratory, and frontline staff about patients with suspected or confirmed SARS-CoV-2 infection and facility plans for response.
- Communicate and collaborate with public health authorities.

Patient Placement:

- For patients with COVID-19 or other respiratory infections, evaluate need for hospitalization. If hospitalization is not medically necessary, home care is preferable if the individual's situation allows.

- If admitted, place a patient with suspected or confirmed SARS-CoV-2 infection in a single-person room with the door closed. The patient should have a dedicated bathroom.
- Airborne Infection Isolation Rooms (AIIRs) should be reserved for patients who will be undergoing aerosol generating procedures.
- Personnel entering the room should use PPE as described below.
- As a measure to limit HCP exposure and conserve PPE, facilities could consider designating entire units within the facility, with dedicated HCP, to care for patients with suspected or confirmed SARS-CoV-2 infection.
- To the extent possible, patients with suspected or confirmed SARS-CoV-2 infection should be housed in the same room for the duration of their stay in the facility.
- Limit transport and movement of the patient outside of the room to medically essential purposes.
- Communicate information about patients with suspected or confirmed SARS-CoV-2 infection to appropriate personnel before transferring them to other departments in the facility and to other healthcare facilities.
- Patients should wear a facemask or cloth face covering to contain secretions during transport.
- If patients cannot tolerate a facemask or cloth face covering or one is not available, they should use tissues to cover their mouth and nose while out of their room.
- Once the patient has been discharged or transferred, HCP, including environmental services personnel, should refrain from entering the vacated room until sufficient time has elapsed for enough air changes to remove potentially infectious particles.
- After this time has elapsed, the room should undergo appropriate cleaning and surface disinfection before it is returned to routine use.

Personal Protective Equipment "PPEs":

- **Hand Hygiene:**
    - HCP should perform hand hygiene before and after all patient contact, contact with potentially infectious material, and before putting on and after removing PPE, including gloves. Hand hygiene after removing PPE is particularly important

to remove any pathogens that might have been transferred to bare hands during the removal process.
    - HCP should perform hand hygiene by using ABHS with 60-95% alcohol or washing hands with soap and water for at least 20 seconds. If hands are visibly soiled, use soap and water before returning to ABHS.
    - Healthcare facilities should ensure that hand hygiene supplies are readily available to all personnel in every care location.
- **Personal Protective Equipment Training:**
  Employers should select appropriate PPE and provide it to HCP in accordance with PPE standards (29 CFR 1910 Subpart I).
- HCP must receive training on and demonstrate an understanding of:
    - When to use PPE
    - What PPE is necessary
    - How to properly use PPE in a manner to prevent self-contamination
    - How to properly dispose of or disinfect and maintain PPE
    - The limitations of PPE.

Any reusable PPE must be properly cleaned, decontaminated, and maintained after and between uses.

Facilities should have policies and procedures describing a recommended sequence for safely donning and doffing PPE.

The PPE recommended when caring for a patient with suspected or confirmed COVID-19 includes the following:

- **Respirator or Facemask:** Cloth face coverings are NOT PPE and should not be worn for the care of patients with suspected or confirmed COVID-19 or other situations where use of a respirator or facemask is recommended.
    - Put on an N95 respirator or facemask before entry into the patient room or care area, if not already wearing one as part of extended use. Other respirators include

other disposable filtering face piece respirators, powered air purifying respirators (PAPRs), or elastomeric respirators.
    - N95 respirators or respirators that offer a higher level of protection should be used instead of a facemask when performing or present for an aerosol generating procedure.
    - Disposable respirators and facemasks should be removed and discarded after exiting the patient's room or care area and closing the door unless implementing extended use or reuse.
    - Perform hand hygiene after removing the respirator or facemask.
    - When the supply chain is restored, facilities with a respiratory protection program should return to use of respirators for patients with suspected or confirmed SARS-CoV-2 infection.
    - Those that do not currently have a respiratory protection program, but care for patients with pathogens for which a respirator is recommended, should implement a respiratory protection program.
- **Eye Protection:**
    - Put on eye protection (i.e., goggles or a face shield that covers the front and sides of the face) upon entry to the patient room or care area, if not already wearing as part of extended use.
    - Ensure that eye protection is compatible with the respirator so there is not interference with proper positioning of the eye protection or with the fit or seal of the respirator.
    - Remove eye protection after leaving the patient room or care area, unless implementing extended use.
    - Reusable eye protection must be cleaned and disinfected according to manufacturer's reprocessing instructions prior to re-use.
    - Disposable eye protection should be discarded after use unless following protocols for extended use or reuse.
- **Gloves:**
    - Put on clean, non-sterile gloves upon entry into the patient room or care area.
    - Change gloves if they become torn or heavily contaminated.

    - Remove and discard gloves before leaving the patient room or care area, and immediately perform hand hygiene.
- **Gowns:**
    - Put on a clean isolation gown upon entry into the patient room or area. Change the gown if it becomes soiled.
    - Remove and discard the gown in a dedicated container for waste or linen before leaving the patient room or care area.
    - Disposable gowns should be discarded after use.
    - Cloth gowns should be laundered after each use.
    - Facilities should work with their health ministries and healthcare coalition to address shortages of PPE.

Aerosol Generating Procedures (AGPs):

- Some procedures performed on patients with suspected or confirmed SARS-CoV-2 infection could generate infectious aerosols.
- Procedures that pose such risk should be performed cautiously and avoided if possible.

Collection of Diagnostic Respiratory Specimens:

- When collecting diagnostic respiratory specimens (e.g., nasopharyngeal or nasal swab) from a patient with possible SARS-CoV-2 infection, the following should occur:
    - Specimen collection should be performed in a normal examination room with the door closed.
    - HCP in the room should wear an N95 or equivalent or higher-level respirator or facemask if a respirator is not available, eye protection, gloves, and a gown.
    - If respirators are not readily available, they should be prioritized for other procedures at higher risk for producing infectious aerosols (e.g., intubation), instead of for collecting diagnostic respiratory specimens.
    - The number of HCP present during the procedure should be limited to only those essential for patient care and procedure support.
    - Visitors should not be present during specimen collection procedures.

- Clean and disinfect procedure room surfaces promptly as described in the section on environmental infection control below.

Manage Visitor Access and Movement within the Facility:

- Limit visitors to the facility to only those essential for the patient's physical or emotional well-being and care.
- Encourage use of alternative mechanisms for patient and visitor interactions such as video-call applications on cell phones or tablets.
- If visitation to patients with SARS-CoV-2 infection occurs, visits should be scheduled and controlled to allow for the following:
  - Facilities should evaluate risk to the health of the visitor (e.g., visitor might have underlying illness putting them at higher risk for COVID-19) and ability to comply with precautions.
  - Facilities should provide instruction, before visitors enter patients' rooms, on hand hygiene, limiting surfaces touched, and use of PPE according to current facility policy while in the patient's room.
  - Visitors should not be present during AGPs or other procedures.
  - Visitors should be instructed to only visit the patient room. They should not go to other locations in the facility.

Environmental Infection Control:

- Dedicated medical equipment should be used when caring for patients with suspected or confirmed SARS-CoV-2 infection.
  - All non-dedicated, non-disposable medical equipment used for patient care should be cleaned and disinfected according to manufacturer's instructions and facility policies.
- Ensure that environmental cleaning and disinfection procedures are followed consistently and correctly.
- Routine cleaning and disinfection procedures (e.g., using cleaners and water to pre-clean surfaces prior to applying an EPA-registered, hospital-grade disinfectant to frequently

touched surfaces or objects for appropriate contact times as indicated on the product's label) are appropriate for SARS-CoV-2 in healthcare settings, including those patient-care areas in which aerosol generating procedures are performed.

- Management of laundry, food service utensils, and medical waste should also be performed in accordance with routine procedures.

Information about Airborne Infection Isolation Rooms (AIIRs):

- AIIRs are single-patient rooms at negative pressure relative to the surrounding areas, and with a minimum of 6 air changes per hour (12 air changes per hour are recommended for new construction or renovation).
- Air from these rooms should be exhausted directly to the outside or be filtered through a high-efficiency particulate air (HEPA) filter directly before recirculation.
- Room doors should be kept closed except when entering or leaving the room, and entry and exit should be minimized.
- Facilities should monitor and document the proper negative-pressure function of these rooms.

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The Ninth Protocol: Guidelines on Psychosocial Support for Patients with COVID-19"[8]":

- Mental health is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, work productively and fruitfully, and is able to make a contribution to his or her community
- Psychosocial wellbeing is a state in which Individuals, Families and Communities have Cognitive, Emotional and Spiritual strengths combined with positive social relationships within the environment.

Why MHPPS should be prioritized in COVID-19 outbreak?

- Fear of falling ill and dying
- Fear of losing source of livelihoods due to not being able to work during isolation and of being dismissed from work

- Fear of being socially excluded/placed in quarantine because of being associated with the disease
- Feeling powerless in protecting loved ones and fear of losing loved ones because of the infection
- Fear of being separated from loved ones and caregivers due to quarantine
- Refusal to care for unaccompanied or separated minors, people with disabilities or the elderly due to fear of infection, because parents or caregivers have been taken into quarantine.
- Feelings of helplessness, boredom, loneliness and depression due to isolation
- Fear of reliving the experience of a previous epidemic
- Fear of being infected and infecting others, especially if the transmission mode of COVID-19 is not 100% clear
- Some of these fears and reactions spring from realistic dangers, but many reactions and behaviours are also borne out of lack of knowledge, rumours and misinformation.
- Social stigma and discrimination can be associated with COVID-19, including towards persons who have been infected, their family members and health care workers.
- Psychosocial support include all actions and processes that enable a victim/patient, their households or communities to cope with stress in their own environment, develop resilience, and reach their full potential.
- Psychosocial support enables people to experience love, feel protected, build meaningful relationships, and have a sense of self-worth and belonging.
- MHPSS staff should introduce self and the facility
- Be sensitive to culture, ethnicity, gender, sexuality, and maintain a safe distance.
- Be empathetic.
- Build a therapeutic relationship.
- Briefly highlight the services provided by the treatment centre such as isolation of suspected cases and contacts, treatment of confirmed cases.
- Explain in clear terms the need for isolation and the use of PPEs.
- Assess and respond to emotional reactions.
- Recognize cognitive coping strategies e.g. denial, blame, intellectualization
- Explore what the news means to the patient

- Offer realistic hope/optimism
- Establish measures to reduce the negative impact of social isolation in quarantine e.g. Communication with family and friends to reduce loneliness and psychological Isolation
- Institute measures that promote autonomy (e.g. choice in daily activities).
- At admission, the GHQ should be administered by a trained health care worker to have an objective base-line score against which future assessments will be compared
- There is need for further diagnostic interview and appropriate care by a mental health Expert if score is 4 and above

Health education:

- Assess the knowledge of patient
- Speak frankly, but compassionately
- Avoid euphemisms and medical terms
- Allow silence and tears
- Avoid the urge to talk to avoid your own discomfort
- Proceed at the patient's pace
- Have the patient tell you his or her understanding of what you have said
- Encourage questions
- Encourage and validate emotions

Counseling and emotional support:

- Use of detailed and extensive psycho-education.
- Cognitive restructuring
- Active listening
- Seek for clarification
- Reflect on thematic issues discussed during the health talk and counseling session.
- Summarize discussions and provide feedback during session
- Discuss and schedule counseling sessions for follow up

Spiritual Support:

- Provide Spiritual Support on request by the patient
- Link patient with a well-informed spiritual leader
- Interaction should be supervised by the counselor at the treatment center.

Psychiatric Care for COVID-19 patients:

- For all patients who manifest psychiatric symptoms, a trained Psychiatrist should evaluate and offer treatment options appropriate for the patient.
- Treatment modalities are:
- Supportive Psychotherapy
- Cognitive Restructuring
- Use of medications only when necessary (To be prescribed by a trained psychiatrist)
- Regular review and mental state monitoring.

Evaluation at Discharge:

- Assess the patient's psychosocial stability through clinical interview and formal assessment tools (the GHQ-12 Tool should be administered).
- Assess social needs and available resources
- Assess Occupational needs and available Resources

Post- Discharge Care:

- Evaluate worry about stigma and coping skills
- Discourage maladaptive coping skills e.g. social withdrawal, misuse of alcohol and psychoactive substances
- Help patient and relatives plan social and occupational reintegration.
- Discuss the plan for home visit and future contact
- The Oslo Social Support Scale should be administered to assess for social support at home.
- Explore for symptoms of post-trauma and treat if present

Support for Survivors:

- A survivor network (where possible) should be established in conjunction with the treatment centres
- Engage peer educators (if available) to facilitate group counselling
- Provide testimony with the aim of inspiring others
- Share coping skills

The Tenth Protocol: Guidelines for International and Local Travellers"9":

Introduction:

The World Health Organization (WHO) recommends a comprehensive approach to supporting and managing travellers before departure and on arrival**,** which includes a combination of measures for consideration before departure as well as on arrival destination.

This guideline is customized from the "***WHO guideline on public Health Considerations while resuming international travel***" which was published on July 30th 2020.

It outlines key considerations for South Sudan's national health authorities when implementing the gradual return of local and international travel operations.

Factors to be considered when resuming travel:

The priority for gradual resumption of travel is given to:

a. Emergencies.
b. Humanitarian actions.
c. Travel of essential personnel such as health providers and diplomatic officers.
d. Repatriation.
e. Persons at risk including the elderly and the people with chronic underlying health conditions should avoid travelling to areas with community transmission.
f. Cargo transport should also be prioritized for essential medical, food and energy supplies.

Epidemiological situation and transmission patterns at origin and destination countries:

COVID-19 epidemiological situation varies among countries, hence; international travel carries different levels of risk of exportation/importation of SARS-CoV-2 virus, depending on the passenger's country of departure and country of arrival.

The epidemiological situation of COVID-19 in each country is available through WHO Situation Reports, which follow the transmission scenarios defined in the Interim Guidance of WHO Global surveillance for COVID-19 caused by human infection with COVID-19 virus published on March 20th 2020 in which the following four scenarios are considered:

- No cases: Countries / territories / areas with any reported cases.
- Sporadic cases: Countries/territories/areas with one or more cases, imported or locally detected.
- Clusters: Countries/territories/areas experiencing cases, clustered in time, geographic location and/or by common exposures
- Community transmission: Countries/territories/areas experiencing larger outbreaks of local transmission defined through an assessment of factors including, but not limited to:
    - Large numbers of cases not linkable to transmission chains
    - Large numbers of cases from sentinel laboratory surveillance
    - Multiple unrelated clusters in several areas of the country/territory/area.

Coordination and planning:

The transport sector is central to travel operations, but the involvement of other sectors such as trade, agriculture, tourism and security are essential to capture all the operational aspects associated with the gradual resumption of international travels.

Surveillance and case management capacity:

Active epidemiological surveillance for case detection, case isolation, contact identification and contact follow-up are central to the effective management of the COVID-19 pandemic.

Persons who are suspect or confirmed to have COVID-19 and contacts of confirmed cases should not be allowed to travel.

International contact tracing:

When a cluster or chain of transmission involves several countries, international contact tracing can be done in a coordinated and collaborative manner through rapid information sharing via the international network of National "WHO International Health Regulations (IHR)" IHR Focal Points (NFPs).

The NFPs should be accessible at all times and can receive direct support from the regional WHO International Health Regulations (IHR) Contact Points.

Risk communication and community engagement:

It is essential to proactively communicate to the public through traditional media, social media and other channels about the rationale for gradually resuming international travels, the potential risk of travel and the measures required to ensure safe travel for all, including regular updates on changes in international travel to disseminate information and provide advice tailored to sub-national level situations.

This is essential to build trust in travel advice, increase compliance with health advice and prevent the spread of rumors and false information.

Required Capacity at Points of Entry:

We should strengthen our capacity at Juba International Airport and other Points of Entry (PoE) for the COVID-19 response, especially:

a. Entry/exit screening
b. Early detection through active case finding
c. Isolation and testing of ill passengers
d. Supply of personal protective equipment (PPEs) at PoE
e. Cleaning and disinfection
f. Case management
g. Identification of contacts for contact-tracing;
h. Physical distancing and wearing of masks;
i. Sharing of emergency phone numbers; and
j. Risk communication and education on responsible travel behavior.
k. Adapted procedures for handling baggage, cargo, containers, conveyances, goods and postal parcels should be available and clearly communicated.

General advice for travellers:

a. Adequate personal and hand hygiene,
b. Proper respiratory etiquette,
c. Maintaining physical distance of at least one meter from others

d. Use of a mask as appropriate.
e. Sick travellers and persons at risk, including elderly travellers and people with serious chronic diseases or underlying health conditions, should postpone travelling to and from areas with community transmission.

Laboratory testing at Points of Entry:

a. Molecular testing for SARS-CoV-2 within a short period prior to departure or on arrival provides good information about the status of travellers.
b. International travellers should self-monitor for the potential onset of symptoms on arrival, report symptoms and travel history to local health facilities and follow our national protocols.
c. International passengers who test negative with a recommended RT-PCR upon their arrival can be discharged immediately from their self- isolation and allowed to continue their local journey within the country without any further restriction.

Public – Private Partnership on COVID-19:

a. The current capacity of our public health laboratory (PHL) may not meet the increasing demand of the international travellers.
b. Competent private hospitals and clinics should be encouraged to run molecular testing using recommended RT –PCR provided that these private laboratories are working in tandem with the PHL and they must have a clear chain of communicating secured data**.**

Guidelines and Surveillance for Local Travellers:

a. An appropriate rapid diagnostics tests (RDTs) should be used to screen all local travellers whether using air or land routes as part of community based serosurveillance.
b. The sensitivity and specificity of most of the available RDTs is around 90%; hence those who screen positive on RDTs will be considered as suspects and hence referred to do RT-PCR confirmatory testing at the public health laboratory (PHL).
c. RDTs that use antigens such as the one approved by the American FDA (Sofia 2 SARS Antigen FIA) will be introduce as soon as they are available.

The Eleventh Protocol: Guidelines for Enforcement Agencies on COVID-19 Measures"[10]":

Purpose:

The main purpose of these guidelines is to enhance the safety and effectiveness of law enforcement agencies during COVID-19 Pandemic. The guidelines provide information on how can law enforcement personnel protect themselves and their families, and outline the various roles carried out by the law enforcement agencies such as**:**

1. Border control
2. Maintaining public order
3. Assisting health authorities in identifying cases and their origin
4. Relaying public health measures to the population
5. Securing deliveries of medical equipment
6. Securing transfer of COVID-19 patients.
7. These guidelines warn of emerging crimes linked to this pandemic including intimidation, fraud or phishing, cybercrime and counterfeiting.

Risk assessment for protective security - factors to consider:

1. A risk assessment that considers protective security should be conducted in addition to, or as part of any health and safety.
2. Mandatory broader assessment of the hazards and threats to the people in and around the places of gathering should be made for safe functions.
3. Whilst law enforcement agents and other related security officers may be focused on managing people for COVID-19 safety reasons, they should continue to remain vigilant for and report any suspicious activity as soon as possible.
4. Law enforcement leadership should ensure that there is a good communication system in place to inform people of any incident or security threat.
5. Proper coordination and harmony is expected among the different enforcement agencies.

Law Enforcement Agents may include the following.

- Local staffs
- Volunteers

- Police officers
- Security officers
- Army
- Other organized forces

The Expected Role of Law Enforcement Agents:

- Enforcing the set rules and disperse crowds of people at gatherings and other events which contravene the order.
- The critical role of law enforcement is to provide effective plan to slow the spread of COVID19.
- Apprehension to enforce actions may require detention which in turn could raise public safety and civil liberty concerns; hence proper training and clear chain of command should be availed by the NTF and the leadership of the law enforcement agencies.
- NTF policies related to COVID-19 should be clearly communicated to all law enforcement officers and personnel.
- Law enforcement leaders should clearly establish how officers are to interact with the community and enforce the rules.
- They should promote rumor reporting through proper mechanisms to combat fake news.
- Officers should be prepared to answer questions about:
  - Testing kit availability,
  - Travel restrictions,
  - Quarantine and isolation, and
  - Personal safety measures.
- The role of law enforcement should be focused on informing the public about the current restrictions and encouraging individuals to comply with the state and local emergency health declarations.

Arrest and Detention:

- Officers and personnel should have clear guidance on the proper procedures regarding the isolation and detention of infected community members.

- Law enforcement officers should be provided information about how to detain or isolate a person who is perceived as having an infectious disease, including how to handle situations when a person fails to comply.
- Policies should clearly stipulate how to handle arrests.
- Law enforcement may also need to identify a location other than the local jail for detention and isolation of individuals who do not comply with health emergency declarations.
- These locations should ensure that social distancing guidelines are followed.

Health and Safety:

- Like health practitioners, law enforcement agents will most likely encounter an infected individual; hence they are potentially at high risk of being infected with COVID-19 Virus.
- In addition to potential hazards related to contracting the COVID-19 virus, law enforcement officers could also experience considerable stress during this time.
- Increased pressures and continued obligations outside of work, along with the potential of family members falling ill, will create stress, fear and anxiety.
- Law enforcement agencies should have in place a plan for critical incident stress management to address officer physical and emotional well-being and provide support services for officers and their families.
- Law enforcement personnel should take particular care when approaching uncooperative individual and they should wear PPEs in such cases.
- Recommended RDT testing kits should be provided by the NTF for screening survey of all law enforcement personnel.
- Those who test positive on RDTs should be referred to the PHL for confirmatory molecular testing and case management accordingly.

Fake and Counterfeit Medical Products:

Law enforcement agents should be aware that the COVID-19 Pandemic has offered an opportunity for fast cash, as predatory criminals take advantage of the high market demand for personal protection and hygiene products such as:

- Disposable surgical masks

- Hand sanitizers
- Antiviral and antimalarial medication
- Fake herbal medicines
- Fake COVID-19 testing kits.

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The Twelfth Protocol: Guidelines on Resumption of Public Meetings and Gatherings"[12]":

Background:

This protocol is extracted from different guidelines, including the guidance for the safe use of places of worship during COVID 19 Pandemic published by the UK Government on July 4th 2020.

Purpose of this protocol

As we are adapting to the new normal and coping with COVID19 Pandemic, this guidance is designed to direct meeting/Gatherings places for a broad range of Official gatherings or occasions. The guidance sets out how this can be done in a manner that is COVID-19 secure and in line with social distancing guidelines, in order to minimize the risk of exposure to infection.

Definition:

Meetings/gatherings include congregation of individuals in a confined or enclosed space within buildings or outdoors which is used for the purpose of coming together for that event or similar activity such as offices and government's premises.

Introduction:

The entire world is currently experiencing a public health emergency as a result of the Coronavirus (COVID-19) pandemic. The transmission of COVID-19 occurs mainly through respiratory droplets generated by coughing and sneezing, and through contact with contaminated surfaces.

Meetings/gatherings places play an important role in providing trainings or deliberating leadership and governing guidance for many individuals and in bringing communities and generations together. However, the nature of these Meetings/Gatherings also makes those places particularly vulnerable to the spread of COVID-19.

Consideration should be given to how fair and access can safely be provided for all users equally to be able to undertake the purpose of coming together in conducting the meetings/gathering. . This guidance for places of Meetings/Gathering has been drafted on the basis of the scientific evidence available and will be subject for updating as necessary as more data becomes available on this novel virus.

Preparing the building for use:

In order to ensure that those who are attending the Meetings/gathering are able to adhere to the Protocol on resuming meetings/Gatherings; the setting of those places should ensure the followings:

1. Maintaining the distance of 2 meters between every person except between two members of the same household.
2. Maintain proper open ventilation.
3. The necessary actions to mitigate any risks identified in the risk assessment are in place.
4. Avoid congregating in confined spaces.
5. Identifying entry and exit points and a one way system within the building
6. Closing off unused areas within the same building where the Meeting/Gathering is being conducted.
7. Preparedness for an adverse eventuality during the event of these meeting.

Permitted use for places of Meetings/Gatherings:

1. Private meetings/Gathering by individuals or household members less than 50 in number.
2. Remote Meetings through broadcasting, webinars and video conferences.
3. Offices and government premises.

Adapting practices to reduce the spread of infection:

Champions of Meetings/Gatherings should adopt this guidance and seek to include additional changes that could be made to the events that usually involve close contact and shared items between individuals.

Places of Meetings/Gatherings should adapt strict infection prevention and control measure, especially where events otherwise have taken place over a number of hours or days, to ensure the safety of those present and minimize spread of infection.

1. It is advised that the Meetings/Gathering should be concluded in the shortest reasonable time.

2. Once completed, participants should be encouraged to move on promptly, to minimize the risk of contact and spread of infection.
3. If appropriate, you should reconfigure spaces to enable individuals attending Meeting/Gathering seated rather than standing which reduces the risk of contact.
4. Attendants should limit their interactions with anyone they are not Meetings/Gathering i.e. if they are attending Meeting/Gathering with one another, wherever possible they should try not to engage in conversation with anyone outside of this group.
5. It is recommended that, where possible, Meetings/Gatherings should continue to stream or other events to avoid large gatherings and to continue to reach those individuals who are self-isolating or particularly vulnerable to COVID-19.
6. Individuals should be prevented from touching or kissing objects that are handled during the event. Barriers and/or clear signage should be put in place where necessary to avoid this taking place.
7. Individuals should also avoid touching property belonging to others while adhering to social distancing principles.
8. Reusable resources or material should be removed from use. Single use alternatives should be provided as long as they are removed and disposed of by the attendants.
9. Items owned by the individual should be removed once the event. Is over.

Food and Drink

1. Where food or drink 'consumables' are essential to the Meetings/Gatherings they can be used; however the sharing of food should be avoided, as should the use of communal vessels.
2. If it is necessary to handle consumables as a part of a faith practice, those giving and receiving food items should wash their hands thoroughly before and after consumption, or wear gloves.
3. The person distributing the consumable should release it, into the hand only, in such a way to avoid any contact between them and those receiving it, or wear gloves. If accidental contact does occur, both people should cleanse their hands immediately.
4. Other actions taken to reduce the risk of transmission should also be considered, for example, foodstuffs should be pre-wrapped, and a system should be in place to prevent

individuals from coming into contact with consumables and any dishes other than their own.

5. Hospitality spaces within a place of Meeting/Gathering, such as cafes, are permitted to open but should be limited to table-service, social distancing should be observed, and with minimal staff and customer contact.

Social distancing:

1. Social distancing measures are actions to reduce social interaction between people in order to minimize the opportunity for transmission of COVID-19.
2. Queue management is important so the flow of groups in and out of the premises can be carefully controlled in a socially distanced way, reducing the risk of congestion or contact. Considerations should be made for how to manage those waiting outside a Meeting place, including the introduction of socially distanced queuing systems.
3. All meetings practices should be carried out such that adherence to social distancing can be maintained between individuals from different background.
4. Those leading the Meetings/Gathering should remind attendants of the importance of social distancing and hygiene.
5. Introducing a one-way flow in and out of the premises with appropriate floor markings or signage, with restrictions on accessing non-essential areas. At the end of Meetings/Gathering, this could include attendants leaving one row at a time, in order to prevent crowding at entry or exit points.
6. Multiple entry points could be opened, and clear signposting or assistance could be offered to guide attendants and to avoid congestion.
7. Using screens, barriers or alternative rooms and spaces to separate worshippers.
8. Any changes to entrances, exits and queues should take into account reasonable adjustments to accommodate those who need them, such as attendant with physical disabilities.
9. Introducing a system to help with managing numbers, particularly for Meeting/gathering where demand will be high.
10. Venue managers advertising set days or times when places of worship are open solely for those particularly vulnerable to COVID-19, such as those over 70 or clinically vulnerable.

11. Leading attendants in different spaces of the place of Meetings/Gathering to limit the number of people in any one location - while avoiding risk of crowding at entry/exit points.
12. Where social distancing cannot be maintained, extra attention needs to be paid to cleaning and hygiene to reduce the risk of transmission. Consider how well ventilated the venue is and improve this where possible, for example by fixing doors open where appropriate.
13. Following the guidance on hand hygiene:
14. Wash your hands more often than usual, for 20 seconds using soap and water or hand sanitizer, particularly after coughing, sneezing and blowing your nose, or after being in public areas.
15. When you cough or sneeze, cover your mouth and nose with a tissue, or the crook of your sleeved arm (not your hands) if you don't have a tissue, and throw the tissue away hygienically immediately afterwards. Then wash your hands thoroughly for at least 20 seconds using soap and water or hand sanitizer if hand washing facilities are not available.

People who are symptomatic:

1. Anyone showing symptoms of COVID-19 such as a new continuous cough, a high temperature or a loss of, or change in, their normal sense of taste or smell; should not attend the Meeting/Gathering due to the risk that they pose to others; they should self-isolate at home immediately with other members of their household.

Hygiene:

1. On entering and leaving a place of Meetings/Gatherings, everyone, including staff, should be asked to wash their hands thoroughly for at least 20 seconds using soap and water or to use hand sanitizer if hand washing facilities are not available.
2. There should be signs and posters to build awareness of good hand-washing technique, the need to increase hand-washing frequency, avoid touching your face and to cough or sneeze into a tissue which is binned safely or into the crook of your sleeved arm if a tissue is not available.
3. Provide hand sanitizer in multiple locations in addition to toilet facilities.

Check List on Resumption of Public Meetings and Gatherings

3. Preparing the place of Gathering for reopening:

S/No.	Activity	Yes	No	Not Sure
1.	Risk assessment of the place is done			
2.	Distance of 2 meters is maintained between individuals			
3.	Proper open ventilation is maintained in the building			
4.	Congregating in confined places is avoided			
5.	Entry and exit points are identified within the building			
6.	Unused areas are closed off			
7.	Preparedness for an adverse eventuality is maintained.			

4. Promoting behaviors that reduce COVID-19 spread:

S/No.	Activity	Yes	No	Not Sure
1.	Staying home or self-isolating when appropriate is reinforced			
2.	Hand hygiene and respiratory etiquette is reinforced			
3.	Cloth face mask covering is observed			
4.	Communal food and drinks are discouraged			
5.	Awareness signs and messages are provided			

10. Maintaining Healthy Environments:

S/No.	Activity	Yes	No	Not Sure
1.	General cleaning and disinfection is maintained			
2.	Shared objects are discouraged			
3.	Ventilation systems operate properly			
4.	Safe water systems is maintained			
5.	Physical barriers and guidelines are installed			
6.	Shared spaces are closed			
7.	Instruments, books and podiums are disinfected regularly			

11. Maintaining Healthy Operations:

S/No.	Activity	Yes	No	Not Sure
1.	Clergy and congregation are protected from COVID- 19			
2.	Regulatory awareness messages are displayed			
3.	Gatherings are controlled			
4.	Telework and virtual meetings are encouraged			
5.	Visiting and transit clergy are limited			
6.	A COVID-19 focal-point of contact is designated.			
7.	Participation in national response efforts is maintained			
8.	Proper communication systems is put in place			

12. Toilets:

S/No.	Activity	Yes	No	Not Sure
1.	Toilets are carefully and regularly cleaned			
2.	Hand sanitizers are available on entry to toilets			
3.	Communal towels are replaced with single use paper towels			
4.	Toilets are well ventilated			
5.	A visible cleaning schedule of the toilet is put in place			
6.	Waste facilities and refuse collection are provided.			

13. Face coverings and masks:

S/No.	Activity	Yes	No	Not Sure
1.	Face coverings/ masks are worn in closed spaces			

14. Preparedness for when someone gets sick:

S/NO.	**Activity**	**Yes**	**No**	**Not Sure**
1.	Testing centers are prepared			
2.	Isolation centers are prepared			
3.	Ambulances for medical evacuation are provided			

15. Preparedness for a second wave:

S/NO.	**Activity**	**Yes**	**No**	**Not Sure**
1.	Institution is ready for an early detection of a new outbreak			
2.	Institution is prepared for an immediate closure			
3.	Institution is maintaining communication with the national taskforce			

16. Enforcement:

S/No.	Activity	Yes	No	Not Sure
1.	Measures enforcement personnel are identified			

Toilets:

1. Toilets inside or linked to places of Meetings/Gatherings should be kept open and carefully managed to reduce the risk of transmission of COVID-19.

2. Make hand sanitizer available on entry to toilets where safe and practical, and ensure suitable hand-washing facilities including running water and liquid soap and suitable options for drying are available.
3. Communal towels should be removed and replaced with single use paper towels.
4. Keep the facilities well ventilated, for example by fixing doors open where appropriate and safe to do so.
5. Putting up a visible cleaning schedule that is kept up to date and visible.
6. Providing more waste facilities and more frequent refuse collection.

General Cleaning:

1. All surfaces, especially those most frequently touched such as door handles and rails, should be regularly cleaned using standard cleaning products.
2. Sufficient time needs to be allowed for this cleaning to take place, particularly before Meetings/gatherings for the first time.
3. Frequently used objects, surfaces or spaces, including for example doorways between outside and inside spaces should be given particular attention when cleaning.

Face coverings and masks:

1. Face coverings are currently mandatory on public transport, shops and in other public places of gatherings.
2. People are encouraged to wear face coverings in enclosed public spaces where there are people they do not normally meet, such as a place Meetings/gatherings.

Protecting the vulnerable:

1. There should be a particular focus on protecting people who are clinically vulnerable and more likely to develop severe illness.
2. Certain groups of people may be at increased risk of severe disease from COVID-19, including people who are aged 70 or older, regardless of medical conditions.
3. Individuals who fall within this group are advised to stay at home as much as possible and, if they do go out, to take particular care to minimize contact with others outside of their household.

Enforcement:

1. It is important to be aware of the enforcement provisions, as is the case for other sectors.

2. Identify responsible individuals who are not taking action to comply with the relevant public health guidance to control public health who will consider taking a range of actions to improve control of risks.

Risk assessment for protective security - factors to consider:

1. A risk assessment that considers protective security should be conducted in addition to, or as part of, any health and safety/ fire safety or other broader assessment of the hazards and threats to the people in and around the place of worship as a result of changes made to how that place of worship functions.

Staff, security officers/ volunteers and stewarding

1. It is vital for staff to remain vigilant and act on potential security threats including terrorism and wider criminality.
2. Continue to ensure that awareness of security threats is raised alongside health and safety risks through staff briefings.
3. Whilst stewards, and in some cases security officers, may be focused on managing people and queues for COVID-19 safety reasons, they should continue to remain vigilant for and report any suspicious activity as soon as possible.
4. Consider having separate stewarding for managing social distancing and health and safety aspects, and for security as this will allow proper due attention to be given to keeping the site safe from threats.
5. Ensure there is a good communication system in place to inform people of any incident.

References:

1. Laboratory Testing for Coronavirus Disease (COVID-19) in Suspected Human Cases, Interim Guidance, Released on March 2nd 2020 by the World Health Organization.
2. Clinical Management of COVID-19, Released on May 27th 2020 by World Health Organization.
3. Home care for patients with suspected or confirmed COVID-19 and management of their contacts, an Interim guidance released by the WHO on August 12 2020.
4. Guidance for discharge and ending isolation in the context of widespread community transmission ofCOVID-19, released on April 8th 2020 by the CDC.
5. Standard Operating Procedures for COVID-19 Related Fatalities in South Sudan, Adopted by the MoH in June 2020.
6. Considerations for Reopening Institutions of Higher Education in The COVID-19 Era, Released on May 7th 2020 by the American College Health Association (ACHA).
7. Guidance for the safe use of places of worship during COVID19 Pandemic published by the UK Government on July 4th 2020.
8. Healthcare Workers Return to Work Criteria, updated on August 10th 2020 by the CDC.
9. Standard Operating Procedures for Mental Health and Psychosocial Support (MHPSS) during COVID-19, Adopted by the MoH, South Sudan in June 2020.
10. WHO Guideline on Public Health Considerations while resuming international travel, published on July 30th 2020.
11. COVID-19 Pandemic: Guidelines for Law enforcement, released on March 26th 2020 by the Interpol.

End.