

UNITED NATIONS MEDICAL DIRECTORS COVID-19 PANDEMIC GUIDELINES

March 31, 2020

INTRODUCTION

SCOPE AND PURPOSE

This United Nations Medical Director's document provides guidance and tools on COVID-19 Pandemic Preparedness to ensure a **consistent and coordinated public health response across the UN System**. This guidance should be adapted to local authorities' and local WHO office's protocols, where available. The emerging evidence based on COVID-19 is rapidly evolving and further updates may be made to this guidance as new evidence emerges. For any questions on this document, contact dos-dhmosh-public-health@un.org

DISEASE CHARACTERISTICS

In late 2019, a novel coronavirus, now designated as SARS-CoV-2, was identified as the cause of an outbreak of an acute respiratory illness in Wuhan, a city in China. In February 2020, the World Health Organisations (WHO) designated the disease as COVID-19, which stands for coronavirus 2019 which is the disease caused by the virus SARS-CoV-2.

Since the first reports of COVID-19, the infection has spread worldwide, prompting the WHO to declare a public health emergency of international concern in late January 2020 and characterize it as a pandemic in March 2020. The rate of new infections outside of China has surpassed that within China as epidemics have grown in other countries. For the latest situation report from WHO, see <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/situation-reports/>

Transmission through person-to-person spread of SARS-CoV-2 is thought to occur mainly via respiratory droplets generated by coughing and sneezing, and through contact with contaminated surfaces i.e. droplet and contact transmission. Droplets typically do not travel more than 2 meters and do not linger in the air. The **incubation period** is thought to be 2-14 days following exposure, though most cases occur around 5 days after exposure. Studies show that patients are not thought to be **infectious until the onset of symptoms**. The median time from symptom onset to clinical recovery is approximately 2 weeks for mild cases.

Spectrum of symptomatic infection varies from mild to critical. The most common symptoms of COVID-19 are fever, cough and shortness of breath. Some patients may have aches and pains, fatigue, nasal congestion, runny nose, sore throat or diarrhea though these are described much less commonly. Most people experience mild or moderate symptoms. These symptoms are non-specific and can mimic other respiratory illnesses such as those caused by the seasonal influenza and other respiratory viruses. Asymptomatic infections have also been described but their frequency is unknown. Further study is required to determine the actual occurrence and impact of asymptomatic transmission.

DISEASE SEVERITY / PLANNING ASSUMPTIONS

A study of the Chinese Center for Disease Control and Prevention of 44,500 confirmed infections showed that:

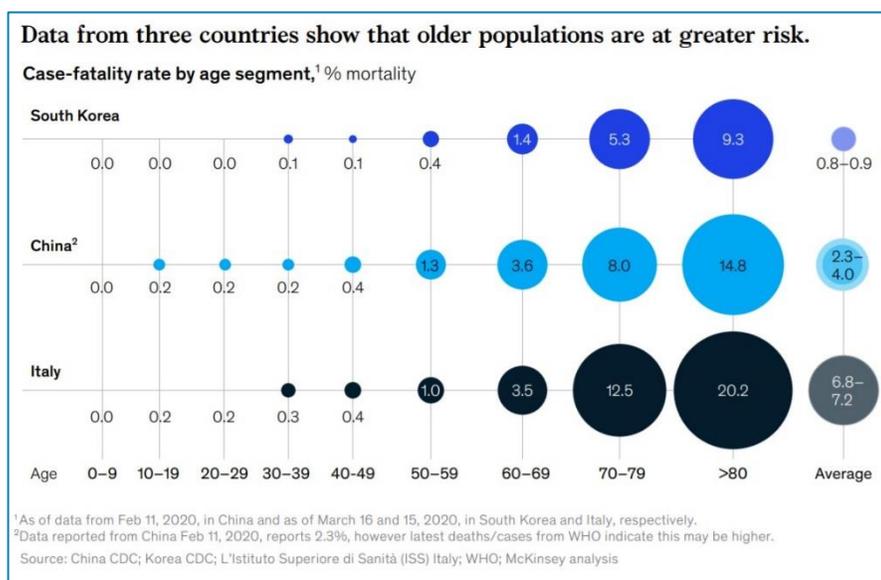
- 40% of confirmed cases reported **mild disease** – i.e. treatment is symptomatic and can be managed at home, and does not require inpatient care;
- 40% of confirmed cases reported **moderate disease** – i.e. can be managed either at home, or as inpatient;
- 15% of confirmed cases reported **severe disease** – i.e. requires oxygen therapy, has dyspnea, hypoxia, or >50 percent lung involvement on imaging within 24 to 48 hours;
- 5% of confirmed cases reported **critical disease** – i.e. requires mechanical ventilation, has respiratory failure, shock, or multiorgan dysfunction.

This study had an overall 2.3% **case fatality rate**; no deaths were reported among noncritical cases. It should be noted that the proportion of severe or fatal infections may vary by location and age. This may be due to distinct demographics of infection¹.

In terms of the **impact of age on severity**, to date, most of the fatal cases have occurred in patients with advanced age or underlying medical comorbidities. **Known risk factors** for severe COVID-19 are age >60 years, hypertension, diabetes, cardiovascular disease, chronic lung disease, and cancer. The experience of several countries was that mortality was highest among older individuals, e.g. in China 80 % of deaths occurring in those aged ≥65 years. Symptomatic infection in children appears to be uncommon; when it occurs, it is usually mild, although severe cases have been reported.

Based on current information and studies, WHO estimates that **in a general population**, about **15% of COVID-19 cases will be severe** (requiring hospitalization and oxygen), and **5% of COVID-19 cases will be critical** (requiring ventilation), requiring significant health capacity and critical-care infrastructure. This reflects a higher level of severity compared to influenza and is likely due to the fact that many mild cases are not diagnosed.

It should be noted that the severity of cases and the case-fatality rate differ by age segment as shown below. **For the UN, the case fatality rate in our UN personnel population will vary according to the age-profile and underlying medical comorbidities of our workforce.**



¹ As an example, in Italy, 12 percent of all detected COVID-19 cases and 16 percent of all hospitalized patients were admitted to the intensive care unit; the estimated case fatality rate was 5.8 percent in mid-March [45]. In contrast, the estimated case fatality rate in mid-March in South Korea was 0.9 percent [46]. This may be related to distinct demographics of infection; in Italy, the median age of patients with infection was 64 years, whereas in Korea the median age was in the 40s.

GENERAL ORGANIZATIONAL PREPAREDNESS

GENERAL BUSINESS CONTINUITY PLANNING

Effective **business continuity planning (BCP)** is critical during the COVID-19 pandemic to ensure that the organization can function successfully with a minimal number of in-house personnel. Active reduction of the number of UN personnel on site is the most effective strategy that the UN can implement to lower the risk of personnel exposure to sources of infection and should be in implementation phase. Flexible or alternative working arrangements should be strongly considered. Possible reduction in productivity should be accepted by all organizational levels and stakeholders and transparently communicated in time.

More information and administrative and human resources guidance for COVID-19 can be found at <https://www.un.org/en/coronavirus/reference-documents-administrators-and-managers>.

COVID-19 PREPAREDNESS IN THE WORKPLACE (WITH OR WITHOUT UN MEDICAL PRESENCE)

Several tools and guidances have been developed to help all **UN workplaces, whether they have a UN medical presence or not, prepare for and respond to a COVID-19 outbreak situation**. These tools can be found at <https://www.un.org/en/coronavirus/reference-documents-administrators-and-managers> and include:

A comprehensive preparedness checklist to help you identify any gaps in preparedness areas (This checklist is available in other languages on the webpage above):
https://hr.un.org/sites/hr.un.org/files/2019-nCoV%20Preparedness%20Checklist%20English_0.pdf

A detailed guide to help you write your contingency plan:
https://hr.un.org/sites/hr.un.org/files/Coronavirus_ContingencyPlanGuide_2020-03-09_FINAL_0.pdf

A checklist of actions that needs to be taken to prepare for the first case occurring amongst UN personnel or dependents in your duty stations:
https://www.un.org/sites/un2.un.org/files/coronavirus_preparing4firstcase_2020-03-15.pdf

A guide on how to identify and manage suspect cases that occurs in your workplace:
https://hr.un.org/sites/hr.un.org/files/Coronavirus_SuspectCaseGuideNonMedical_DHMOSHPH_0.pdf

A sample tabletop exercise scenario to guide on how to identify and manage suspect cases that occurs in your workplace:
https://www.un.org/sites/un2.un.org/files/coronavirus_ttxscenario_2020-03-11.pdf

Clear instructions on how to report any cases identified:
https://www.un.org/sites/un2.un.org/files/coronavirus_casereporting_requirements_2020-03.pdf

PANDEMIC ACTION PLAN: 3-PHASE RESPONSE ACTIVATION SYSTEM

In addition to the above tools for UN offices, a **“3-Phase Response Activation System”**, available at https://hr.un.org/sites/hr.un.org/files/Coronavirus_ThreePhases_FINAL_0.pdf is **used to manage and coordinate health emergency responses in the UN system, including for COVID-19**. This system can be activated in response to disease outbreak and other public health emergencies.

All UN offices should develop or update their outbreak contingency plans to include the recommendations and corresponding actions suggested in these three phases. As per standard practice, all contingency plans should take into account local health authorities' and WHO office's advice and protocols.

The 3 phases are:

PHASE 1: READINESS MODE

In this mode, there is a specific outbreak of concern globally. All duty stations should get ready that such an outbreak may have an impact on their daily operations. It is therefore necessary to prepare, review and continuously update medical response plans and strategies, and start preparedness actions as indicated, including awareness, disease-specific education and targeted communications. During this mode, duty stations should have an outbreak / health emergency contingency plan in place for the duty station and test it regularly. In this mode, all duty stations should be ready to ramp up quickly to the next phase of preparedness.

PHASE 2: ACTIVE RISK REDUCTION MODE

In this mode, implemented when the outbreak has reached the duty station with some community spread, implementation of active measures to mitigate risk in the workplace is required. Measures include management of meetings and reduction of staffing footprint, with a specific focus on vulnerable personnel such as immunocompromised staff or those with comorbidities. The workplace remains open, but measures are put in place to reduce risk such as implementation of social distancing and other activities.

PHASE 3: EMERGENCY MODE

In this mode, full implementation of risk management and medical response measures is required due to the fact that there are a large number of cases in the host country and widespread community spread.

The medical staff and/or Country Team at each duty station, in coordination with the UN Medical Directors, can make a decision on which mode is appropriate to their local circumstances, taking into account the unfolding health emergency situation in their region/country.

For the full action plan corresponding to each of the above 3 phases, please see https://hr.un.org/sites/hr.un.org/files/Coronavirus_ThreePhases_FINAL_0.pdf

MEETINGS & TRAVEL RISK ASSESSMENT

As is standard practice, all UN managers and/or UN personnel should undertake a **risk assessment to evaluate the criticality of the proposed travel or meeting** balanced against the risks to the traveller/meeting participant for any travel to, or meetings in, areas experiencing local transmission of COVID-19. Several guidance documents and tools have been developed for management of UN meetings in the context of the pandemic including:

- This set of guidance for UN meeting organisers which provides a decision process for meeting risk assessment and decision flow chart:

https://hr.un.org/sites/hr.un.org/files/Global%20Guidance%20for%20UN%20Meetings%20for%20COVID-19_10Mar%20_0.pdf More information related to this is available at: <https://www.un.org/en/coronavirus/reference-documents-administrators-and-managers>

- For meetings that are taking place, the following guidelines for meeting organisers and information package for participants are provided. UN offices should use these global guidelines to develop local ones in accordance with local health authorities' advice and protocols.
https://hr.un.org/sites/hr.un.org/files/Coronavirus_MeetingGuideOrganisersGlobal_2020-02_24_0.pdf
https://hr.un.org/sites/hr.un.org/files/Coronavirus_MeetingGuideParticipantsGlobal_2020-02_26_0_2.pdf
- The WHO has also released an interim guidance with key planning recommendations for mass gatherings in the context of the current pandemic:
https://hr.un.org/sites/hr.un.org/files/WHO-2019-nCoV-POEmassgathering-2020%20ENG_0.pdf

On Transportation: Crowded travel settings may increase the risk of exposure to COVID-10, especially for those at risk for severe COVID-19 are age >60 years, hypertension, diabetes, cardiovascular disease, chronic lung disease, and cancer. If you must travel, you should maintain social distance of 2 meters with others and exercise all COVID-19 precautions including washing your hands frequently, covering your mouth and nose with a tissue when you cough or sneeze, avoid contact with people who are sick and stay home when ill yourself.

UNITED NATIONS MEDICAL DIRECTORS RISK MITIGATION PLAN

For diseases of importance or high impact, **the UN Medical Directors will issue, from time to time, a comprehensive risk mitigation plan to guide the UN system in their response.** These are occupational health recommendations provided by the UN Medical Directors to all UN Organizations and apply to all UN personnel to reduce the risk of UN personnel acquiring a disease of high impact or to mitigate its impact. The recommendations are allocated according to the specific "Risk Category" that UN personnel belong to.

The **UN Medical Directors Risk Mitigation Plan for COVID-19** is currently available at <https://www.un.org/en/coronavirus/covid-19-information-un-healthcare-workers> All duty stations need to take into account the local host country/authorities' guidance and regulations when implementing these recommendations. The following sections are based on this risk mitigation plan and elaborates further on them.

COVID-19 PREVENTION MEASURES

GENERAL PREVENTION TIPS

The following **general prevention measures** are recommended for ALL UN Personnel to reduce the transmission of infection. They should be shared frequently with UN personnel:

- Wash your hands frequently with an alcohol-based hand rub (with at least 60% alcohol), or with soap and water.
- Maintain at least 2 meter distance between yourself and anyone who is coughing or sneezing. Avoid crowds (especially in poorly ventilated spaces) if possible.
- Avoid touching eyes, nose and mouth
- Practice respiratory hygiene. This means covering you mouth and nose with your bent elbow or tissue when you cough or sneeze, then dispose of the used tissue immediately, and wash your hands after that.

- Stay home if you feel unwell. If you have fever, cough and difficulty breathing, seek medical attention and call in advance. Follow the directions of your local health authority.

IN A COMMUNITY SETTING

The above prevention tips should be emphasized. Additionally, it should be noted that for individuals without respiratory symptoms, WHO states that **wearing a medical mask (also known as surgical or procedural mask) in the community is not recommended**² nor is it evidence-based, even if COVID-19 is prevalent in the area. Wearing a medical mask does not decrease the importance of other general measures to prevent infection, and it may result in unnecessary cost and supply problems.

Individuals who are caring for patients with suspect or confirmed patients at home, however, should wear a tightly fitted medical mask when in the same room as that patient.

Individuals who are ill and develop an acute respiratory illness (e.g. with fever and/or respiratory symptoms) should be encouraged to stay home and away from the workplace. Medically, this is known as **"isolation"** (i.e. an individual who has symptoms and who stays at home until they are well). Such individual should remain in their bedroom and the door should remain closed.

Individual who are fit the WHO definition³ of a "contact" should monitor themselves for development of signs and symptoms consistent with COVID-19. In some jurisdiction, they may be advised to undergo a 14-day **"quarantine"** (i.e. an individual who is well with no symptoms but may have been exposed to COVID-19 and stays at home to monitor for symptoms). As soon as these symptoms develop, the individual should self-quarantine with social distancing, and call his or her health provider for a medical evaluation.

For patients with mild or moderate illness who were under home isolation, **where tests are not available, a non-test-based strategy should be used to determine when isolation can be stopped. In this situation**, patients may discontinue home isolation 14 days after resolution of symptoms.

Recommendations may vary if test-based strategies are used and if the patient has illness that required hospitalization.

More detailed interim recommendations on home management of patients with COVID-19 can be found on the WHO⁴ and CDC⁵ websites.

IN A HEALTH CARE SETTING

WHO has developed a practical manual on how to set up and manage a severe acute respiratory infection (SARI) treatment centre and a SARI screening facility in health care facilities. Please see document here. <https://www.who.int/publications-detail/severe-acute-respiratory-infections-treatment-centre> The following section however, is focused solely on how to establish a COVID-19 screening facility in your health-care facility/ies.

SCREENING AND TRIAGE STATION

Screening patients before they come to your health facility can help identify patients who require additional infection control precautions. This should be preferably done by phone before the patient

² [https://www.who.int/publications-detail/advice-on-the-use-of-masks-in-the-community-during-home-care-and-in-healthcare-settings-in-the-context-of-the-novel-coronavirus-\(2019-ncov\)-outbreak](https://www.who.int/publications-detail/advice-on-the-use-of-masks-in-the-community-during-home-care-and-in-healthcare-settings-in-the-context-of-the-novel-coronavirus-(2019-ncov)-outbreak)

³ <https://apps.who.int/iris/bitstream/handle/10665/331506/WHO-2019-nCoV-SurveillanceGuidance-2020.6-eng.pdf>

⁴ [https://www.who.int/publications-detail/home-care-for-patients-with-suspected-novel-coronavirus-\(ncov\)-infection-presenting-with-mild-symptoms-and-management-of-contacts](https://www.who.int/publications-detail/home-care-for-patients-with-suspected-novel-coronavirus-(ncov)-infection-presenting-with-mild-symptoms-and-management-of-contacts)

⁵ <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-prevent-spread.html>

presents in person to your facility.

A **24/7 COVID-19 telephone hotline** should be set up to refer patients to the appropriate destination for clinical assessment and/or testing as per local protocol. This number should be disseminated to all UN personnel for this purpose.

For individuals that physically come to the UN health facility, you should set up a **triage station at the entrance** of your health facility, i.e. outside of your waiting area, so as to screen patients. This enables you to immediately **segregate patients with COVID-19 symptoms from the non-symptomatic patients**, and limits potential spreading infection throughout the health facility. Signage should be displayed at this station instructing patients with symptoms to inform reception staff immediately on their arrival.

UN personnel involved in triage or screening at the points of entry should **wear a medical mask when screening patients** at the triage station if they are closer than 2 meters from the patients. A plexiglass window/physical barrier may be used depending on the personnel's role. Ensure to have alcohol-based hand rub (ABHR) or soap and water handwashing stations readily available at this station.

Any individual that fits the WHO case definition⁶ of a suspect case should be immediately advised to wear a medical mask, and then triaged to a separate waiting and assessment area immediately. The WHO case definition of a suspect case is living and dynamic, be sure to check <https://apps.who.int/iris/bitstream/handle/10665/331506/WHO-2019-nCoV-SurveillanceGuidance-2020.6-eng.pdf> for the latest case definitions.

No UN personnel should be allowed to enter the UN health facility without having first passed the triage area. A sample layout of the triage area can be found in Annex 16-18 at <https://www.who.int/publications-detail/severe-acute-respiratory-infections-treatment-centre>

WAITING AREA

Within your waiting area, set up a **well-defined and separate waiting area for COVID-19 suspect cases**. This separate area should be designated at least 2 meters away from your regular waiting area. In your waiting area/s, post information like posters and flyers, reminding patients and visitors to practice good respiratory and hand hygiene. Patients should be instructed to stay in this waiting area and not visit other parts of your facility.

Ensure to follow the steps on **“Management of a Suspect COVID-19 Case: Brief Guidelines for UN Medical Staff”** by DHMOSH when evaluating patients for COVID-19. This is available at https://hr.un.org/sites/hr.un.org/files/Coronavirus_SuspectCaseGuide_DHMOSHPH_2020-03-04_0.pdf There is a helpful algorithm on the last page to assist you in your decision-making.

INFECTION PREVENTION AND CONTROL MEASURES FOR SUSPECT/CONFIRMED CASES

Infection control to limit transmission is an essential component of care in suspect/confirmed cases. All suspect cases should be advised to wear a surgical mask to contain their respiratory secretions prior to seeking medical attention. All UN health care workers should be reminded of **WHO's “5 Moments for Hand Hygiene”** per below figure.

⁶ <https://apps.who.int/iris/bitstream/handle/10665/331506/WHO-2019-nCoV-SurveillanceGuidance-2020.6-eng.pdf>



Single Room

Where possible, place any suspect/confirmed COVID-19 patients in a single room with a closed door and dedicated bathroom. In an escalating situation however, there may be lack of single rooms/isolation facilities. Where single/isolation rooms are in short supply, and cohorting is not possible, prioritize patients who have excessive cough and sputum production for single/isolation room placement. Note that if resources allow, an airborne infection isolation room (i.e., a single-patient negative pressure room) should ideally be made available for patients undergoing aerosol-generating procedures⁷.

Cohorting Patients

If a single/isolation room is not available, you can **cohort confirmed respiratory infected patients with other patients confirmed to have COVID-19**. Ensure suspect and confirmed cases are kept physically separated. A 2-meter distance should be maintained by all times between all patients. Use privacy curtains between beds to minimize opportunities for close contact. Where possible, a designated self-contained area should be used for the treatment and care of patients with COVID-19.

This area should:

- Include a reception area that is separate from the rest of the health facility and should, if feasible, have a separate entrance/exit from the rest of the building;
- Not be used as a hallway by other patients, visitors, or staff, including patients being transferred, staff going for meal breaks, and staff and visitors entering and exiting the building;
- Be separated from non-segregated areas by closed doors; and
- Have signage displaying warning of the segregated area to control entry.

Where your health facility can no longer manage patients with mild/moderate disease, patients who are not at high risk for severe disease (i.e. under 60 years of age, no co-morbid diseases) can be isolated in community facilities (e.g. building, tent, temporary structures) with access to rapid health advice (i.e. via dedicated hotline, or telemedicine), or even at home according to WHO guidance. If the patient develops symptoms that may correspond to severe disease or

⁷ Aerosol-generating procedures include tracheal intubation, non-invasive ventilation, tracheotomy, CPR, manual ventilation before intubation, upper endoscopy, and bronchoscopy. Nasopharyngeal or oropharyngeal specimen collection is not considered an aerosol-generating procedure.

complications, ensure rapid referral to hospital.

Depending on local testing strategy and capacity, mild and moderate patients may not be tested, and simply advised to self-isolate in either a cohorted community facility or at home.

WHO provides more operational information on COVID-19 case management in health facilities vs community at https://apps.who.int/iris/bitstream/handle/10665/331492/WHO-2019-nCoV-HCF_operations-2020.1-eng.pdf. Further guidance on laboratory testing strategies can be found at https://apps.who.int/iris/bitstream/handle/10665/331509/WHO-COVID-19-lab_testing-2020.1-eng.pdf.

Other IPC Considerations

Assigning a **dedicated team of staff to care for patients in isolation/cohort rooms/areas** is an additional infection control measure. This should be implemented whenever there are sufficient levels of staff available (so as not to have a negative impact on non-affected patients' care). Ensure that UN health care workers have a rotational shift to ensure proper rest and recovery time.

Limit the movement of patients within the health facility to reduce potential infection throughout the health facility. If the patient needs to be moved, plan the move ahead, all staff and visitors who come into direct contact with the patient should wear appropriate PPE.

Perform regular environmental cleaning and disinfection. Maintain good ventilation, if possible, open doors and windows. Limit the number of visits per patient. All visitors should wear the required PPE and their visits should be recorded.

PERSONAL PROTECTIVE EQUIPMENT (PPE) IN HEALTH CARE SETTING

With regards to **PPE for healthcare workers** caring for a suspect/confirmed COVID-19 case, the WHO recommends⁸ standard, contact, and droplet precautions (i.e. gown, gloves, and mask) with eye (e.g. goggles) or face protection. Note that boots and coverall suits are not required.

WHO recommends that the addition of airborne precautions (i.e. using a particular respirator such as an N-95 – **do a seal check!**) is warranted during aerosol-generating procedures.

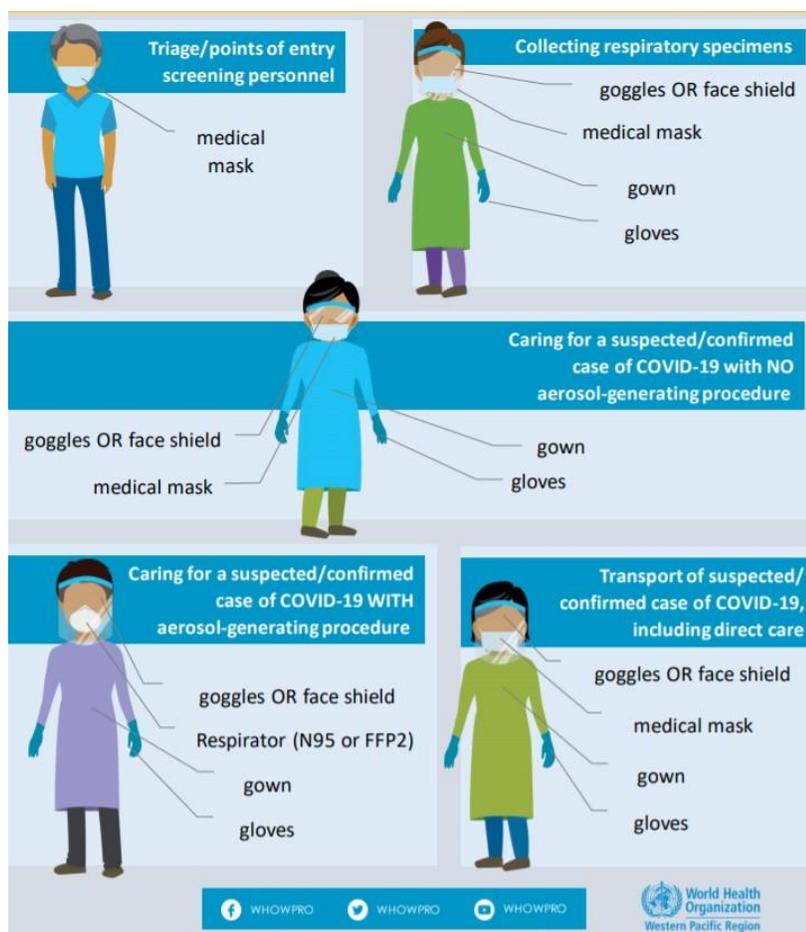
Due to the desire for a more conservative approach, the UN Medical Directors is recommending that airborne precautions (i.e. use of an N-95 mask) should be implemented at all times when caring for a suspect/confirmed case. All healthcare staff who wear an N-95 mask should be fit-tested to ensure an adequate seal/fit according to the manufacturer's guidance. Ensure to conduct a fit check (according to the manufacturers' guidance) every time an N-95 is donned to ensure an adequate seal has been achieved;

PPE should be changed between use and for each different patient. If utilizing single-use PPE, dispose in a waste bin with a lid and wash your hands thoroughly. Anything single-use should not be reused or sterilized.

For a **WHO summary⁹ of the minimum needed PPE by health care activities** conducted, see figure below.

⁸ [https://www.who.int/publications-detail/infection-prevention-and-control-during-health-care-when-novel-coronavirus-\(ncov\)-infection-is-suspected-20200125](https://www.who.int/publications-detail/infection-prevention-and-control-during-health-care-when-novel-coronavirus-(ncov)-infection-is-suspected-20200125)

⁹ <https://iris.wpro.who.int/bitstream/handle/10665.1/14482/COVID-19-022020.pdf>



A detailed table with WHO recommendations on type of PPE to be used for which activity is also available.¹⁰ UN offices should review WHO's PPE recommendations and determine the amount of PPE required by your office/duty station.

ENVIRONMENTAL CLEANING AND DISINFECTION

It is unknown how long SARS-CoV-2 can persist on surfaces; other coronaviruses have been tested and may survive on inanimate surfaces for up to six to nine days without disinfection. To help reduce the spread of COVID-19 virus, environmental infection control procedures should also be implemented. According to the WHO, **routine cleaning and disinfection procedures are appropriate for COVID-19 virus¹¹**. Linens and bedding should also be clean regularly.

In a health care setting, patient isolation rooms, cohort areas and clinical rooms must be decontaminated at least daily. Clinical rooms should also be decontaminated after clinical sessions for patients with suspected/known pandemic COVID-19.

An increased frequency of cleaning and disinfection is important for "frequently touched" surfaces should be cleaned at least twice daily and when known to be contaminated with secretions, excretions or body fluids.

Domestic/cleaning staff performing environmental decontamination should be allocated to specific

¹⁰ https://apps.who.int/iris/bitstream/handle/10665/331215/WHO-2019-nCov-IPCPE_use-2020.1-eng.pdf

¹¹ <https://www.who.int/publications-detail/severe-acute-respiratory-infections-treatment-centre>

area(s) and not be moved between COVID-19 and non-COVID19 care areas; and be trained in which personal protective equipment (PPE) to use and the correct methods of wearing, removing and disposing of PPE.

LAB TESTING RECOMMENDATIONS IN ACCORDANCE WITH CASE DEFINITIONS

The **decision to test a suspect case should be made in conjunction with the local WHO office and the local health authorities'** and in accordance with the local health authorities' case criteria for testing.

In general, WHO recommends that all suspected COVID-19 cases be tested in accordance with WHO case definitions available at: [https://www.who.int/publications-detail/global-surveillance-for-human-infection-with-novel-coronavirus-\(2019-ncov\)](https://www.who.int/publications-detail/global-surveillance-for-human-infection-with-novel-coronavirus-(2019-ncov))

More information on testing strategies as recommended by WHO is available at https://apps.who.int/iris/bitstream/handle/10665/331509/WHO-COVID-19-lab_testing-2020.1-eng.pdf

MEDICAL MANAGEMENT

HOME-BASED CARE

All UN personnel should be made aware of the general COVID-19 precaution measures to take. Where inpatient facilities do not exist for all COVID-19 patients, **for mild to moderate cases of COVID-19, such individuals should stay at home and try to separate themselves** from other people and animals in the household. They should wear a medical mask when in the same room (or vehicle) as other people and when presenting to health care settings.

Cleaning and disinfection of frequently touched surfaces is also important. WHO guidance on home care for patients with suspected COVID-19 who present with mild symptoms and when managing their contacts is available¹².

Patients can discontinue home isolation after 14 days from symptom resolution when using a non-testing based strategy. Where a testing based strategy is used the WHO recommends two negatives tests (PCR) at least 24 hours apart.

CARE IN UN HEALTH CARE FACILITY (WHERE AVAILABLE)

A **step-by-step guide for the UN health care worker on how to identify and manage a suspect case** is found at https://hr.un.org/sites/hr.un.org/files/Coronavirus_SuspectCaseGuide_DHMOSHPH_2020-03-04_0.pdf

For the **clinical management of severe acute respiratory infection (SARI)**, please see WHO recommendations at [https://www.who.int/publications-detail/clinical-management-of-severe-acute-respiratory-infection-when-novel-coronavirus-\(ncov\)-infection-is-suspected](https://www.who.int/publications-detail/clinical-management-of-severe-acute-respiratory-infection-when-novel-coronavirus-(ncov)-infection-is-suspected)

For a practical manual on how to set up and manage a SARI treatment center and SARI screening facility in health care facilities see WHO guidance: <https://www.who.int/publications-detail/severe-acute-respiratory-infections-treatment-centre>

¹² [https://www.who.int/publications-detail/home-care-for-patients-with-suspected-novel-coronavirus-\(ncov\)-infection-presenting-with-mild-symptoms-and-management-of-contacts](https://www.who.int/publications-detail/home-care-for-patients-with-suspected-novel-coronavirus-(ncov)-infection-presenting-with-mild-symptoms-and-management-of-contacts)

TRANSPORT BY AMBULANCE

A dedicated ambulance should be made available for transport of COVID-19 cases. At least two stand-by drivers should be made available.

Within the ambulances, patient segregation can be achieved by:

- Designating an ambulance/s for transfer of patients with suspected/confirmed COVID-19 for the duration of each shift;
- Transporting coughing and sneezing patients on their own whenever possible. However, if pressure upon the transport service occurs, two patients with symptoms of COVID-19 may be transferred together and should wear a surgical mask each.
- Ambulance staff should wear a surgical mask if they will be within 2 meters of the patient.
- All ambulance staff should be trained on how to put on and take off needed PPE.

LOCAL MEDICAL INFRASTRUCTURE AND MEDEVAC

If possible, the preferred option for UN personnel to obtain medical consultation and advice is through the standard local medical infrastructure. Each duty station needs to provide clear guidance to their personnel on how to do that. Each country team, in consultation with the appropriate government offices, should have already identified the most appropriate local health care facilities to treat UN personnel and dependents in case of a COVID-19 case/outbreak in your duty stations in light of the COVID-19 pandemic. Information including what to do if they or their family members have symptoms of COVID-19, which healthcare facilities to go to, whom to notify, etc. should be clearly communicated to all UN personnel. As the duration of the COVID-19 pandemic is unknown it is important that this information is reiterated during the course of the pandemic and whenever new personnel join the office.

If the local medical infrastructure is inadequate or proves unable to cope with demand in the pandemic circumstance, the local UN medical service should prepare to provide support to the extent feasible. Where there is no local UN medical service, Heads of Office should ensure that a practical and realistic plan is in place that optimizes access and considers potential travel restrictions. Clear guidance should be available for all UN personnel on how to access such services regardless of the provider. Requests for medical evacuation of severe cases that cannot be dealt with locally will be dealt with according to the established practice, rules and regulations. It is highly likely that medical evacuation during the current pandemic will be affected, and in many cases, cease due to factors beyond the UN's control such as public health regulations or the logistic difficulties of transporting infectious persons safely, especially across national borders.

Further information on medical evacuation for UN personnel is available at <https://www.un.org/en/coronavirus/reference-documents-administrators-and-managers>

MANAGEMENT OF THE DEAD BODIES

Handling of deceased bodies infected by COVID-19 is different from that of pathogens causing viral haemorrhagic fever e.g. Ebola virus disease. Until more is known about COVID-19 the WHO recommends those who are managing dead bodies to use standard and contact and droplet precautions.

Where the deceased was known or suspected to have been infected with COVID-19, the body

should be packed in a specific body bag with absorbent pads. See: <https://www.who.int/publications-detail/severe-acute-respiratory-infections-treatment-centre> for body bag procurement specifications.

In order to avoid aerosol production it is not recommended to spray the body. If more than 24 hours has passed since the person died, or if burial/cremation is not anticipated in the next 24-48 hours, a second body bag should be used.

Details on post-mortem exam (if performed) and engineering and environmental controls during autopsy are available in the WHO document referenced below.

Cleaning and disinfection procedures should be followed the same as for a room that had a live COVID-19 patient.

See https://apps.who.int/iris/bitstream/handle/10665/112656/9789241507134_eng.pdf?sequence=1 and [https://www.who.int/publications-detail/infection-prevention-and-control-during-health-care-when-novel-coronavirus-\(ncov\)-infection-is-suspected-20200125](https://www.who.int/publications-detail/infection-prevention-and-control-during-health-care-when-novel-coronavirus-(ncov)-infection-is-suspected-20200125) for more information.

CASE REPORTING REQUIREMENTS

Reporting of cases should be to your respective medical directors of your entity. If you do not have one, then follow the reporting requirements here:

https://www.un.org/sites/un2.un.org/files/coronavirus_casereporting_requirements_2020-03.pdf

SPECIAL SITUATIONS

PREGNANT AND BREASTFEEDING WOMEN

Little information is available regarding COVID-19 during pregnancy. Intrauterine or perinatal transmission has not been identified. The risk of COVID-19 infection to pregnant women should be similar to that in nonpregnant individuals, with consideration that pregnant women with other potentially severe respiratory infections, such as influenza, severe acute respiratory syndrome (SARS)-CoV, or Middle East respiratory syndrome (MERS)-CoV, appear to be more vulnerable to developing severe disease.

It is unknown whether the virus can be transmitted through breast milk. However, droplet transmission could occur through close contact during breastfeeding. Thus, mothers with confirmed COVID-19 or symptomatic mothers with suspected COVID-19 should take precautions to prevent transmission to the infant during breastfeeding (including assiduous hand hygiene and use of a medical mask). Women who choose not to breastfeed must take similar precautions to prevent transmission through close contact when formula is used.

PSYCHOSOCIAL SUPPORT

The Novel Coronavirus (COVID-19) Psychosocial Contingency Plan Preparation Guidelines for Staff/Stress Counsellors in the field is available¹³.

¹³ https://hr.un.org/sites/hr.un.org/files/COVID-19%20Psychosocial%20Contingency%20Planning%20Guidelines%2CCISMU%2CUNDSS-16%20Feb%202020_0.pdf

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For more information:

- A dedicated COVID-19 website for UN personnel is available at <https://www.un.org/en/coronavirus>
- A dedicated COVID-19 website for UN health care workers is available at <https://www.un.org/en/coronavirus/covid-19-information-un-healthcare-workers>

For any questions, please contact dos-dhmosh-public-health@un.org