# General Guidelines: Response to COVID-19 within UN Somalia

**In Somalia a UN COVID-19 Case is**:
Somebody suspected, or confirmed to have the COVID-19 virus, in the following categories:

- A UN person[1],
- a UN Camp resident who is not a UN person[2], or
- a non-UN person who routinely enters a UN managed camp.

A non-UN person in the above categories may not be entitled receive UN medical treatment, but it remains important for UN Somalia to be aware of suspected or confirmed cases to inform risk assessment and manage public health (non-medical) preventative measures in UN camps.

**UN Somalia COVID-19 Treatment capacity**
UN Somalia has prepared COVID19 treatment capacity for entitled personnel comprising intensive care unit (ICU) beds and other hospital beds to treat symptomatic patients. Quarantine facilities or arrangements have also been established to monitor non-symptomatic cases, including personnel awaiting COVID-19 test results of a closely associated patient (see full description below).

**Self-quarantine by UN personnel**
A UN person whether in their duty station or in another location, may decide to implement self-quarantine at any time, and then immediately inform their supervisor. In a UN regional office, the Head of office is to be informed. The Heads of all UN entities shall actively monitor members who have taken this decision, and ensure measures are enabled to maintain work output. UN supervisors may instruct members of their unit or section to self-quarantine in response to an identified immediate or urgent concern. This decision and its circumstances are to be immediately shared with the relevant Head of the UN entity and a medical officer.

UNSOS in AAIA, or the RAO in regional offices, is to be informed of UN personnel who are in self-quarantine and any support requirements, such as room service for meals.

The SRSG is to be kept informed of all decisions or proposed actions of self-quarantine taken within UN Somalia, including through the UN COVID-19 Task Force monitoring and reporting arrangements. The SRSG may also direct self-quarantine.

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[1] International civilian, military, police, and justice and corrections personnel, including UNV, GPPs, military and police 'experts on mission' and contingent members. National UN personnel are managed through national healthcare arrangements. Includes UN international personnel resident in a non-UN camp.

[2] Includes AMISOM and contractors' personnel living in a UN camp

## COVID-19 Patient confidentiality

The UNSOS Chief Medical Officer (CMO), SRSG and other UN managers and individual UN personnel are obligated to observe patient confidentiality to respect individual privacy and mitigate against possible stigmatization. The SRSG will ensure this responsibility is managed in a manner that also ensures appropriate measures are implemented to safeguard the health and well-being of all UN personnel in Somalia, and address any potential risk to non-UN personnel and the Somalia population. UN personnel who learn the identity, or suspected identify, of a UN COVID-19 case shall not share this information except for official purposes to enable requisite public health measures.

## Public Health and Safety Prevention Measures

Decisions on public health and safety COVID-19 preventative measures are taken by the SRSG, including through recommendations received from the Crisis Coordinator of the UN COVID-19 Task Force. The range of restrictions imposed on movement will be adjusted based on a risk assessment.

Since March 2020, UN Somalia senior management have implemented several measures to strengthen COVID-19 preventative measures, including for:
- Access into and exit from a UN camp, including access to a PX inside a UN camp
- Approved activities for UN personnel outside a UN camp
- Approved activities for visitors inside a UN camp (e.g. delivery of essential support services)
- Supply and Use of COVID19 PPE for personnel activities that are not part of medical treatment or healthcare services, including for visitors to a UN camp

The COVID-19 situation inside Somalia is closely monitored by the UN COVID-19 Task Force to enable the SRSG to take decisions modifying specific public health measures, in response to the evolving COVID-19 threat to UN personnel.

## Immediate response

Once a suspected '***UN COVID-19 case'*** in Somalia has been reported to, or identified by the CMO or a designated representative, an urgent assessment will be conducted to ascertain if COVID-19 testing is required. The CMO or designated representative shall also immediately provide key details to the SRSG (including through a designated UN official such as the COVID-19 Crisis Coordinator), who will initiate an urgent risk assessment that may lead to development of recommend adjustments to existing public health and safety COVID-19 preventative measures.

## COVID-19 PCR Testing policy

The CMO decides whether COVID-19 testing, known as polymerise chain reaction (PCR) testing, shall be administered to a UN case based on a medical assessment – PCR testing is not automatic. A UN case presenting COVID-19 symptoms is more likely to be PCR tested. 'Close contacts' (see below) of a UN case will not be tested unless symptoms are presented during the 14 days of quarantine. Currently, the time between COVID-19 PCR testing and receipt of results varies, and may take up to several days because the laboratory used is not managed by the UN and may be subject to other prioritisation. UN Somalia are constantly seeking options to shorten delays.

When a UN case is PCR tested and the results are negative, then this case will likely be considered closed, and any 'close contacts' will likely be allowed to leave quarantine, unless they are presenting symptoms.

When a UN case is PCR tested and the results are positive, then the case will be medically managed and further testing will be conducted until two sequential negatives PCR test results are received. The 'close contacts' (see below) presenting symptoms may also be PCR tested.

## Contact Tracing
The primary reference for contact tracing can be found at the WHO Coronavirus website (https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/surveillance-and-case-definitions).

Contact tracing is the process of identifying, assessing, and managing people who have been exposed to a disease to prevent onward transmission. When systematically applied, contact tracing will break the chains of transmission of an infectious disease and is thus an essential public health tool for controlling infectious disease outbreaks. Contact tracing for COVID-19 requires identifying persons who may have been exposed to COVID-19 and following them up daily for 14 days from the last point of exposure.

In UN Somalia, the decision on whether to conduct contact tracing is made by the CMO or a designated representative. The CMO also supervises the contact tracing process.

## Defining Contacts *(reference WHO technical guidance issued on 10 May 2020, please check on the WHO website for updates))*
A contact is defined as anyone with the following exposures to a COVID-19 case, from 2 days before to 14 days after the case's onset of illness:
- Being within 1 metre of a COVID-19 case for >15 minutes;
- Direct physical contact with a COVID-19 case;
- Providing direct care for patients with COVID-19 disease without using proper personal protective equipment (PPE);
- Other definitions, as indicated by local risk assessments, as outlined in the Annex to these guidelines.

## Anti-Body testing
UN Somalia has received several thousand kits of the ***Standard Q-COVID-19 IgM/IgG 'Duo Test'***, which is manufactured by Sd BIOSENSOR in the Republic of Korea and approved by the USA FDA. These kits are available in Mogadishu and can be transported to regional offices who have trained and equipped medical personnel able to administer the test.

The 'duo test' allows qualitative detection for specific antibodies to SARS-Cov2 present in human serum, plasma or whole blood. It can aid to diagnoses of SARS-Cov-2 infection in the convalescent phase of in-patients with clinical symptoms. The test only provides initial screening test results and a PCR test, or similar, should be performed to obtain confirmation. The 'duo test' can be used to help identify acute or early infection because the blood sample can detect antibodies (IgM & IgG, hence 'duo'), which are generated to fight the virus, usually 10 -15 days after initial infection. Diagnosis based on the antibody responses will often only be possible in the 'recovery' phase.

The benefits of taking a 'duo test' include:
- Inexpensive, simple to use and interpret
- Quick results (within 15 minutes)
- Good specificity 96,7% (false positive only in 3% of cases).
- Good sensitivity (95,7% 10 days after onset of symptoms).

The limitations of this 'duo test' include:
- Does not provide definitive confirmation of COVID-19 active infection - a PCR test is required for confirmation.
- Antibody response varies with age, severity illness, medications, & immune status.
- A 'false negative' may be obtained.
- Possible cross-reaction with other coronavirus antibodies ('false positive').
- A 'true' positive result of existing anti-body does not guarantee immunity against COVID-19.
- It is a qualitative test that does not indicate overall immune system response.
- No evidence is currently available regarding risks of re-infection or duration of antibodies or effectiveness and length of immunity conferred by the antibodies.
- WHO currently does not recommend the use of anti-body tests for patient care, although they are encouraging research into the test's performance and potential diagnostic utility.

There may be limitations with administering the duo test in each UN location, and so UN personnel wishing to be tested should submit a request to their local medical team and schedule a visit.

**ANNEX: Examples of Identifying COVID-19 Contacts** *(WHO technical guidelines – 10 May 2020)*

| | Specific contact by setting | Ways to identify contacts |
|---|---|---|
| **Known/identifiable contacts** | | |
| Household and community/social contacts | • Face-to-face contact with a case within 1 metre and for >15 mins<br>• Direct physical contact with a COVID-19 patient<br>• Providing direct care for a COVID-19 patient in the home without proper PPE<br>• Anyone living in the household | • Direct interview with the COVID-19 patient and/or their caregiver(s). This could be done in person or by telephone |
| Closed settings, such as long-term living facilities, and other high-risk congregational/closed settings (prisons, shelters, hostels) | • Face-to-face contact with a case within 1 metre and for >15 mins<br>• Direct physical contact with a COVID-19 patient<br>• Providing direct care for a COVID-19 patient in the home without proper PPE<br>• Sharing a room, meal, or other space with a confirmed patient<br>• If contact events are difficult to assess, a wider definition may be used to ensure that all residents, especially high-risk residents, and staff are being monitored and screened | • Direct interview with the COVID-19 patient and/or their caregiver<br>• List of residents, visitors, and all staff members working during the relevant timeframe<br>• Interview with coordinator or manager of facility |

|  | **Specific contact by setting** | **Ways to identify contacts** |
|---|---|---|
| **Known context, but contacts unknown** | | |
| Healthcare settings | • Health care workers: any staff in direct contact with a COVID-19 patient, where strict adherence to PPE has failed.<br>• Contacts exposed during hospitalization: any patient hospitalized in the same room or sharing the same bathroom as a COVID-19 patient, visitors to the patient, or other patient in the same room; other situations as dictated by risk assessment<br>• Contacts exposed during outpatient visits: Anyone in the waiting room or equivalent closed environment at the same time as a COVID-19 should be listed as a contact<br>• Anyone within 1 metre of the COVID-19 patient in any part of the hospital for >15 minutes | • Identify all staff who have been in direct contact with the COVID-19 patient or who may have been within 1 metre of the COVID-19 patient without PPE for >15 minutes without direct contact (e.g. chaplain)<br>• Review the list of patients hospitalized in the same room or room sharing same bathroom<br>• List of visitors who visited the patient or another patient in the same room during the relevant timeframe<br>• Undertake a local risk assessment to determine whether any additional exposures may be relevant, such as in common dining facilities |
| Public or shared transport | • Anyone within 1 metre of the COVID-19 patient for >15 minutes<br>• Direct physical contact with a COVID-19 patient<br>• Anyone sitting within two rows of a COVID-19 patient for >15 minutes and any staff (e.g. train or airline crew) in direct contact with the case | • Contact identification is generally possible only where there is allocated seating<br>• Airlines/transport authorities should be contacted to obtain details of passengers and flight manifests<br>• For public or shared transport where passenger lists or allocated seating is not available, a media release may be required to request passengers to self-identify. Media release may specify the date, time, pick-up location and arrival/destination, and stops along the way, requesting people self-identify as a potential contact |

| Other well-defined settings and gatherings (places of worship, workplaces, schools, private social events) | • Anyone within 1 metre of the COVID-19 patient for >15 minutes<br>• Direct physical contact with a COVID-19 patient<br>• When events are difficult to assess, the local risk assessment may consider anyone staying in the same close and confined environment as a COVID-19 patient as a contact | • Undertake a local risk assessment and collaborate with organizers/leadership to notify potential contacts either actively or passively (for example, through 'warn and inform' messages to an audience of potential attendees)<br>• Communication with focal points, such as faith leaders, about potential transmission events to raise awareness ('warn and inform')<br>• For private social events, work from guest registration and booking lists<br>• When necessary, consider media release specifying the event day and time, with request for people to self-identify as a potential contact |