Standard Operating Procedure for COVID-19 Related Fatalities

Approved By:

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Abbreviations and acronyms

ICRC	International Committee of the Red Cross
IFRC	International Federation of Red Cross and Red Crescent Societies
IMC	International Medical Corps
IPC	Infection prevention and control
MSF	Médecins Sans Frontières
MoH	Ministry of Health
NTF	National Task Force
PoCs	Protection of civilian sites
PPE	Personal protective equipment
RRT	Rapid Response Team
SOP	Standard operating procedure
SDB	Safe and dignified burial
SSRC	South Sudan Red Cross
TWG	Technical working group on COVID-19
WHO	World Health Organization

1.0 Introduction

During the COVID-19 emergency, it is crucial to enhance and apply infection prevention and control (IPC) measures including but not limited to: appropriate hand hygiene and the rational use of personal protective equipment (PPE) when handling the dead bodies that are either confirmed or suspected to result from COVID-19. It is essential to apply Level 2 Infective control measures to suspected or confirmed COVID-19 bodies as part of control measures that are being applied to safeguard the public health.[1]

Level 2 infection prevention control measures are applied to COVID-19 dead body safe handling management and burial, even due is not classified as level 3 infectious there is risk of Fomite (droplets on surfaces) transmission from the dead body even though the body is no longer breathing

[1] Biological Safety Level (BSL 1, 2, 3, or 4) is typically assigned to a biological lab in order to protect its personnel, environment and community, when such laboratory is involved in handling samples of particular viruses. The airborne transmissible diseases like COVID-19 are typically categorized as Biosafety Level 3 (BSL-3).
For further guidance see: Centers for Disease Control and Prevention, 'Interim Guidelines for Biosafety and COVID-19', 11 May 2020, https://www.cdc.gov/coronavirus/2019-ncov/lab/lab-biosafety-guidelines.html

out droplets. We treat surfaces as contaminated, knowing the length of time virus can survive on different materials and surfaces.

Discouraging family from kissing, touching and unnecessarily handling the body that is why PPE is required and recommended .

All deaths occurring during the emergency should be reported to the Birth and Deaths registration office. Depending on the scenario of spread of COVID-19 the dead bodies could be buried either by families of the deceased or specially authorized teams. Such burials must be carried out in strict observance of the minimum requirements of IPC and safe handling of COVID-19 bodies since the latter might remain contagious and pose a public health risk if managed without the due caution.

In South Sudan, it is the common practice for people to die at their respective residence as opposed to the designated health facilities. Furthermore, the dead bodies regardless of the place of death are frequently prepared for the burial by family members or community / religious leaders. In this context, family members and traditional burial attendants need to be properly equipped and educated in order to ensure safe handling and burial of community members, who have died of suspected or confirmed COVID-19. In addition to the necessary modifications of traditional practices related to handling and preparation of the dead bodies, funeral ceremonies must be equally adapted to ensure physical distance between mourners enhancing hand hygiene, minimizing the number of attendants of the funeral to 12 people to key family members and eliminate contact with the deceased. Such modifications should be implemented in cooperation with the affected communities in order to ensure that management of the dead in times of COVID-19 continues to meet cultural, social, and religious needs of the families.

2.0 Purpose

The primary purpose of the present Standard Operation Procedures (SOPs) is to provide operational guidance on response and communication strategies in managing many COVID-19 related deaths and burials. This document includes sections on engaging the families, proper burial of the deceased and ensuring decontamination of reusable materials and disposal of potentially contaminated none useable materials.

3.0 Scope

The procedures apply to COVID-19 Mortality surveillance team and burial teams and all personnel involved in burial of suspected or confirmed COVID-19 bodies.

4.0 Authorities and Legislation

The National Public Health Bill of 2013 (Directorate of Legislation of the Ministry of Justice – 15.01.2013) sets the legal framework for South Sudan in an epidemic and public health crisis, which in its turn enables deployment of the safe and dignified burial teams.

It shall be the responsibility of the Ministry of Health (MoH) in collaboration with other relevant governmental authorities, including but not limited to the state bodies partaking in the National Task

Force, **agencies and partners** (WHO, MSF, IMC, IFRC, SSRC, ICRC, PoC and Refugee camp management partners) to ensure that management and burial of suspected or confirmed COVID-19 bodies is undertaken in accordance with the SOPs. The MoH can request the agencies and partner organizations for support to be provided in accordance with the dictates of the present SOPs including in the sphere related to the issuance of death notifications.

5.0 Effective Coordination & Planning:

In order to provide a comprehensive response to the COVID-19 the effective coordination between all actors involved in management of the dead should be established based on already existing pillars of case-management, risk communication, surveillance and IPC. The measures directed at enhancement of coordination are expected to have a positive impact on the humanitarian response and planning increasing the effectiveness of the latter beyond the scope of the current outbreak.

Effective coordination needs to be established as soon as possible on several levels and should remain consistent and transparent. It requires excellent two-way communication between all actors involved on all levels.

The COVID-19 National Task Force (NTF) as established by the government of South Sudan with the support provided by the MoH should further clarify roles and expectations in relation to the management of the dead associated with the current outbreak.

Main Responsibilities of National Task Force in relation to COVID-19 fatalities
The NTF will identify agencies responsible for coordinating efforts on the management of the dead (WHO, IMC, MSF, PoC & Refugee camp management partners and/or the National Society[2]).

Identification of led coordination partner by the MoH is essential to handle coordination and providing technical support to the implementing partners dealing with COVID-19 suspected and confirm deaths. The leading implementing agencies responsible for the management of the dead in relation to COVID-19 fatalities should work in close collaboration with the local authorities, religious and community leaders and local funeral parlors at all levels.

In particular the following roles and responsibilities should be properly clarified and attributed:

- Management of the deceased;
- Development of SOPs for collecting diagnosis samples from the deceased (who, when, where, what) and further support of this process.

The NTF shall ensure establishment of a Mortality surveillance team to enhance real-time data of COVID-19 suspected and confirmed deaths and establish real time dissemination of the information and data and its proper analysis that is essential for successful and timely handling and burials of suspected or confirmed COVID-19 bodies.

- During previous outbreaks (in neighbouring countries) local communities have been reluctant to report hemorrhagic fevers (e.g. EVD). Therefore, the authorities concerned as well as the affected communities should be sensitized by risk communication team on the importance of

[2] Some national societies already have SOPs in place for safe and dignified burials, which should be applied in case they are asked to support.

reporting all suspected, probable or confirmed deaths of COVID-19 in order to aid surveillance of and provide an effective and timely response to control the outbreak and prevent further transmission of the virus. If community and religious leaders present on the ground understand why proper management of the COVID-19 cases is important they will be more likely to support the implementation of the present SOPs and contribute to the overall success of the response provided to the outbreak.

- All deaths regardless of their potential cause or place (either health facility or household) should be reported using the national statistics system adopted by South Sudan (e.g. births and death registers).
- All suspected, probable and confirmed cases of COVID-19 should be registered and reported via the same route used for other reportable disease fatalities in order to avoid underreporting of deaths resulting from the present outbreak.

The call center established within the framework of the national public health emergency center (6666) shall be considered as the main hotline for receiving real time alerts on the cases involving deaths that are suspected or confirmed to be caused by COVID-19. This call center should be also used for the purposes of providing the necessary technical support to the Mortality surveillance and dead body management teams, both at National and State level. The Mortality surveillance and dead body management teams will further be technically supported by the WHO, the co-lead for the pillar.

The access to the formal reporting system for documenting all burials at all community levels (central, urban, rural) should be available while the information contained in it should be disseminated to the key partners.

- The reliable data as provided by the COVID-19 body management teams should support EPI-surveillance and analysis in order to identify potential outbreak clusters and guide further prevention and surveillance operations.
- Reliable data collection should be utilized to guide planning and decision making regarding the scope and scale of the overall operational response considered as necessary to bring the outbreak under control.

The leading implementing partners/ agencies responsible for managing deceased patients should:

- Consider the demographics of the population, religious beliefs, customs and traditions surrounding management of the dead (including funerals); undertake a rapid cultural assessment in areas that have not experienced previous outbreaks and adapt COVID -19 dead body management processes in accordance with the respective findings and in consultation with local population including, in particular, community and religious leaders;
- Work in close collaboration with the NTF risk communication and community engagement pillar in order to:
  - Ensure that the facts of the outbreak are effectively communicated using words and language that is easy to understand by the affected communities.
  - Utilize communication channels that are trusted and accessible to the communities (Radio, TV, SMS, Megaphone, Faith based facilities, face to face etc.). As each group and/or community may use different channels of communication, it is preferable to

use a mix of different approaches. During the previous outbreaks messages delivered via music proved to be a successful mode of communicating essential messages on the outbreak and as such can be utilized in the context of COVID-19.

- Establish system of two-way communication for the purpose of collecting rumors, myths, comments and concerns from the affected communities. The information collected shall be further analyzed and used to inform and update relevant activities and response at large, including the necessary update of messages shared with the affected communities regarding COVID-19 and related response. Inaccurate rumors and misperceptions concerning the outbreak and procedures associated with safe and dignified burial should be countered with clear and accurate information provided to the local population.

Primarily, the leading implementing partner and co-lead for the pillar has been identified as WHO.

Additionally, it is worth noting, that despite the ministry of health leading COVID-19 dead body management, several agencies (mentioned above) will provide support and assistance as required and appropriate. These leading agencies may have their internal COVID-19 fatalities protocols and may wish to strictly adhere to assist as per their protocols. These agencies may adhere to their internal protocols provided they are in line with the National SOPs (this document) and the IPC measures do not fall below Infection/Hazard Level 2 for COVID-19 dead bodies as per WHO/CDC recommendations.

6.0 Strategy:

6.1 Epidemic fatality plan:

6.1.1 Description:

The normal societal structures are still functioning. Ensuring technical support briefing note on infection prevention control guidance provided to Families of the deceased emphasizing limiting the number of people to attend the funeral to 12 people, adhering to social distancing of 2 meters, use of mask of all people and hand hygiene establishment provision of clean water and soap all persons practice hand hygiene the families of the deceased are able to carry out burials without posing significant risks to their personal and public health. Health and mortuary facilities continue to hand over the deceased back to their families for burials.

6.1.2 Strategy to address this eventuality:

The families and the facilities need to be supported with basic IPC messages and equipment to minimize the risk of their exposure in the home setting and when they receive their loved ones from a health facility or a mortuary.

The main focus shall be put on development and implementation of the coherent communication strategy and minimization of further transmissions. The Mortality surveillance and contact tracing procedures shall be developed and applied at a community level in relation to suspected or probable COVID-19 deaths.

One aspect for consideration is to have Burial assistance kits at all health facilities, mortuaries, communities and religious leaders offices for the potential use by the families. When a particular family either reports to the facility with a copy of an ID document or collects a body from the health facility/mortuary they should be provided with a kit and offered to sign a liability waiver that would ensure their understanding of importance of compliance with the IPC measures, risks associated with their failure to respect the latter, and potential need to modify some funeral/mourning practices in order to secure safety of the family and the community at large.

These kits can have a form of a single plastic bag containing: a burial information brochure, 10 pairs of gloves, soap/hand sanitizer and a waste disposal bag. Depending on the local availability of body bags, families can be advised to use fabric and or and plastic sheets provided that the burials take place as soon as possible. If the body is received from a health facility or mortuary it should be already placed in a body bag and prepared in accordance with IPC (the body bag should be disinfected before being handed over to the family). In this case dead bodies can be placed in a coffin while wearing gloves and masks in order to ensure necessary protection.

Facilities such as hospitals and mortuaries should abide by more stringent guidelines as detailed in the in the SOP and can consult other guidance document from (WHO, CDC and ICRC) ICRC guidance document for health care and death care workers. (See Annex 1: ICRC COVID-19 Guidance note and its posters).

The adaptation of certain religious/community practices through engagement with the local religious leaders is very important as ritual washing and large funerals to be discourage, must be adapted modified to safeguard the public health. (See Annex 2: Muslim burial posters).

6.1.3 Burials in the community/family

In order to reduce the risk of transmission of COVID-19 during the management of the dead family members, community and religious leaders shall be supported and equipped to carry out safe burials. Apart from necessary materials and technical guidance psychosocial support should be available for all community members supporting burials.

The affected communities should be sensitized and if necessary, further provided with the support to modify traditional funerals to exclude further transmission of the virus.

The affected communities should be engaged while responding to the COVID-19 fatalities in a following manner:

- In order to secure support of the community and avoid the resistance to potential modification of local customs its members should be provided with the comprehensive information regarding the disease and measures necessary to prevent it. Community engagement volunteers might need to respond to fears and misperceptions about handling the dead shared by the affected communities.
- Community feedback, including feedback on perceptions of adapted burials, should be collected and analyzed on a regular basis, to guide the response provided and encourage community engagement.

- Wherever possible, community and religious leaders should be involved before, during and after any support to modified burials and funerals. The local faith leaders can provide their support to the families of the deceased by performing substitution rituals if necessary.

6.2 Mass epidemic fatality plan:

6.2.1 Description:

The community and the existing health/death system are no longer able to deal with the number of fatalities due to a large number of bodies at hospitals/mortuaries that surpass capacities of the latter or a large number of dead in the affected communities, a mass epidemic fatality plan needs to be activated.

6.2.2 Strategy to address this eventuality:

The activation of MoH or multi-agency burial teams shall be necessary. Such teams will be tasked with assisting families, communities and health facilities in retrieving the deceased, documenting the deaths and transporting them for burial in a designated burial site with the family being informed of the time and place for their attendance.

This is done in order to ensure the dignified management of the deceased and the public health concerns surrounding cases are minimized. It shall be treated as an additional measure on top of the previous stage aimed at providing assistance in management of a large number of cases.

It can be envisaged that the transportation of the dead body is operated by the family. However, this option is not recommended unless IPC measures (including an alternative vehicle) are strictly observed.

Given the serious psychosocial impact and distress caused by uncertainty associated with care for the deceased, it is important that communication between the family and those caring for the deceased be ongoing, open and detailed to remove as much uncertainty as is possible. Acceptable care for the deceased may differ according to religious, ethnic and cultural group and it is essential to guard against actions that may be perceived as disrespectful or contrary to existing traditions. Community acceptance is essential to the successful uptake of any policy related to burials, particularly in an emergency context. Opposition to funeral practices may result as part of broader resistance to epidemic response measures, particularly when there is lack of trust or misinformation. Opposition to changes in funeral practices during a pandemic may also result from the failure to fully understand local customary practices, to involve community members in planning alternative practices, or to fully explain modifications and why they are needed. Working with community members helps to balance their needs and public health measures, creating more acceptable guidelines.

During COVID-19 there have been numerous examples of rituals and ceremonies taking place remotely (e.g. memorial between family members in a different location; lighting candles and putting flowers around patient's picture; writing a letter to say goodbye, reading it out loud and burning it; burying a dear possession of the patient, etc). In many settings, the bereaved are encouraged to plan a ceremony or memorial to be held once restrictions are lifted. The act of planning such an event may provide some immediate support. Practices that are chosen and managed by the family and their community, aligned with cultural values, will be the most beneficial.

Grief is a normal response to loss, and for many, coming together for a funeral or other cultural ritual to honor the death of their loved one is an essential part of the bereavement process. COVID-19 has complicated the process of mourning due to the ambiguous loss (grieving without a body). These circumstances may increase the likelihood of one experiencing disrupted, complicated or prolonged grief.

7.0 SOP for burial teams:

7.1 Community engagement to support safe burials

In order to facilitate the management of the dead and ensure its understanding and support from the respective families and affected communities it is recommended to engage the latter with the following aims:

- To ensure that the families and other community members fully understand, accept and support the modified burials before, during and after the burial process has been completed.
- To ensure that the bereaved feel involved and respected throughout the adapted burial process and provided with an opportunity to raise their questions and concerns and see them addressed.
- To alleviate confusion and fear related to burial procedures modified due to COVID-19.
- To involve bereaved families and communities in the burial of their loved ones.
- To assist the communities in dealing with their loss and reducing the associated stigma, while making sure that they fully realize the risks posed by COVID-19.

The burial teams are advised to:

- Inform the family and community members of the justification behind the use of PPE and related precautionary procedures to be followed before the latter is donned.
- Informed in a careful, timely and compassionate manner about what will happen with the remains of their relative and expectations must be sensitively managed. Community and faith leaders can support this process.
- Ensure that the body of the deceased is always handled in a careful and dignified manner while the family is provided with an opportunity to observe the team's conduct.
- Ensure that any procedure throughout the process of management of the dead is discussed and agreed with the family and community members prior to its commencement in order to ensure their support and acceptance.

Inform the family and community members of procedures that will be followed after the burial (e.g. potential tracing of contacts of the deceased) and provide them with the contacts that can be approached for additional information.

7.2 Psycho-education - key messages for people experiencing Grief and Loss:

- **Normalizing grief**: Emotional pain is inevitable after experiencing the loss of a loved one, so mourners should be encouraged to accept their feelings and rely on the support of their friends and family during the grieving process. Each person takes different time to mourn, and no one should be pressured to recover, but rather take his/her own time to recover and ask for support if needed.
- **Holding on to believes and faith** (if the person/family is religious): Faith and believes about the meaning of life and death can help mourners to find emotional peace
- **Normalizing Guilt and Anger**: People can feel guilty and/or angry about the death of their loved. They may feel that the person did not receive enough care or feel guilty for being distant. Explaining that guilt is as normal human reaction to loss and helping the person to focus on the good memories she has from his/her loved one could help to relieve the pain of the mourner.
- **Advising family members to maintain social connectedness** (applying physical distancing measures, etc).
- **Inform people of where they can be supported** for basic needs (provisions, medicines, etc.), if needed, as well as how to access counselling or mental healthcare.
- **Remind mourners and their families to stay healthy**: Taking good care of each other is key during the mourning process (eating and sleeping adequately, taking time to rest and recover).

7.3 Coordination:

The coordination with the local authorities and community leaders should be established to ensure outstanding final marriage and inheritance settlements for relatives of the deceased are postponed until after the outbreak has been declared over. This practice has been found to be one of the barriers for rapid burials of the deceased in previous outbreaks. The following considerations have to be taken into account:

- Work needs to be carried out in close collaboration with the district authorities, religious and community leaders in order to ensure appropriate burial ground has been identified for all religious denominations.
- Muslim communities normally bury their dead in Muslim only burial grounds, therefore cultural practices need to be considered when allocating the land.
- Contact lists of the religious leaders who are leading the different denominations and could potentially perform the religious components of the associated religious traditions in the community should be prepared.

7.4 Stress Management for Burial Teams

Despite the preventative and safeguarding actions taken, safe and dignified burial teams are exposed to high levels of stress, as well as conflicts and misunderstandings with family and community members. Dealing with burials and the grief of family members is likely to exacerbate stress levels, including sleeping difficulties, nightmares or negative thoughts especially in the case of mass burials. Staff should have a self-care plan in place that includes scheduling time for rest, relaxation and leisure; and regularly monitoring negative emotions, psychological and physical discomfort.

- Training in stress management and regular meetings to review guidelines, community leader's suggestions, concerns, fears and threats and ethical dilemmas are advised.
- Creation of a peer support group and/ or buddy system can help to create safe spaces where staff can listen and support each other.
- Supportive Supervision for staff is highly recommended, highlighting aspects of self-care and stress management. Briefing and debriefing meetings to check on staff's well-being are recommended.

7.5 Burial Team planning

- Ensure that all required resources and equipment (PPE, decontamination, disinfection supplies, vehicles etc.) essential to implement these SOPs is available and culturally appropriate. (See Annex 4).
- Establish and train burial teams to implement these SOPs ensuring that roles and responsibilities are well defined and understood.
- Each burial team consists of approximately 8 team members (max), including drivers.
- Ensure that enough burial teams are established to collect a manageable number of deceased per day (see text box below for guidance).

Guidance for The Number of Burial Team/Day

- The collection of a **maximum** of **5 Deceased/Burial Team/Day** is recommended based on lessons learnt from previous outbreaks,
- The collection of **1-2 Deceased/Burial Team/Day** is advised for burial teams that must travel extensively to reach remote locations

The number of cases conducted per day is for guidance and to aid planning only, figures should be adjusted according to the context and set by the TL/TS

7.6 Team Composition

- Team Leader/Risk Communicator – 1;
- Body handlers/carriers – 4 (one of which can be a trained community member if available);
- Hygienist /PPE/OHS – 1;
- Vehicle drivers – 2.

NB: In communities where the burial teams already exist, their members should be considered as part of the body carriers to be trained. Such participation should not be considered as compulsory and shall depend on their willingness to join the team.

Gender balance should be considered while determining the composition of burial teams in communities where the local traditions may limit the access to prepare the bodies for burial. For instance, if a lady dies, and the cultural beliefs do not allow men to prepare the body, female members

of the team will take up the task of preparing the body for the burial. At least one of the body handlers should be a female. However, culturally and socially, it is males who eventually carry the body to its final resting place.

7.7 Responsibilities

Team Leaders: are responsible for many components of the emergency operations including:

- Monitoring security situation on the ground and ensure that all procedures are carried out in accordance with the present SOPs;
- Authorizing adjustments to the safe handling and management of the dead process as requested by the family of the deceased while ensuring that the security of team members and IPC is not compromised;
- Monitoring performance of team members and their psycho-social wellbeing;
- Performing the ongoing incident analysis, ensuring that the team members are debriefed on any critical incidents and that the latter are recorded and reported in accordance with the present SOPs.

Drivers: It is the responsibility of **two drivers** to drive and maintain the hearse / pick-up for the body and an additional vehicle for the team members. The hearse / pick-up should be used solely for the transportation of dead bodies, while the additional vehicle should be used to commute the burial team members.

Trained community members

The Hygienist

- Disinfects the scene of death;
- Decontaminate the beddings that were in contact with the dead body;
- Decontaminate the surrounding environment (especially at community/household level);
- Disinfect the body bag (not the body);
- Disinfects the vehicle at the designated decontamination site;
- Prepares the 0.5% chlorine solution;
- Fills the backpack with the 0.5% chlorine solution;
- Discards the unused 0.5% chlorine solution and cleans the backpack for future use;
- Hands-over the backpack to the logistician for safe keeping.

The body carriers[3] should be adults who shall:

- Prepare the body for burial;
- Transfer the body to the body bag;

[3] Teams can be trained to take the PM swab if the RRT lacks the capacity to cover all requests/needs (recommendation of research articles on SDB).

- Put the body and body bag in the hearse/pick-up;
- Bring down the body bag and the body from the vehicle;
- Lower the body bag and the body to the grave.

All the members of the burial should remain in the vicinity of the graveyard up until the grave is covered with sand and properly marked. The burial team must use an identification mark for each grave, while the family of the deceased shall be provided an opportunity to choose whether to mark the grave of their relative.

The authorized burial team's coordinator or logistician, supervisors, and members of the burial teams should strictly adhere to the provisions of the present SOPs while conducting burials during the COVID-19 outbreak.

Note: The community members should be consulted in order to ascertain of their willingness to be part of a burial team.

At the Depo/base

The logistician of the team shall oversee the logistics supply for the respective team. S/he should ensure that all the supplies for the team are available in adequate quantities and good condition. It is his/her responsibility to take stock of all the supplies and reorder for new stock through the Team Leader. The logistician should issue the needed materials to the team and keep all the re-usable stock for future use. S/he is also responsible for all the PPE stock and all equipment.

7.8 Equipment:

7.8.1 Vehicles:

The vehicles used by through the process of the safe and dignified burial should be reliable and identifiable. They must be also reserved for the use by the designated teams and management of the dead. If the setting requires the vehicle should be 4x4 capable. The vehicle should be easily identifiable as an official vehicle due to security considerations.

Each team would require **one team vehicle** and **one hearse/pick-up** truck to limit the exposure of the transporting team to the dead body.

Team Vehicle:

Depending on the setting the team vehicle should be capable of carrying the full crew along with one driver to any location through the assigned area of responsibility. In South Sudan the hard-top Toyota land cruiser would be an ideal 8-seater vehicle. The hard top shall be used to transport the burial team from their work base, to the place housing the deceased, to the burial ground and back to base.

Hearse:

The hearse can be a 4x4 pickup. The cabin of a driver must be separated with a physical barrier from the deceased. This vehicle shall be used for transportation of the deceased only from the place of death to the designated burial ground. The hearse must to be similarly marked in order to be recognized for its official capacity and the hazardous nature of the cargo. Relatives of the deceased must not be allowed to ride with the coffin. The pick-up should be covered to provide privacy and respect for the deceased, but this is not mandatory.

Note: In localities where automatic vehicles are not available on the ground the alternative means of transportation should be considered provided that relevant IPC measures are strictly observed.

7.8.2 Staff Equipment:

Table 1. Transmission based precautions (TBPs): Personal protective equipment (PPE) for care of deceased during COVID-19 pandemic[4]

	No risk procedures: Team commuting to the scene and dealing with the family	Low risk Procedures*: -Admission of deceased -Placing in a Body Bag -Preparation for viewing -Release of deceased	Medium risk Procedures**: -Rolling deceased -Undressing deceased -Significant manual handling ONLY FOR MEDICAL FACILITIES	High risk Procedures: -Autopsy -Other invasive procedures ONLY FOR MEDICAL FACILITIES
Uniform	Yes	Yes	Yes	Yes
Disposable gloves	No	Yes	Yes	Yes
Disposable plastic apron / re-useable	No	Yes	Yes	Yes
Disposable gown	No	No	No	Yes
Fluid-resistant (Type IIR) surgical mask (FRSM)	Yes	Yes	No	No
Filtering face piece (class 3) (FFP2) respirator	No	No	Yes	Yes
Reusable eye protection	No	Yes	Yes	Yes
Plastic Boots	Yes	Yes	Yes	Yes

[4] Table adapted from '*COVID-19: Guidance for infection prevention and control in healthcare settings*', Department of Health and Social Care, Public Health Wales, Public Health Agency (PHA) Northern Ireland, Health Protection Scotland and Public Health England, 2020.

Uniforms:

Should be provided to teams in order to identify them in their role in the community. It shall also allow them to be identified by the families. The uniform should represent a base layer allowing the PPE to be further donned over it. It is also designed to preserve the teams normal clothing and decrease the risk of accidental transmission. The uniform can be defined as the scrub suits, gloves and reusable wellington boots.

PPE:

Is separated into two distinct categories for burial teams. They both have different usages in the COVID-19 12 step process.

The personal protective equipment (low risk PPE) conforms to the international standards for coming into direct contact with a deceased level 2 pathogen and minimal manipulation. (See Annex 4)

The low risk PPE can be used if there will be no contact between the team member and the deceased or once there is a barrier (i.e. Body Bag) between the team member and the deceased.

7.8.3 Burial Equipment/kit:

IS defined as any further equipment that would be used to support the team in the execution of their duties.

7.8.4 Procedures for Safe management and handling of COVID-19 bodies for Burials

7.8.4.1 Criteria for team activation:

- Notification of possible COVID-19 death through 666 call center and its decentralized offices at state and county level across the country.
- Mortality surveillance team activation or National & State RRT investigators activated
- The Mortality surveillance team / 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 Mortality surveillance team or RRT.
- Location of the burial site is identified.
- Incident manager or local authorities responsible for the dead body management authorize the team deployment.

7.8.4.2 Settings of COVID-19 suspected or confirmed deaths (Annex 0 for diagram):

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

- Community members shall call the mortality surveillance team /RRT – 6666.

- Mortality surveillance team/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 mortality surveillance team/ 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 with the designed burial kit 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 PPE:
    - Medical mask;
    - Water resistant gown;
    - Gloves;
    - Eye protection.
- The burial can be done by the community members following the burial briefing note step by step guidance provided in the burial kit, limits 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.

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

- The medical personnel shall call the Mortality surveillance team/ 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 Mortality surveillance team/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 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.

7.8.4.2.3 Death of an unidentified person suspected or confirmed case of COVID-19

- Call the police forensics department who will collaborate with the Mortality surveillance team RRT or other relevant authority to verify the body (identification).
- Mortality surveillance team/ 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.

7.8.4.2.4 Death of a suspected or confirmed case of COVID-19 in PoCs

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 Mortality surveillance team / 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 preidentified 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 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, 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.

Additional notes:

- For any scenario (partial or total lockdown, restriction of movement to the sites), the dead body management is considered to be a critical activity inside the PoC sites and should be prioritized.

- Trainings to staff handling dead bodies and/or identified community groups will be provided by designated teams (usually led by WHO trainer and composed of MoH and partner volunteers or staff members).
- Designated dead body management agency shall provide PPE to body handlers. Should deaths occur in a health facility, the actor responsible for the health facility will provide PPE to staff handling the dead body.

7.8.4.2.5 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 to avoid excessive manipulation of the body.

Death of a suspected or confirmed case of COVID-19 in custody (National Prisons and detention centers)

- The detention place management shall call the – 6666 to activate Mortality surveillance Team or RRT
- Mortality surveillance team / RRT shall collect a sample from the body (to be sent to the laboratory for further testing/ confirmation) and if not available, the health clinic will take the sample and send it to the lab.
- 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 of the health facility of the detention place.
- Relatives of the deceased shall be immediately notified by the detention place management and asked for collection of the safely prepared dead body (the safely preparation is to be operated by the health facility of the detention place either alone or under the supervision of the RRT) for immediate burial (within 24h maximum). If the family cannot come to the prison within 24h or if no family is reachable/claims the deceased within 24h, the prepared dead body is buried in the nearest burial site.
- 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 (responsibility of the health staff of the detention place to inform the relatives of the deceased of safety measures to take under COVID-19).
- The body handling team (health team of the detention place) should handle suspect and confirmed deaths in the same manner to ensure the staff protection.
- **Burials should not wait for the test results. Burials should be conducted within 24 hours maximum. If the test result is positive, contact tracing should be initiated in relation to the co-detainees of the deceased.**

- No designated site is required for suspected or confirmed COVID-19 cases; the same burial site used for common deaths can be used.

8.0 General procedures:

8.1 12 steps for handling and management of COVID-19 confirmed or suspected dead bodies and burial

Twelve steps have been identified describing the different phases burial teams have to follow in order to ensure safe handling , management of COVID -19 dead body and dignified burials, starting from the moment when the respective team arrives to the community up to their return after completion of the whole process to their respective base (hospital, EOC, 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 considered. 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.

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

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

8.2 Exceptional procedures:

Holding of a body overnight: Annex 9

Decomposed remains (>24 hours): Annex 10

Bodies of children: Annex 11

Post-exposure procedures for staff: Annex 12

Decontaminating the Vehicle after Transporting the Body: Annex 13

Security Situation: Annex 14

OHS considerations: Annex 15

9.0 Documentation to be handed over to the mortality surveillance team (attachment COVID-19 fatality registration form)

9.1 Check Lists and posters:

- 12 step check list (attachment);
- Chlorine preparation check list (attachment);
- Donning and doffing check list (attachment).

Annex 0: Scenario diagram (attachment)

Annex 1: ICRC COVID-19 Guidance note and its posters (attachment)

Annex 2: Muslim burial posters (attachment)

Annex 3: 12 steps for management of COVID-19 Cases (attachment)

Annex 4: PPE definitions, composition and check list

Mask (disposable)

- Must be fluid resistant medical/surgical mask.
- Structured design that does not collapse against the mouth (e.g. duck bill, cup shaped).
- May incorporate a filter or respirator (e.g. FFP2/FFP3/N95).

Goggles or face shield (reusable after disinfection)

- Must fit comfortable and securely.
- Must be anti-fog proof or anti fog applied before donning goggles.
- Goggles/Face Shields need to be decontaminated after every use.

Gloves (disposable)

- Inner layer: single nitrile gloves (not latex).
- Outer layer: rubber glove.

- Double gloving provides an easy way to remove gross contamination by changing an outer glove during patient care and when removing PPE;
- Must be resistant to water and air penetration.

Heavy duty gloves (reusable)

Scrub Suits /OT trouser and shirt (reusable after disinfection)

- Personal clothing should not be worn under the PPE. Scrub suits are provided so that burial teams do not use their personal clothing when performing duties.
- In case of wear and tear, scrub suits can usually be made locally.
- Reusable scrub suits need to be decontaminated after every use.

Protective body wear: coveralls with or without hood and gown (disposable)

This should either consist of either a disposable gown and apron or a disposable hooded coverall and apron.

- Should cover the body completely (from neck to boots and front to back) have long sleeves.
- Should be made of fabric that is tested for resistance to penetration by blood or body fluids or to blood borne pathogens.
- Thumb hooks can be useful to help secure the cuff of the gown or coverall, but they are not mandatory.

Apron heavy duty reusable waterproof apron (disinfected between uses) or disposable

plastic apron

- Aprons should be wide enough to extend around the back of the body and long enough to extend from the neck/upper chest to the top surfaces of the boots.
- Aprons should be labelled with the owner’s name for security purposes.
- Every individual is responsible for ensuring that his or her apron is disinfected after use.

Hooded Head cover

- Hoods with integrated mask with lateral ties.

Footwear (reusable after decontamination)

- Personnel footwear should not be used.
- Rubber boots OR closed puncture and fluid resistant shoes and overshoes.
- Footwear needs to be decontaminated after every use.

When all of the PPE items are worn collectively this is known as donning FULL PPE

BE AWARE

- The eyes, nose and mouth are the most vulnerable parts of the body. Thus, the attention should be given to ensure masks and goggles fit correctly.

- A major problem with goggles can be the condensation that can impair the user's vision and increase the risk of contamination (e.g. if reposition is made while handling the deceased person during the burial procedure) use of the **anti-fog** spray can help to prevent condensation build up.
- If it is not possible for a person to fit their mask and goggles correctly, then they must not be allowed to handle the deceased.
- Hooded head covers should be worn in conjunction with coveralls to ensure the head is fully covered.
- If there is a breach in PPE through accidental exposure caused by injury or tear, follow the post-exposure instructions in Annex 12.

Annex 5: Chlorine preparation check list (attachment)

Annex 6: Application of the Standard Case Definitions in Regard to Deceased Individuals:

The confirmation of the status of the death should be the responsibility of the RRT. The RRT members (surveillance officers, epidemiologists, and clinicians) are responsible for determining the status of the death (whether it is a confirmed, probable or suspected COVID-19 death). In doing so, the RRT should apply the most recent case definitions for the classifications.

- Confirmed case;
- Probable case;
- Non-COVID-19 death.

Annex 7: Cemetery specifications.

1. Beside home burials or burials taking place within community, safe and dignified burials can take place in designated sites that have been identified by the government and approved by local authorities/communities. Such sited should be located within 20 km of the city center and main treatment facility.
2. The cemetery should be fenced and have adequate security for the contexts needs.
3. The cemetery should be 30 meters (almost 100 feet) from any water source and 500 meters from the nearest habitat.
4. Burial depth should be at least 15 meters (50 feet) above ground water table.
5. Incinerator/designated fire pit should be included in design of the cemetery for COVID-19 and disposal of PPE where a large outbreak is observed.
6. The cemetery manager will document every burial and mark each grave with the prescribed burial marker for identification and register the location of each burial.
7. Within the designated area consideration should be given to cultural preferences (such as Muslim Graves orientation) and different sections for specific religions should the situation allow.

8. Should the grave diggers be overwhelmed mass/communal burials should be considered as per the specifications of the ICRC with individual identification of each burial and with the local authority's permission. Example below.

Annex 8: Grave Specifications

1. The grave should be at least 2.4 meters (8 feet) deep and be dug by a grave digger before the burial teams arrive with the bodies. The burial team should liaise with the family of the deceased to identify grave diggers.
2. The Ministry of Health should arrange for the payment of grave diggers
3. The burial team will carefully place the body in a designated pre-dug grave, slowly lowering the coffin or body bag into the grave with a rope.
4. Only one body will be placed in each grave. In case of overwhelming situation authorize mass/communal burial (trench burial) in accordance with ICRC/SSRC mass burial SOPs.
5. All of the clothes or other objects that were given by the family should be buried with the body. These should have been placed with the body into the body bag
6. The burial team will mark the grave[5] with the full names of the deceased, identification number (State abbreviation/County abbreviation/Year/a number XXXX), date of birth and date of death. Lengthy grave marks are highly discouraged. If the family of the deceased provides mark for the grave, the burial team members should document the full name of the deceased, identification number (State abbreviation/County abbreviation/Year/a number XXXX), date of birth and date of death in a register and transmit same to safe and dignified technical working group at the national and state levels for safe keep.

[5] Local metal workers can be employed to make respectful markers and a local calligrapher can write the inscriptions. See Image for reference.

7. The family may place an additional marker should they wish to identify the grave.
8. If the family or mourners do not attend the safe and dignified burial, the burial team supervisor should inform the family of the exact location of the grave in the cemetery.

Figure 1 Example of possible grave markers.

Annex 9: Holding of a body overnight:

Step 9 adaptation: Should the need arise as the team is unable to perform the prescribed burial before 18h00 the body bag may be stored in a designated mortuary holding facility. The case that is retained overnight should be considered as the priority for the burial the following morning.

Annex 10: Decomposed remains (>24 hours):

Step 5 adaptation: Should a deceased be showing advanced stages of decomposition or be deceased for longer than 24 hours all the steps in the 12 step safe and dignified burial procedures should be completed along with the addition of a second body bag double seal (or the use of a leak-proof dead body bag which has a cover over the zip part) and isolation of the deceased.

Annex 11: Deaths of children:

Step 5 adaptation: Deaths of children from COVID-19 should entail additional psycho-social support along with the correct sized body bag to be used.

Annex 12: Post-exposure procedures for staff:

Step 1: Observe a break / puncture / tear or accidental exposure to potentially contaminated body fluids.

Step 2: Discontinue work immediately BUT inform team of the Risk to be avoided.

Step 3: Inform the Sprayer, the Logistician and the Team Leader about the PPE Breach.

Step 4: Proceed to the doffing phase of the 12 steps with additional attention being given to the exposed area being cleaned.

Step 5: Fill in an incident report and report to the incident command.

Step 6: Get medical treatment.

Annex 13: Decontaminate the Vehicle after Transporting the Body

Step 1. The burial team members (Sprayer) disinfecting the vehicle must wear full personal protective equipment.

Step 2. The Sprayer should rinse the interior of the vehicle where the body was carried with strong (0.5%) chlorine (1:10 bleach solution.)

Step 3. The Sprayer should allow it to soak for 10 minutes.

Step 4. The Sprayer should then rinse the ambulance well with clean water and let the ambulance air-dry. The Sprayer should make sure to rinse it well because the solution is corrosive to the vehicle.

Step 5. The Sprayer should decontaminate the ambulance/vehicle irrespective of the occurrence of accidental spills.

Annex 14: Security Considerations:

Step 1: The burial team should be consulted to determine if there is a possible solution to a security incident.

Step 2: If there is in any danger to the burial team they should withdraw to a safe distance and contact the control room for further directions.

Annex 15: OHS considerations

First consideration:

The climatic conditions in South Sudan and challenges associated with wearing the PPE while being under physical strain should be taken into account.

Second consideration:

For the same reason as mentioned above the teams are recommended to carry out a maximum of 5 Deceased/Burial Team/Day based on lessons learnt from previous outbreaks. However, this limit can be expanded if the team is dispatched to treatment facilities.

The burial of 1-2 Deceased/Burial Team/Day is advised for burial teams that must travel extensively to reach remote locations.

Third consideration:

Support for the teams should to be provided in the form of water and food supplies.

Fourth Consideration:

In the event of extended emergency situation, the team’s rotation should be prioritized.

Fifth Consideration:

Vaccination of teams against COVID-19 is a priority when one comes available.

Sixth Consideration: Briefing and Debriefing for teams

The burial Team Leader should organize a briefing and debriefing at the end of any safe and dignified burial process to reinforce the team and sharpen their skills. If there is more than one safe and dignified burial in a day, the Team Leader may decide to defer the debriefing up until after the last safe and dignified burial for the day.

Annex 16: Areas where additional support may be required to ensure smooth operational response:

Managing a response to a COVID-19 outbreak in poor resource settings can be complicated and frequently requires multi-partner and multi-sectoral coordination and communication. Nevertheless, during the complex emergency settings (e.g. internal conflict, failing political and health structures) or protracted infectious disease outbreaks (e.g. 2014 West Africa Ebola outbreak), National Societies may require additional support from their sister agencies, (IFRC or ICRC) in order for them to increase their operational capacity and achieve the program objectives. Additional support may be sought from three main sectors as see in Box 3 below:

Sectors from who to seek additional support		
Operational Support	**Supply Chain Management**	**Health Logistics**
• Security assessment and advice • Fundraising and financing operations (e.g. daily cash, payment of stipends, larger procurement orders), financial gaps and additional awards to meet program expansion in case of protracted emergency • HR-recruitment of specialist staffing (e.g. PSS) • General office support (e.g. administration or finance) • Development of SOPs	• Needs forecasting, estimating quantities based on need/projection of needs • Procurement of medical and non-medical supplies • Warehousing-stock management • Fleet management and good distribution • Coordination at national and provincial/district level • Development of SOPs	• IPC • Community engagement • Post mortem sampling and transportation of samples • Medical utilities; power, water and sanitation, decontamination • environmental considerations for burials (e.g. cholera outbreaks) • Development of SOPs

MSSPH: Mental health component of the SOP on the dead body management

Steps on how to move COVID-19 body from one location to home country

The body can be transported under the condition of adhering to the infection prevent and control measure listed below.

- Ensure the adherence of IPC and safety of staff members that will be involve in the body handling provide them with the minimum required personal protective equipment.
- Gloves (single use, heavy duty gloves)

- Gum boots
- Waterproof plastic apron
- Long sleeve gowns
- Anti-fog googles /face shield
- N95 mask / medical mask

Disinfections supplies to ensure proper safe decontamination during and after the process

- Alcohol based hand rub
- Availability of Clean water for hand hygiene
- Soap
- Disposable towel for hand hygiene
- Disposable biohazard bags for infectious waste collection for final incineration
- Chlorine solution 0.5% for decontamination or ethanol 70% for decontaminating of surfaces of were the body is handled
- Body bag

Very importantly to establish hand hygiene station availability of clean water and soap for hand hygiene.

Ensure all personals involved in the process of handling the body perform hand hygiene with soap and water, and persons not in direct contact with the body should do the same practicing hand hygiene with clean water and soap and ensure social distancing of 2 meters between persons.

The staff handling the body are to be trained on PPE donning and doffing (non-trained staff re not to be involve in the process handling the body until the body is put in a body bag/ coffin)

Note: use two body bags in the event if there is a risk of body decomposition during transportation to destination of burial.

This document has been out together with efforts from MoH,, ICRC, WHO, SSRC, JTH, JMRH, ACTED and MoJ,