Republic of Somaliland

Ministry of Health Development (MoHD)

National Technical Guidelines for Integrated Disease Surveillance and Response (IDSR)
(Tools and Standard Operating Procedures)

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MoHD, Hargeisa, Somaliland

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Acronyms and abbreviations

AAR: After Action Review
AEFI: Adverse Event Following Immunization
AFP: Acute Flaccid Paralysis
CDC: Centers for Disease Prevention and Control
CFR: Case Fatality Rate
EPR: Epidemic Preparedness and Response
EPRC: Emergency Preparedness and Response Committee
FP: Focal Person
HF: Health Facility
ToR: Terms of Reference
I/C: In-Charge
IAR: Intra Action Review
IDSR: Integrated Disease Surveillance and Response Strategy/System
IEC: Information, Education and Communication
ILI: Influenza Like Illness
IMT: Incident Management Team
IPC: Infection Prevention and Control
IT: Information Technology
MCM: Medical Counter Measures
MOHD: Ministry of Health Development
PHEIC: Public Health Event of international Concern
PHEOC: Public Health Emergency Operation Center
PoE: Point of Entry
RC: Risk Communication
RRT: Rapid Response Team
RT-PCR: Real-Time Polymerase Chain Reaction
SARI: Severe Acute Respiratory Illness
SCD: Standard Case Definition
SITREP: Situation Report
SOP: Standard Operating Procedure
TWG: Technical Working Group
WHO: World Health Organization

Acknowledgement

The Ministry of Health Development (MOHD) for Somaliland made a strategic decision to implement the Integrated Disease Surveillance and Response Strategy 2024. With support from the World Health Organization, the MOHD embarked on the steps towards the realization of the first country-owned multi-disease surveillance system. This included advocating and sensitizing relevant stakeholders; conducting a baseline assessment of existing surveillance systems; identification of priority conditions for reporting; development of the IDSR operational plan which includes activities to strengthen integrated surveillance; and development of IDSR technical guidelines for Somaliland with standard operating procedures for implementing IDSR at different levels. IDSR will reinforce preparedness, timely detection and response to public health events in line with the International Health Regulations (IHR 2005).

Previously, Somaliland implemented the Early Warning Alert and Response Network (EWARN) to monitor 15 priority diseases and conditions. During the past years, many changes have occurred in the country health status, social, economic and technical enabling environment. As a result of climate change, Somaliland has experienced drought, cyclones, desert locusts, natural disasters and infectious disease outbreaks such as chikungunya and dengue fever, necessitating the need to review the evolving public health priorities for disease surveillance and response.

The transition from EWARN to IDSR was necessitated by the need to conduct surveillance for priority conditions, including emerging and re-emerging diseases and zoonoses; expand surveillance to more sites; collect additional data on detected cases; conduct further surveillance data analysis. The selected 47 diseases and conditions will be used the IDSR surveillance data collection for purposes of outbreak detection and response; and MoHD have ownership of the whole integrated Diseases Surveillance & Response (IDSR) system in the country.

These technical guidelines have been developed and reviewed by subject matter experts within MOHD and partners. Thus, I urge all healthcare professionals tasked with carrying out various surveillance duties across all tiers of the healthcare system in Somaliland to strictly adhere and adopt these guidelines, tools, and standard operating procedures (SOPs) during their IDSR surveillance activities.

Additionally, I ask all collaborating partners involved in the execution of surveillance-related functions to utilize these tools and abide by the procedures outlined in these guidelines of MoHD, Somaliland.

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I acknowledge the following people for their tireless effort in developing, reviewing and validating these IDSR technical guidelines for Somaliland.

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Introduction and background

Integrated Disease Surveillance and Response (IDSR) is a comprehensive evidence-based strategy for strengthening national communicable disease surveillance systems for all priority conditions at all levels (community, facility, district, region and national) of the health system. IDSR seeks to improve **integration** and **coordination** when conducting public health surveillance. Integration means that the same structures, processes, tools and human resources are used to conduct similar surveillance functions for all priority conditions at all levels of the health system. Coordination means aligning the resources and activities of the different actors to jointly defined surveillance priorities/activities. It includes joint planning, joint information sharing and joint supervision, monitoring and evaluation.

Among others, implementation of the IDSR strategy;

1. Strengthens the capacity of countries to conduct effective surveillance and response activities at all levels of the health system
2. Increases involvement of clinicians and other cadres of health staff in surveillance activities
3. Integrates multiple surveillance systems so that tools, personnel and resources are used more efficiently.
4. Improves the triangulation, aggregation and use of information to detect changes in disease trends in order to conduct a rapid response to suspected and confirmed outbreaks
5. Improves the flow of surveillance data between and within levels of the health system
6. Builds strong laboratory systems/networks at national, regional and district levels
7. Triggers epidemiological investigations of reported public health problems and the implementation of effective public health interventions.
8. Brings surveillance and response as close together as possible
9. Mounts an effective response to public health emergencies
10. Emphasizes community participation in detection, reporting and response to public health problems

These guidelines specify the standard tools and Standard Operating Procedures (SOPs) for conducting all the core and support functions of IDSR at national, regional, district, facility and community level in Somaliland.

IDSR as a platform for implementing Early Warning Systems, IHR and One-Health requirements

Early Warning Alert and Response Network (EWARN)

EWARN is a surveillance system normally established rapidly in settings where the routine surveillance system has broken down, is ineffective or does not exist to rapidly detect and respond to alerts of

selected epidemic prone conditions. IDSR has 2 types of reporting; immediate reporting and weekly reporting. The immediate-reporting component of IDSR serves the same functions as EWARN.

International Health Regulations (IHR)

International Health Regulations (IHR 2005) is a legally binding agreement that requires its 196 member states to prevent, protect against, control and provide a public health response to the international spread of diseases in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade.

One Health (OH)

One-Health (OH) is an approach to address shared health threats at the human-animal-environment interface at all levels of the health system. One Health is based on collaboration, communication, and coordination with the ultimate goal of achieving optimal health outcomes for both people and animals. Intersectoral collaboration, communication and coordination are intrinsic and strongly re-enforced by IHR (2005) and the IDSR strategy

IDSR, IHR and the OH all focus on improving systems for timely response to acute public health events/conditions through early detection, verification, notification and response.

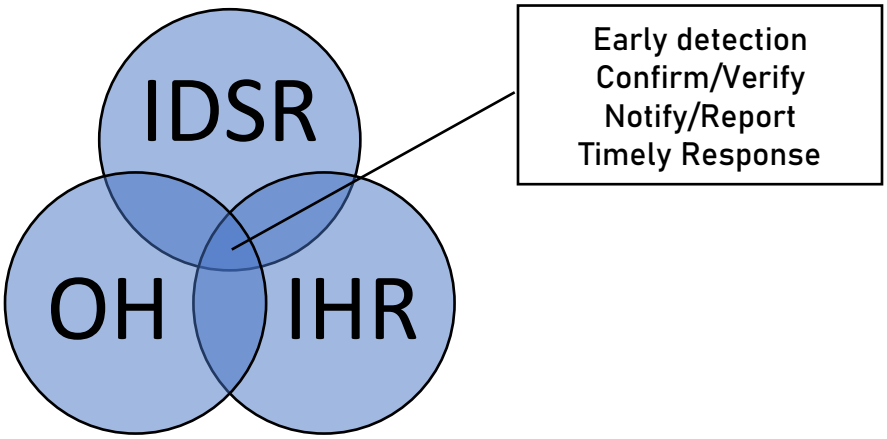

Figure 1: Intersection between One-Health, IHR and IDSR

Surveillance System Functions

Surveillance system functions are standard activities/processes that are required to be conducted systematically and continuously by a surveillance system. Core surveillance system functions include; 1) detection, 2) reporting, 3) data analysis and feedback, 4) outbreak investigation, 5) preparing to respond, 6) responding to outbreaks and 7) risk communication. Support surveillance system functions

include 1) laboratory support, 2) Information Technology (IT), 3) coordination, 4) training and supportive supervision, 5) monitoring and 7) evaluation.

Identification (and recording) of cases of priority conditions

This is the systematic application of standard case definitions to detect cases of priority conditions at health facilities, in the community or at Points of Entry (PoEs).

Reporting of priority conditions

There are 2 types of reporting; *immediate* (which is case based) and *weekly* reporting (which is aggregate). Immediate case-based reporting is the use of the fastest means possible by the surveillance focal person (at the health facility or in the community) to share information on a priority condition as soon as it is detected by completing and submitting a case-based reporting form. Weekly reporting is the reporting of aggregate summaries of all cases (and deaths) seen in the previous epidemiological week which is done by completing and submitting a weekly aggregate reporting form. Weekly reporting also includes ZERO reporting; which means reporting a ZERO for a condition which was not detected in the week being reported instead of leaving the cell blank.

Data analysis and feedback

This is the validation, aggregation, cleaning, analysis, sharing and use of surveillance data analysis findings to inform decision/action at different levels of the health system. In these guidelines, we describe the procedure for minimum data analysis at facility and the epidemiological bulletin produced weekly at national level and disseminated to all levels of the health system.

Outbreak Investigation

This is the systematic process of collecting and analyzing data to; 1) confirm an outbreak, 2) identify and treat affected cases, 3) describe the outbreak, 4) identify factors associated with spread of the outbreak, 5) identify and implement effective response interventions and 6) strengthen prevention activities to reduce re-occurrence of outbreaks in the future.

Preparedness

This refers to the availability of outbreak preparedness and response plans, stockpiling of logistics and supplies (vaccines, drugs and laboratory reagents), designation of isolation facilities, setting aside resources for outbreak response and training of relevant personnel for outbreak investigation and response. Currently there is no multi-hazard preparedness and response plan for Somaliland, and there is need to develop this plan. Preparedness also includes establishing functional coordination

committees, mapping stakeholders, developing and testing contingency response plans for high-risk hazards and establishing functional rapid response teams (RRTs).

Responding to outbreaks of priority conditions

This is the implementation of systematic actions to a confirmed outbreak. It includes notification of the Director General of health services, activation of the outbreak response coordination structures, deployment of rapid response teams (RRTs), review and updating hazard specific contingency plans, mobilization of resources, implementation of standard outbreak response interventions, conducting an intra-action review (IAR) if required, declaring the end of the outbreak, production of an outbreak response report and conducting an after-action review (AAR).

Risk communication

This is the real-time exchange of information, advice and opinions between experts, community leaders, or officials and the people who are at risk. Risk communication encourages future cooperation by communicating with all levels including communities that provided data, reported outbreaks, cases and events, about the investigation outcome and success of response efforts.

Supportive supervision, monitoring and evaluation

According to these guidelines, supportive supervision refers to quarterly review of IDSR implementation at facility level, identification of IDSR challenges, their causes and development of feasible solutions. Monitoring refers to monthly tracking of planned IDSR activities/indicators at facility. Evaluation refers to every 2.5- and 5-year assessment of the extent to which surveillance and response system objectives have been achieved and the explanation behind the level of achievement.

Summary of IDSR structures, data flow and functions for Somaliland

Sites for detection of priority conditions in Somaliland include; the community (by CHWs), Points of Entry (PoEs) and health facilities. Facility case definitions will be used by trained health workers to detect priority conditions at health facilities. Community case definitions will be used by trained community health workers (CHWs) to detect cases of priority conditions in the community. When a case is reported by CHWs, the same case should be referred to the nearest health facility for further management. Cases of priority conditions detected at facility level will be reported on immediate and weekly basis into eIDSR/DHIS2. Immediate reporting also includes notification of WHO country office (with 48 hours) of any confirmed outbreak or any condition with potential to cause a Public Health Event of International Concern (PHEIC).

A condition reported by a health facility on an immediate basis into DHIS2 (called an alert) will automatically generate and send a request for alert verification to the district surveillance officer. Within 24 hours of the alert being reported, the district surveillance officer will be required to verify the alert. Alert verification involves calling the reporting health facility to check if the reported information is accurate/true. If the reported information is accurate/true, the alert becomes a true alert, which is also known as a suspected case. Once a case is suspected, the district surveillance officer will work with the district rapid response team (RRT) to conduct a detailed investigation of the true alert/suspected case with technical and logistical support from upper levels if required/requested.

Analysis of all data reported through immediate and weekly reporting from health facilities will be automated by eDHIS2. The analysis results will be provided in real time through the eIDSR dashboard on the DHIS2. At any level of the health system, technical persons who have access to the eIDSR dashboard will be able to view the data analysis results to inform their actions/decisions.

Any surveillance level above should provide support supervision, training, feedback, laboratory support and logistical and technical support to the surveillance level below. The flow of eIDSR data/information in Somaliland's surveillance and response system is summarized in figure2.

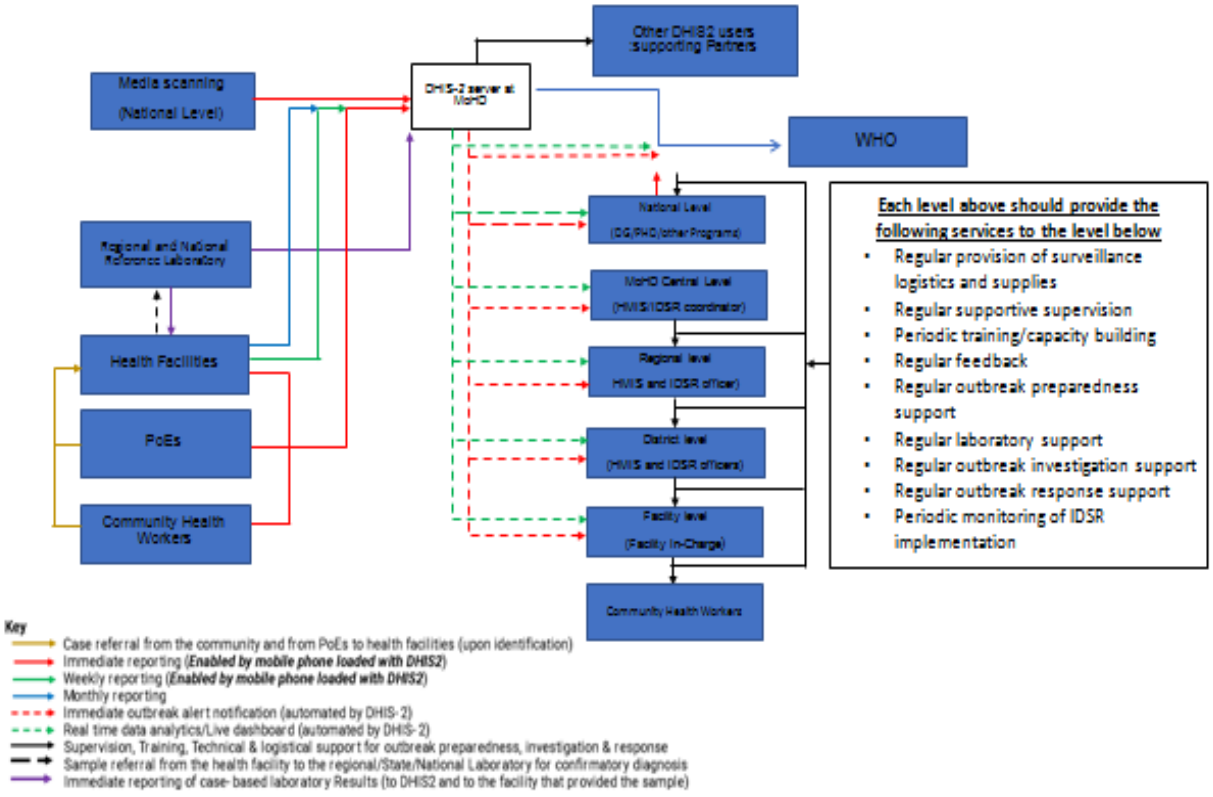

Figure 2: Reporting Structure of Somaliland's Integrated Disease Surveillance and Response System

Summary of Community-Based surveillance (CBS)

Community Based Surveillance (CBS) involves a network of Community Health Workers (CHWs) who are given basic training, provided with basic supplies and supervised to routinely identify, refer and report any unusual events from their community to the nearest health facility. CBS is one of the functions of Community Health Workers (CHWs). It is important to note here that CHWs have other functions like participation in community nutrition and vaccination programs beyond CBS. CBS is linked to facility-based surveillance. Figure 2 describes how priority conditions detected through CBS and data on CBS is integrated with surveillance data from other sources. To identify cases of priority conditions, CHWs will use community case definitions. These will be translated into the local language. Health facility in-charges will provide regular training to CHWs on how to use the community case definitions to identify, refer and report any unusual events/diseases in the community. CHWs will regularly visit households and community gatherings (like mosques and markets) in their community to look out for any unusual events/diseases as described in the community case definitions. On identification of any unusual events/diseases in the community, CHWs will as soon as possible report and refer the detected event/disease to the nearest health facility. If possible, CHWs will capture some minimum information on the reported unusual event using a simplified version of the immediate case-based reporting form. On a monthly basis (or any frequency determined by the in-charge of the nearest health facility), CHWs will meet at the nearest facility for supportive supervision and feedback on the cases/unusual events they reported during the previous month. The CHWs will take this feedback back to their communities.

Use of information technology (IT) can improve timely reporting and response unusual events/diseases from the community. Where IT is used, collected CBS data should be integrated within the broader national HMIS as reflected in figure 2. In line with these IDSR guidelines, detailed CBS guidelines in form of a simplified booklet, containing the simple case definitions, using pictorials and in the local language, clearly describing how community health workers (CHWs) should detect, report and refer priority conditions from the community to the nearest health facility will be developed and widely disseminated to all CHWs in the country.

Summary of Event Based Surveillance (EBS)

Outbreak alerts can be detected through a combination of both Indicator Based Surveillance (IBS) and Event Based Surveillance (EBS). Indicator Based Surveillance (IBS) involves the systematic ongoing

collection and analysis of disease specific data to detect and respond to outbreak alerts in a timely manner. IBS is facility based. Event Based Surveillance (EBS) involves the systematic ongoing collection and analysis of unstructured, non-disease specific data looking out for possible signals of outbreaks or potential events of public health concern. Integrating both IBS and EBS concurrently increases the sensitivity of the surveillance system. In Somaliland, EBS will be implemented at community level, facility level and at national level. The integration of Event Based Surveillance (EBS) with Indicator based Surveillance (IBS) and with the national HMIS is reflected in figure 2. For EBS at community level; a list of unusual events (like cluster of deaths, cluster of illnesses) and their definitions is part of the community case definitions. Within the broader plans for CBS, CHWs will routinely be trained and supervised to increase their detection and reporting of unusual events. A list of unusual events like cluster of illnesses, cluster of deaths, chemical and radio nuclear events to be detected at health facility level has been developed and their definitions are part of the facility case definitions. Health facility-based health workers will be trained and routinely supervised to increase their suspicion, detection, investigation and response to unusual events for EBS at national level.

In the future, media scanning, which is also a critical part of event-based surveillance, will be established at the national level. Software and the required hardware for media scanning will be procured and installed at the national level office responsible for surveillance. National level staff will be selected and trained on how to conduct media scanning for potential alerts/signals of outbreaks. This will involve the scanning of multiple online media. Upon identification of any alerts, an automated signal will be generated and sent to the head of surveillance at the affected level for further investigation. Detailed guidelines for media scanning at the national level will be developed while ensuring that the data generated from media scanning activities is integrated within the broader national health information management system (HMIS).

Summary of Surveillance and Response at Points of Entry (PoEs)

Points of Entry (PoEs) refer to international airports and ground crossing points between Somaliland and its neighbors. To prevent, quickly detect and respond to outbreak alerts and other potential public health events (PHEICs) at these PoEs, International Health Regulations (IHR 2005) require that certain capacities are developed at these PoEs. These capacities include both routine and emergency capacities. At the minimum, every PoE will have a health desk, operated by at least one CHW. The desk will serve as a screening point for persons entering into Somaliland. In-coming travelers will also be screened for

signs/symptoms suggestive of priority diseases in figure 8. Travelers meeting the community case definition of any of these priority diseases will be recorded, reported and referred to the nearest health facility of the community where the PoE is located. In regions and districts with PoEs, a technical officer from the PoE will be part of the regional level or district level surveillance coordination structure. At national level, MOHD will engage the ministries of health of its neighbors to develop a framework for bilateral cooperation in the planning and implementation of joint cross border outbreak preparedness and response activities, including prompt sharing of information on current outbreaks in border communities. At lower levels, joint cross border surveillance and response committees having representation from either side of the border will be established. During times of no outbreak on either side of the border, the joint cross border surveillance and response committee will coordinate (through less frequent joint meetings) development and implementation of joint preparedness capacities like joint designation of PoEs and joint simulation exercises. When there is a confirmed outbreak in the local community sharing a border with Somaliland, screening at the health desk on Somaliland's side of the border will be intensified. During this time, the cross-border committee will meet more frequently and intensify sharing of outbreak preparedness and response information. When the same outbreak is confirmed on both sides of the border, beyond country specific outbreak response activities, the cross-border committee will coordinate the implementation of planning and implementation of joint cross-border outbreak response activities. Detailed guidelines for development and implementation of basic and public health emergency preparedness and response capacities at PoEs will be developed. These guidelines will be aligned with these national technical guidelines for IDSR.

Summary of Rapid Response Teams (RRTs)

The concept of Rapid Response Teams (RRTs) is at the center of effective outbreak preparedness and response. Below, the operationalization of the RRT concept in Somaliland is summarized. Rapid Response Teams (RRTs) are constituted to lead on investigation or response to a suspected or confirmed outbreak. The generic composition of the RRT is indicated in figure 10. The exact composition of the RRT will depend on the nature of the outbreak and its scale (size). The generic functions of the RRT are also reflected in figure 20. At the time of outbreak investigation or response, the exacts roles of the RRT will be specified in the terms of reference (ToRs) of their deployment. Every level of the health system should have some level of capacity to investigate and respond to a suspected or confirmed outbreak. Therefore, RRTs should exist at all levels of the health system. The primary focus of building RRT capacity in Somaliland is the district. RRT capacity will also be built at other levels of the health system. During

outbreak investigation and outbreak response, and when required, the higher level RRT will support the lower level RRT. Being a member of the RRT is a responsibility but not a fixed position. RRTs are constituted when there is a specific suspected or confirmed outbreak to investigate or respond to. During times of no outbreaks, RRTs should be trained how to investigate and respond to suspected and confirmed outbreaks. The generic structure of outbreak investigation is shown in figure 2. World health organization (WHO) will provide technical support in building the capacity of the national level RRT. National level RRTs will build the capacity of regional level RRTs. Regional level RRTs will build the capacity of district level RRTs. During times of no outbreaks, RRTs will be involved in planning and implementing preparedness activities as detailed in figure 37 and implementing their routine functions. When investigating or responding to a suspected or confirmed outbreak, the RRT reports to the IMT (Incident Management Team). In other words, the RRT is the operational arm of the incident management team (IMT). When investigation or response to a specific outbreak is over, the RRT should be decommissioned. RRT members will then resume their routine duties and responsibilities within the health system. A detailed curriculum for training RRTs including a plan, schedule and budget for conducting standard and refresher RRT trainings will be developed. This will be aligned with these IDSR guidelines

IDSR matrix: Key IDSR functions and their responsible persons

At any one level of the health system, multiple technical persons are involved in the implementation of IDSR functions. These, however, need leadership. At any level, there should be a team of technical people directly responsible for leading on and coordinating IDSR related functions. The technical persons responsible for leading IDSR implementation at different levels of the health system in Somaliland are shown in figure 3.

Level	IDSR Team	IDSR Team lead or Focal Person	Major IDSR Functions to be led by the IDSR Team Lead/Focal Person
WHO	OIC National PH/Surveillance/Officer	National Surveillance/ Public Health Officer	1. Provision of technical support to MOHD for IDSR implementation
National	Director Public Health National IDSR coordinator National HMIS head National Emergency Response Head National PHEOC Head National Public Health Lab Head	National IDSR Coordinator	1. Coordination of IDSR implementation 2. Mobilization of resources for IDSR 3. Technical support to the regions 4. Production of the weekly epi-bulletin 5. Quarterly supportive supervision to the regions

Regional	Regional Medical Officer Reginal HMIS coordinator Regional surveillance coordinator Regional Laboratory coordinator	Regional IDSR Surveillance coordinator	1. Provision of technical and logistical support to the districts 2. Quarterly supportive supervision to the districts
District	District Medical Officer District HMIS officer District surveillance Officer	District Surveillance Officer	1. Verification of reported alerts 2. Investigation of suspected cases and outbreaks 3. Quarterly supportive supervision to the health facilities
Health Facility	Health Facility In-Charge Health Facility data focal person	Health Facility In-Charge	1. Identification of cases 2. Recording of cases 3. Immediate reporting of cases of priority conditions 4. Weekly aggregate reporting
Community	Community Health Worker	Community Health Workers	Reporting (and referral) of cases from the community to the nearest health facility

Figure 3: Key IDSR functions and their responsible persons

Detection of IDSR conditions

List of sites participating in IDSR

Every district surveillance officer/focal person will maintain a list of facilities in the district participating in IDSR and the people who are reporting to the surveillance officer. The list should be updated regularly and shared with the next surveillance level. The template for sites participating in IDSR at district level is provided in figure 4.

Somaliland Ministry of Health Development
Integrated Disease Surveillance and Response
List of facilities participating in IDSR

District:
Region:

Site name		Facility	Name of surveillance focal person	Contact of surveillance focal person
1				
2				
3				
4				
5				

6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
.....				
Name and contact of district surveillance focal person				
Name and contact of regional surveillance focal person				

Figure 4: Template for list of sites participating in IDSR at district level in Somaliland

Priority Conditions for IDSR in Somaliland

IDSR deals with conditions for immediate and conditions for weekly reporting. In total, Somaliland prioritized 29 conditions for weekly reporting. Out of these, 25 will also be reported on an immediate basis. These are shown in detail in figure 5.

Somaliland list of IDSR priority conditions and frequency of reporting

Prioritized Diseases, Conditions and Events for IDSR notification and reporting

Final revise 21.6.2024

No	Priority Disease/Event/Condition	Categorization	Reporting Frequency
1	Adverse Drug Reaction (ADR)	Public Health Importance	Immediate
2	AEFI	Public Health Importance	Immediate
3	Chemical event	IHR	Immediate
4	SARS	IHR	Immediate
5	Zika	IHR	Immediate
6	Acute Flaccid Paralysis	Epidemic prone	Immediate/Weekly
7	Acute Hemorrhagic Fever Syndrome	Epidemic prone	Immediate/Weekly
8	Dengue Fever	Epidemic prone	Immediate/Weekly
9	Chikungunya	Epidemic prone	Immediate/Weekly
10	Acute Jaundice syndrome	Epidemic prone	Immediate/Weekly
11	Acute Watery Diarrhea/Cholera	Epidemic prone	Immediate/Weekly
12	Anthrax	Epidemic prone (also OH)	Immediate/Weekly
13	Bloody diarrhea	Epidemic prone	Immediate/Weekly
14	Brucellosis	Epidemic prone (also OH)	Immediate/Weekly
15	Cluster of deaths (humans or animals)	Epidemic prone (also EBS)	Immediate/Weekly
16	Cluster of illness (humans or animals)	Epidemic prone (also EBS)	Immediate/Weekly
17	COVID-19	PHEIC	Immediate/Weekly
18	Influenza Like Illness (ILI)	Epidemic prone (also OH)	Immediate/Weekly
19	Measles	Epidemic prone	Immediate/Weekly

20	Diphtheria	Epidemic prone	Immediate/Weekly
21	Whooping Cough (Pertussis)	Epidemic prone	Immediate/Weekly
22	Meningococcal Meningitis	Epidemic prone	Immediate/Weekly
23	Rabies	Public Health importance	Immediate/Weekly
24	Rift Valley Fever	Epidemic prone (also OH)	Immediate/Weekly
25	Severe Acute Respiratory Illness (SARI)	Epidemic prone	Immediate/Weekly
26	Typhoid fever	Epidemic Prone	Immediate/Weekly
27	Yellow Fever	Epidemic prone	Immediate/Weekly
28	Maternal Death	Public Health importance	Weekly
29	Neonatal Death	Public Health importance	Weekly
30	Neonatal Tetanus	Elimination/Eradication	Weekly
31	Perinatal Death	Public Health importance	Weekly
32	Acute and chronic Hepatitis	Public Health importance	Monthly
33	Confirmed Malaria cases	Public Health importance	Monthly Weekly
34	Diabetes (new cases)	Public Health importance	Monthly
35	HIV/AIDS (new cases)	Public Health importance	Monthly
36	Hypertension (new cases)	Public Health importance	Monthly
37	Injuries (RTAs) (new cases)	Public Health importance	Monthly
38	Malnutrition (<5 years) (new cases)	Public Health importance	Monthly
39	Mental disorders (new cases)	Public Health importance	Monthly
40	Multi Drug Resistant / MDRX TB	Public Health importance	Monthly
41	Polio (lab confirmed)	Epidemic Prone/IHR	Immediate
42	Severe Pneumonia in <5 years	Public Health importance	Monthly
43	Sexually Transmitted Infections	Public Health importance	Monthly
44	Snake Bites	Public Health Importance	Monthly
45	Trachoma	Public Health importance	Monthly
46	Tuberculosis (new cases)	Public Health importance	Monthly

Fig 5: List of priority conditions for IDSR and their frequency of reporting

Case definitions for priority conditions for IDSR in Somaliland

A case definition is a standard criterion applied to determine whether a case can be classified as having a given priority condition or not. Case definitions used by community health workers/volunteers to identify priority conditions from the community are called community case definitions and are more simplified than those used by health workers in health facilities. Community case definitions for priority conditions for IDSR in Somaliland are given in figure 6. These have been translated into the local language. Facility case definitions for priority conditions for IDSR in Somaliland are given in figure 7. These have also been translated into the local language. The facility case definitions should be available at all IDSR-participating health facilities at all times. All persons responsible for application of these case definitions whether at community or health facility level should regularly be trained and supervised to effectively apply these case definitions in identification of priority diseases/events/conditions for IDSR.

No	Priority condition	Community case definition	Local Language Translation
1	Adverse event following immunizatio n	Any unusual health event that follows immunization	Dhacdo kasta oon caadi ahayn lana xidhiidha caafimaadka qofka uu keenay tallaal.
2	Chemical event	A deliberate or accidental uncontrolled release of a chemical from its usual storage to the environment (land, air or water)	Kiimiko si kas ah ama kama'a loogu sii daayay deegaanka(dhulka, hawada ama Biyaha).
3	AFP	Any sudden muscle weakness or paralysis in a child less than 15 years of age	Xaalad kasta oo degdeg ah curyaamida ama daciiftinimo murqaha ah, taas oo saameysa ilmo ka yar da'da 15 sano jir
4	Acute Haemorrhag ic Fever Syndrome)	Any person who has an unexplained illness with fever and bleeding or who died after an unexplained severe illness with fever and bleeding	Qofkasta oo qaba xanuun aan la aqoonin oo qandho iyo dhiig-baxleh, amaba u dhintay xanuun daran oo aan la garanaynin oo leh qandho iyo dhiig-bax.
5	Acute Jaundice Syndrome	Sudden onset of yellowing of eyes	Indhaha oo si lama-filaana u noqda huruud
6	Acute Watery Diarrhoea (Cholera)	Any person with a rapid onset of frequent watery non-bloody watery diarrhoea	Qofkasta oo uu kubilaabmo shuban biyood isku xiga oo degdega dhiigna aan lahayn.
7	Bloody Diarrhoea (dysentery)	Any person with diarrhoea, and visible blood in the	Qofkasta oo shubma, Saxaradiisana lagu arki karo dhiig

		stool	
8	Brucellosis	Persistent fever not responding to anti-malaria	Qandho joogto ah oon ku ladnaan daawooyinka Duumada
9	Cluster of deaths	Two or more deaths (both humans and animals) in the same community in the same week with symptoms that did not respond to the treatment for the usual causes of such symptoms	Dhimashada laba ama in ka badan (dad iyo xayawaan-ba) oo bulshada dhexdeeda ka jira, waliba hal toddobaad gudihiisa oo leh astaamo aan ka jawaabin daaweynta sababaha caadiga ah ee calaamadahaas.
10	Cluster of illness	Two or more cases (humans or animals) in the same community in the same week presenting with similar signs/symptoms that did not respond to the treatment for the usual causes of such signs/symptoms	Laba kiis ama in ka badan (dad ama xayawaan) isla beeshaas mudo todobaad gudihiis oo leh calaamado isku mid ah oo aan ku ladnaan daaweynta xaaladaha caadiga ah ee calaamadahan.
11	Influenza-like illness (ILI)	Any person with fever and cough, throat pain or runny nose	Qof kasta oo leh qandho iyo qufac, cune xanuun ama san siin leh
12	Measles	Any person with fever and a skin rash	Qofkasta oo leh qandho iyo finan maqaarka ah lagu arko
13	Diphtheria	Any person with pain on swallowing with a swollen neck with or without white membrane at the back of the mouth	Qofkasta oo xanuun dartiisa liqitaanku ku adag yahay, qoortuna ay bararsantahay, oo dalqada xuub dherad ah kuleh ama kulahayn

14	Whooping Cough (Pertussis)	A person with a cough lasting at least 2 weeks and any of the following; Uncontrolled coughing which painful, Inspiratory whooping, vomiting immediately after coughing without an apparent cause	Qof kasta oo qufacaya ugu yaraan 2 todobaad, lehna mid ka mid ah calaamadahan soo socda: Qufac aan la xakameynkarin kaas oo xanuunleh, cod xiiq-dheernaleh, matagana qufaca kadib, sababla'aan
15	Meningococcal Meningitis	Any person with fever and neck stiffness	Qofkasta oo xumad/qandho iyo qoortoo adkaata yeesha.
16	Rabies	Any person who is bitten by an infected dog, animal, or other mammal	Qofkasta oo uu qaniino Ey cudur qaba ama qaniinyo xayawaan ama naasleyda kale ah.
17	Yellow Fever	Any person with fever and yellowing of eyes or bleeding	Qofkasta oo leh astaamo ah xumad/qandho iyo indhaha oo midab huruuda leh ama dhiig-baxaaya
18	Maternal death	The death of a woman while pregnant or during labour or within 42 days after delivery or termination of the pregnancy	Dhimashada haweeney iyadoo uur leh ama xilliga foosha ama 42 maalmood gudahood kadib dhalmada ama uurka.
19	Neonatal death	Any death of a live neonate occurring before the first 28 days of life	Ilma kasta oo dhinta 28 ka maalmood ee noloshiisa uugu horeya.
20	Neonatal tetanus	Any neonate who is normal at birth and then after 2 days, becomes stiff and unable to suck or feed or has convulsions	Muujay kasta oo caadi ku dhasha, laba maalmood kadibna, noqda mid kogsan oo aan awoodin inuu nuugo ama quuto ama qaba gariir.

21	Confirmed Malaria cases	Uncomplicated Malaria Any person with a positive test (either by microscopy or Rapid Diagnostic Test-RDT) for malaria without any danger sign Complicated Malaria Any person with a positive test (either by microscopy or Rapid Diagnostic Test-RDT) for malaria with any danger sign.	**Duumo aan khatar ahayn** Qof kasta oo laga helo baadhitaan togan (ama microscopy ama Tijaabada Baadhista Degdega ah-RDT) ee duumada iyada oo aan lahayn calaamad khatar ah **Duumada khatar ah** Qof kasta oo laga helo baadhis togan (ama microscopy ama Baadhitaanka Degdega ah ee RDT) ee duumada oo leh calaamad kasta oo khatar ah.

Figure 6: Community case definitions for IDSR

No	Condition	Suspected Case definition	Suspected Case Definition in local language
1	Adverse Drug Reaction	Harmful reaction to medicines that occurs at normal dozes used for diagnosis, prophylaxis or treatment	Dareen-celinta waxyeellada leh ee daawooyinka ku dhaca daraasiin caadi ah oo loo isticmaalo ogaanshaha, ka hortagga ama daaweynta
2	Adverse event following immunizatio n	A medical incident that takes place after immunization, causes concern and is believed to be caused by the immunization.	Dhacdo caafimaad oo timaad tallaalka ka dibna keenta walaac la dareensan yahay in uu sababay tallaalku.
3	Chemical event	A deliberate or accidental uncontrolled release of a chemical from its usual storage to the environment (land, air or water)	Si ula kac ah ama shil ah oo kiimiko ah looga sii daayo kaydkeeda caadiga ah deegaanka (dhulka, hawada ama biyaha)
4	Severe Acute Respiratory Syndrome (SARS)	***Suspected case of SARS*** is an individual with: 1. A history of fever, or documented fever ≥ 38 °C **AND** 2. One or more symptoms of lower respiratory tract illness (cough, difficulty breathing, shortness of breath) **AND**	**Qof looga shakisan yahay SARS waa shaqsi leh:** 1. Taariikh qandho, ama qandho la diiwaan galiyay ≥ 38 °C IYO 2. Hal ama in ka badan oo calaamadaha jirrooyinka hoose ee neef-mareenka (qufac, neef-sashada oo adkaata, neefta oo ku dhegta) IYO

		3. Radiographic evidence of lung infiltrates consistent with pneumonia or ARDS or autopsy findings consistent with the pathology of pneumonia or ARDS without an identifiable cause **AND** 4. No alternative diagnosis can fully explain the illness. ***Confirmed case of SARS***: An individual who tests positive for SARS-CoV infection by the WHO recommended testing procedures.	3. Caddaynta shucaaca ee sambabada gudaha u soo galay si waafaqsan oof-wareenka ama ARDS ama baadhitaanka meydka ee la socda pathology of pneumonia ama ARDS iyada oo aan sabab la aqoonsan karin 4. Ma jiro baadhitaan kale oo si buuxda u sharxi kara cudurka. Kiis la xaqiijiyay oo ah SARS: Shakhsi laga helay caabuqa SARS-CoV ee WHO waxay ku talisay hababka baaritaanka.
5	Zika Virus Disease	Suspected Case: A person presenting with rash and/or fever and at least one of the following signs or symptoms: • arthralgia; or • arthritis; or • conjunctivitis (nonpurulent/hyperaemic). Probable case: A suspected case with presence of IgM antibody against Zika virus and an epidemiological link (with no evidence of infection with other flaviviruses).	Kiis laga shakisan yahay: Qofka leh finan iyo/ama qandho iyo ugu yaraan mid ka mid ah calaamadaha soo socda ama calaamadaha: • arthralgia; ama • arthritis-ka; ama • conjunctivitis (nonpurulent/hyperemic). Kiis macquul ah: Kiis looga shakisan yahay oo leh jiritaanka IgM antibody ka-hortagga fayraska Zika iyo xiriirinta cudurrada faafa (oo aan lahayn wax caddayn ah caabuqyada kale ee flavivirus).
6	Acute Flaccid Paralysis	Any child under 15 years of age with acute onset of focal weakness or paralysis or any person with paralytic illness at any age in whom the clinician suspects poliomyelitis.	Ilmo kasta oo da'diisu ka yar tahay 15 jir, leh bilawga tabar-dari-daran ama curyaannimo ama qofkasta oo qaba jirro curyaan ah da' kasta oo uu dhaqtarku uugu shakiyo cudurka dabaysha.
7	Acute haemorrhagic Fever Syndrome	Acute onset of fever of less than 3 weeks duration in a severely ill patient/ or a dead person AND any 2 of the following: haemorrhagic or purpuric rash; epistaxis (nose bleed); haematemesis (blood in vomit); haemoptysis (blood in sputum);	Qandho daran ootaaso wax ka yar 3 toddobaad tahay xilihuuriskeeda bukaanka aad kaugu xanuunsada/ama qofdhintay IYO mid kasta oo kamid ah 2 astaamod ee soo socda: finan dhiigbax ah ama nabar afka ah; epistaxis (dhiig-bax sanka); hematemesis (dhiig-mataga); hemoptysis (dhiig tufa); saxarada oo dhiigleh; Calaamadaha kale ee

		blood in stool; other haemorrhagic symptoms and no known predisposing factors for haemorrhagic manifestations OR clinical suspicion of any of the viral diseases.	dhiig-baxa oo aan la garanayn sababaha keeni kara calaamadaha dhiigbaxa AMA shakiga bukaan-socodka ee mid ka mid ah cudurrada fayraska.
8	Dengue Fever	**Suspected case:** Any person with acute febrile illness of 2-7 days with 2 or more of the following: headache, retro-orbital pain, myalgia, arthralgia, rash, hemorrhagic manifestations, leucopenia. **Confirmed case:** A suspected case with laboratory confirmation for Dengue.	Kiis laga shakisan yahay: Qof kasta oo qaba xanuunka qandho ba'an oo 2-7 maalmood ah oo leh 2 ama ka badan oo ka mid ah kuwan soo socda: madax-xanuun, xanuunka retro-orbital, myalgia, arthralgia, finan, calaamadaha dhiigbaxa, leucopenia. Kiis la xaqiijiyay: Kiis la tuhunsan yahay oo leh caddaynta shaybaadhka ee Dengue.
9	Chikungunya	**Suspected case**: Any person with acute onset of fever >38.5°C and severe arthralgia/arthritis not explained by other medical conditions. **Confirmed case**: A suspected case with laboratory confirmation.	Kiis laga shakisan yahay: Qof kasta oo leh qandho aad u daran>38.5°C iyo arthralgia/arthritis daran oo aan lagu sharraxin xaalado kale oo caafimaad. Kiis la xaqiijiyay: Kiis la tuhunsan yahay oo leh xaqiijinta shaybaadhka.
10	Acute Jaundice Syndrome (Acute Viral Hepatitis)	Any person with discrete onset of an acute illness with signs/symptoms of: (i) Acute infectious illness (fever, malaise, fatigue); AND (ii) Liver damage (anorexia, nausea, jaundice, dark coloured urine, right upper quadrant tenderness of body); AND/OR (iii) Raised alanine aminotransferase levels more than 10 times the upper limit of normal.	Qofkasta oo sigaar ah ugu bilaabma xanuun degdeg ah oo leh calamadaha muuqda/calaamadaha aan muqaanin: (i) Xanun sidhaqsa ah ku bilaabma (qandho, xanuun, daal); IYO (ii) Dhaawac beerka (Cuno xumo, lallabo, Joonis, kaadida oo midab huruuda leh leh, Xanun laga dareemo qeybta kore ee midig caloosha); IYO/AMA (iii) Kor u kacday heerka alanine aminotransferase in ka badan 10 jeer heerka sare ee caadiga ah.

11	Acute Watery Diarrhea / Cholera	In areas where a cholera outbreak has not been declared: any patient aged 2 years and older presenting with acute watery diarrhoea and severe dehydration or dying from acute watery diarrhoea. In areas where a cholera outbreak is declared: any person presenting with or dying from acute watery diarrhoea.	Meelaha aan laga sheegin cudurka daacuunka in uu ka dilaacay: bukaan kasta oo da'diisutahay 2 sano ama ka weyn oo uu hayo shuban biyood daran iyo fuuqbax daran ama u dhimanaya shuban biyood daran. Meelaha lagu sheegay in uu ka dillaacay daacuun: qofkasta oo la kulmo ama u dhimanaya shuban biyood daran.
12	Anthrax	Any person with acute onset characterized by several clinical forms which are: 1.Cutaneous form: any person with skin lesion evolving over 1 to 6 days from a papular through a vesicular stage, to a depressed black eschar invariably accompanied by oedema that may be mild to extensive; 2.Gastrointestinal: any person with abdominal distress characterized by nausea, vomiting, anorexia and followed by fever; 3.Pulmonary (inhalation): any person with brief prodrome resembling acute viral respiratory illness, followed by rapid onset of hypoxia, dyspnoea and high temperature, with X-ray evidence of mediastinal widening; 4.Meningeal: any person with acute onset of high fever possibly with convulsions, loss of consciousness, meningeal signs and symptoms; commonly noted in all systemic infections, but may present without any other clinical symptoms of anthrax; AND Has an epidemiological link to	Qofkasta oo leh xaalad degdeg ah oo lagu garto dhowr nooc oo bukaan-socod ah kuwaasoo kala ah: 1. Qeybaha nabarrada: qofkasta oo qaba nabarmaqaarkaah ookasoobaxay 1 ilaa 6 maalmoodlagabilaabomeelahamuuqdaiyada oo loo marayomarxaladahanabrahaeebacoolaha, ilaaheerkanabarkamadowaadeyoo had iyo jeer la socdabararlagayaaboinuudhexdhexaad ama yahay mid balaaran; 2. XanuunadaCaloosha: qofkastaoocalool-xanuunlehoolaguarkolalabo, matag, Cuno xumooo ay lasiijirtoqandho; 3. Sambabada (neefsashada): qofkastaooqabaxanuunadahawomareenkagaabanoo u egjirrodaranooneef-mareenkafayras ah, oo ay kuxigtobilawgadegdega ah eeneeftaooadkaata, neefyariiyoheerkulkasare, oolaguarkaayocadayntaraajadaeeballaarinta; 4. XanuunadaMaskaxda: qofkastaoolehqandhosareoodegdeg ah oo ay suurtogaltahaysuuxdin, miyirbeelid, calaamadahaxanuunadamaskaxda; sidacaadiga ah laguxusaydhammaancaabuqyadahabdhiska, laakiinwaxaalagayaabaainaysoobaxaaniyada ooaanlahayn wax calaamadocaafimaadoo

		confirmed or suspected animal cases or contaminated animal products.	kale ookudka ah; IYO In uuxiriir la lahaadocudur-faafiyeedoo la xaqiijiyey ama la tuhunsanyahaykiisaskaxayawaanka ama badeecooyinkaxoolahawasaqaysan.
13	Bloody diarrhoea (dysentery)	A person with (abdominal pain) and diarrhoea with visible blood in stool.	Qofka qaba (calool xanuun) iyo shuban dhiigleh shubmaya. Ama saxaradiisa ay dhiig leedahay.
14	Brucellosis	**PROBABLE Case** A clinically compatible illness (characterized by acute or insidious onset of fever and one or more of the following: night sweats, arthralgia, headache, fatigue, anorexia, myalgia, weight loss, arthritis/spondylitis, meningitis, or focal organ involvement (endocarditis, orchitis/epididymitis, hepatomegaly, splenomegaly)), with at least one of the following: A)Epidemiologically linked to a confirmed human or animal brucellosis case B)Presumptive laboratory evidence, but without definitive laboratory evidence, of Brucella infection **CONFIRMED Case** A clinically compatible illness with definitive laboratory evidence of Brucella infection	Kiiska macquulka ah Xanuun caafimaad ahaan la jaanqaadi kara (oo lagu garto qandho ba'an ama degdeg ah iyo mid ama in ka badan oo kuwan soo socda: dhididka habeenkii, arthralgia, madax-xanuun, daal, anorexia, myalgia, miisaan lumis, arthritis/spondylitis, meningitis, ama xubin ka mid ah xuddunta (endocarditis, orchitis/ epididymitis, hepatomegaly, splenomegaly)), oo leh ugu yaraan mid ka mid ah kuwan soo socda: A)Epidemiologically la xidhiidha kiis brucellosis aadanaha ama xayawaanka la xaqiijiyay B) Caddaynta shaybaadhka mala-awaalka ah, laakiin aan lahayn caddayn shaybaar oo qeexan, caabuqa Brucella Kiiska XAQIIJIN Jirro caafimaad ahaan la jaanqaadi karta oo leh caddaymo shaybaar oo sugan oo ah caabuqa Brucella
15	Cluster of unexpected deaths	Two or more deaths (both humans and animals) in the same community in the same week with symptoms that did not respond to the treatment for the usual causes of such symptoms	Dhimashada laba ama in ka badan (dad iyoxayawaan-ba) oobulshadadhexdeeda ah walibahalusbuucgudihiisaoolehastaamoaan ka jawaabindaaweyntasababahacaadiga ah eecalaamadahaas.

16	Cluster of illness	Two or more cases (humans or animals) in the same community in the same week presenting with similar signs/symptoms that did not respond to the treatment for the usual causes of such signs/symptoms	Laba kiis ama in ka badan (dad ama xayawaan) isla beeshaas isla todobaad gudihiis oo soo bandhigaya calaamado isku mid ah oo aan ka jawaabin daaweynta sababaha caadiga ah ee calaamadahan.
17	COVID-19 (SARS-CoV-2 infection)	**SUSPECTED Case** A) A person who meets the clinical **or** epidemiological criteria: Clinical criteria: • Acute onset of fever AND cough (ILI) OR • Acute onset of ANY THREE OR MORE of the following signs or symptoms: fever, cough, general weakness/fatigue, headache, myalgia, sore throat, coryza, dyspnoea, nausea/diarrhea/anorexia OR Epidemiological criteria: • Contact of a probable or confirmed case, or linked to a COVID-19 cluster B) A patient with severe acute respiratory illness (SARI: acute respiratory infection with history of measured fever of ≥38^{o}C; and cough; with onset within the last 10 days; and requires hospitalization) C) A person with no clinical signs or symptoms OR meeting epidemiological criteria with a positive professional-use or self-test SARS-CoV-2 Antigen-RDT **PROBABLE Case** A) A patient who meets clinical criteria AND is a contact of a probable or confirmed case, or linked to a COVID-19 cluster B) Death, not otherwise	Qof loo tuhunsan yahay A) Qofka buuxiya shuruudaha bukaan-socodka ama cudurrada faafa: Shuruudaha caafimaad: • Xumad iyo qufac ba'an (ILI) AMA • Bilaw aad u daran oo ah saddex ama ka badan oo ka mid ah calaamadaha ama calaamadaha soo socda: qandho, qufac, daciifnimo/daal guud, madax-xanuun, myalgia, dhuun xanuun, coryza, dyspnea, lallabbo/shuban/anorexia AMA Shuruudaha Epidemiological: • Xiriirka kiis macquul ah ama la xaqiijiyay, ama ku xiran kooxda COVID-19 B) Bukaanka qaba jirro neef-mareen oo daran (SARI: caabuq neef-mareenka degdega ah oo leh taariikh qandho la qiyaasay ≥38^{o}C; iyo qufac; oo bilawday 10-kii maalmood ee ugu dambeeyay; waxayna u baahan tahay isbitaal) C) Qofka aan lahayn calaamado caafimaad ama astaamo AMA buuxinaya shuruudaha cudurrada faafa oo leh adeegsi xirfad leh oo togan ama is-baari SARS-CoV-2 Antigen-RDT Kiiska macquulka ah A) Bukaanka buuxiya shuruudaha caafimaad IYO la xidhiidha kiis suurtogal ah ama la xaqiijiyay, ama ku xidhan kooxda COVID-19 B) Dhimashada, oo aan si kale loo sharraxin, qof weyn oo qaba xanuunka neef-mareenka ka hor dhimashadiisa IYO kaasoo la xidhiidhay kiis suurtogal ah ama la xaqiijiyey ama ku xidhan koox COVID-19 Kiiska XAQIIJIN A) Qofka leh Tijaabada Kordhinta Acid

		explained, in an adult with respiratory distress preceding death AND who was a contact of a probable or confirmed case or linked to a COVID-19 cluster **CONFIRMED Case** A) A person with a positive Nucleic Acid Amplification Test (NAAT), regardless of clinical criteria OR epidemiological criteria B) A person meeting clinical criteria AND/OR epidemiological criteria (a suspect case) with positive professional-use or self-test SARS-CoV-2 Antigen RDT	Nucleic Acid togan (NAAT), iyadoon loo eegin shuruudaha caafimaad AMA shuruudaha cudurrada faafa B) Qofka buuxinaya shuruudaha bukaan-socodka iyo/ama shuruudaha cudurrada faafa (kiis laga shakisan yahay) oo leh adeegsi-xirfadeed togan ama is-baaritaan SARS-CoV-2 Antigen RDT
18	Influenza Like Illness (ILI)	An acute respiratory infection in a child or adult with: • sudden onset of fever >38 ºC AND • cough • with onset within the last 10 days.	Caabuqa neef-mareenka ood egdeg ah oo kudhaca caruur ama qof weyn oo leh: • Qandho/xumaddegdeg ah>38ºC IYO • qufac • kasoobilawday 10-kii maalmoodee u dambeeyay.
19	Measles	Any person with fever and maculopapular (non-vesicular) generalized rash and cough, coryza or conjunctivitis (red eyes) or any person in whom a clinician suspects measles.	Qofkastaolehqandhoiyonabrodaran (aanahayn vesicular) finanguudiyoqufac, xuubkasankaoofaruuracguduudyeesha ama (indhoguduudan) ama qofkastaoouudhakhtarkaugushakiyojadeeco.
20	Diphtheria	Any person with an illness of the upper respiratory tract with pharyngitis, nasopharyngitis, tonsilitis or laryngitis AND adherent pseudo-membrane on the pharynx, tonsils, larynx and/or nose	Qofkasta oo qaba xanuun ka hawo mareenka sare oo qaba caabuq hunguri-mareenka, quman ama caabuq dhuunta ah IYO xuub looga sahkiyo inuu ku dheggan yahay dhuunta, qumanka, larynx iyo/ama sanka

21	Whooping Cough (Pertussis)	A case diagnosed as Whooping cough by a physician **OR** A person with a cough lasting at least 2 weeks with one or more of the following; Violent and uncontrolled coughing which is exhausting and painful Inspiratory whooping Vomiting immediately after coughing without an apparent cause	Qof uu dhakhtarku kusheegay xiiqdheer AMA Qofka qufacaya uguyaraan 2 todobaad oo leh mid ama in ka badan oo calaamadaha soo socda; • Qufac xoog leh oo aan la xakamayn Karin oo daran xanuuna leh • Cod dhawaqa Xiiqdheerta ah • Matag islamarka qufaco kadib iyada oo aan sabab muuqata lahayn
22	Meningococcal meningitis	Any person with sudden onset of fever (>38.5 ºC rectal or 38.0 ºC axillary) and one of the following signs: neck stiffness, altered consciousness or other meningeal signs.	Qofkasta oo si lama filaan ah qandho ugu bilaabato (>38.5ºC dabada ama 38.0ºC kilkisha) iyo mid ka mid ah calaamadaha soo socda: qoorta oo adkaata, miyir beelka ama calaamadaha kale ee qoorgooye (meningitis)-ka.
23	Rabies	A person with one or more of the following: headache, neck pain, nausea, fever, fear of water, anxiety, agitation, abnormal tingling sensations or pain at the wound site, when contact with a rabid animal is suspected.	Qofka qaba hal ama in ka badan oo ka mid ah calaamadaha soo socda: madax-xanuun, qoorxanuun, lalabo, qandho, walwal, walaac, dareemo aan caadi ahayn ama xanuun goobta boogta, marka la tuhunsan yahay in uu la xiriiriyo xayawaan raabiyada qaba.

24	Rift Valley Fever	Suspected case Early disease ▪ Acute febrile illness (axillary temperature >37.5 ºC or oral temperature of >38.0ºC) of more than 48 hours duration that does not respond to antibiotic or antimalarial therapy, and is associated with: ▪ Direct contact with sick or dead animal or its products AND / OR: ▪ Recent travel (during last week) to, or living in an area where, after heavy rains, livestock die or abort, and where RVF virus activity is suspected/confirmed AND / OR: ▪ Abrupt onset of any 1 or more of the following: exhaustion, backache, muscle pains, headache (often severe), discomfort when exposed to light, and nausea/vomiting AND / OR: ▪ Nausea/vomiting, diarrhoea OR abdominal pain with 1 or more of the following: - Severe pallor (or Hb < 8 gm/dL) Low platelets (thrombocytopenia) as evidence by presence of small skin and mucous membrane haemorrhages (petechiae) (or platelet count < 100x109 / dL) - Evidence of kidney failure (oedema, reduced urine output) (or creatinine > 150 mol/L) AND / OR: -Evidence of bleeding into skin, bleeding from puncture wounds, from mucous membranes or nose, from gastrointestinal tract and unnatural bleeding from vagina AND / OR: - Clinical jaundice (3-fold increase above normal of transaminases) Late stages of diseases or complications (2-3 weeks after	Qof loo tuhunsan yahay Cudurka xili hore Xanuun daran oo qandho ah (heerkulkakilkisha>37.5ºC ama heerkulkaafka ee>38.0ºC) oohaysa in ka badan 48 saacadoodooaan ka jawaabindaawooyinkii antibiyootikeeuuqaatey ama daawayntadaawadakahortaggaduumada, waxayna la xiriirtaa: ▪ Xiriirtoos ah oolalayeeshoxayawaankaxanuunsan ama dhintay ama agabkiisa IYO/AMA: ▪ Socdaalkii u dambeeyay (intalagugudajiraytodobaadkiihore), ama kunoolaashahameel, ka dib roobabculus ka da'een, xooluhu ay kudhintaan ama ilamahoodakaagasooridma/abort, iyohalkauufayraska RVF lagaheli karo, waa la tuhunsanyahay/la xaqiijiyay IYO/AMA: ▪ Xaalad deg deg ah 1 ama in ka badan oo ka mid ah xaaladahasoosocda: daal, dhabarxanuun, murqoxanuun, madaxxanuun (badanaaaad u daran), raaxola'aan markauu la kulmoiftiin, iyolalabo/matag IYO/AMA: Lalabbo/ matag, shuban AMA caloolxanuunleh 1 ama ka badan xaaladahasoosocda: - cad cadaaddaran (ama Hb <8 gm/dL) Xinjirowgaooyar (thrombocytopenia) sidacaddayntajoogitaanka dhiigbaxamaqaarka yar iyoxuubkaxabka (petechiae) (ama tirooyinkatiftaafyada<100x109 / dL) - Caddayntakelyahaooshaqadajoojiya(barar, kaadidaooyaraatay) (ama creatinine> 150 mol/L) IYO / AMA: -Caddayntadhiig-baxamaqaarka, dhiig-baxanabarradadhaawaca. xuubabkacaloosha ama sanka, caloolkujirtaiyomindhicirka

		onset) ▪ Patients who have experienced, in the preceding month a flu-like illness, with clinical criteria, who additionally develop the following: ▪ CNS manifestations which resemble meningoencephalitis AND/OR ▪ Unexplained visual loss OR ▪ Unexplained death following sudden onset of acute flu-like illness with haemorrhage, meningo-encephalitis, or visual loss during the preceding month. Confirmed case: Any patient who, after clinical screening, is positive for antiRVF IgM ELISA antibodies (typically appear from fourth to sixth day after onset of symptoms) or tests positive on Reverse Transcriptase Polymerase Chain Reaction (RT-PCR).	iyodhiigbaxaancaadiahaynoo ka yimaadaxubintatarankahaweenkaiyo/ama: - xaaladcagaarshowah (3-ljibaar ka sareeyaheerkacaadiga ah ee Isugudbinta) Marxaladdadambeeecudurada ama dhibaatooyinka ka dhalan kara (2-3 todobaad ka dib bilawgacudurka) ▪Bukaanolaguarkayxanuun u egsidahargabkamudobil ah, oolehshuruudocaafimaad, kuwaasoosidoo kale horumariya soosocda: Calaamadaha CNS ee u egmaskax-garaadkadaran IYO/AMA ▪ lumidaarragaooaan la sharaxinkarin AMA ▪Dhimashoaan la garanayn ka dib markiiuusi lama filaan ah ugubilaabmatayxanuunaad u daranoo u eghargabka oolehdhiigbax, maskaxgaraadkadaran ama lumintaaraggaintalagujiray bishiihore. Kiis la xaqiijiyay: Bukaankastaoo, baaritaankabukaan-socodka ka dib, lagahelo d RVF IgM ELISA (sidacaadiga ah waxaysoobaxaan afar ilaamaalintalixaad ka dib bilawga. Calaamadahalaguarko) ama lagabaarohabka Reverse Transcriptase Polymerase Falcelinta (RT-PCR).
25	Severe Acute Respiratory Illness (SARI)	**SARI (persons ≥ 5 years old)** Any severely ill person presenting with manifestations of acute lower respiratory infection with: Sudden onset of fever (>38 ºC) AND cough or sore throat and shortness of breath, or difficulty breathing with or without clinical or radiographic findings of pneumonia OR Any person who died of an unexplained respiratory illness.	**SARI (dadka ≥ 5 jir ah)** Qofkastaooaad u xanuunsanoolehastaamocaabuqhawo-mareenhooseoodaranlehna: • qandhosi lama filaan ah u bilaabmata (>38ºC) IYO qufac ama dhuunxanuuniyoneefyari, ama neefsashadaookuadkaata ama aanbaaritaancaafimaadmarin ama raajocadeyneysa in burikiitotahay AMA Qofkastaoo u dhintaycudurhawomareen ah

			ooaan la sharraxin.
26	Typhoid fever	Any person with gradual onset of steadily increasing and then persistently high fever, chills, malaise, headache, sore throat, cough, and, sometimes, abdominal pain and constipation or diarrhoea.	Qofkastaoositartiibtartiib ah ugubilaabataqandhoheerkeedasiikordhayao ojoogto ah, qarqaryo, xanuun, madax-xanuun, dhuunxanuun, qufac, iyo, mararkaqaarkoodcaloolxanuuniyocalool-istaag ama shuban.
27	Yellow Fever	Any person with acute onset of fever, with jaundice appearing within 14 days of onset of the first symptoms. **Probable case** A suspected case with epidemiological link to a confirmed case or an outbreak or a positive postmortem liver histopathology	Qofkastaoo ay haysoqandhodaran, oo ay la socotacagaarshowayaasoo if baxaysacalaamadamudo 14 maalmoodgudahooda ka dib bilawgacalaamadahauguhorreeya **Kiis macquul ah** Kiis la tuhunsan yahay oo xiriir la leh kiis la xaqiijiyey ama dillaacay ama xaqiijin taariikh-cilad beerka ka dib dhimashada.
28	Maternal death	The death of a woman while pregnant or within 42 days of the delivery or termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.	Dhimashada haweeneyda iyadoo uurleh ama 42 maalmood gudahooda laga bilaabo marka ay dhasho ama joojinta uurka, iyadoon loo eegin mudada iyo goobta uurku, sabab kasta oo la xiriirta ama khatar gelinkarta uurka ama is ilaalinta balse aan ka imaan shil ama wax sababi kara shil.
29	Neonatal Death	Death of a neonate during the first 28 completed days of life (days 0 - 27)	Dhimashada ilmo dhashay 28-ka maalmood ee ugu horreeya nolosha (maalmaha 0 - 27)
30	Neonatal tetanus	Any neonate with a normal ability to suck and cry during the first two days of life, and who, between the 3rd and 28th day of age, cannot suck normally, and becomes stiff or has convulsions or both.	Muujay kasta oo awood u leh inuu nuugo oo hadana ooyi kara labada maalmood ee ugu horeeysa noloshiisa, oo inta u dhaxaysa maalinta 3aad iyo 28aad da'ahaan, aan sicaadi ah u nuugi karin, oo noqda mid murqihiisa adkaada ama leh gariir ama labadaba.

31	Perinatal death	**A perinatal death** Defined as a death occurring from a period commencing at 22 completed weeks of gestation and ending at seven days after birth. **A stillbirth** Defined as any death of a baby born with no signs of life at or after 28 weeks' gestation. **Early neonatal death** Defined as any death of a live neonate occurring before the first 7 complete days of life. A neonatal death is defined as any death of a live neonate occurring before the first 28 complete days of life.	**Dhimashada dhalmada** Waxaa lagu qeexaa dhimasho ilmaha laga bilaabo 22 toddobaad ee uurka dhamaaneysa todoba maalmood kadib dhalashada. **Dhimasho** Waxaa lagu qeexaa dhimasho kastaooilmodhashaooaanlahayncalaamadonololeedkadib 28 toddobaadeeuurka**.** **Dhimashadaxilihoreeedhallaanka** Waxaalaguqeexaasidadhimashokastaeedhalaannooloodhacaysa ka hor 7da maalmoodeeuguhorreeyanolosha Dhimashadadhallaankawaxaalaguqeexaainaytahaygeerikastaooilmonooloodhasha ka hor 28ka maalmoodeeuguhorreeyanolosha.
32	Acute and chronic hepatitis	**(a) Acute Viral Hepatitis:** ***Suspected case***: Any person with discrete onset of an acute illness with signs/symptoms of: (i) Acute infectious illness (for example, fever, malaise, fatigue) and (ii) Liver damage (for example, anorexia, nausea, jaundice, dark coloured urine, right upper quadrant tenderness of body), **AND/OR** (iii) Raised alanine aminotransferase (ALT) levels more than ten times the upper limit of normal ***Confirmed case***: A suspected case that is laboratory confirmed by virus specific biomarkers: **Acute Hepatitis A:** anti-HAV IgM positive or positive for HAV RNA **Acute Hepatitis B:** Hepatitis B surface antigen **(**HBsAg) positive AND anti-hepatitis B core antigen	**a) Fayraska Joniska ee degdega ah:** Kiis laga shakisan yahay: Qof kasta oo si gaar ah ugu bilaabma jirro degdeg ah oo leh calamadaha/calaamadaha: (i) Cudur faafa oo ba'an (tusaale, qandho, jirro, daal) iyo (ii) Dhaawaca beerka (tusaale, anorexia, lallabbo, cagaarshow, kaadi midab madow, jilicsanaanta jirka ee midig ee midig), IYO/AMA (iii) Kor loo qaaday heerarka alanine aminotransferase (ALT) in ka badan toban jeer xadka sare ee caadiga ah Kiis la xaqiijiyay: Kiis la tuhunsan yahay oo shaybaadhka ah oo ay xaqiijiyeen fayrasyada biomarkers gaarka ah: **• Joonis ba'an: anti-HAV IgM togan ama togan u leh HAV RNA** **• Joonis B ba'an: Hepatitis B surface antigen (HBsAg) togan IYO ka hortagga Joonis B core antigen (anti-HBc) IgM positive, HBV DNA positive** **• Joonis daran ee C: HCV RNA togan (Viral Load), HCV core antigen positive (meesha la heli karo) iyo anti-HCV IgM togan.** **Calaamadaha Joonis ba'an A (anti-HAV IgM) iyo Joonis E (anti-HEV IgM) waa taban.**

		(anti-HBc) IgM positive, HBV DNA positive **Acute Hepatitis C:** HCV RNA positive (Viral Load), HCV core antigen positive (where available) and anti-HCV IgM positive. Markers of acute hepatitis A (anti-HAV IgM) and hepatitis E (anti-HEV IgM) are negative. **Acute Hepatitis D:** HBsAg positive (or anti-HBc IgM positive) plus anti-HDV positive (usually IgM), and HDV RNA (HDV infection ONLY occurs as co-infection or super-infection of hepatitis B) **Acute Hepatitis E:** anti-HEV IgM positive **(b) Chronic Viral Hepatitis Case definition (HBV and HCV):** **Chronic Hepatitis B:** HBsAg is the first serological marker to appear. Persistence of HBsAg for at least six months indicates chronic infection Anti-HBc positive (usually IgG) **Chronic Hepatitis C:** Hepatitis C virus RNA positive in a person with anti-HCV positive (usually IgG) HCV RNA positive OR HCV core antigen positive **NB:** Antibody detection (that is, HCV Ab positive) cannot differentiate between acute, chronic infection and past infection	**• Joonis daran D: HBsAg togan (ama anti-HBc IgM positive) oo lagu daray anti-HDV togan (badanaa IgM), iyo HDV RNA (Infekshanka HDV KALIYA wuxuu u dhacaa sida caabuqa la wadaago ama caabuqa cagaarshow B)** **• Joonis ba'an E: anti-HEV IgM togan** **(b) Qeexitaanka Kiis Cagaarshowga Viral Chronic (HBV iyo HCV):** **C Joonis B ee joogtada ah:** **HBsAg waa calaamadihii ugu horreeyay ee serological ee soo baxa. Joogitaanka HBsAg ugu yaraan lix bilood waxay muujinaysaa caabuq dabadheeraad ah** **Anti-HBc togan (badanaa IgG)** **Joonis C ee joogtada ah:** **• Joonis C fayraska RNA togan ee qofka leh anti-HCV togan (badanaa IgG)** **• HCV RNA togan AMA HCV core antigen positive** **FG: Ogaanshaha difaaca jirka (yacni, HCV Ab positive) ma kala saari karo inta u dhaxaysa caabuqa ba'an, dabadheeraada iyo caabuqa hore**

33	Confirmed Malaria cases	<u>Uncomplicated Malaria</u> Any person with a positive test (either by microscopy or Rapid Diagnostic Test-RDT) for malaria without any danger sign <u>Complicated Malaria</u> Any person with a positive test (either by microscopy or Rapid Diagnostic Test-RDT) for malaria with <u>any</u> danger sign. The danger signs are; unable to drink, convulsions (fits), repeated vomiting, passing very little or no urine, abnormally sleepy, difficult to wake or confused, unconsciousness, unresponsive to pain (coma), weak and rapid pulse, severe anaemia, yellow eyes (jaundice), severe dehydration, bleeding with no known cause, difficulty breathing, unable to stand or sit (>1 year).	Duumo Sahlan Qof kasta oo laga helo baardhis togan (ama microscopy ama baadhis degdeg ah oo lagu baadho-RDT) duumada oo aan lahayn kasta oo khatar ah. Calaamadaha khatarta ah waa; cabbitaanka kari la', gariir (qabow), matag soo noqnoqda, kaadida oo aad u yar ama la'aan, hurdo aan caadi ahayn, ay adagtahay in la tooso ama jahawareero, miyir la'aan, xanuunka oo aan ka jawaabin (coma), garaaca wadnaha oo daciif ah, dhiig-yaraan daran, indho huruud ah) fuuqbax daran, dhiigbax aan la garanayn sabab, neefta oo ku adkaata, awoodin in uu istaago ama fadhiisan kari waayo (>1 sano).
34	Diabetes (new cases)	**Suspected new case**: Any person presenting the following symptoms: (a) Increased thirst (b) Increased hunger (c) Frequent urination **Confirmed new case:** Any person with a fasting 6.1 mmol/L (110 mg/dl) Or venous plasma glucose measurement of ≥ 7 mmol/L (126 mg/dl) or capillary glucose ≥ 6.1 mmol/L (110 mg/dl) **OR** Any person with a non-fasting glucose ≥ 11.1 mmol/L (200mg/dl) Or venous plasma glucose measurement of ≥ 11.1mmol/L (200 mg/dl)	Xalad cusub oo looga shakisan yahay: Qof kasta oo muujiya calaamadaha soo socda: (a) Haraadka oo kordhay (b) Gaajada oo korodhay (c) Kaadi soo noqnoqda Kiis cusub oo la xaqiijiyay: Qof kasta oo sooman 6.1 mmol/L (110 mg/dl) Ama cabirka gulukooska balaasmaha xididka ≥ 7 mmol/L (126 mg/dl) ama gulukooska xididka ≥ 6.1 mmol/L (110 mg/dl) Qof kasta oo qaba gulukoos aan soomin ≥ 11.1 mmol/L (200mg/dl) Ama cabirka gulukooska balaasmaha xididka ≥ 11.1mmol/L

35	HIV/AIDS (new cases)	A positive enzyme-linked immunosorbent assay (ELISA) for confirming HIV and a rapid test for confirming the positive results are sufficient for an epidemiologic case definition for HIV Infection.	Baaritaanka la xaqiijiyey ee difaaca jirka ee kuxiran dhecaanka (ELISA) ee xaqiijinta HIV iyo baaritaan ka degdega ah ee xaqiijinta natiijooyinka saxda ah ayaa kufilan qeexida kiisfaafa ee Caabuqa HIV.
36	Hypertensio n (new cases)	Any individual presenting with a resting blood pressure measurement (based on the average of three readings) at or above 140 mm Hg for systolic pressure, or greater than or equal to 90 mm Hg for diastolic pressure.	Shakhsi kasta oo heer-cabbirka cadaadiska dhiigisa ah (oo ku salaysan celceliska saddexda akhrin) ee ama ka sareeya 140 mm Hg cadaadiska dhiiga kore, ama ka badan ama la mid ah 90 mm Hg cadaadiska dhiiga hoose.
37	Injuries (road traffic accidents) (new cases)	Road traffic injury Any person who has sustained an injury because of a road traffic crash presenting for the first time. Road traffic fatality Any person killed immediately or dying within 30 days because of an injury crash.	Dhaawaca Shilalka wadadooyinka Qofkasta oo uu kudhaawacma shilalka waddooyinka markii uugu horaysay. Dhimashada Shilalka waddooyinka Qofkasta oo islamarkiiba kudhinta ama u dhinta 30 maalmood gudahood shil dhaawac awgiis.
38	Malnutrition (< 5 years) (new cases)	**Low birth weight neonate** Any neonate with a birth weight less than 2500 grams (or 5.5 lbs) **Malnutrition in children** Children under 5 who are underweight (indicator: weight for age <-2 Z Score)	**Muujay ku dhasha miisaan yar** Muujaykasta oo miisaankiisu ka yar yahay 2500 garam (ama 5.5 lbs) **Nafaqo-darada carruurta** • Carruurta ka yar 5 sano ee miisaankoodu ka hooseeyo (tusaale: miisaankada'da<-2 Z Score)
39	Mental Disorders (new cases)	Patient with a mental health disorder such as anxiety, depression, or epilepsy and that is associated with significant distress, impairment in functioning, or risk of self-harm.	**Bukaanka qaba xanuunka dhimirka sida walaaca, niyad-jabka, ama suuxdinta oo lala xiriiriyo murugo weyn, daciifnimo xagga shaqada, ama khatarta is-waxyeelaynta.**
40	Multi Drug Resistant / MDRX TB	Patient with TB infection who does not respond to at least two of the anti-TB medicines isoniazid and rifampicin and requires treatment with second-line regimens.	**Bukaanka qaba infekshinka TB ee aan ka jawaabin ugu yaraan laba ka mid ah dawooyinka ka hortagga tiibayda ee isoniazid iyo rifampicin oo u baahan daawaynta hababka safka labaad.**

41	Polio (lab confirmed)	Confirmed case: A suspected polio case with virus isolation in stool.	**Kiis la xaqiijiyay: Kiis looga shakisan yahay dabaysha oo fayraska lagu go'doomiyay saxarada.**
42	Severe pneumonia in children under 5 years	**Clinical case definition (integrated management of childhood illness) for pneumonia** A child presenting with cough or difficult breathing and: 50 or more breaths per minute for infant age 2 months to 1 year; 40 or more breaths/minute for young child age 1 to 5 years.	**Qeexitaanka bukaan-socodka (maaraynta cuddurada caruurta ee iskudhafan) ee ofwareenka** Ilmo leh qufac ama neefsashada ku adag iyo: • 50 ama in ka badan oo neefsasho ah daqiiqadii ilmaha da'da 2 bilood ilaa 1 sano; • 40 ama ka badan neefsasho/daqiiqo loogu talagalay ilmaha da'doodu u dhaxayso 1 ilaa 5 sano.
43	Sexually transmitted infections	**Genital ulcer syndrome** **Suspected case** Any male with an ulcer on the penis, scrotum or rectum, with or without inguinal adenopathy, or any female with ulcer on labia, vagina or rectum, with or without inguinal adenopathy. **Urethral discharge syndrome** **Suspected case** Any male with urethral discharge with or without dysuria.	**Bukaan lagu tuhunsan yahay Cudurka boogaha xubinta taranka** Rag/Nin kasta oo nabar/boog ka soo gaadhay xubinta taranka, xiniinyaha ama dabaada, oo leh ama aan lahayn adenopathy inguinal, ama naag kasta oo nabar kuyaal faruuryaha, xubinta taranka ama dabada, leh ama aan lahayn adenopathy inguinal. **Cudurka qoyaanka kaadimareenka la tuhunsan yahay** Rag/Nin kasta oo qaba cudurka qoyaan kaadimareenka oo kaadida gubeyso ama aan gubeynin**.**
44	Snake Bites	Snakebite caused by the bite of a snake. Includes envenoming that can occur when venom is sprayed into the eyes.	Qaniinyada Maska ama Abesada oo sababi karta sun markay indhaha ku buufiyaan.
45	Trachoma	Any patient with red sticky eyes who complains of pain and itchiness of the eyes.	Bukaan kasta oo leh indho casaan ah oo ka cabanaya xanuun iyo cuncun indhaha.
46	Tuberculosis (new cases)	Any person with a cough lasting 3 weeks or more.	Qofkasta oo leh qufac sadexdii toddobaad ee udanbeeyey ama ka badan.
47	Intestinal Worms	Patient diagnosed with intestinal helminths based on clinical symptoms and laboratory testing of stool or blood specimens.	Bukaan laga helay gooryaan mindhicirka oo ku salaysan calaamadaha bukaan-socodka iyo shaybaadhka saxarada ama muunadaha dhiiga.

Figure 7: Facility Case Definitions for Priority conditions for IDSR in Somaliland

Standard Operating Procedure (SOP) for Detection

SOMALILAND MINISTRY OF HEALTH DEVELOPMENT INTEGRATED DISEASE SURVEILLANCE AND RESOPNSE **DETECTION** SOP	
Purpose	To provide standard guidance to surveillance focal persons at all IDSR sites on how to identify and record all immediately reportable priority conditions
Scope	This SOP should be implemented by surveillance focal person at all IDSR sites
Responsibility	1. The surveillance focal person at the IDSR reporting site is responsible for implementing this SOP 2. The in-charge of the IDSR site is responsible for supervising the facility surveillance FP to ensure implementation of this SOP 3. The district surveillance FP is responsible for provision of required supplies, capacity building and provision of supportive supervision to the IDSR site
Procedure	Upon identification (through consistent application of community case definitions in the community and consistent application of facility case definitions at health facilities) of cases of priority conditions equal to the alert threshold, the surveillance focal person will; 1. Correctly record the case in the rumor log (figure 9). 2. Initiate the immediate reporting procedure

Approved by:	National IDSR technical Working Group
Date of next review;	December, 2025

Figure 5: SOP for detection and recording of Immediately Reportable Condition

SOMALILAND MINISTRY OF HEALTH DEVELOPMENT
INTEGRATED DISEASE SURVEILLANCE AND RESPONSE

RUMOR LOG

Name of health facility:
District;
Region:

Date the alert or rumor or suspected outbreak was detected (DD/MM/YY)	Brief description of the cases	Suspected priority disease or condition	Date of reporting to the next level (DD/MM/YY)	Date of verification (DD/MM/YY)	True alert? (Y/N)	Date of outbreak investigation for true alerts (DD/MM/YY)	Date of initiation of comprehensive outbreak response to investigated outbreaks

Figure 6: Rumor Log

Reporting of Detected Priority Conditions by Health Facilities

These guidelines address 2 types of reporting; 1) immediate case-based reporting and 2) weekly aggregate reporting.

Immediate Case-Based Reporting

Immediate case-based reporting is the sharing of standard information on an immediately reportable priority condition by the surveillance focal person of the site where the case has been detected. This standard information should be shared immediately using the fastest available means possible (like a phone call) followed by completing and submitting (into DHIS2) a case-based reporting form (generic or case specific) (figure 11). MOHD will allocate unique codes/numbers for each reporting site. Upon completing and sending the immediate reporting form, the reporting surveillance focal person should not wait but instead follow-up/call the district surveillance officer to conduct alert verification and participate in investigation of the alert if it is verified by the district surveillance officer as a true alert/suspected case. The standard operating procedure for immediate case-based reporting is summarized in figure 10.

Weekly aggregate summary reporting

Weekly aggregate reporting will be conducted by health facilities. Weekly aggregate reporting is the sharing of aggregate summaries of all cases (and deaths) of immediately reportable conditions and a few other priority conditions reported in each epidemiological week. Aggregates of cases (and deaths) for the previous epi-week should be reported on Monday (the first day of the next epi-week) before midday by the facility's surveillance FP into DHIS2. This reporting should also include ZERO reporting; which means reporting a ZERO for priority conditions which were not detected in the epi-week being reported instead of leaving the cell blank. Weekly aggregate reporting provides data for monitoring trends of priority conditions for early detection of outbreaks which might not have been reported through the immediate reporting arm of the system. The standard procedure for weekly aggregate reporting in summarized in figure 12. The tool for weekly aggregate reporting is in figure 13.

Both tools for immediate and weekly reporting will be adjusted as necessary during the customization of the DHIS2 tracker application which will be used to support reporting.

Standard Operating Procedure (SOP) for Immediate Reporting

SOMALILAND MINISTRY OF HEALTH DEVELOPMENT
EPIDEMIOLOGICAL SURVEILLANCE AND RESOPNSE

IMMEDIATE CASE-BASED REPORTING SOP	
Purpose	To provide standard guidance to surveillance focal persons at IDSR sites/HF on how to conduct immediate case-based reporting of immediately reportable conditions detected at all IDSR sites in Somaliland
Scope	This SOP should be implemented by all surveillance focal persons at IDSR sites
Responsibility	1. The surveillance focal person at the IDSR site is responsible for implementing this SOP 2. The in-charge of the IDSR site is responsible for supervising the surveillance FP to ensure implementation of this SOP 3. The district surveillance focal person is responsible for provision of required supplies, capacity building and provision of supportive supervision to the reporting sites
Procedure	Upon identification and after recording the identified priority condition in the suspected outbreak rumor log, the surveillance focal person of the IDSR site should; 1. Use the fastest available means of communication (phone call) to immediately share information on the suspected priority condition with the surveillance focal person at district and/or regional and/or national level 2. Fill the generic or case specific case-based reporting form (figure 11) and submit it through/into the DHIS2. 3. Immediately collaborate with the rapid response team (RRT) of the nearest health facility to conduct a preliminary investigation and implement preliminary public health action while waiting for logistical and technical support from the district or the region or national level, if required.
Approved by:	National IDSR TWG
Date of next review	December, 2025

Figure 7: SOP for Immediate Case-Based Reporting

SOMALILAND MINISTRY OF HEALTH DEVELOPMENT
INTEGRATED DISEASE SURVEILLANCE AND RESPONSE
Immediate Case-based Reporting Form

No	Variable/Question	Value/Response
1	Reporting Site Name	
2	Reporting Site Number	
3	Reporting District	
4	Region	
5	Immediately reportable priority disease/condition **(to be provided in a drop-down menu)**	
6	In-patient or Out-patient?	
7	Date seen at health facility (day/month/year)	_________\
8	Patient ID	
9	Age (Years, Months)	_________\
10	Sex (male or female)	
11	Patient's residence: Town/City /Village	
12	Neighborhood or main landmarks	
13	District of residence	
14	Recent history of travel (Yes/No)	
15	Address, (cell) phone number ... If applicable, name of mother and father if neonate or child	
16	History of contact with confirmed case	
17	Date of onset (day/month/year) of first symptoms	_________\
18	Number of vaccine doses received in the past against the disease being reported	
19	Date of last vaccination (Day/Month/Year) against the suspected disease being	_________\
20	Laboratory results	
21	Outcome: (Alive/Dead/Admitted/Transferred/Escaped)	
22	Final Classification : Confirmed, Probable, Compatible, Discarded	
23	Date the health facility notified District (day/month/year)	_ _ _ _ _ _ _ _
24	Date form sent to district (day/month/year)	_________\
Completed by; Name: Position: Contact:		

Figure 8: Immediate Case-Based Reporting Form

Standard Operating Procedure (SOP) for weekly aggregate reporting

SOMALILAND MINISTRY OF HEALTH DEVELOPMENT INTEGRATED DISEASE SURVEILLANCE AND RESPONSE **WEEKLY AGGREGATE SUMMARY REPORTING** SOP	
Purpose	To provide standard guidance to health facility surveillance FPs on how to conduct weekly aggregate summary reporting of all immediately reportable priority diseases or conditions
Scope	This SOP should be implemented by all surveillance focal persons at all IDSR health facilities
Responsibility	1. The facility surveillance focal person is responsible for implementing this SOP 2. The in-charge of the surveillance site is responsible for supervising the surveillance FP to ensure implementation of this SOP 3. The district and/or regional surveillance FP is responsible for provision of required supplies, capacity building and provision of supervision to the reporting sites
Procedure	Every Monday before midday, the facility surveillance FP of every surveillance site should; *1.* Obtain a blank weekly aggregate summary reporting form through DHIS2 and correctly fill in the preliminary section. A copy of this form is included in figure 13. *2.* Next, review the suspected outbreak log (as the primary data source) together with other relevant registers and sum up the total number of new cases for each of the immediately reportable diseases/conditions in the previous 7 days. This should be put in the cell for cases. 3. Stratify the identified cases by sex (male and female) *4.* Out of the recorded cases, and starting with males, count the total number of cases under 5 years and over 5 years. Stratify the under 5 years and over 5 years by cases and deaths. Note that deaths should be part of the cases. Fill the respective cell for each of the priority conditions for weekly aggregate reporting *5.* For every cell, put a ZERO where there is no reported case or death instead of leaving the cell blank *6.* Repeat steps 4-5 for the female cases *7.* Indicate any comments, decisions taken, recommendations, the reporting date and the name and contact of the reporting officer. *8.* Submit the completed form through DHIS2.
Approved by:	National IDSR TWG
Date of next review:	December, 2025

Figure 9: SOP for Weekly Aggregate Summary Reporting

Weekly Summary Report Form: IDSR Reporting Hospital & HCs (WF-12)					HF Name:			
Immediate Reporting	Cases				Deaths			
	0-59 m		5+ yrs		0-59 m		5+ yrs	
	Male	Female	Male	Female	Male	Female	Male	Female
Acute Flaccid Paralysis								
Acute Jaundice Syndrome (AJS)								
Adverse Events following Immunisation (AEFI)								
Severe Acute Respiratory Illness (SARI)								
Suspected Cholera								
Suspected COVID-19								
Suspected Human Rabies								
Suspected Measles								
Suspected Meningococcal Meningitis								
Suspected Shigellosis / Bloody Diarrhoea								
Suspected Yellow Fever								
Viral Haemorrhagic Fever								
Cluster of unwell people / animals with similar signs & symptoms (Y=1 / N=0)								
Cluster of death in a community, human and/or animals (Y=1 / N=0)								
Leprosy								
Lymphatic Filiarisis								
Neonatal Tetanus								
Suspected Diphtheria								
Suspected Typhoid								
Suspected Whooping Cough								
Anthrax								
Brucellosis								
Influenza Like Illness (ILI)								
Polio (Lab confirmed)								
Trypanosomiasis								
Maternal death (weeks total)								
Neonatal death (weeks total)								
Perinatal death (weeks total)								
Radiological or chemical event								

Figure 10: Weekly aggregate Reporting Form

Analysis and interpretation of weekly aggregate data

Data analysis and interpretation involves timely and complete receipt, merging, cleaning and analysis of weekly aggregate surveillance data, and sharing and use of analysis findings to inform decisions. Primarily, analysis of weekly aggregate surveillance data enables detection of outbreak alerts through observation of disease specific trends and stratification of disease burden by variables available in the weekly aggregated data like location, sex and age to determine preliminary risk factors for disease spread. To the extent possible, some or all these processes will be automated by DHIS2 with complement IDSR form.

Surveillance data analysis at facility level

At the minimum, the surveillance focal person at the health facility should identify the commonest priority conditions at the health facility and draw a line-graph for each of these conditions. For each of the identified conditions, like summary tabulation, line graph should show the total number of alerts/cases detected/reported every epi-week and should be updated on a weekly basis. The line graphs should be displayed in a visible area at the health facility.

Surveillance data analysis at district and regional level

District and Regional level IDSR focal points can access facilities' data to analyze core key indicators and check data quality dimensions like completeness, timeliness, and accuracy and reshare the feedback with the facilities based on the level and production of reports and disseminate to national level

Surveillance data analysis at national level

Surveillance is not complete until surveillance data is analyzed and used for action. Action includes detection of outbreaks and monitoring of disease trends among others. The epidemiological bulletin (epi-bulletin) is the standard format for sharing results from surveillance data analysis. In Somaliland, the epi-bulletin will be developed at national level and on a weekly basis. The national IDSR coordinator is responsible for development of the weekly epi-bulletin in collaboration with national HMIS focal point and will also conduct ad hoc or additional analysis if needed. The bulletin will be developed from data reported from the health facilities available from the DHIS2 database. The standard procedure for developing the epi-bulletin is shared in figure 14. The standard format which will be used for the weekly epi-bulletin is shown in figure 15. In summary, the bulletin will contain key highlights for the week, a summary of timeliness and completeness of reporting from the facilities, a summary of number of cases

(and deaths) for every priority condition, a descriptive analysis (including epidemiological curves) for selected priority conditions (especially for confirmed outbreaks) and a summary of public health events in the region. A template for the weekly epi-bulletin is provided in figure 15. The weekly epi-bulletin should be widely shared to stakeholders at all levels of the health system in Somaliland.

Standard Operating procedure (SOP) for Weekly Analysis of Surveillance Data

SOMALILAND MINISTRY OF HEALTH DEVELOPMENT INTEGRATED DISEASE SURVEILLANCE AND RESOPNSE **WEEKLY SURVEILLANCE DATA ANALYSIS AT NATIONAL LEVEL** SOP	
Purpose	To provide standard guidance on minimum analysis of surveillance data and use of analysis findings to inform decision and public health action. Further ad hoc analysis or additional analysis can be conducted.
Scope	This SOP should be implemented by all facility level surveillance focal persons and surveillance focal persons at district, regional and national level
Responsibility	1. The facility surveillance focal person at the surveillance site is responsible for conducting facility level data analysis 2. The IDSR focal person at national level is responsible for generating the weekly epi-bulletin 3. The clinician team at facility level is responsible for use of analysis findings to inform decision and public health action 4. Surveillance focal persons at regional and national level are responsible for wide dissemination of the weekly epi-bulletin 5. All surveillance and response stakeholders are responsible for using the findings in the weekly epi-bulletin to inform their decisions
Procedure	On a weekly basis, upon receipt of completed weekly aggregate surveillance data report forms, the HMIS focal person at the respective level working with the IDSR focal person and other team members at the same level should; 1. Merge the data received from multiple reporting sites for the same epi-week. This step is not necessary at facility level 2. Clean the data including completion of ZERO reporting requirements and correction of any data errors. 3. Conduct a time analysis of the data. To do this, the data for the current epi-week is merged with the dataset for the previous epi-weeks. Next, the total number of reported cases per epi-

	week is plotted against epi-weeks up to the current epi-week. The points are then joined by a line to create a line graph/trends line (figure 15). This is done for each of the selected priority conditions. Developed line graphs are displayed in a visible area and updated every week. 4. Conduct a place analysis. To do this, a spot map is drawn (manually or by using mapping software) showing the geographical dispersion of weekly reported cases. This is repeated for each of the selected priority conditions. Developed spot maps (figure 16) are displayed in a visible area and updated every week. 5. Conduct a person analysis. To do this, for each of the selected priority conditions, the total cases (and deaths) are stratified by key variables like location, sex and age group in form of absolute numbers or proportions to determine disease risk. These results are presented in tabular form. 6. Compare the observed time-place-person findings against the expected time-place-person thresholds 7. Through regular meetings at the specified level of the health system present, discuss and draw clear conclusions on the findings and use the conclusions to make public health recommendations like intensification of surveillance or conducting a detailed outbreak investigation At national level, the national level surveillance focal person and other members of the national level surveillance data analysis team should; 8. Review and format the analysis findings into the weekly epidemiological bulletin (figure 12) 9. Widely disseminate the bulletin to all IDSR stakeholders at all levels of the health system. This serves to give feedback and update the stakeholders about the current epidemiological situation and the IDSR interventions being implemented.
Approved by:	National IDSR TWG
Date of next review;	December, 2025

Figure 11: SOP for Data Analysis at national level

SOMALILAND MINISTRY OF HEALTH DEVELOPMENT INTEGRATED DISEASE SURVEILLANCE AND RESPONSE **WEEKLY EPIDEMIOLOGICAL BULLETIN**

<table>
<tr><td colspan="2">Epi-Week: Reporting Duration:</td></tr>
<tr><td colspan="2">Major highlights in this epi-week/reporting duration, including public health actions (in bullet form)
•
•
•
•
•
•
•</td></tr>
<tr><td colspan="2">Reporting Rates (in short text and a map)</td></tr>
<tr><td>In short sentences;
• National the average completeness and timeliness of reporting
• National the completeness of reporting per State
• National the timeliness of reporting per state
• National the best performing National in completeness and timeliness of reporting
• National how many districts have a completeness and timeliness of 80% and above
• National how many districts are reporting between 99% and 80%
• Refer the reader to the map summarizing reporting rates</td><td>Insert map here showing different districts with their reporting rates. Use color codes</td></tr>
</table>

Epidemiological summary of selected priority conditions in this epi-week

Condition	Cases	Deaths	CFR

Map showing the location of major priority conditions

Descriptive analysis of selected priority conditions

- Give a summarized time-place-person analysis of selected priority conditions
- Indicate the public health action that was instituted for every occurring priority condition

Summary of other ongoing health events/conditions

- Report on any other occurring health events/conditions which are not selected for detailed descriptive analysis this week

Public health conditions/events in the neighboring countries

- Report on any other occurring public health events/conditions in the countries neighboring Somaliland
- You can use a table

Public health conditions/events in the region

- Report on any other occurring public health events/conditions in the region
- You can use a table

Recommendations

- Highlight recommendations for priority disease/condition prevention
- Highlight recommendations for priority disease/condition preparedness
- Highlight recommendations for priority disease/condition response

Annexes

- You can include accuracy of data quality dimensions with condition
- You can include trends in timeliness of reporting
- You can include trends in completeness of reporting

Editorial

- List the names of persons who contributed to the development of this epidemiological bulletin

Figure 12: Weekly Epi-Bulletin Template

Outbreak Investigation (plus alert verification as part of outbreak investigation)

Introduction

Outbreak investigation is a systematic process that involves collection and analysis of data to confirm an outbreak; identification and treatment of affected cases; description of the outbreak in person, place and time; analysis of factors associated with spread of the outbreak; analysis of outbreak data to identify and implement effective outbreak response interventions; and strengthening prevention activities to reduce re-occurrence of outbreaks in the future. Outbreak investigation will be led by the district RRT with logistical and technical support from the next upper level whenever required.

An outbreak investigation should be conducted within 48 hours of verifying an alert as true. The alert verification process will include immediately communicating (preferably by phone call) back to the source of the alert to ascertain the accuracy of the alert in terms of the source of the alert, the date and location of the alert, the number of suspected cases, severity (including deaths) of suspected cases, and any response interventions that have been implemented. Upon verification of the alert as true, the district surveillance officer should immediately mobilize the other members of the district RRT, brief the RRT about the suspected outbreak, brief the RRT on the Terms of Reference (ToRs) for the investigation, clarify the roles and responsibilities of each member of the RRT, clarify the communication channels during the investigation, mobilize the required outbreak investigation logistics and supplies, develop/adjust/review and print off the necessary outbreak investigation tools, obtain the necessary authorization and deploy the RRT to the field to conduct the investigation. The members of the RRT should be mobilized from the RRT register maintained at district level. The generic composition and ToRs of the RRT is indicated in figure 16.

Upon reaching the field, the RRT lead should conduct the necessary field entry activities including necessary courtesy visits to relevant offices to introduce the RRT and the purpose and duration of their deployment and a summary of how the investigation will be conducted. Next, the deployed RRT should integrate with the local technical persons for capacity building and to have a locally led outbreak investigation, logistically and technically supported by the deployed RRT. Under the overall leadership of the RRT lead, the integrated RRT should conduct a systematic investigation of the suspected outbreak following the standard steps of outbreak investigation. As a critical step in outbreak investigation, for every identified case, a case investigation form should be completed. Every priority condition should have a specific outbreak investigation form. Templates of disease specific case investigation forms are

available from WHO. These should be adapted to country context during the preparedness phase. If the cases are multiple, they should be entered in a line-list. The generic line list is indicated in figure 17.

For all or some of the identified cases (or as the specific outbreak investigation guidelines will dictate), a laboratory sample is required. Led by the laboratory specialist on the RRT, the appropriate sample will be collected from the cases, packaged appropriately and transported to the laboratory for confirmatory diagnosis. Every sample sent to the laboratory must be accompanied by a completed laboratory investigation request form. The majority of disease specific case investigation forms are integrated to also serve as the laboratory investigation request form. In this case, a copy of the completed case investigation form should be sent together with the laboratory sample. For every identified case, its contacts must be identified. The generic contact identification form is indicated in figure 18. Every identified contact should be followed up for a duration of one incubation period from the last contact with a confirmed case or until they become suspected cases, whichever comes first. The generic contact follow-up form is indicated in figure 19.

Before the RRT exits the field, they should disseminate their preliminary investigation findings to the community and district staff where the investigation was conducted. Upon exit from the field, the RRT should submit and be prepared to present the outbreak investigation report to the DHMT and other health system levels depending on the scale of the investigated outbreak. The standard template for an outbreak investigation report is indicated in figure 20. The Standard Operating Procedure (SOP) for outbreak investigation is detailed in figure 21.

The purpose of an investigation is to:

- Verify the existence of an outbreak or the public health event.
- Identify and treat additional cases that have not been reported or recognized.
- Collect information and laboratory specimens for confirming the diagnosis.
- Identify the source of infection or cause of the outbreak.
- Describe the epidemiological situation by time, place and person
- Describe mode of transmission and risk factors in the affected populations

- Identify and select appropriate response interventions to control the outbreak or the public health event
- Strengthen control and prevention activities to avoid future recurrence of outbreaks and other public health events.

SOMALILAND MINISTRY OF HEALTH DEVELOPMENT INTEGRATED DISEASE SURVEILLANCE AND RESPONSE **GENERIC COMPOSITION AND RESPONSIBILITIES OF RRTS**
• Coordination – Team Lead • A clinician – to oversee case management including Infection Prevention and Control (IPC) • Nurse • Surveillance officer • Epidemiologist • Data manager • Laboratory scientist • Environmental Health Officer/Scientist • Veterinary/Livestock Officers/Wildlife Officers • Social Mobilization and risk communication • Psychosocial Support (PSS) officer • Logistic officer • Others based on specific characteristics of the outbreak

Responsibilities
• Investigate rumors and reported outbreaks, verify diagnosis and other public health emergencies including laboratory testing • Collect additional samples from new patients and old ones if necessary (human, animals, food, and water • Make a follow up by visiting and interviewing exposed individuals, establish a case definition and work with community to find additional cases • Assist in laying out mechanisms for implementation of Infection Preventive Control Measures • Assist in generating a line list of the cases, and perform descriptive analysis of data (Person, Place and Time) to generate hypothesis including planning for a further analytical study • Propose appropriate strategies and control measures including risk communications activities • Establish appropriate and coordinated risk communication system through a trained spokesperson • Coordinate rapid response actions with national and local authorities, partners and other agencies • Initiate the implementation of the proposed control measures including capacity building • Conduct ongoing monitoring and evaluation of effectiveness of control measures through continuous epidemiological analysis of the event • Conduct Risk Assessments to determine if the outbreak is a potential PHEIC • Prepare detailed investigation reports to share with PHEMC committee • Contribute to ongoing preparedness assessments and the final evaluation of any outbreak response • Meet daily during outbreaks, and quarterly when there is no outbreak • Participate in simulation exercises

Figure 13: Generic Composition and roles of each Rapid Response Team (RRT) member

SOMALILAND MINISTRY OF HEALTH DEVELOPMENT
INTEGRATED DISEASE SURVEILLANCE AND RESPONSE
GENERIC OUTBREAK INVESTIGATION LINE-LIST OF CASES

No	Case ID	Location Details			Patient demographics			Exposures (Y/N)			Presenting signs and symptoms (Y/N)				Laboratory Specimen collected (Y/N)	Lab results Positive Negative Pending	Location Facility Home	Final Outcome Dead Alive
		Region	District	Ward	Age	Sex	Occupation	Exp 1	Exp 2	Exp 3	SS 1	SS 2	SS 3	SS 4				

Figure 14: Generic Line-List

SOMALILAND MINISTRY OF HEALTH DEVELOPMENT
INTEGRATED DISEASE SURVEILLANCE AND RESPONSE
GENERIC OUTBREAK CONTACT LISTING FORM

Contacts[1] Recording Sheet filled in by _____

Case name_____ Case number (if assigned)_____

Case's Village/neighbourhood _____ Chief or Community leader _____

District/Town _____Province/Region _____

Date of symptom onset_____ Hospitalized/Found in the community_____

If hospitalized, Hospital _____Date of Admission: _____

Surname	Other name	Relationship with the case	Health worker (Y/N) , if yes which facility ?	Age (years)	Sex (M/F)	Phone number	Head of household	Village/ neighbourhood	Chief or Community leader	District/ Town	Type of Contact (1, 2 or 3, list all)	Date of last contact	Last date for follow-up	First Visit	Outcome

Contacts are defined as persons who:

1. sleep in the same household with a suspected case;
2. have direct physical contact with the case (dead or alive);
3. have touched the linen or body fluids of the case;
4. have eaten or touched a sick or dead animal.

Figure 15: Generic Contact Listing Form (For every Confirmed case)

SOMALILAND MINISTRY OF HEALTH DEVELOPMENT

INTEGRATED DISEASE SURVEILLANCE AND RESPONSE

GENERIC OUTBREAK CONTACT TRACING/FOLLOW-UP FORM

Contact Tracing Form – by Village Team ..... **Volunteer's name** .....

Village ..... **Chief or Community leader**

District/Town ..... **Province/Region** .....

CN	Family Name	First Name	Age	Sex	Date of last contact	Day of Follow-up																				
						1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21

Record "O" if the contact has not developed fever or bleeding

Record "X" if the contact has died or developed fever and/or bleeding (complete Case Investigation Form and, if alive, refer to the hospital)

Figure 16: Generic Outbreak Contact Tracing (Follow-Up) Form

SOMALILAND MINISTRY OF HEALTH DEVELOPMENT INTEGRATED DISEASE SURVEILLANCE AND RESPONSE **OUTBREAK INVESTIGATION REPORT**
Title
Introduction and background
Objectives
Hypothesis
Methodology (study area, study period, case definitions used, data collection methods)
Findings (including field pictures, tables, graphs)
Other findings
Measures implemented
Challenges
Recommendations
Conclusion

Figure 17: Outbreak Investigation Report Format

Standard Operating Procedure (SOP) for outbreak investigation

SOMALILAND MINISTRY OF HEALTH DEVELOPMENT

INTEGRATED DISEASE SURVEILLANCE AND RESOPNSE **OUTBREAK INVESTIGATION** SOP	
Purpose	To provide standard guidance on how to investigate a suspected outbreak
Scope	This SOP should be implemented by members of the Rapid Response Team (RRT) at any level of the health system
Responsibility	1. It is responsibility of the district IDSR/RRT lead to ensure that this SOP is adhered to 2. It is the responsibility of the RRT at any level to build the capacity (technical and logistics) for outbreak investigation at the level below 3. It is the responsibility of the national IDSRTWG to mobilize and deploy required resources for outbreak investigation at all levels of the health system
Procedure	*Within 48 hours of notification of a suspected outbreak, the head of the district RRT should*; 1. Verify that the information received is accurate. The verification process will include immediately communicating (preferably by phone call) back to the source of the alert to ascertain the accuracy of the alert in terms of the source of the alert, the date and location of the alert, the number of suspected cases, severity (including deaths) of suspected cases, nd any response interventions that have been implemented *Upon verification of the alert as true, the head of the district RRT should update the system database and;* *2.* Immediately mobilize the other members of the district RRT, brief the RRT about the suspected outbreak, brief the RRT on the Terms of Reference (ToRs) for the investigation, clarify the roles and responsibilities of each member of the RRT, clarify the communication channels during the investigation, mobilize the required outbreak investigation logistics and supplies, develop/adjust/review and print off the necessary outbreak investigation tools, obtain the necessary authorization and deploy the RRT to the field to conduct the investigation. The members of the RRT should be mobilized from

	the RRT register maintained at district level. The generic composition and specific roles of RRT members is indicated in figure 16. *Upon reaching the field, the RRT lead should;* 3. Conduct the necessary field entry activities including necessary curtesy visits to relevant offices to introduce the RRT and the purpose and duration of their deployment and a summary of how the investigation will be conducted *The deployed RRT should;* 4. Integrate with the local technical persons for capacity building and to have a locally led outbreak investigation, logistically and technically supported by the deployed RRT. 5. Conduct a systematic investigation of the suspected outbreak following the standard steps of outbreak investigation. As a critical step in outbreak investigation, for every identified case, a case investigation form should be completed. Every priority condition should have a specific outbreak investigation form. Templates of disease specific case investigation forms are available from WHO. These should be adapted to the country context during the preparedness phase. If the cases are multiple, they should be entered in a line-list. The generic line list is indicated in figure 17. For all or some of the identified cases (or as the specific outbreak investigation guidelines will dictate), a laboratory sample is required. Led by the laboratory specialist on the RRT, the appropriate sample will be collected from the cases, packaged appropriately and transported to the laboratory for confirmatory diagnosis. Every sample sent to the laboratory must be accompanied by a completed laboratory investigation request form. The majority of disease specific case investigation forms are integrated to also serve as the laboratory investigation request form. In this case, a copy of the completed case investigation form should be sent together with the laboratory sample. For every identified case, its contacts must be identified. The generic contact identification form is indicated in figure 18. Every identified contact should be followed up for a

	duration of one incubation period from the last contact with a confirmed case or until they become suspected cases, whichever comes first. The generic contact follow-up form is indicated in figure 19. 6. Disseminate preliminary investigation findings before field exit 7. Recommend and participate in the implementation of recommended outbreak response interventions while continuing to investigate the outbreak 8. Write and submit an outbreak investigation report to the office of the district medical officer. The standard template for an outbreak investigation report is indicated in figure 20.
Approved by:	National IDSR TWG
Date of next review;	December, 2025

Figure 18: SOP for Outbreak Investigation

Preparing to respond to outbreaks

Introduction

Preparing to respond to outbreaks means conducting certain activities in advance to better respond to outbreaks when they occur. Preparedness is wide and can include a number of activities conducted in advance. These guidelines will prioritize the following advance activities; 1) establishment of functional IDSR Technical Working Group (TWG) and their sub-committees at district, regional and national level, 2) development, testing and monitoring the implementation of an all-hazard plan and hazard/event/disease specific contingency plans, 3) conducting periodic risk assessments and updating hazard/event/disease specific contingency plans, 4)establishment of RRTs at different levels (health facility, district, regional and national) of the health system and 5) pre-positioning of outbreak investigation and response logistics and supplies.

Establishment of PHEOCs to coordinate outbreak preparedness and response is a core preparedness activity adequately addressed elsewhere and will not be included in these technical guidelines.

Establishment of a functional IDSR TWG and its sub-committees

The IDSR TWG is responsible for overall resource mobilization, coordination, oversight, policy and strategic guidance in planning and monitoring the implementation of public health emergency management interventions. Broadly, the major function of the IDSR-TWG is to oversee the development and monitoring the implementation of the emergency preparedness and response activities. At national level, chaired by the director of Public Health (and co-chaired by WHO), the IDSR TWG is composed of representatives of relevant government ministries, UN agencies, NGOs, teaching institutions, civil society and private sector organizations with a role in prevention and response to public health emergency management. At regional level, chaired by the regional medical officer, and at district level chaired by the district medical officer. The composition of the TWG at regional and district levels mirrors its composition at national level. The generic composition of the IDSR TWG is shown in figure 22. IDSR TWG sub-committees are constituted to oversee daily management of public health emergencies and report to the TWG for decision making. The heads of these sub-committees make up the TWG. The generic sub-committees of the IDSR TWG and their summary functions are reflected in figure 23.

Proposed IDSR TWGs in Somaliland context: (revised version-as final-1)

SOMALILAND MINISTRY OF HEALTH DEVELOPMENT INTEGRATED DISEASE SURVEILLANCE AND RESPONSE
IDSR TECHNICAL WORKING GROUP LIST AND MEMBERSHIP

Organization	Title	Member
MoHD	PHD Director (Chairman/Chairperson)	Mahdi Dahir Bahdon
WHO	Co-Chairperson	Dr. Deq Saed Jama
MoHD	DG-Advisor, MoHD, Somaliland	Dr. Amal Ali
MoHD	IDSR Coordinator	Abdillahi Abdi Yusuf
MoHD	Public Health Consultant to DG	Dr. Abdirahman Omar Mohamed
MoHD	Risk Communication	Hussein Mohamed Arab
MoHD	PHEOC Advisor	Dr. Ahmed Saleban Jama
MoHD	NPHL Manager	Ahmed Hashi
MoHD	Emergency-PHEOC Manager	Mohamed Weheliye
UNICEF	Health Specialist	Hamse Abdilahi Omer
SRCS	Health Emergency Manager	Mustakim Mohamed Muhamud
NADFORD	Emergency Planning Officer	Sharmake Abdi Muse

SOMALILAND MINISTRY OF HEALTH DEVELOPMENT
INTEGRATED DISEASE SURVEILLANCE AND RESPONSE
GENERIC COMPOSITION OF THE IDSR TWG AT NATIONAL LEVEL

- National administrator
- National police commissioner
- National Chief Executive, Mayor
- National director of public health services
- National medical officer
- Medical superintendents-in charge of hospitals
- National director of Veterinary/Agricultural services or equivalent
- National public health nurse
- National disease control officer or equivalent
- National environmental health officer or equivalent
- National education officer
- National water officer
- National engineer
- National wildlife officer

- National natural resources/veterinary expert
- National laboratory technician
- National community development officer
- National immigration officer
- National risk communication
- National legal officer
- National security officer
- National influential leaders
- National community health programs and faith-based health facilities
- National Red Cross/Red Crescent or similar agencies
- National civil society organizations
- National UN organizations
- National representative from private health facilities
- National representative from private laboratories
- National representatives of business community
- National research and training institutions
- National level professional associations

Note

At national level, an equivalent of the above should be used in order to ensure a more comprehensive multi-sectoral structure of the IDSR TWG

Figure 19: Generic Composition of the IDSR TWG

SOMALILAND MINISTRY OF HEALTH DEVELOPMENT INTEGRATED DISEASE SURVEILLANCE AND RESPONSE **IDSR TWG SUB-COMMITTEES**	
Sub-committee	**Summary description of tasks**
Coordination and planning	• Coordinate all aspects of the operations response, planning and management including: • Selecting participating organizations and assigning responsibilities • Designing, implementing and evaluating control interventions • Co-ordination of technical EPR subcommittees and overall liaison with partners • Daily communication through situation reports about the evolution of the outbreak • Managing information for public and news media • Operational support including mobilization of resources
Finance and Administration	• Tracks expenditure, makes payments, and provides administrative services • Ensures appropriate cash flow management, tracking material and human resources, looking at cost, budget preparation, monitoring, and maintenance of administrative records.
Logistics	• Provide budgetary support/ funding for epidemic preparedness & response • Procurement of equipment and supplies • Maintain adequate stocks of supplies and equipment • Arrange for transport and communication systems • Liaison with other agencies for logistic support • Provide accountability for all the resources used during epidemic preparedness & response
Case management and infection prevention & control	• Ensure or make available guidelines and SOPs for case management and infection prevention and control at all health facilities • Strengthen isolation facilities and reinforce infection prevention and control measures • Conduct risk assessment of health care workers • Ensure appropriate medical care is being provided to patients • Provide ambulance services • Collect data from all treatment facilities and submit to the surveillance sub-committee • Ensure appropriate disinfection of homes and environments with suspected/ probable/ confirmed cases/ deaths of an infectious disease • Conduct safe burial of dead bodies from isolation facilities and community deaths • Training of health workers in the isolation facility and other health facilities in the affected district
Surveillance and Laboratory	• Ensure or make available all surveillance guidelines and tools in the health facilities • Ensure the use of the outbreak case definition • Conduct active case finding, case investigation, contact tracing and follow-up • Verification of suspected cases/ alerts/ rumors in the community • Ensure proper filling of case investigation, contact tracing and follow-up forms • Ensure proper collection, packaging, transport, and testing of laboratory specimen

	• Communicate test results to clinical services • Conduct data management and provide regular epidemiological analysis and reports • Training of health personnel in disease surveillance • Close linkage with burial, infection control and social mobilization groups.
Risk Communication and Social Mobilization /Community engagement	• Ensure or make available risk communications materials and plans • Conduct rapid assessment to establish community knowledge, attitudes, practices & behavior on prevailing public health risks/events • Organize sensitization and mobilization of the communities • Serve as focal point for information to be released to the press and public • Liaise with the different subcommittees, local leadership and NGOs involved in activities on mobilizing communities
Psychosocial support	• Provide psychological and social support to suspected/ • probable/confirmed cases; affected families and communities • Provide wellness care and psychological support to the response team • Prepare bereaved families/ communities for burials • Prepare communities for reintegration of convalescent cases/ patients who have recovered
Water, Sanitation and Hygiene (WASH)	• Conduct environmental health risk assessment for the outbreak • Ensure provision of clean water • Improved water management at household and community level. • Plan for sanitation improvement campaign • Plan for improved hygiene practices including handwashing, food hygiene and sanitation.
Vaccination campaign	• Identify high risk groups during the outbreak that should be targeted for vaccination • Compute the targeted population for the vaccination campaign • Conduct micro-planning for all vaccination logistics including cold chain facilities, vaccine delivery and distribution, human resource needs, waste handling, social mob. • Conduct the vaccination campaign and post vaccination campaign validation exercise

Figure 20: Functions of different Sub-committees of the *IDSR* TWG

Development of the All-Hazard plan

One of the major functions of the IDSR TWG is to oversee the development and implementation of the all-hazard plan. The plan should; 1) identify and rank the hazards, 2) identify mechanisms for monitoring the hazards, 3) identify minimum preparedness actions (MPA) for all hazards and 4) have hazard-specific contingency plans for each of the high-risk hazards as annexes. The summary of the generic outline of the all-hazard plan is reflected in figure 24.

Stakeholder mapping

Stakeholder mapping involves identifying all stakeholders within and outside the health sector who have a critical role to play in prevention, preparedness, response and recovery from public health emergences. The process involves identification of the stakeholder, identification of the area of support, the specific activities to be supported by each stakeholder as guided in figure 25. Stakeholder mapping is usually completed in a workshop setting and should be repeated periodically (every 5 years) because over time – old stakeholders exit while new stakeholders join the outbreak or public health emergency management arena.

Pre-positioning of medical counter measures (MCMs)

MCMs are often quantified and pre-positioned in terms of kits. The composition of many of such kits has been defined/standardized by organizations like UNICEF, MSF and WHO. An example is kits for cholera management. Regularly, country level experts (the IDSR TWG in this case) are only required to determine how many such kits are required at which locations. The IDSR TWG will be required to constantly monitor the availability of kits at the predetermined locations and keep replenishing whenever the number of available kits falls below the minimum required volumes of each of the MCMs. Supplies required for outbreak response differ from outbreak to outbreak. Where no standard kits exist, the logistics and supplies sub-committee of the IDSR TWG should develop their content, determine how many kits should be available at different levels of the health system, have them delivered and their availability constantly monitored and replenished when their number drops below the required minimum.

Constitution and training of Rapid Response Teams (RRTs)

Rapid Response Teams (RRTs) are a multi and inter-disciplinary team of members trained and equipped to rapidly respond to suspected and confirmed public health emergences. Having trained and readily deployable RRTs is one of the required minimum preparedness actions which should be overseen by the IDSR TWG. Rapid Response Team (RRT) capacity should be built all levels of the health system, logically

beginning from national to regional/district and facility level. The operational plan for strengthening surveillance and response in Somaliland envisions creation of Rapid Response Team (RRT) capacity at national and district/regional levels. Depending on availability of resources, this can be scaled up to lower administrative levels. The guide on the composition and the functions of Rapid Response Teams (RRTs) is reflected in figure 16.

Periodic risk assessments

A risk assessment can be conducted before or during an active outbreak. When it is conducted during an outbreak, the objective is to determine the likelihood of further spread and the further impact an ongoing outbreak will have if the current level of response is sustained. When it is conducted before an outbreak, the objective is to determine the likelihood of occurrence of an outbreak and the potential impact it will have if the current level of preparedness stays the same. When a risk assessment is conducted before an outbreak, the findings are used to strengthen prevention and preparedness interventions at community level, facility level and all other levels of the health system. The frequency of such risk assessments differs. For the very high-risk outbreaks, preparedness assessments should be more frequent; at least once a year or after an event which increases the likelihood of a given outbreak. The scope of the assessment can also vary depending on the urgency with which results are needed, the time within which the assessment should be conducted and available resources (including human resource capacity). Because the determinants of occurrence and spread of different outbreaks are different, risk assessment tools differ from outbreak to outbreak. Such tools should be developed before an outbreak occurs. The tools should be reviewed to be sure that the assessment needs of different stakeholders are met by the assessment tool. Generic risk assessment tools are available from agencies like UNICEF and WHO.

SOMALILAND MINISTRY OF HEALTH DEVELOPMENT
INTEGRATED DISEASE SURVEILLANCE AND RESPONSE
GENERIC ALL-HAZARD PLAN OUTLINE

1. Introduction and background
2. Risk Analysis and Mapping
    a. Identifying all hazards using an all-hazards approach
    b. Assigning risk to each of the hazards using a combination of likelihood (very unlikely, unlikely, moderately likely, likely, very likely) and potential impact (negligible, minor, moderate, severe and critical) of each hazard
    c. Ranking/Prioritizing hazards
    d. Setting thresholds for hazard monitoring
    e. Mechanism for monitoring mapped hazards (for example through periodic risk assessments)
3. Plan for implementation of minimum preparedness actions. This involves identification of the core preparedness activities which should be ongoing, which lay the foundation for implementation of contingency plans for high-risk hazards. They include basic preparedness readiness activities like;
    a. Conducting needs assessments
    b. Risk monitoring
    c. Establishment of EOCs
    d. Routine surveillance
4. Contingency plan for each of the high-risk hazards. For each of the high-risk hazards, the contingency plan should contain;
    a. A situation analysis (what is likely to happen, the likely impact and the current capacity to respond)
    b. Response strategy
        i. Objectives of hazard specific contingency plan in the areas of surveillance, laboratory, case management, risk communication and or social mobilization
        ii. Response interventions; how to achieve/realize the objectives
    c. Operational strategy; how the response interventions will be implemented
    d. Coordination arrangements
    e. Preparedness gaps
        i. Response resource mapping
        ii. Response resource pre-positioning
        iii. Response resource monitoring
    f. Funding requirements/Budget/Resource Mobilization Strategy

Note

MOHD can decide to use the CDC or the WHO guidelines for developing Emergency Preparedness and Response (EPR) Plans. These are available from CDC/WHO website

Figure 21: Generic Outline of an Emergency Preparedness and Response Plan

SOMALILAND MINISTRY OF HEALTH DEVELOPMENT
INTEGRATED DISEASE SURVEILLANCE AND RESPONSE
IDSR STAKEHOLDER MAPPING TOOL

Region/District Name:

No	Name & Contact of Stakeholder	Technical Area of Support	Specific Activities Supported	Details of support (finances OR Logistics OR Supplies)
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				
21				
22				
23				

Figure 22: Stakeholder Mapping Tool

Standard Operating Procedure (SOP) for Preparing to Respond to Emergences

SOMALILAND MINISTRY OF HEALTH DEVELOPMENT INTEGRATED DISEASE SURVEILLANCE AND RESOPNSE **PREPARING TO RESPOND TO EMERGENCES** SOP	
Purpose	To provide standard guidance on how to prepare to respond to outbreaks and other public health emergences
Scope	This SOP should be implemented by the IDSR TWG at national and regional level
Responsibility	1. It is the responsibility of the chair of the TWG to ensure that this SOP is adhered to 2. It is the responsibility of the national level TWG to build the capacity of TWGs at lower levels of the health system
Procedure	*The director of Public Health and the heads of IDSR at national level, RMO at regional levels should;* 1. Constitute/designate the IDSR TWG and its sub-committees (and their chairs) guided by the generic composition of the IDSRTWG in figure 32 and the functions of the IDSR TWG sub-committees in figure 33. *The WHO country office should;* 2. Support the development of training materials and the training of national level IDSR TWG and its sub-committees on their ToRs *The national level IDSR TWG should;* 3. Support the development of training materials and training of sub-national IDSR TWGs and their sub-committees on their ToRs *Through regular meetings, the TWG at national and regional level should;* 4. Provide strategic oversight in the development an all-hazard plan as guided by figure 34 including; a. Overseeing the identification, risk profiling, mapping, ranking and prioritization all the hazards at the respective level b. Overseeing the determination and implementation of minimum preparedness actions (MPAs) which should be implemented for all hazards c. Overseeing the development of a contingency plan for each of the hazards that have been ranked as moderate to high-risk hazards d. Conducting periodic risk assessment of prioritized hazards and making necessary adjustments in the hazard specific contingency plans e. Conducting periodic testing of hazard specific contingency plans and making necessary adjustments 5. Oversee the mobilization and deployment of resources for implementation of the EPR plan including; a. Overseeing stakeholder mapping b. Overseeing resource mapping c. Designation and periodic training of Rapid Response Teams (RRTs) at different levels of the health system d. Determination and pre-positioning of outbreak investigation kits e. Determination and pre-positioning of outbreak response kits for prioritized hazards f. Monitoring the levels of emergency response resources 6. Monitor the implementation of the other activities reflected in the EPR plan
Approved by:	National IDSR TWG
Date of next review;	December, 2025

Figure 23: SOP for Preparing to Respond to Outbreaks

Outbreak response

Immediate notification to the director general MOHD/regional medical officer

Declaration of outbreaks is political. Whenever an outbreak is confirmed, the director general (DG) of the MOHD, the director of public health, the head of the PHEOC, the head of HMIS, the head of public health laboratories, head of surveillance (IDSR) and the regional and district medical officer of the affected district/region should be notified immediately (by the head of lab or the head of IDSR). The DG (or the director of public health) will call for an urgent meeting to decide on whether to declare the outbreak and subsequently activate the outbreak response structures.

Activation of outbreak response structures

Upon activation of the outbreak response structures, the Incident Manager (IM) will be appointed who will then constitute the Incident Management Team (IMT). The size of the IMT will depend on the scale of the outbreak and the capacity of the lower levels to implement an expedient and well-coordinated response. At the same time, the international health regulations national focal point (IHR NFP) will apply the IHR decision instrument to determine whether the outbreak is a potential PHEIC and immediately notify the WHO IHR FP office about the potential PHEIC.

Immediate mobilization and deployment of the RRT

As the operational arm of the IMT, the RRT will quickly be mobilized and deployed to work within the structures in the affected district/region to conduct a rapid assessment (if not done recently), further investigate the outbreak and implement preliminary response interventions. The RRT will also conduct a rapid assessment of the capacity of the affected district/region to implement an expedient and well-coordinated response to the outbreak. This information will be critical in updating the contingency/response plan to the outbreak.

Review/adjusting/updating the contingency/outbreak response plan

Using the report submitted by the RRT, the planning section of the IMT will develop/update the outbreak response improvement plan (and cost budgeting) which will be reviewed and approved by the IMT. This will then act as the blueprint for guiding response to the outbreak.

Implementation of selected outbreak response strategies

This includes carrying out the outbreak response actions as indicated in the approved outbreak response plan. These actions will relate to; 1) strengthening coordination (for example through regular coordination meetings, 2) building of HW and CHW capacity to respond to the outbreak(for example through rapid re-fresher trainings), 3) enhancing active surveillance and laboratory, 4) strengthening case management, IPC and Psychosocial Support, 5) RCCE, 6) Improving WASH, 7) Ensuring availability of required logistics and supplies, 8) Provision of regular information about progress of the response

through daily situation reports as shown in figure 27, and 9) Constantly monitoring the extent to which outbreak response actions are implemented as planned.

Conducting an Intra-Action Review

For prolonged outbreaks, an intra action review (IAR) is necessary. Unlike the After-Action Review (AAR), an IAR is conducted during an ongoing outbreak. The IAR reviews outbreak implementation progress, identify what is being done well so that it is maintained and what is not being done so well so that it can be improved to strengthen overall response to an ongoing outbreak. The methodology of conducting an IAR is available from WHO.

Declaring end of an outbreak

The end of the outbreak is normally declared by the DG. Technically, an outbreak is declared over after a duration of 2 incubation periods after the death or after the recovery of the last known confirmed case of the outbreak. Operationally, this duration can be increased depending on the confidence in the sensitivity of active surveillance not to declare the end of the outbreak pre-maturely. End of outbreak declaration is accompanied by an outbreak response report.

Documenting the response (Outbreak response report)

This is a description of how the outbreak was detected, investigated, confirmed and responded to. The report also includes a self-assessment of the timeliness and quality of outbreak preparedness, detection, investigation, confirmation and response (figure 28). The report also makes recommendations on improving outbreak preparedness, detection, investigation, confirmation and response at different levels of the health system.

Conduct an After-Action Review

An after-Action Review (AAR) is an in-depth peer-to-peer review of how well/not so well outbreak response was implemented. It describes the evolution of the response, identifies the capacities that were in place before the outbreak, the major strengths and the major weaknesses of the response and how the available capacities facilitated/inhibited implementation of outbreak response interventions. The AAR ends with identification of tangible actions that need to be implemented to strengthen response to the subsequent outbreak, prioritization of these actions and development of an implementation plan for these actions. A detailed standard operating procedure (SOP) for responding to outbreaks is detailed in figure 29.

SOMALILAND MINISTRY OF HEALTH DEVELOPMENT
INTEGRATED DISEASE SURVEILLANCE AND RESPONSE
SITUATION REPORT (SITREP)
Date…… SITREP Number: …….

Situation Update

Highlights (in bullet form)

-
-
-

Summary Statistics (in tabular form)

Statistic	Value

Time-Place-Person Analysis (maps and curves)

Background

……
……

Implemented Public Health Actions (in bullet form)

Coordination
Surveillance and laboratory
Risk Communication and Community Engagement
Case Management
Logistics and Supplies

Current Public Health Challenges (in bullet form)

Coordination
Surveillance and laboratory
Risk Communication and Community Engagement
Case Management
Logistics and Supplies

Planned/Next Public Health Actions (in bullet form)

Coordination
Surveillance and laboratory
Risk Communication and Community Engagement
Case Management
Logistics and Supplies

Figure 24: Generic Outbreak Response Situation Report (SITREP)

SOMALILAND MINISTRY OF HEALTH DEVELOPMENT
INTEGRATED DISEASE SURVEILLANCE AND RESPONSE

OUTBREAK RESPONSE REPORT

Title (include the disease, place and time of the outbreak)

Executive Summary

……

……

Introduction

Describe how the outbreak was detected, investigated and confirmed

Describe the time, place and person characteristics of the outbreak responded to

Give a summary of the planned response interventions to the outbreak

Objectives

List specific reasons why the outbreak response evaluation was conducted for example;

1. To document the response to the outbreak
2. To determine the difference between planned and implemented outbreak response interventions
3. To assess the timeliness and quality of outbreak response interventions that were implemented.
4. To provide recommendations and actions to be taken.

Methods

Describe how each of the stated specific objectives was achieved

Results

Show results for each of the specific objectives of the outbreak response report

Self-Evaluation of timeliness and quality of;

- Outbreak Preparedness
- Outbreak Detection
- Outbreak Investigation
- Outbreak Response
- Evaluation and Feedback

Evaluation of Other Aspects of the Response

……

……

Conclusion on performance of prevention, preparedness, response and recovery

……

……

Recommended Public Health Actions (across prevention, preparedness, response and recovery)

- Community level recommendations
- Facility level recommendations
- District/regional level recommendations
- National level recommendations

Figure 25: Generic Format of an Outbreak Response Report

Standard Operating Procedure for Outbreak Response

SOMALILAND MINISTRY OF HEALTH DEVELOPMENT INTEGRATED DISEASE SURVEILLANCE AND RESOPNSE **RESPONDING TO OUTBREAKS AND OTHER PUBLIC HEALTH EMERGENCES** SOP	
Purpose	To provide standard guidance on how to respond to outbreaks and other public health emergences in Somaliland
Scope	This SOP applies to outbreak response at district, regional and national level in Somaliland
Responsibility	It is the responsibility of the IDSRTWG, its sub-committees, RRT and frontline health workers at facility and community level to implement this SOP
Procedure	*Upon confirmation of an outbreak, the national laboratory lead should;* 1. Use the fastest means to share information about the confirmed outbreak with the director general of MOHD, Public Health Director, national EOC manager, the head of the surveillance and response unit/department at MOHD and regional medical officers of the affected region *After making the necessary consultations, the director general of MOHD should;* 2. Call for an urgent meeting of the IDSRTWG to share information on the confirmed outbreak, make a decision on declaration of the outbreak and activate outbreak response structures (which includes appointment of the Incident Manager to take overall responsibility of command and control of the response) *Upon appointment of the Incident manager (IM), the IM should;* 3. Immediately constitute and call for a debrief meeting of the Incident management Team (IMT). The scale of the IMT should reflect the scale of the outbreak 4. Immediately mobilize, debrief and deploy the RRT to work with the structures in the affected district/region to conduct a detailed investigation of the outbreak, a rapid assessment of the current capacity of the affected district/region to implement an expedient response to the outbreak and institute preliminary outbreak response interventions *Using the rapid assessment findings submitted by the RRT, the different technical sub-committees of the IDSRTWG should;* 5. Review and update the generic outbreak response strategies and determine the resource needs (draw up a budget) for comprehensively responding to the outbreak *The coordination sub-committee of the IDSRTWG should;* 6. Receive, review and approve the outbreak response plan and budget as the blueprint for guiding the implementation of selected outbreak response interventions.

	7. Submit the approved outbreak response plan and budget to the unit responsible for approving and providing the required finances and logistics for outbreak response. This also includes sharing of the approved plan and budget to other government and non-government ministries, departments and agencies and other stakeholders who support outbreak management in Somaliland *Through regular meetings, the respective technical sub-committees of the IDSRTWG should;* 8. Oversee the implementation of outbreak response interventions under their jurisdiction. This includes; 1) coordination (through regular coordination meetings), 2) rapid capacity building of frontline health workers and community health workers (for example through rapid refresher trainings and supportive supervision), 3) enhancing surveillance and response, strengthening case management, infection prevention and control (IPC) and psychosocial support, 4) mobilizing, educating and engaging the affected community, 5) ensuring availability of required outbreak response logistics and supplies and 6) intensifying sanitation, hygiene and safe food handling practices among others as laid down in the approved outbreak response plan. *The surveillance and laboratory sub-committee on top of its other responsibilities as stipulated in the response plan should;* 9. Produce and widely disseminate a daily outbreak situation report to serve as a means of constantly informing the wider stakeholders on the current situation of the outbreak and the progress in implementation of outbreak response interventions *Through regular meetings (daily in the early days of the outbreak), the coordination sub-committee should;* 10. Receive implementation updates (and challenges) from all the heads of other sub-committees of the IDSRTWG 11. Provide technical oversight and guidance on how to optimize implementation of outbreak response interventions 12. Constantly monitor the implementation of response activities as reflected in the response plan *For prolonged outbreaks, the IDSRTWG should;* 13. Provide guidance and technical oversight in planning and implementation of an Intra Action Review (IAR) to assess mid-term progress in responding to the outbreak and identify and scale up success factors and propose solutions to address any challenges in responding to the ongoing outbreak *On advice from the IDSRTWG, the director general of health services should;* 14. Declare the end of the outbreak after a duration of 2 incubation periods after the

	death or recovery of the last confirmed case of the outbreak *When the end of the outbreak is declared, and under the technical oversight of the IDSRTWG, the RRT should;* 15. Write an outbreak response report clearly detailing how the outbreak was detected, investigated, confirmed and responded to. The report should also include a self-assessment of the timeliness and quality of outbreak preparedness, detection, investigation, confirmation and response. The report should also include recommendations on how to address experienced challenges when responding to outbreaks in the future. *Under the overall strategic oversight of the IDSRTWG, the EOC manager or the head of the unit responsible for surveillance and response should;* 16. Collaborate with WHO (and CDC or any other assigned stakeholders) to plan and conduct an After-Action Review (AAR). The AAR will serve as an in-depth analysis of the capabilities that were in place before the outbreak, and how these capabilities facilitated or inhibited the execution of planned outbreak response interventions. The AAR will also synthesize actions that need to be implemented and an action plan for implementation of these actions
Approved by:	National IDSR TWG
Date of next review;	December, 2025

Figure 26: SOP for Responding to Outbreaks and other emergencies

Risk communication and Community Engagement (RCCE)

Introduction

Risk communication and community engagement (RCCE) is the exchange of information, advice and opinions between experts, community leaders and affected communities to facilitate uptake and maintenance of behaviors and practices required to prevent and effectively respond to outbreaks. Effective RCCE is hinged on availability of functional risk communication structures, plans and procedures that enable the development and implementation of a comprehensive all-hazard and hazard-specific RCCE plan/strategy before, during and after an outbreak/emergency.

The components of effective risk communication include health education, social mobilization, community engagement, use of mass media (print and electronic), social media, outbreak communication, crisis communication, messaging (Information Education and Communication (IEC) and Behaviour Change Communication (BCC), as well as advocacy and rumour monitoring and management.

RCCE before an emergency

Through regular (for example monthly) meetings, RCCE subcommittee of the IDSR TWG should oversee; the mapping of all risk communication stakeholders and resources and the development, testing, regular update and monitor implementation of the all-hazard and hazard-specific risk communication strategy/plan, the development, dissemination and sensitization of health workers and other stakeholders on the risk communication plan, the development, approval and dissemination of priority disease specific fact sheets (figure 42) and other risk communication IEC materials, harmonization of IEC materials, guidelines, protocols and SOPs, build capacity of social mobilizers and harmonize their tools, and the development and testing of a framework for management of rumors and misinformation during outbreak response, the development and testing of a framework for regular monitoring of the effectiveness of risk communication before, during and after outbreak response.

RCCE during an emergency

During outbreak response, and through regular sub-committee meetings, the RCCE subcommittee of the IDSR TWG should oversee; the revision of the hazard-specific risk communication strategy, which is part of the hazard specific contingency/response plan, the determination/establishment of the resource gap for implementation of the risk communication strategy, the implementation of outbreak response risk communication strategies as laid down in the hazard-specific contingency/response plan. Among others, these include trainings in risk communication, review, translation, harmonization, approval and

dissemination of IEC materials, community sensitizations, engagements through multiple platforms and rumor management, constantly monitor the impact of risk communication strategies on uptake and maintenance of required outbreak response behaviors and practices during outbreak response and expediently respond to all legitimate risk communication requests from the frontline responders.

The risk communication and community engagement (RCCE) team which is part of the deployed RRT, which is the operational arm of the IMT should map stakeholders and constantly communicate with the affected community using clear, understandable, harmonized, consistent and actionable messaging through distribution of approved IEC materials and other community engagement channels for example through mass media talk shows, constantly collect, analyze and respond to rumors and any other misinformation about the outbreak and periodically collect and analyze information to determine the extent to which risk communication strategies are producing the required outbreak response behaviors and practices in the community.

The designated outbreak/emergency communication officer as designated by the Director General (DG) at the respective level should conduct regular media briefs/updates about the outbreak and current and future response interventions and liaise with the surveillance team to ensure that the daily SITREP is widely disseminated among all outbreak response stakeholders

RCCE after an emergency

After the outbreak, the risk communication and community engagement (RCCE) subcommittee of the IDSR TWG should;

1. Oversee the writing of the risk communication component of the overall outbreak response report
2. Oversee the planning and implementation of risk communication evaluation activities; as part of the overall evaluation of the response to the outbreak
3. Oversee the process of updating the risk communication component of the EPR plan using the risk communication evaluation findings

The WHO guide for monitoring the implementation of risk communication and community engagement (RCCE) requirements is provided in figure 30. The outline of a fact sheet is also provided in figure 31. The Standard Operating Procedure (SOP) for emergency risk communication is detailed in figure 32.

IHR Core Capacity Monitoring Questionnaire: Risk Communication
1. Have risk communication partners and stakeholders been identified?
2. Has a risk communication plan[A] been developed?
3. Has the risk communication plan been implemented or tested through actual emergency or simulation exercise and updated in the last 12 months?
4. Are policies, SOPs or guidelines developed on the clearance[B] and release of information during a public health emergency?
5. Are regularly updated information sources accessible to media and the public for information dissemination? [C]
6. Are there accessible and relevant IEC (Information, Education and Communications) materials tailored to the needs of the population? [D]
7. In the last three national or international PH emergencies, have populations and partners been informed of a real or potential risk within 24 hours following confirmation?
8. Has an evaluation of the public health communication been conducted after emergencies, for timeliness, transparency[E] and appropriateness of communications, been carried out?
9. Have results of evaluations of risk communications efforts during a public health emergency been shared with the global community?
Notes: A. Plan includes inventory of communication partners, focal points, stakeholders and their capacities in the country B. Procedures in place for clearance by scientific, technical and communications staff before information is released during public health events C. This may include website/webpage (national level), community meetings, radio broadcasts nationally as appropriate etc. D. The views and perceptions of individuals, partners and communities affected by public health emergencies should be systematically taken into account; this includes vulnerable, minority, disadvantaged or other at-risk populations. E. Transparency here implies openness, communication and accountability, i.e. all information about public health risk is open and freely available.

Figure 27: Guide for Monitoring the Implementation of Emergency Risk Communication Requirements

INTEGRATED DISEASE SURVEILLANCE AND RESPONSE

CHOLERA FACT SHEET

What is Cholera?

What is known about Cholera in my area?

How does one get Cholera?

Can a person infected with Cholera infect another person?

How can you prevent yourself and others from getting Cholera?

How do I know that someone might be having Cholera?

Are there medicines (and vaccines) for preventing Cholera?

Are there medicines for treating Cholera?

What should I do when I suspect that someone has Cholera?

Where can I get more information about Cholera?

Figure 28: Generic Fact Sheet (using the example of Cholera)

Standard Operating Procedure (SOP) for Risk Communication and Community Engagement

SOMALILAND MINISTRY OF HEALTH DEVELOPMENT EPIDEMIOLOGICAL SURVEILLANCE AND RESOPNSE **RISK COMMUNICATION AND COMMUNITY ENGAGEMENT** SOP	
Purpose	To provide standard guidance on how to plan for and implement comprehensive risk communication activities before, during and after and outbreak/emergency
Scope	This SOP should be implemented by risk communication sub-committee of the PHEMC/IDSR TWG and the risk communication team (as part of the RRT) at national, regional and district level
Responsibility	It is the responsibility of the risk communication sub-committee of the PHEMC, the risk communication teams and the designated risk communication officer during outbreak response to implement this SOP
Procedure	Before an outbreak/emergency, and through monthly meetings, **the risk communication sub-committee of the PHEMC (also known as the IDSRTWG)** should; 1. Oversee the mapping of all risk communication stakeholders and resources, including their commitments to supporting risk communication activities before, during and after an outbreak or emergency 2. Oversee the development, testing, regular update and monitor implementation of the all-hazard and hazard-specific risk communication strategy/plans (using the guide in figure 41) 3. Oversee the development, dissemination and sensitization of health workers and other stakeholders on the risk communication plan and guidelines for critical risk communication activities like release of information during outbreak response. 4. Oversee the development, approval and dissemination of priority disease specific fact sheets (figure 42) and other risk communication IEC materials. 5. Oversee the development and testing of a framework for management of rumors and misinformation during outbreak response 6. Oversee the development and testing of a framework for regular monitoring of the effectiveness of risk communication during outbreak response 7. Organize risk communication related trainings for health workers and other stakeholders 8. Oversee the dissemination risk communication related policies, guidelines, standard operating procedures (SOPs) and IEC materials through multiple channels to the community 9. Oversee the periodic collection of data related to the effectiveness of risk communication activities implemented before outbreaks During outbreak response, and through regular sub-committee meetings, **the risk communication sub-committee of the PHEMC/IDSR TWG** should; 10. Oversee the revision of the hazard-specific risk communication strategy, which is part of the hazard specific contingency/response plan 11. Oversee the determination/establishment of the resource gap for implementation of the risk communication strategy 12. Oversee the implementation of outbreak response risk communication strategies as laid down in the hazard-specific contingency/response plan. Among others, these include trainings in risk communication, dissemination of IEC materials, community sensitizations, engagements through multiple platforms and rumor management

	13. Constantly monitor the impact of risk communication strategies on uptake and maintenance of required outbreak response behaviors and practices during outbreak response 14. Expediently respond to all legitimate risk communication requests from the frontline responders During outbreak response, **risk communication team (as part of the RRT) should**; 15. Constantly communicate with the affected community using clear, understandable, harmonized, consistent and actionable messaging through distribution of approved IEC materials and other community engagement channels for example through mass media talk shows 16. Constantly collect, analyze and respond to rumors and any other misinformation about the outbreak 17. Periodically collect and analyze information to determine the extent to which risk communication strategies are producing the required outbreak response behaviors and practices in the community During outbreak response, the **designated outbreak/emergency communication officer** at the respective level should; 18. Conduct regular media briefs/updates about the outbreak and current and future response interventions 19. Liaise with the surveillance team to ensure that the daily SITREP is widely disseminated among all outbreak response stakeholders After the outbreak, the **risk communication sub-committee of the PHEMC/IDSR TWG** should; 20. Oversee the writing of the risk communication component of the overall outbreak response report 21. Oversee the planning and implementation of risk communication evaluation activities; as part of the overall evaluation of the response to the outbreak 22. Oversee the process of updating the risk communication component of the EPR plan using the risk communication evaluation findings
Approved by:	National IDSR TWG
Date of next review;	December, 2025

Figure 29: SOP for Risk Communication and Community Engagement

Supportive supervision of IDSR implementation

Introduction

According to these guidelines, supportive supervision refers to quarterly review of progress in execution of surveillance and response functions, identification of surveillance and response problems, their causes and development of feasible solutions. At least once every quarter, or more frequently in districts with few health facilities and on a day and time communicated and agreed upon between the support supervision team and the facility personnel, a multidisciplinary support supervision team from the office of the district medical officer will visit each facility and be guided by the facility level support supervision tool in figure 33 to;

1. Jointly assess (through records review, interviews, structured observations) how well facility staff are executing each of the surveillance and response functions (detecting and recording cases of priority conditions, immediate and weekly aggregate reporting, analysis and use of surveillance data, participation in outbreak investigation, participation in outbreak response, receipt of feedback, monitoring of surveillance and response and outbreak preparedness) including the availability of resources, supplies and logistics to execute each of these surveillance and response functions
2. Jointly identify challenges (if any) that hinder effective execution of each of the surveillance and response functions
3. Jointly identify corrective action(s) to each of the challenges identified and discuss their implementation arrangements
4. Deliver any routine feedback and/or any previously requested logistics and supplies or any capacity building sessions
5. Follow up on how well corrective action to any previously identified problem is working
6. Conduct a debrief to share their findings and any corrective actions that require to be implemented

After the debrief, the supportive supervision team and the facility team will sign the completed supportive supervision tool in duplicate; one copy to be retained at the facility and the other copy for filling and aggregation with other reports at district level. A summary of key findings (that should be brought to the attention of higher levels) should be shared with the regional and national levels. The standard procedure for conducting facility level supportive supervision is detailed in figure 34.

SOMALILAND MINISTRY OF HEALTH DEVELOPMENT

Integrated Disease Surveillance and Response (IDSR)

QUARTERLY FACILITY LEVEL SUPPORTIVE SUPERVISION TOOL

(Note: Every Health facility participating in IDSR should be visited/supervised at least ONCE every quarter)

Facility Name	
Facility code/No.	
District	
Region	

Surveillance and response function	Question (To be asked during the visit to the health facility)	Answer (To be given by the health worker)	Any challenges (To be identified by the health worker)	Required action (and time when the action will be implemented)
Identification of cases	1. How often do you collect information from the community about reports of suspected cases or deaths due to a priority disease or condition?			
Recording of cases	2. Are diagnoses of cases of priority diseases recorded in the clinic register according to the Standard Case Definitions (SCD)?			
Reporting of cases	3. Do health staff use a SCD to report the suspected cases and outbreaks?			
	4. Do you record information about immediately notifiable diseases on a case form or line list?			
Analysis of surveillance data	5. Do you plot the numbers of cases and deaths for each priority disease on a graph? (Ask to see the health facility's analysis book. Look to see if the trend lines are up to date.)			
	6. Do you plot the distribution of cases on a map?			
Verification of alerts, investigation of	7. If an epidemic-prone disease was suspected (or the numbers crossed the threshold), was it reported immediately			

suspected cases	to the district office?			
	8. For the cases of priority diseases needing laboratory tests seen since the last supervisory visit, how many had laboratory results?			
	9. Are appropriate supplies available or set aside for collecting of laboratory specimens during an emergency? Can I see them?			
Response to confirmed cases/outbreaks	10. Are appropriate supplies available for responding to a confirmed case or outbreak (for example, immunization supplies and vaccine, ORS, antibiotics, and so on)?			
	11. Please show me the supplies for carrying out a recommended response.			
	12. Who is the outbreak coordinator for this facility?			
	13. How often do you provide information and training in outbreak response to the staff of this facility?			
Receiving and giving feedback	14. How often do you provide feedback /information to the community?			
	15. Do you receive the latest bulletin from the (central, subnational) level?			
Monitoring of IDSR implementation	16. Were the last three routine monthly monitoring reports sent to the district office?			
	17. Were the last three routine monthly monitoring reports sent on time?			

Preparedness to detect and respond to outbreaks	18. What precautions do health staff (including laboratory staff) take routinely with all patients regardless of the patients' infection status? (Observe the practice)			
	19. How do you estimate the supplies to set aside for use during outbreak response?			

Any other activities that were conducted during the supportive supervision visit		
Supportive supervision team		
Name	Position	Phone number and email address
Health Facility Team who participated in the supportive supervision visit		
Name	Position	Phone number and email address

Figure 30: Quarterly Facility Level Supportive Supervision Tool

Standard Operating Procedure (SOP) for Quarterly Supportive Supervision

SOMALILAND MINISTRY OF HEALTH DEVELOPMENT INTEGRATED DISEASE SURVEILLANCE AND RESOPNSE **QUARTERLY FACILITY LEVEL SUPPORTIVE SUPERVISION** SOP	
Purpose	To provide standard guidance on how to conduct facility level supportive supervision
Scope	This SOP should be implemented by the supportive supervision team
Responsibility	1. It is the responsibility of the district supportive supervision team to conduct scheduled supportive supervision sessions to all health facilities participating in surveillance and response in the district. 2. It is the responsibility of the facility staff to participate in facility level supportive supervision sessions
Procedure	*Every after 3 months; following an annual supportive supervision schedule developed by the office of the district medical officer, and on a day and time communicated and agreed upon between the supportive supervision team and the facility personnel, a multidisciplinary supportive supervision team from the office of the district medical officer (sometimes joined by officers from regional or national level) will visit a scheduled facility and apply the quarterly facility level supportive supervision tool (figure 34) to;* 1. Jointly assess how well facility staff are executing each of the surveillance and response functions including the availability of resources, supplies and logistics to execute each of these surveillance and response functions 2. Jointly identify challenges (if any) to the effective execution of each of the surveillance and response functions 3. Jointly identify corrective action(s) to each of the challenges identified and discuss their implementation arrangements 4. Deliver any routine feedback and/or any previously requested logistics and supplies or any capacity building sessions 5. Follow up on how well corrective action to any previously identified problem is working 6. Conduct a debrief meeting with facility staff to share findings and any corrective actions that require to be implemented After the debrief, the supportive supervision team and the facility team will; 7. Sign the completed supportive supervision tool in duplicate; one copy to be retained at the facility and the other copy for filling and aggregation with other reports at district level
Approved by:	National IDSR TWG
Date of next review	December 2025

Figure 31: SOP for Facility Level Support Supervision

Monitoring of IDSR implementation

Introduction

According to these guidelines, monitoring refers to monthly tracking of planned surveillance and response functions and activities at facility level using a monthly IDSR monitoring. IDSR monitoring serves three major functions; 1) tracking the implementation of planned surveillance and response activities at multiple levels of the health system, 2) tracking the quality attributes of the surveillance and response system, such as timeliness and completeness of reporting at multiple levels of the health system and 3) identifying problems related to implementation of planned activities and those related to the quality of surveillance and response and instituting corrective actions in a timely manner. At the end of every month, and guided by the facility monthly IDSR monitoring chart (figure 35) the facility level surveillance focal person shall;

1. Review relevant facility level records and reports and fill in the required values for each of the indicators for monthly IDSR monitoring at facility level using the facility level monthly IDSR monitoring chart.
2. Submit a completed facility IDSR monitoring chart during the first week of the new month to the district surveillance officer. To ease the process of submitting the completed IDSR monitoring form, the form will be transformed into an online tool.

During routine facility level meetings, facility level staff should;

3. Discuss the data in the monitoring chart to inform decisions aimed at improving the performance of surveillance and response at facility level.

3.1 After the monitoring chart is reviewed at facility level with inputs from the district and facility teams, it should be reviewed and verified at Regional HMIS/IDSR, for their added inputs, and after that they will request review and approval at the national level.

At the end of every month, the office of the IDSR coordinator at national level shall;

4. Aggregate all the received NHMIS/IDSR monthly monitoring data that has been reviewed at facility level with inputs from the district and facility team. The Regional HMIS/IDSR verifies the information and adds their inputs and forwards for approval to national level as a single dataset. When the completed forms are submitted online (using the online tool), aggregation will be automated.
5. Generate a monthly IDSR monitoring report reflecting on areas that are performing well and areas that are not performing well. For the areas that are not performing well, action points will be synthesized.
6. Share the monthly IDSR monitoring report with all stakeholders involved with IDSR monitoring in Somaliland.

7. A quarterly IDRS review monitoring meeting is recommended with participation of all stakeholders including DG, Public health director, National HMIS/IDSR, RHMIS, IDSR focal person, RMO and DHMIS.

The Standard Operating Procedure (SOP) for monthly IDSR monitoring at facility level is shared in figure 36.

SOMALILAND MINISTRY OF HEALTH DEVELOPMENT
INTEGRATED DISEASE SURVEILLANCE AND RESPONSE
FACILITY LEVEL MONTHLY IDSR MONITORING CHART

Name of Health Facility:
Level of Health Facility:
District:
Region:
Year:

Instructions on filling the Chart

1. It is the responsibility of the facility surveillance focal person to update this monitoring chart at the end of every month
2. This monitoring chat should be filled using relevant records at the facility
3. Put a tick in the corresponding cell if the indicator was done/available by the end of each month, otherwise, put a cross or number where applicable
4. Information in the monitoring chat should be reviewed during each support supervision visit
5. This chat should be displayed at the facility
6. At the end of every quarter, the updated chat should be shared with the district surveillance focal person through DHIS2

No	Indicator	J	F	M	A	M	Ju	Ju	A	S	O	N	D
1	SCD and all recording and reporting forms/registers available												
2	Total number of weekly aggregate reports submitted												
3	Total number of weekly aggregate reports submitted on time												
4	Facility level emergency preparedness and response plan available												
5	Supplies for laboratory specimen collection and transportation available												
6	Contingency stocks for emergency response available												
7	Rumor log available												

8	Total number of rumors/suspected outbreaks recorded in the rumor log												
9	Total number of suspected outbreaks notified to the next level												
10	Total number of suspected outbreaks notified within 24 hours of detection												
11	Total number of suspected outbreaks for which laboratory samples were picked and sent to the laboratory												
12	Total number of suspected outbreak investigation samples sent to the laboratory for which results were received												
13	Number of suspected outbreaks responded to by the district level (or any level above) within 48 hours of notification												
14	Number of weekly epi-bulletins received												
15	Number of priority diseases for which a trends graph is available												
16	Number of trends graphs that are up to date												
17	Number of facility level meetings held												
18	Number of facility level meetings in which the trends of priority diseases are discussed												
19	Number of community level meetings held and feedback given												
20	Number of support supervision visit received in this month												
21	Number of surveillance and response related trainings received in this month												

Figure 32: Facility Level Monthly IDSR Monitoring Chat

Standard Operating Procedure (SOP) for IDSR Monitoring

SOMALILAND MINISTRY OF HEALTH DEVELOPMENT INTEGRATED DISEASE SURVEILLANCE AND RESPONSE **MONTHLY IDSR MONITORING** SOP	
Purpose	To provide standard guidance on how to conduct monthly monitoring of IDSR at multiple levels of the health system in Somaliland
Scope	This SOP should be implemented by the surveillance focal persons at their respective levels of the health system
Responsibility	It is the responsibility of the facility surveillance focal person to implement this SOP. It is the responsibility of the district/regional surveillance focal person to implement this SOP It is the responsibility of the heads of medical services to monitor implementation of this SOP at their respective levels.
Procedure	*At the end of every month, guided by figure 46, the facility level surveillance focal person shall;* 1. Review relevant facility level records and reports and fill in the required values for each of the indicators for monthly IDSR monitoring at facility level using the facility level monthly IDSR monitoring chat. 2. Keep the facility level monthly IDSR monitoring chat updated every month 3. Display the facility level monthly IDSR monitoring chat visibly at the facility 4. Submit the updated facility level monthly IDSR monitoring chat every 3 months to the district surveillance officer *During routine facility level meetings, facility level staff should;* 5. Discuss the data in the monitoring chat to inform decisions aimed at improving the performance of surveillance and response at facility level *At the end of every month, guided by figure 47, the district/regional surveillance focal person shall;* 6. Review and aggregate monthly IDSR monitoring data submitted by the level below and summarize it in the district/regional monthly IDSR monitoring chat. 7. Keep the district/regional level monthly IDSR monitoring chat updated every month 8. Display the monitoring chat visibly in the district/regional medical office 9. Submit the updated monitoring chat every 3 months to the surveillance focal person at the next health system level *During routine district/regional medical office meetings, the district/regional medical team should;* 10. Discuss the data in the district, regional monthly IDSR monitoring chat to inform decisions aimed at improving the performance of surveillance and response
Approved by:	National IDSR TWG
Date of next review;	December, 2025

Figure 33: SOP for Monthly IDSR monitoring

Evaluation of IDSR implementation at national level

Introduction

According to these guidelines, evaluation refers to an assessment of the extent to which the goal/objectives of IDSR have been achieved and the explanation behind the level of achievement. The purpose of IDSR evaluation is to assess the effectiveness of IDSR in terms of timeliness, quality of data, preparedness, case management and overall performance. The process of evaluation also identifies gaps or areas for strengthening IDSR implementation. In Somaliland, IDSR evaluation will be conducted every 2 - 5 years. A comprehensive evaluation of IDSR implementation should:

1. Show the extent to which the surveillance and response objectives have been achieved
2. Provide explanations for achievements, disparities and failures
3. Document how quality of the surveillance and response system has changed over the evaluation period

Evaluation of IDSR will be conducted using a combination of 14 IDSR indicators (figure 37) and 7 IDSR system quality attributes (figure 38). Detailed guidance for evaluation of IDSR can be found in standard guidelines developed by WHO and CDC.

At national level, the IDSR TWG should;

1. Every 5 years commission a multi-disciplinary evaluation team preferably consisting of both internal and external evaluators for objectivity to conduct a comprehensive evaluation of IDSR implementation.

Under the oversight of the IDSRTWG, the evaluation team guided by IDSR system performance indicators and IDSR quality attributes should; develop a protocol for IDSR evaluation (might require ethics approval), gather and analyse the required data to reflect on the results for every evaluation objective, provide/present a high-level summary of the evaluation findings, recommendations and an action plan to the IDSRTWG and submit a detailed evaluation report to the IDSRTWG. The Standard Operating Procedure (SOP) for IDSR evaluation is detailed in figure 39.

WHO selected indicators for measuring overall performance of Integrated Disease Surveillance and Response at national level
1. Proportion of health facilities submitting weekly (or monthly) surveillance reports on time to the district 2. Proportion of districts submitting weekly (or monthly) surveillance reports on time to the next

higher level

3. Proportion of cases of diseases targeted for elimination, eradication and any other diseases selected for case-based surveillance that were reported to the district using case-based or line-listing forms
4. Proportion of suspected outbreaks of epidemic-prone diseases notified to the next higher level within 24 hours of crossing the epidemic threshold
5. Proportion of health facilities in which a current trend analysis (line graph or histogram) is available for selected priority diseases
6. Proportion of districts in which a current trend analysis (line graph or histogram) is available for selected priority diseases
7. Proportion of reports of investigated outbreaks that include analyzed case-based data
8. Proportion of investigated outbreaks with laboratory results within 7 days
9. Proportion of confirmed outbreaks with a nationally recommended public health response within 24 to 48 hours of notification **(target >80%)** *
10. Case fatality rate for each epidemic prone disease reported
11. Attack rate for each outbreak of a priority disease
12. The number of epidemics detected at the national level that were missed by the district level during the last year
13. Proportion of selected laboratories that are reporting monthly laboratory data for priority diseases under surveillance
14. Proportion of district laboratories that received at least one supervisory visit that included written feedback from the provincial or national level during the last year

Footnote:

*What constitutes Response standards within 24 to 48 hours

1. Conduct initial rapid assessment/situational analysis
2. Inform WHO of the outbreak/public health event
3. Activate country emergency response structures and assign critical functions.
4. Initiate response activities using a pillar approach
5. Convene first multisectoral emergency coordination meeting
6. Develop an initial response strategy, objectives and action plan
7. Issue initial internal situation report (sitrep)

Figure 34: IDSR System Performance Indicators

Attribute	**Definition**
Timeliness	This is a measure of whether data has been submitted to the next level within the required duration of time since it was received. Timeliness is measured against standards developed by each country following guidance from WHO. Important aspects of timelines of reporting include timeliness of immediate notification, i.e. within 24 hours and timeliness of weekly reporting.
Completeness	Completeness in surveillance can have varying dimensions and may include the following; Completeness of reporting sites submitting surveillance forms

Attribute	Definition
	Completeness of reporting sites refers to the proportion of reporting sites that submitted the surveillance report irrespective of the time when the report was submitted Completeness of case reporting Completeness of case reporting refers to the match between the number of cases reported and the actual number of cases. Completeness of surveillance data Completeness of surveillance data is the match between the expected data requirement and what is reported.
Usefulness	Describes if the surveillance system has been able to contribute to the prevention and control initiatives or has been useful in contribution to the performance measures e.g., Usefulness of surveillance data in an early warning system
Simplicity	Simplicity refers to the structure of the system and the ease of implementation from the end user to those at higher levels
Acceptability	Acceptability of a system is a reflection of the willingness of the surveillance staff to implement the system, and of the end users to accept and use the data generated through the system
Representativeness	Representativeness refers to the degree to which the reported cases reflect the occurrence and distribution of all the cases in the population under surveillance
Data quality	Data quality reflects the completeness and validity of the data recorded in the public health surveillance system.

Figure 35: IDSR System Quality Attributes

Standard Operating Procedure (SOP) for Evaluation of IDSR implementation

SOMALILAND MINISTRY OF HEALTH DEVELOPMENT INTEGRATED DISEASE SURVEILLANCE AND RESOPNSE **EVALUATION OF IDSR IMPLEMENTATION** SOP	
Purpose	To provide standard guidance on how to evaluate IDSR implementation in Somaliland
Scope	This SOP should be implemented by the team constituted and commissioned by the IDSRTWG to evaluate IDSR implementation in Somaliland
Responsibility	It is the responsibility of the IDST TWG to commission a team to evaluate IDSR implementation in Somaliland and to provide technical oversight to the evaluation team. It is the responsibility of the evaluation team to implement the procedure laid out in this SOP
Procedure	At national level, the IDSR TWG should; 1. Every 2-5 years commission a multi-disciplinary evaluation team consisting of internal and external evaluators to objectivity to conduct a comprehensive evaluation of IDSR implementation. Under the oversight of the IDSR TWG, the evaluation team should; 2. Develop evaluation objectives. The objectives should be simple, measurable, attainable, realistic, and time-bound (SMART) 3. Identify indicators for each of the evaluation objectives. These indicators should be harmonized as much as possible with the monitoring indicators 4. Develop a protocol for conducting the evaluation. When necessary, ethical review and approval deemed should be sought. The evaluation protocol should describe how the evaluation will be conducted, methods, target group, data sources, data collection methods, and plan for data analysis and utilization 5. Gather the relevant evaluation data from records and interviews with selected respondents. This should preferably be at community, facility, regional and national level 6. Conduct data analysis by objective 7. Conduct a problem analysis for the identified gaps 8. Identify the required actions and develop an action plan (and budget) for implementation of corrective action 9. Provide (and make a presentation) a high-level summary of the evaluation findings, recommendations and an action plan to the IDSRTWG 10. Submit a detailed evaluation report to the IDSRTWG
Approved by:	National IDSR TWG
Date of next review;	December, 2025

Figure 36: SOP for Evaluating Surveillance and Response

Notes