

Republic of South Sudan



Ministry of Health

Standard Operating Procedure for Rapid Response Teams (RRTs)

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Acronyms/Abbreviations

CBS	Community Based Surveillance
COVID-19	Novel Corona Virus-2019
IDSR	Integrated Disease Surveillance and Response
IPC	Infection Prevention and Control
MOH	Ministry of Health
NPHL	National Public Health Laboratory
NRRT	National Rapid Response Team
PHEOC	Public Health Emergency Operations Center
PPE	Personal Protective Equipment
POE	Point of Entry
RRT	Rapid Response Team
MST	Mortality Surveillance Team
SOP	Standard Operating Procedure
SRRT	State Rapid Response Team
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

Introduction

Integrated Disease Surveillance and Response (IDSR) highlights the essential link between surveillance and response to epidemics and strengthens the capacity for the national public health system of South Sudan to detect, confirm and respond to public health threats in time to prevent unnecessary illness, death, and disability. The Rapid Response Team (RRT) is a key component of IDSR which initiates the “Response” element of the IDSR. An RRT is a technical, multi-disciplinary team of experts readily available for quick mobilization and deployment in case of emergencies to undertake the lead in conducting the initial investigation, confirm the nature and extent of the reported disease/public health event and take initial control measures. The existence of an RRT is critical for early investigation and timely response to epidemic-prone disease or unusual events, which will minimize the extent and impact of potential outbreaks and widespread transmission of infectious diseases. This Standard Operating Procedure (SOP) outlines the steps for an RRT to properly investigate and confirm outbreak or events of public health importance.

The purpose of an RRT is to respond within 24 hours to rumors or alerts of public health events in the community, identified through health facility or community-based surveillance (CBS). This includes infectious diseases and events including cholera, viral hemorrhagic fevers (VHF), yellow fever, measles, COVID-19, and others on the IDSR list of epidemic-prone diseases for South Sudan (Annex 1). These priority syndromes should be investigated immediately because of their potential to spread rapidly, resulting in potential loss of lives and disruption of health care services. Delayed investigation and response may result in rapid spread of disease within communities and to contacts of initial cases.

The overall mandate of the Ministry of Health (MOH) is to investigate and respond to any public health event of national or international concern. If these events occur, the MOH will recruit and activate a network of RRTs to work at the national level or with the affected State/County in the investigation and response.

At the national level, the Director General of Preventive Health Services will work in consultation with the public health emergency operations center (PHEOC) manager or incident manager to deploy national-level RRTs (NRRTs) to any level of governance (state, county) to initiate investigations and implement initial measures. At the State level, it is the responsibility of the Director General in the State Ministry of Health in consultation with MOH Surveillance Officers to deploy the state-level RRT (SRRT). Technical partners such as the World Health Organization (WHO) should work closely with the health authorities at all levels to assist in investigating any reported public health event.

Purpose of RRT SOP

The purpose of this SOP is to give guidance on the functionality and response mechanisms of an RRT including:

- Team Composition
- Roles and responsibilities
- Activation and deployment
- Outbreak investigation
- Reporting, linkages and follow up

Objective of an RRT

- Verify outbreaks and alerts
- Conduct outbreak and alert investigation
- Collect laboratory samples to confirm disease
- Line-list contacts and undertake active case finding
- Produce outbreak investigation report with risk assessment and provide information to the State health authorities, National MOH, WHO, and other relevant health staff to inform response
- Propose and initiate appropriate strategies and control measures in the event of an outbreak

Terms of reference of the RRT

- Conduct preliminary epidemiological investigations to identify the likely cause, risk factors, origin, extent and potential for spread of the disease or public health event under investigation
- Collect history and conduct clinical examination of the patient(s)/contact(s) affected by the event under investigation
- Collect relevant samples from the suspected cases and potential sources for laboratory confirmation
- Commence initial response to contain, control, and prevent further exposure
- Undergo contact identification and listing in preparation for contact tracing
- Immediately notify the relevant authorities including but not limited to Director General of Preventive Health Services, Incident Manager, PHEOC manager, State health authorities, and WHO about the findings and results of the investigation and recommend possible interventions
- Environmental decontamination of all locations where patient was isolated prior to transfer to isolation and/or treatment facility (e.g., patient home, health facility)
- Prepare and disseminate investigation reports to PHEOC Manager for leadership briefing and wider dissemination.
- Support and coordinate follow-up control measures based on the findings/results as directed by the PHEOC Incident Manager and according to National intervention policies and guidelines
- Make appropriate recommendations to MOH Surveillance Officer and PHEOC Manager
- Facilitate capacity building for health workers and community-based surveillance (CBS) officers to support the control measures
- Coordinate with other response pillars, including surveillance, case management, risk communications, laboratory, and infection prevention and control (IPC).

Rapid Response Teams for COVID-19

A person with signs and symptoms of Novel Corona Virus Disease 2019 (COVID-19) can spread the COVID-19 virus to others; therefore, it is critical to identify and isolate symptomatic persons immediately to stop the disease from spreading.

Early detection of cases and outbreaks is critical to prevent further spread. This includes rapid investigation and early laboratory verification of the cause of all suspected cases. It is critical for the RRT to investigate all suspected cases and to initiate appropriate contact tracing. During epidemics, most infected patients do not show symptoms, and a specific case definition according to the suspected or confirmed disease should be used. When an RRT is

deployed for a suspected case or any public health event, special precautions and specific steps must be taken by the RRT in order to protect themselves and the community from exposure. This may include isolation of the case and infection prevention and control measures.

Composition of an RRT

The National and State MOHs should designate experienced trained technical personnel who can respond immediately to a suspected outbreak. They should have permission to suspend their regular duties when the need arises and promptly undertake the tasks of initiating outbreak investigation and response.

RRTs shall be established at National and State levels. The NRRT should be equipped to cascade training when necessary and build capacity of SRRTs. The following is a guide of the core and extended membership of RRTs. The team core members should be on every RRT, whereas the extended members are fluid and can expand or contract as required.

Core Team Members

- Team Leader (can be any team member)
- Clinical Officer/Medical Doctor/Nurse
- Epidemiologist or Surveillance Officer
- Laboratory/IPC Specialist
- Driver

Roles and responsibilities

Table 1. Detailed roles and responsibilities of the core RRT members

Designation	Roles and Responsibilities of Core Team Members
Team Leader	<ul style="list-style-type: none"> • Coordinates team, investigation of suspected cases, and IPC • Develops and executes investigation plan • Assigns roles and responsibilities • Accesses and organizes supplies • Activates ambulance or SDB team as needed • Notifies the National Public Health Laboratory (NPHL) to be prepared to receive samples • Communicates with national health authorities, state MOH, and other officials • Liaises with all stakeholders involved in investigation and response of the outbreak
Epidemiologist/ Surveillance officer	<ul style="list-style-type: none"> • Verifies that alert meets appropriate case definition • Fills out Case Investigation Form with clinician • Supervises data collection and data analysis • Takes patient history and lists all potential contacts in Contact Listing Form • Conducts rapid assessments to establish predisposing factors, risk behavior, determinants and gaps • Identifies potential modes of exposure and community transmission, and coordinates IPC measures with Health Promotion officer • Actively seeks information for other suspected cases or unexplained deaths

	<ul style="list-style-type: none"> Provides case definitions to local health workers
Clinician	<ul style="list-style-type: none"> Establishes clinical picture Takes patient medical history Fills out case investigation forms with Epidemiologist Institutes case management and infection control measures Advises on area hospital bed capacity and medical capability Advises on collection of clinical specimens from cases/patients
Laboratory/IPC Specialist	<ul style="list-style-type: none"> Safely collect samples according to protocol and clinician advice Ensure sample is transported to the airstrip/transportation hub. Receives and interprets results from NPHL or other testing site once delivered Assessment of environmental, water and sanitation situation Implements appropriate IPC protocols with epidemiologist including use of personal protective equipment (PPE) and decontamination Advises health units on proper infection control Oversees preparation of chlorine solutions for disinfection at Isolation and/or Treatment facility Oversees water supply and sanitation at Isolation and/or Treatment facility Oversees disinfection of households
Driver	<ul style="list-style-type: none"> Transports RRT to investigation site

Activation and deployment

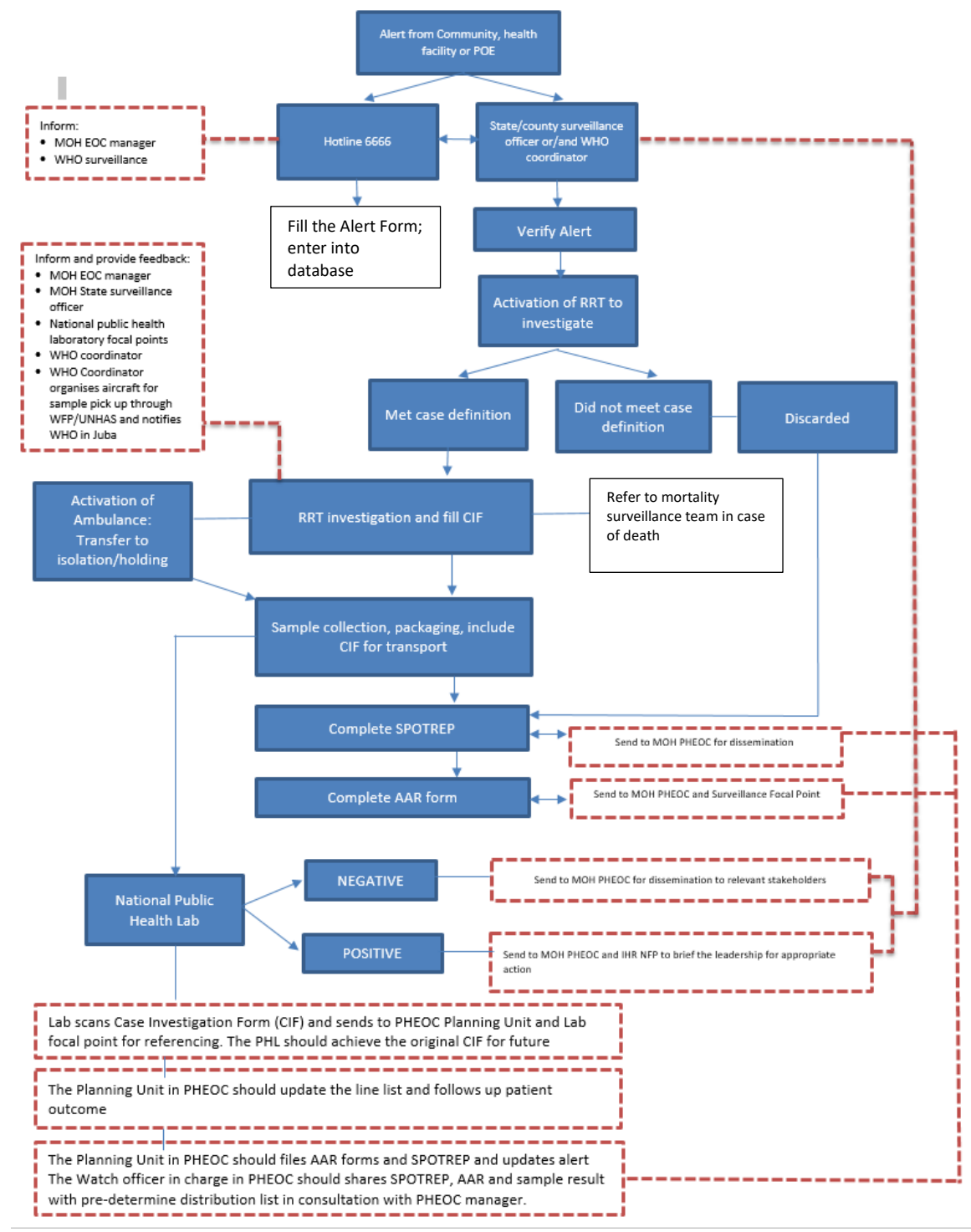
Alerts

An alert occurs if a suspected case of a high-priority disease or public health event is detected in the community. Community members, staff at health facilities, or staff at a border crossing or other point of entry (POE) will notify the MOH Surveillance Officer and/or WHO State coordinator if the following scenarios take place:

- Suspected outbreak of an immediately notifiable disease (Annex 1)
- An unusual increase is seen in the number of cases in routine analysis of data
- Communities report rumours of deaths or a large number of cases that are not being seen in the health facility
- A cluster of illnesses, events of public health concern or deaths occurs for which the cause is not explained or is unusual

An alert can take place through a designated hotline (e.g. 6666) or through existing surveillance channels. Refer to Figure 1 for alert management and communication flow.

Figure 1. Alerts management and communication flow chart



Verification of alert

When a suspected outbreak or event is reported, the MOH Surveillance Officer, WHO State coordinator, and/or Public Health Officer promptly verifies that the information is accurate and reflects conditions suggesting a true outbreak or event. This will help to ensure that resources are used effectively.

To verify the information, consider the following factors:

- Agreement with alert case definition (See Annex 4)
- Source of information (for example, is the source of the rumour reliable? Is the report from a health facility, community or POE?)
- Severity of the reported illness and use of standard case definition for reporting
- Number of reported cases and deaths
- Date of onset
- The age and gender of reported cases or deaths
- Transmission mode of suspected pathogen and risk for wider transmission
- Political or geographic considerations
- Importance of maintaining good partner and community relations
- Confirm location and information to assist with locating suspected cases

Activation of the RRT

State RRT activation

If there is a verified alert, the MOH Surveillance Officer (or other delegated authority) activates the SRRT and assigns a team lead. The MOH Surveillance Officer will decide on the composition of the RRT based on preliminary alert information. Activation of the SRRT should be within 2 hours of the initial alert, and the RRT should arrive at the site no more than 24 hours after the initial alert.

The team lead is the first person to be called to activate the team. The team leader can be any member of the team as designated by the MOH Surveillance Officer and is responsible for the coordination of the team and ensuring all of the supplies are available. If supplies are in storage, the team leader will have the ability to access the supplies (e.g., will have a key). The team lead will also oversee calling to activate the ambulance or Mortality Surveillance Team if required.

NB: For alerts that were generated in Central Equatoria State, the SRRT will be notified to respond or will be requested as support from NRRTs.

National RRT activation

The States may be supported by the NRRT to conduct an investigation in the following situations:

- The State requests the involvement of the NRRT based on the scale or complexity of the alert, or due to capacity constraints of the SRRT
- The State is unable to deploy the SRRT or the SRRT is already deployed to investigate a subsequent case
- The MOH receives a report of a suspected outbreak due to a disease that is targeted for immediate notification, e.g., COVID-19
- An unusual increase is seen in the number of cases or deaths during routine analysis of data alert or epidemic, or thresholds have been reached for specific priority diseases

- Communities report rumours of deaths or many cases that are not being seen in the health facility
- A cluster of illnesses or deaths occurs for which the cause is not explained or is unusual.

Field Preparation

Strong preparation to deploy to the field will improve the efficiency of the RRT to investigate and take actions in the field. RRTs will be deployed to the field with a rapid response kit (Annex 3). The kit includes the following:

- The appropriate case investigation forms (e.g., Annex 4)
- Contact listing forms (Annex 5)
- Equipment for sample collection (Annex 6), including PPE and decontamination equipment

If entering areas that are not secure, teams should consult with relevant government authorities and community leaders to understand the security situation and how to ensure safety of the RRT before departure. If required based on intelligence, government authorities should organise security escort. If a disease is suspected, treatment, rapid diagnostic tests, prevention, control and other basic medical supplies for affected health centres can be carried by the team.

Preparing to go to the field after an alert

	Pre-field debrief and organisation:
<input type="checkbox"/>	Designate a team lead and decide on chain of communication
<input type="checkbox"/>	Review roles and responsibilities of each member
<input type="checkbox"/>	Review sample collection, storage and transport. Pack supplies outlined in the sample collection check list (Annex 6) including PPE.
<input type="checkbox"/>	Review current information about the alert and develop investigation plan
<input type="checkbox"/>	Verify means and channels of communications, including plan for reporting up and back to the community, completing spot report (SPOTREP), and completing after action review (Annex 9)
<input type="checkbox"/>	Negotiate community entry with appropriate authorizations
<input type="checkbox"/>	Pack RRT kit and equipment needed to investigate and respond, including appropriate forms. Where applicable prepare basic medical supplies and other materials to support the affected health facilities.
<input type="checkbox"/>	Develop plan for logistics, security, and transport including sufficient vehicles, drivers, and fuel
<input type="checkbox"/>	Review case definitions (Annex 2, Annex 8)

Communication

- When the RRT is responding, all members report all activities to the team lead.
- RRT members should practice confidentiality at all times. RRT team members should not inform outsiders on sensitive and confidential matters.
- The team should discuss any sensitive issues before deployment to the field.

- The team should assign a responsible person who completes the spot report and who communicates the results.
- The team lead should communicate frequently with MOH Surveillance Officer and PHEOC for situational awareness and guidance.

Field investigation

Community entry and household visit

- Upon arriving in the community, ensure that the team has the appropriate authorizations, clearances, and permissions required to do the investigation
- Obtain permission from community leaders and/or local authorities to conduct the investigation in the community, making sure to observe relevant cultural practices.
- Where possible, include local leaders and local health workers to guide the investigation.
- Make sure to follow all standards for risk communication and psychosocial support (See Risk Communications SOP).

Determine if the alert meets the clinical case definition

- Review the clinical history and epidemiology of the alert case
- Based on the investigation, confirm whether the patient's signs, symptoms and history meet the suspect case definition (Annex 8 for suspect case definition, Annex 1 for other IDSR priority diseases).
- If the alert case is unable to answer questions, request a present health worker, caretaker or close family member who can speak on behalf of the case
- The investigation team should search for information about the contact with an index case for possible exposure in terms of environment, travel history, visitors, eating habits or any other form of behaviour that could have led to the infection. Notes on these details should be captured for reporting in the SPOTREP.

Fill case investigation form

- For each suspected case that meets the case definition, fill out the Case Investigation form (e.g., Annex 4)
- Fill all fields. Do not leave blank sections. Where information is not available, state that it is not available
- The laboratory cannot open packages when case investigation forms are incomplete. If the name of a deceased person is unknown, state that the name is unknown.

Suspected case: initial response

If there is a suspected case in the community that meets the case definition, the following steps should be taken immediately:

- **Strengthen** infection control and case management procedures as indicated by the case management guidelines (including isolation of patients if indicated)
- **Activate** the ambulance team or MST
- **Initiate** contact identification and listing
- **Collect** samples
- **Decontaminate** areas and surfaces as per SOP
- **Reinforce use of IPC standard precautions** with family members and health facilities
- **Reinforce use of case definition**

- **Provide risk communications** and education to health care worker, family and community and make referrals for psychosocial support where needed.

Suspected case: living

- Patient and family are informed of the procedure and psychosocial support offered.
- The trained laboratory technician at the isolation and/or treatment facility or the RRT laboratory technician collects the sample
- Review further details in Case Management SOP

Collection of Samples

General Guidelines

Proper collection of specimens is the most important step in the laboratory diagnosis of infectious diseases. A specimen that is not collected correctly may lead to false negative test results. The following specimen collection guidelines follow standard recommended procedures.

Laboratory technicians have been identified in each state for inclusion in the RRT. Laboratory technicians are trained in IPC, sample collection, packaging for transport and completion of forms. A step by step check list for sample collection has been developed (Annex 6). For additional information refer to the Laboratory SOP.

Swabs should be placed immediately into a sterile transport tube containing 2-3mL of either viral transport medium (VTM), Amies transport medium, phosphate buffered saline, or sterile saline.

The NW specimen and the non-bacteriostatic saline used to collect the specimen should be placed immediately into a sterile transport tube.

Collecting and Handling Specimens Safely

For collecting specimens or working within 6 feet of patients suspected to be infected with SARS-CoV-2, maintain [proper infection control](#) and use recommended personal protective equipment (PPE), which includes an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection, gloves, and a gown, when collecting specimens.

For RRTs handling specimens, but are not directly involved in collection (e.g. self-collection) and not working within 6 feet of the patient, follow [Standard Precautions](#).

PPE use can be minimized through patient self-collection while the trained provider maintains at least 6 feet of separation.

Suspected case: dead

If the suspected case in the community has died, the following steps should be taken:

- Activation of the MST
- MST member collects swab from the dead body in the community after communication with family members and psychosocial support is offered
- If MST is not available, the swabbing will be done by the RRT lab member
- Refer to lab SOP for detailed process and IPC measures

Activation of the MST

If the suspected case is deceased, the team lead activates the MST if available. The MST should be deployed after the investigation of a deceased suspected alert that meets the case definition and should only commence work after a sample has been collected from the body. Refer to the MST SOP for further information.

Contact Listing

For either living or dead suspected cases that meet the case definition, all contacts of the case should be identified and listed on the Contact Listing Form (Annex 5).

- The RRT will interview the family, friends, medical staff or anyone that had interacted with the suspected case in order to identify all contacts that person has had within the infectious period.
- All contacts of the suspected case should be listed on the Contact Listing Form
- Explain to people why they are contacts and why they are being listed
- RRT will assign exposure risk based on listed categories of exposure on the contact listing form
- Refer to contact tracing SOP for additional information
- Explain to contacts what they should do if they start to experience illness and who to contact

Identify additional cases

The RRT will conduct an investigation to identify any additional cases in the community. This will be done by both passive and active methods.

Passive case search

- Identify any potential cases that have already presented or continue to be present in nearby health facilities.

Active case search

- Conduct outreach activities to the community in the payam and village
- Meet with community leaders to find out where affected areas are, and if there have been reports in the community
- Depending on the type and seriousness of the disease you may consider visiting every household in the area in collaboration with CBS teams and ask if there are people with an illness in the house

Reporting and follow-up

Complete spot report (SPOTREP)

- All reports should be completed within 24 hours of investigation
- If urgent matters regarding the investigation arise, report immediately in brief and provide the report as soon as possible
- Use the Spot report (Annex 7) to record detail of the investigation

Follow-up

- Continue to monitor, follow up and take action where necessary and as directed by the MOH Surveillance Officer

- Report back on results to patient and health care workers
- Follow up outcome of patient and report on outcome
- Ensure the RRT tool kit is prepared once again using the checklist for the next investigation

After-Action Review Report and Closure

Closure of an event should be indicated by the MOH Surveillance Officer. Conduct an After-Action Review Report (Annex 10) led by MOH Surveillance Officer with technical support from WHO and other technical partners.

- Identify what was done well
- Identify challenges
- Discuss solutions
- Record findings in the after-action review template
- Send after action review to PHEOC Manager for review
- Share copy of finalised After-Action Review Report with:
 - MOH (State and National)
 - COVID-19 secretariat
 - WHO
 - Surveillance pillar

ANNEX

Annex 1. Standard case definitions for reporting priority diseases and events in the IDSR Technical Guidelines for South Sudan

Condition/Event		Community Case Definition
1	Acute Flaccid Paralysis (AFP) - body weakness	Any child under 15 years old with a sudden onset of weakness and/or inability to use their hand(s) and/or leg(s)
2	Acute Watery Diarrhoea	Any person with 3 or more watery stools within a day
3	Measles	Any person with fever and skin rash
4	Suspected Ebola	Sudden onset of fever with history of travel to an Ebola-affected area; OR Any form of unexplained bleeding from any part of the body; OR Any sudden unexplained death
5	Unusual health events	Two or more persons presenting with similar severe illness in the same setting (e.g., household, workplace, school, street) within one week; OR Two or more persons dying in the same community within one week; OR Increase in number of animal illnesses and/or deaths, including poultry, within one week
6	Novel Corona Virus Disease 2019 (COVID-19)	Acute onset of fever $\geq 38^{\circ}\text{C}$ AND cough; OR Acute onset of ANY THREE OR MORE of the following signs/symptoms: fever, cough, general weakness/fatigue, headache, myalgia (muscle aches), sore throat, coryza (common cold), dyspnea (difficulty breathing), anorexia, nausea, vomiting, diarrhea, altered mental status.

Annex 2: COVID-19 community case definition for use at the community level

Community-based surveillance	Alert case Acute onset of fever $\geq 38^{\circ}\text{C}$ AND cough; OR Acute onset of ANY THREE OR MORE of the following signs/symptoms: fever, cough, general weakness/fatigue, headache, myalgia (muscle aches), sore throat, coryza (common cold), dyspnea (difficulty breathing), anorexia, nausea, vomiting, diarrhea, altered mental status.
This definition of 'alert cases' for COVID-19 or Novel Coronavirus disease 2019 has been developed for use by the community or community-based volunteers. It may be used for community-based surveillance during the pre-epidemic phase and during the outbreak.	
Report any COVID-19 alerts to the nearest health facility AND Call the Ministry of Health toll-free lines (MTN and Zain): 6666. If the hotline is unavailable or unresponsive, call the County Surveillance Officer.	

Annex 3. Rapid response team field check list for Alert investigation

S/N	Personal protective equipment	Qty	Remark
1	Gumboot pairs	3	
2	Scrub suits (Trouser and shirt)	3	
3	Sets of high level/full PPE	3	
4	Sets of low-level PPE	2	
Laboratory- In case RRT needs to collect sample on site			
5	Nasopharyngeal Swabs	As Needed	
6	Oral swabs	As Needed	
7	Cotton wool or alcohol skin swabs	5	
8	Sterile gauze (5pcs pack)	1	
9	Adhesive bandage	2	
10	Permanent marker	1	
11	Clear zip lock bag	2	
12	Paper/tissue towels packet	1	
13	0.5% sodium hypochlorite solution, freshly prepared	1	
Disinfection and waste management			
14	Chlorine granules 70% (500g grams)	1	
15	Hand sprayer for hand washing chlorine 0.05%	1	
16	Sprayers filled with chlorine 0.5% 12Ltr	2	
17	Plastic sheet for safe zone	1	
18	Biohazard bag for disposable materials (destruction)	6	
19	20-litre bucket for reusable materials (disinfection)	2	
20	Alcohol based hand rub 500ml	1	
Stationary and Risk com material			
21	Case investigation form book	1	
22	Contact listing form book	1	
23	Sets of IEC Materials for risk com (English and Arabic)	1	
24	Pens	3	
25	Case definition A4	2	
Medical supplies			
26	Oral rehydration salts (ORS) Sackets	5	
27	Emergency medical kit	1	

Annex 4. COVID-19 Case Investigation Form

Coronavirus Disease 2019 (COVID-19) Case Investigation Form: V3 (January 2021)

1. General information on source of the alert (tick one)

<input type="checkbox"/> Hotline	<input type="checkbox"/> Community Surveillance	<input type="checkbox"/> POE Screening	<input type="checkbox"/> Contact Tracing (Follow up)	<input type="checkbox"/> Clinic	<input type="checkbox"/> Sentinel Site	<input type="checkbox"/> Travel Screening	<input type="checkbox"/> Other (Specify):
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2. Case contact information

Today's Date ¹ :	Case ID:	DHIS2 Case ID#	Case's Name:	
State:	County:	Payam:	Boma:	GPS Coordinates:
Date of Birth:	Phone (case):	Phone (NoK):	Landmark:	

3. Case demographic information

Sex: ☐ M ☐ F (Pregnant: ☐ Y ☐ N) Age: _____ years ☐ months (<12 months only) Nationality: ☐ SSD ☐ Non-SSD, country: _____
Occupation/Profession: _____ ☐ Unemployed ☐ Student (Name of School): _____

4. Case criteria

Does the case have these signs and symptoms (check all that apply)? ☐ Fever ☐ Severe cough ☐ Sore throat ☐ Shortness of breath ☐ Loss of taste ☐ Loss of smell ☐ Difficulty breathing ☐ Anorexia
☐ General weakness/fatigue ☐ Altered mental status ☐ Chills ☐ Headache ☐ Myalgia ☐ Vomiting ☐ Abdominal pain ☐ Diarrhea ☐ Rigors ☐ Other, Specify _____

Onset date of first symptom: _____

5. In the 14 days before symptoms onset, did the case:

a. Have close contact with a PCR/GXP/Ag-RDT-confirmed COVID-19 case?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown (If yes, please give case # [if known]: _____)	
If yes:		
1. Was the case ill at the time of contact?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown	
2. Was the case confirmed in SSD?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown	
3. Is the laboratory-confirmed case an imported case?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown	
If yes: In which country was the case diagnosed with COVID-19?	_____	
b. No known exposure history (suspected community transmission)	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown	

Only check "Y" if you confirmed that the case has no exposure risk factors such as travel, contact with a confirmed or suspected case, providing care for a confirmed case, etc. If you are unable to ascertain exposure history, check "Unknown."

6. Additional case information

Is the case a healthcare worker? ☐ Y ☐ N ☐ Unknown Has the case been tested for COVID-19 previously? ☐ Y ☐ N ☐ Unknown
If "yes," what were the results? ☐ Positive ☐ Negative ☐ Unknown If "positive" or "negative" is checked, please indicate type of test previously conducted: ☐ RT-PCR ☐ GeneXpert ☐ RDT ☐ Unknown
If "positive" or "negative" is checked, please indicate the date the test was conducted: _____ ☐ Unknown
Have history of being in a healthcare facility (as a patient, worker, or visitor)? ☐ Y ☐ N ☐ Unknown
Have history of being in a congregate setting such as a POC or refugee camp (as a resident, worker, or visitor)? ☐ Y ☐ N ☐ Unknown
Provide care for a COVID-19 patient? ☐ Y ☐ N ☐ Unknown
Is case part of a cluster with severe acute respiratory illness (e.g., fever and pneumonia requiring hospitalization)? ☐ Y ☐ N ☐ Unknown
Diagnosis (select all that apply): Pneumonia (clinical or radiologic) ☐ Y ☐ N Acute respiratory distress syndrome ☐ Y ☐ N
Co-morbid conditions (check all that apply): ☐ None ☐ Obesity ☐ Diabetes ☐ Cardiac disease ☐ Hypertension ☐ Chronic pulmonary disease ☐ Chronic kidney disease ☐ Chronic liver disease
☐ Immunocompromised ☐ Unknown ☐ Other (specify): _____
Status of the case at the time filling this form: ☐ Alive ☐ Died (Date of death: _____) ☐ Admitted to IDU or other isolation facility ☐ Hospitalized ☐ Other: _____
If dead, presumed cause of death: ☐ Suspect COVID-19 ☐ Probable COVID-19 ☐ Confirmed COVID-19 ☐ Other acute respiratory illness ☐ Other (specify): _____

7. Specimen for COVID-19 testing

Specimen type	Specimen ID	Date collected	Date of Results	Lab Name/Location
Nasopharyngeal swab				
Oropharyngeal swab				
Other Specimen Type				
Postmortem sample (Specify):				
RDT used? <input type="checkbox"/> Y <input type="checkbox"/> N				
Investigator's name:	Phone:	Email:	Affiliation:	
Contact tracing form attached	<input type="checkbox"/> Y <input type="checkbox"/> N (if no, explain why): _____			

¹ Date format is DD/MM/YY for all date fields

COVID-19 Laboratory Request Form

Date (dd/mm/yyyy):.....

1. General information on source of the alert (tick one)

<input type="checkbox"/> Hotline	<input type="checkbox"/> Community Surveillance	<input type="checkbox"/> Point of Entry	<input type="checkbox"/> Contact Tracing (Follow up)	<input type="checkbox"/> Clinic	<input type="checkbox"/> Sentinel Site	<input type="checkbox"/> Screening	<input type="checkbox"/> Other (Specify):
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2. Information from reporting facility:

Health Facility Name:		State:
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3. Case details/ demographics

Case Name:		Age		Sex	<input type="checkbox"/> M <input type="checkbox"/> F
Case ID		DHIS2 Case ID			
Case Nationality		State		County	
Case Phone#		Payam		Boma	Village

4. Test Requested (tick one):

<input type="checkbox"/> RT-PCR	<input type="checkbox"/> GeneXpert	<input type="checkbox"/> RDT	<input type="checkbox"/> ELISA
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5. Reason for test request (tick one):

<input type="checkbox"/> Suspect	<input type="checkbox"/> Contact	<input type="checkbox"/> Postmortem	<input type="checkbox"/> Treatment Discharge	
<input type="checkbox"/> Alert	<input type="checkbox"/> Screening	<input type="checkbox"/> Other, specify:		
<input type="checkbox"/> Follow up	<input type="checkbox"/> 1st	<input type="checkbox"/> 2nd	<input type="checkbox"/> 3rd	<input type="checkbox"/> 4th

6. Specimen type (tick one):

<input type="checkbox"/> Oropharyngeal Swab	<input type="checkbox"/> Nasopharyngeal Swab	<input type="checkbox"/> Blood specimen	<input type="checkbox"/> Other, specify:
---	--	---	--

Requested by :..... Date Requested:..... Phone# :.....

Specimen Collected by:..... Date and time collected:..... Phone# :.....

Specimen Received by:..... Date and time Received:..... Lab specimen number:.....

Specimen Tested by:..... Date Tested:..... Date and time results released:.....



Annex 5a: COVID-19 Contact Listing Form

Republic of South Sudan

Ministry of Health

COVID-19 CONTACT LISTING FORM

Case Information								
Outbreak Case ID	Surname	Other Names	Head of Household	Village	Payam	County	Date of Symptom Onset	Location Case Identified

Contact Information												
Surname	Other Names	Sex (M/F)	Age (yrs/mo)	Relation to Case	Date of Last Contact with Case	Type of Contact (1,2,3,4)* <u>list all</u>	Head of Household	Village	Payam	County	Phone Number	Healthcare Worker (Y/N) <i>If yes, what facility?</i>

*Types of Contact:

- 1=direct physical contact with a case
 2=presence in the same room for extended hours
 3=living in the same household or household-like settings
 4=face-to-face contact in any setting within 2 meters of a case for >15 minutes
 5=having been in a closed environment (e.g., a classroom, HF waiting area) within 2 meters of a case for >15 minutes
 6=having been seated on an aircraft within 2 meters of a case
 7=exposed to a health provider who is a case
 8=other

Contact sheet filled by: Name:

Title:

Telephone:



Annex 5b: COVID-19 Contact Follow-Up Form

Republic of South Sudan
Ministry of Health

CONTACT FOLLOW-UP FORM

To be completed by Contact Tracer

Contact Tracer's name.....

Village

Payam

County.....

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

Tick " 0 " if the contact has not developed fever or other symptoms

Tick " X " if the contact has died or developed fever and/or other symptoms (complete Case Report Form and, if alive, refer to nearest health facility)

Annex 6. Laboratory sample collection checklist

PREPARATION for SAMPLE	Completed?
Ensure that Case Investigation Form has been started/filled in	
Prepare marker pen	
Prepare hand-wash or alcohol hand rub	
Prepare PPE for interactions with patient	
SAMPLE COLLECTION PROCEDURE	Completed?
Wash hands thoroughly	
Put on full PPE following correct donning procedure	
Position yourself near the patient and arrange tray with equipment close to hand.	
Exit the red zone and remove full personal protective equipment and place them in a disposable biohazard bag for destruction.	
PREPARATION FOR SWAB SAMPLE	Completed?
Ensure that Case Investigation Form has been started/filled in	
Prepare tray and rack for holding swab tubes once collected	
Prepare marker pen	
Prepare hand-wash or alcohol hand rub	
Prepare PPE for interactions with patient	
Prepare waste management for handling sharps and gloves 1) Biohazard bag for disposable materials (destruction/incineration) 2) Bucket for reusable materials (disinfection)	
PROCEDURE FOR SWAB SAMPLE	Completed?
Explain to family or community members who you are and about the procedure.	
Put on personal protective equipment according to the infection prevention and control SOPs	
Enter cadaver room/patient ward/home and arrange materials on a flat surface within easy reach of the bedside.	
Open the tube containing viral transport media (VTM) and place in the rack. Open the packet containing the swab for VTM but do not yet remove from packaging.	
Take the swab by placing a palm onto the chin of the cadaver and pressing firmly down to open the mouth slightly.	
Insert the swab into the mouth, between the gum line and cheek on the left side	
Using circular motions, swab the inside of the cheek for 20 seconds.	
Move the swab to between the gum line and cheek on the right side.	
Using circular motions swab the inside of the cheek for 20 seconds.	
Remove swab, place into the open VTM tube and replace the lid.	
Repeat swab collection steps.	
Place waste into the infectious waste bag. Once all waste discarded, spray the inside of the bag with 0.5% hypochlorite solution, tie the bag and spray the outside of the bag. Then place the bag in a second waste bag, tie the bag and spray the outside of the bag with 0.5% hypochlorite solution.	
The gloved assistant should then immediately seal the zip-lock bags and disinfect the outer surfaces with 0.5% hypochlorite solution.	

Annex 7. Spot Report template

State	
Date / Time:	
Incident Title or Name:	
Information Source: Who reported the information including their contact if any	
Narrative: <i>Include Who, What, When, Where, and Why.</i>	
Actions: <i>Include actions taken and/or not taken, next steps, notifications, health and safety actions, follow-up requirements, etc.</i>	
Information Controls: <i>Included when and who to distribute.</i>	For Official Use Only by MOH
Submitter's Name:	
Submitter's Duty / Position:	
Submitter's Contact Number:	
Submitter's Email Address:	

Annex 8. COVID-19 standard case definition for use at health facility level

Routine surveillance	<p>3.1 Clinical criteria: Acute onset of fever $\geq 38^{\circ}\text{C}$ AND cough;</p> <p>OR</p> <p>Acute onset of ANY THREE OR MORE of the following signs/symptoms: fever, cough, general weakness/fatigue, headache, myalgia (muscle aches), sore throat, coryza (common cold), dyspnea (difficulty breathing), anorexia, nausea, vomiting, diarrhea, altered mental status.</p> <p>AND</p> <p>Epidemiologic criteria: Residing or working in a setting with high risk of transmission, e.g., closed residential and/or humanitarian settings, any time within the 14 days before symptom onset;</p> <p>OR</p> <p>A. Working in a health care setting anytime within the 14 days before symptom onset.</p> <p>B. A person with severe acute respiratory illness (SARI²).</p> <p>C. An asymptomatic person not meeting epidemiologic criteria with a positive SARS-CoV-2 Ag-RDT test.</p> <hr/> <p>3.2 Probable case</p> <p>A. A patient who meets clinical criteria above AND is a contact of a probable or confirmed case or is linked to a COVID-19 cluster.</p> <p>OR</p> <p>B. A person with recent onset of anosmia (loss of smell) or ageusia (loss of taste) in the absence of any other identified cause.</p> <p>OR</p> <p>C. Death, not otherwise 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.</p> <hr/> <p>3.3 Confirmed case</p> <p>A person with laboratory (PCR/GXP) confirmation of COVID-19 infection, irrespective of clinical signs and symptoms; OR a symptomatic person with a positive SARS-CoV-2 Ag-RDT test; OR an asymptomatic person with a positive SARS-CoV-2 Ag-RDT test AND meets epidemiologic criteria <u>or</u> is a close contact of a PCR/GXP-confirmed case.</p>
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² Assessed per the WHO definition requiring (a) an **acute respiratory** illness (ARI), (b) history of fever or measured fever of $\geq 38^{\circ}\text{C}$, (c) cough, (d) onset within the past 10 days, and (e) requiring hospitalization.

Annex 9. After Action Review Report template



Republic of South Sudan
Ministry of Health
COVID-19 Disease Alert After-Action Review Report

Alert information

Past medical history:

Action taken

Successes

Challenges

Lessons learned

Support required from STF or NTF

Information Source:	
Submitter's Name:	
Submitter's Duty / Position:	
Submitter's Contact Number:	
Submitter's Email Address:	