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| Date | 10/09/2020 | | | |
| **Study details**  Please note that if approved by the OCA Research Committee this concept note will be published on the [*MSF-OCA Research Management and Impact Tool (ReMIT)*](https://remit.msf.org/). Any requests to opt out go to the OCA Research Committee for approval (see **Opting out**). Questions about ReMIT? Email [*remit@oca.msf.org*](mailto:remit@msf.org) | | | | |
| Proposed study title | **Comparative evaluation of community event-based and indicator-based components of MSF’s ‘Tea Team Surveillance System’ in the Somali Region, Ethiopia** | | | |
| Purpose of study | Aiming to detect outbreaks in Dollo zone early to initiate timely response, the Somali region project developed an innovate strategy for surveillance, i.e. the Tea Team Surveillance System.  The core of the ‘Tea Team Surveillance System’ is an indicator- and event-based surveillance system. The system gathers information from communities through a) local informants/volunteers at ‘Tea Team surveillance sites’ and b) MSF community health workers (CHWs) in locations where MSF has mobile clinics, and c) from MSF mobile clinics, in order to detect cases of outbreak‑prone diseases and other pre-defined events. A rapid response team (RRT) that conducts assessments and response is a crucial element of the Tea Team Surveillance System.  A comparative epidemiological evaluation of the usefulness and surveillance attributes of the three components of the Tea Team Surveillance System will be conducted, namely of 1) Tea Team surveillance sites, 2) CHWs implementing community based surveillance in locations where MSF has mobile clinics and 3) Indicator based surveillance at the mobile clinics. The evaluation will be done following CDC’s guidelines on the evaluation of surveillance systems (1)[[1]](#footnote-2).  This study aims to provide a detailed description of the conception, implementation and lessons learnt from this surveillance and response system and compare the attributes of its different components, that will complement the existing body of research and will serve as a guidance to other MSF missions and other organizations when establishing a community indicator-based and event-based surveillance and response mechanism in similar settings. | | | |
| Research question | **Does the Tea Team Surveillance System generate data that is useful for public health action and how do the attributes of the different components of the Tea Team Surveillance System compare?** | | | |
| **Objectives** | *For objectives below, ‘the three components of the Tea Team Surveillance System’ refer to:*  *1) Community event-based surveillance by local informants (volunteers) at ‘Tea Team surveillance sites’;*  *2) Community event-based surveillance by Community Health Workers (CHWs) working in locations where MSF has mobile clinics;*  *3) Indicator based surveillance at MSF mobile clinics.*  ***Primary objective***  *Evaluate the* ***usefulness*** *of data generated by the three components of the Tea Team Surveillance System in terms the number and the type and the scale of public health interventions taken as a result of surveillance alerts (1)*  ***Secondary objectives***  *Evaluate the following surveillance attributes of the three components of the Tea Team Surveillance System:*   * **Acceptability** of the three different components of the Tea Team Surveillance System in the community * **Representativeness** of the three different components of the Tea Team Surveillance System of the population in Dollo zone * **Completeness and consistency** of data generated by the three different components of the Tea Team Surveillance System * **Sensitivity (to detect outbreaks)** of the three different components of the Tea Team Surveillance System * **Positive predictive value (alerts/signals) and validity of case and event definitions** of the three different components of the Tea Team Surveillance System * **Timeliness of signals, assessment and response** of the three different components of the Tea Team Surveillance System * **Simplicity** of the three different components of the Tea Team Surveillance System * **Flexibility** of the three different components of the Tea Team Surveillance System to adapt to changing circumstances using the example of the Covid-19 outbreak * **Stability** of the three different components of the Tea Team Surveillance System over time including with changes in human resources and sites | | | |
| **Background/significance**  *1-2 paragraphs* | Is the study part of an OCA topical research agenda / strategy document?  No  Yes, namely:  The objective of the Tea Team Surveillance System is to contribute to the following project objective “Disease outbreaks and other emergencies in Doolo Zone are identified and responded to in a timely manner.” Prior to the Tea Team Surveillance System, MSF had a comprehensive CHWstructure in place in Dollo zone that conducted community indicator-based surveillance (CBS). The previous CBS system had 100 CHWs spread across 30 sentinel site locations in the Dollo zone. The CHWs conducted daily household visits and collected information on the following illnesses: suspected measles, suspected acute watery diarrhoea (AWD) and suspected acute jaundice syndrome (AJS). The CHWs also conducted regular mid-upper arm circumference (MUAC) screening and population counts. CHWs were present both at sites with mobile clinics and without. This system was perceived as being too heavy and resource intensive and was reduced in January 2019. Since January 2019, the Tea Team Surveillance System consists of **three components**: 1) 17 Tea Team surveillance sites with local informants and elders functioning as sources for event-based surveillance, 2) 16 mobile clinic sites with CHWs functioning as sources for community event- and indicator-based surveillance and 3) 16 mobile clinic sites where consultation data are utilised for health-facility-based surveillance. To note, there are no community health workers at the Tea Team surveillance sites and they are only present at sites where MSF has mobile clinics.  The community indicator-based surveillance (CBS) component of the Tea Team surveillance system monitors the following outbreak-prone diseases: suspected Acute Watery Diarrhoea (AWD), measles, Acute Jaundice Syndrome (AJS) and Acute Respiratory Tract Infections (ARTI) and, since March 2020 suspect COVID-19. The following events are included in the event-based component of the surveillance system i.e. the Tea Team and the CHW surveillance sites: population movement, clusters of similar illnesses (which could include suspected measles, AWD and others), increase in deaths, concern about food insecurity, livestock illness and die-off, and other unusual events or occurrences such as lack of healthcare, flooding and others.  There is currently limited guidance or systematic review available on what the best system is to detect outbreaks in nomadic populations or how different surveillance systems complement each other. The study aims to provide a detailed description of the conception, implementation, comparison and lessons learnt from this comprehensive and innovative Tea Time Surveillance and Response System, which will complement the existing body of research and will serve as a guidance to other MSF missions and other organizations when establishing surveillance and response mechanisms in similar settings. | | | |
| ***Study topic***  *Check all that apply* | AMR  Cholera  Ebola  Environmental Health  Emergency  HIV  Leishmaniasis  Malaria  Nutrition  Other disease outbreak  If Other or Other disease outbreak, please state:  Comparative evaluation of usefulness and other attributes of surveillance system to detect and assess outbreaks and emergencies, including COVID-19 | Maternal & women's health  Measles  Meningitis  Mental health  Mortality  NTDs (excluding leishmaniasis)  Neonatal & child health  Non-communicable diseases  Other | | Upper/lower respiratory tract disease  Sexual violence  Surgery  Tuberculosis  Vaccination  VHF (excluding Ebola)  Violence  Water & Sanitation |
| **Methods - design**  *Check one study design* | Please consult the relevant study reporting guidelines\* listed at the end of this concept note. | | | |
| Observational study  Randomised trial  Systematic review  Case report  Diagnostic study  Routine surveillance data will be used to evaluate most of the attributes of the surveillance system. In addition, qualitative interviews will be held to evaluate the acceptability of the different components of the surveillance system. | | Mixed methods study  Qualitative research  Quality improvement study  Prediction model  Other | |
| **Methods - setting** | **Study location/setting:** *describe where you propose doing the study.* This study will be conducted in MSF-OCA’s Wardher project and its catchment area, in Somali region, Ethiopia.  Wardher project target catchment area is Doolo zone that has an estimated population of 556.870 people. Of this, it is estimated that around 37% are pastoralist *(2007 census)* who are highly mobile throughout the year in search of pastures and water for their animals mainly camels. In general, Doolo zone remains vulnerable to outbreaks hence our presence to timely detect and respond to them.  Unfortunately, the current health care delivery system does not facilitate easy access to health care for the pastoralist leaving them more vulnerable to morbidity and mortality due to treatable and or preventable diseases including childhood diseases and obstetric complications. The situation exacerbated by lack of reliable ambulance services and poor road network infrastructure in the bush where the pastoralist population normally are.  Not only does their lifestyle compromise access to health care, It also extents to decreased access to other humanitarian support that includes food distribution and other social services such as water trucking as they are normally people of no fixed aboard.  **Conflict:** *Are any study sites located in a conflict setting?* Not as such, but inter-clan and land dispute conflicts are not uncommon and these are normally taken care of by the SP and through dialogue of the conflicting parties.  The scale of conflict is now much lower than it used to be during the period of conflict between the Government forces and the Local Militia groups  **Context (1 paragraph):** *outline benefits/risks of using proposed study sites.*  There are more benefits than risks of using the proposed study sites. Firstly, we are operating in sites that have security clearance. This is not to rule out security incidences but we established the necessary contacts, networks and mechanisms to ensure that we always timely get security related reports that we analyse their impact on our activities and make decisions accordingly.  In general, we are working in a context where the level of our acceptance is very high and this also extents to the authorities.  Furthermore, all sites of comparison are our own sites which makes the study easier in terms of accessing data and information in general.  Additionally, we have already been working in almost all of the sites (both Tea Team and Mobile Clinic sites) where the identified voluntary local informants as well as the CHWs have been trained on and are now familiar with surveillance data collection and reporting from their respective communities. There are already established systematic modalities by which we get surveillance data from both entities  Inevitably, sometimes security related incidences may lead to suspension of visits to our sites but this is normally short-lived.  Because some of our sites are in very remote places, a few of them have poor network connections which means it is only them to call us and not for us to call them as they normally have to go to specific spots where the network is working. | | | |
| **Methods – participants, procedures, analysis**  *For retrospective analyses of routine data, if this section is sufficiently complete, this concept note will serve as the study protocol and be shared on the MSF Field Research site. This enables compliance with journal requirements for observational studies. For opt-out requests see* ***Opting out*** | A mix of quantitative and qualitative methods will be utilized for this comparative evaluation.  Firstly, we will provide a **description of the three components of the surveillance system** in terms of:   1. Geographical area, population, coverage 2. Events/diseases under surveillance (including case and event definitions) 3. Components of the surveillance system, data flow and frequency of reporting 4. SOPs or guidance documents 5. Data forms, data bases and outputs 6. Response mechanism and use of surveillance data for public health action   **Quantitative component of the evaluation**  Objective: To provide a comparative evaluation of the three components of the Tea Team surveillance system (1) the Tea Team surveillance sites (TT); (2) CBS by CHWs in locations where MSF has mobile clinics and (3) mobile clinic surveillance (MC). The quantitative component of the evaluation will focus on an evaluation of the following attributes: usefulness, representativeness, completeness and consistency of data, validity of case and event definitions, sensitivity, positive predictive value, timeliness, simplicity, flexibility and stability.  Study participants: For the quantitative component of the evaluation no participants will be recruited, we will conduct retrospective analyses of routine surveillance data.  Data sources: Surveillance data collected in the Somaliland region by MSF-OCA between February 2019 and September 2020 (18 months). The surveillance data that will be analysed for this evaluation has been stored in different data bases, including the ‘Tea Team surveillance data base’, a lessons learnt log, an advocacy and actions log and a locations and activity mapping data base. These databases will be combined/merged, as needed, to form complete databases for the analyses.  Data variables: The following attributes will be assessed in the quantitative component of the evaluation:   1. Usefulness    1. How many alerts of the TT and MC surveillance and CBS resulted in public health action?    2. Which type of response and by whom was it taken as a result of alerts from TT and MC surveillance and CBS?    3. Proportion of alerts reported by TT and MC surveillance and CBS    4. Proportion of alerts that were picked up only by TT surveillance or CBS and not by MC surveillance (gold standard surveillance method) 2. Representativeness    1. What percentage of the catchment area of the TT and MC surveillance and CBS was included/covered during the period under surveillance    2. Comparing the characteristics of reported events and diseases through the TT and MC surveillance and CBS to all such actual events, including characteristics of the population, such as age, socioeconomic status, access to health care, and geographic location 3. Completeness and consistency of the data    1. Completeness of reporting by week by TT and MC surveillance and CBS    2. Completeness of the dataset (missing items) by TT and MC surveillance and CBS    3. Consistency of data by TT surveillance and CBS compared to MC surveillance as gold standard 4. Sensitivity (to detect outbreaks)    1. Proportion: Number of outbreaks identified by TT / Number of all outbreaks    2. Proportion: Number of outbreaks identified by MC / Number of all outbreaks    3. Proportion: Number of outbreaks identified by CBS / Number of all outbreaks 5. Positive Predictive Value (PPV) (alerts/signals) and validity of case and event definitions    1. proportion: Number of true alerts / Number of signals for TT, MC surveillance and CBS    2. proportion: Number of responses / Number of signals for TT, MC surveillance and CBS 6. Timeliness of signals, assessment and response    1. Proportion of signals verified within 24 hours after reporting for TT, MC surveillance and CBS    2. Proportion of alerts assessed within 48 hours after reporting for TT, MC surveillance and CBS    3. Median time to assessment and response (by MSF and non-MSF actors) after reporting for TT, MC surveillance and CBS 7. Simplicity    1. Human, financial and logistical resources needed to implement TT, MC surveillance and CBS 8. Flexibility    1. Ability of system to adapt to changing information or operational needs (including resources needed to include COVID-19 surveillance into the existing surveillance system) 9. Stability    1. Percentage of time that the TT, MC surveillance and CBS have been operating fully, without interruptions   Data collection procedures: Quantitative surveillance data that will be used for this evaluation has already been collected and will be analysed retrospectively. The data collection procedures of the surveillance system will be described under the ‘description of the surveillance system’.  Data analysis: Quantitative data analysis will consist of basic descriptive analysis including proportions and median calculations where appropriate. T-tests and chi-squared tests will be used as appropriate for the specific indicators to comparie the surveillance system evaluation indicators described above between the Tea Team site surveillance, CBS and mobile health clinic surveillance. All analyses will be done using R software (R Core Team (2014). R: A language and environment for statistical computing. R Foundation for Statistical Computing, Vienna, Austria. [http://www.R-project.org/.](http://www.r-project.org/))  **Qualitative component of the evaluation**  Objective: To provide a comparative evaluation of the Tea Team surveillance sites, CBS by CHWs in locations where MSF has mobile clinics and mobile clinic surveillance. The qualitative component of the evaluation will take a participatory approach and focus on an evaluation of the following attributes: usefulness, acceptability, simplicity and flexibility.  Study participants: For the qualitative assessment of usefulness, acceptability, simplicity and flexibility, Focus Group Discussions (FGD) and key staff interviews will be conducted. MSF staff (including Tea Team members, CHWs, data manager/encoders, mobile clinic staff), local informants, local leaders, women and elders will be selected based on their knowledge of the surveillance system.  Data sources: Qualitative data will be collected through 8 FGDs. Each FGD will consists of 4-8 participants and will take 90 to 120 minutes. The focus groups will be stratified by sex and ‘type of participant’ (e.g. one FGD with local informants, one FGD with CHWs, one focus group with women in Tea Team sites, one FGD with the medical team of the mobile clinic etc). FGDs will be facilitated by a field epidemiologist and/or health promotion officer and a member of the outreach team (male or female depending on the group participants). The FGDs will be conducted with the help of a translator (translating from Somali to English), who will receive training on detailed and real-time translation.  In addition to FGD, individual interviews with key staff will be performed.  Data variables for FGD: The following attributes will be assessed in the qualitative component of the evaluation:   1. Usefulness    1. Perceived usefulness of the TT and MC surveillance and CBS    2. What changed since the TT started?    3. What actions were taken as a result of the TT?    4. Any changes in health care seeking behaviors during surveillance system implementation 2. Acceptability    1. Willingness of persons (local informants, elders, MSF staff) to participate in the TT and MC surveillance and CBS    2. Perceived willingness of broader community to participate in the TT and MC surveillance and CBS    3. Seasonality and how it might have affected compliance to the surveillance system    4. Are there aspects of the surveillance system that may have increased community engagement?    5. Feedback on what component of the surveillance system the community could contribute more and how 3. Simplicity    1. Perceived simplicity of the system 4. Flexibility    1. Did the system adapt to participants needs?    2. How has the system changed during its implementation?   Data variables for individual interviews: The following attributes will be assessed in the qualitative component of the evaluation:   1. Simplicity    1. Amount and type of data necessary to establish that the health-related event has occurred (i.e., the case definition has been met)    2. Level of integration with other systems    3. Method of collecting the data, including number and types of reporting sources, and time spent on collecting data    4. Amount of follow-up that is necessary to update data on the case    5. Method of managing the data, including time spent on transferring, entering, editing, storing, and backing up data    6. Methods for analysing and disseminating the data, including time spent on preparing the data for dissemination    7. Staff training requirements    8. Time spent on maintaining the system 2. Flexibility    1. Ability of system to adapt to changing information or operational needs (including resources needed to include ARTI surveillance (as a proxy for COVID-19) into the existing surveillance system)   Data collection procedures: Transcripts will be prepared from FGD notes and individual interview notes and will be password protected and stored on the secure MSF Network drive.  Data analysis: Data analysis: For qualitative data analysis, all hand-written notes and visuals describing concepts will be documented. For interpretative FGDs, the co-analysis of existing data and co-generation of new data between research participants and evaluators will inform an emergent ideas and action about surveillance practice. For transcribed data from individual interviews and FGDs we will use a deductive approach for the analysis in line with the pre-structured topics allowing for new themes emerging from the data. Transcripts will be reviewed and coded and the codes will be grouped under pre-identified themes using a framework approach to facilitate qualitative data synthesis and exploration of patterns across and within articles. Qualitative data analysis will be performed with NVivo software (QSR International Pty Ltd, Australia). | | | |
| **Resources/costs:** | *List resources needed e.g. statistician, input from other specialists, field time. Include cost estimate if known.*   * HQ Epidemiology Advisor to keep overview as Study Coordinator and provide technical support to Field Epidemiologist * Field Epidemiologist to provide remote support (2 months * Qualitative data collectors for 3 weeks (including training) * Transport for qualitative data collectors * Stationary, snacks for training etc. * Dissemination budget including publication costs | | | |
| **Planned dates**  *List proposed* ***start/end date******[mm/yyyy]*** *of each stage and any time restrictions* | **Protocol development:** September-October 2020  **Ethics review:** October 2020  **Study preparation:** November 2020  **Data collection:** January 2021  **Data analysis:** February 2021  **Write up (report):** February 2021  **Write up (other study outputs):** March 2021 | | | |
| **Ethics - exemption from review by the MSF ERB (Ethics Review Board)** | 1. Is your study a retrospective review of routinely collected data and thus a candidate for exemption from MSF ERB review?   No  Yes  *Complete the OCA Ethics Review Exemption Template (see Annex) and submit with this Concept paper.* | | | |
| 1. Will your study use an [MSF Intersectional Standardised Survey Protocol](http://fieldresearch.msf.org/msf/handle/10144/618942)?   No, continue with question 4  Yes, continue with question 3   1. If you used an MSF Intersectional Standardized Survey Protocol, does it meet the [MSF ERB Exemption criteria for surveys](http://fieldresearch.msf.org/msf/handle/10144/618799)?   No  Yes | | | |
| 1. Do you believe that your study is exempt from ERB review for another reason?   No  Yes, because:  *Complete the OCA Ethics Review Exemption Template (see Annex) and submit with this concept paper.* | | | |
| **Ethics -- non-exempt studies**  *Do not complete this section if you have applied for exemption from MSF ERB review.* | **Benefits:** By evaluating the current surveillance system in the Somaliland region in Ethiopia, we are aiming to identify the strengths and weaknesses of the surveillance system, and to identify lessons learnt and recommendation that will be operationalized. Further strengthening the surveillance system will help MSF to better meet one of its programs objectives in the Somaliland region, namely “Disease outbreaks and other emergencies in Doolo Zone are identified and responded to in a timely manner.”  In addition, we will be contributing to the scarce literature of surveillance system evaluation, which can be used by other MSF missions, governments, NGOs and other stakeholders when implementing surveillance systems, especially in similar settings.  **Risks:** We do not foresee any major risks for the implementation of the quantitative component of the evaluation, considering its retrospective character and that all data has been recorded without any identifiers. For the qualitative component, we do not foresee any major risks either. There is a risk that participants may feel that they have to give desirable answers. In order to mitigate this, prior to the focus group discussions, all participants will be explained that they should feel free to answer honestly, and that their answers will not impact their access to MSF services in any way.  **Consent**: For the quantitative component no consent procedure is needed as only routine surveillance data will be included in the retrospective analysis.For the qualitative FGDs we will ask prospective participants for their consent to participate in the study with a clear explanation that their data will be anonymized and will only be used for this evaluation. In addition, the FGD facilitator will explain that their answers and feedback will in no way impact their access to MSF services, and that participants are welcome to withdraw their FGD participation at any point. Consent for the qualitative evaluation will be verbal, it will be explained that all data will be kept confidential, no personal identifiable data will be collected, there is no individual benefit associated with participation, participants can withdraw their consent any time.  **Confidentiality:** For the quantitative component, all data has already been collected as routine surveillance data and has been fully anonymized. The data is stored in four data bases that are password protected.  The FGD notes will be transcribed and translated by a translator, and will then be stored on a password protected computer. Only the Principal Investigator and Study Coordinator will have access to the transcripts, which will be fully anonymized. No personal identifiable data will be collected.  **National/local review:**  A research proposal will be developed based on Somali regional Health bureau /Jigjig university IRB form and submitted to SRHB scientific and ethical review office (SERO) and approved by regional health bureau /Jigjig University . A support letter from RHB and Ethical clearance from JU will be granted and communicated to local administrative offices.   1. Has a protocol been submitted to or approved by National/ Local Ethics Review Committee(s)?   No/Not yet  Yes   1. If not yet submitted, please indicate when and to which committee the protocol will be submitted: 2. If not planned to be submitted to local committees please note why not: | | | |
| **Roles and responsibilities**  If responsibilities are split differently between the roles outlined below or held by other members of the research team, please describe clearly in the sections below. ReMIT responsibility must be held by an MSF staff member. | | | | |
| **Primary Investigator (PI)**  *Responsible for carrying out the study with support and consultation from research team. Will usually lead on all journal correspondence. TOR is* [*here*](https://msfintl.sharepoint.com/:w:/s/Researchsystem/EfCcV3m67ulEpRJ61fpeg3sBJaVnhdvghe8S-TZ4xxPaCA?e=Rc4J3j) | Name: Bashir Ali (Field epidemiologist, Somali Region Project,) [wardher-epidem@oca.msf.org](mailto:wardher-epidem@oca.msf.org)  Remote field epi (TBD)  Email address: | | | |
| **Study Coordinator (SC)**  *Overall responsible for study, must be MSF HQ staff, usually topic specialist or epi advisor. Responsible for: updating ReMIT, translating findings into impact, appropriately disseminating materials (see later section). TOR is* [*here.*](https://msfintl.sharepoint.com/:w:/s/Researchsystem/EfCcV3m67ulEpRJ61fpeg3sBJaVnhdvghe8S-TZ4xxPaCA?e=Rc4J3j) | Name: Patrick Keating, OCA Epidemiological Advisor  Email address: Patrick.keating@london.msf.org  Is the topic specialist / topic holder informed/involved? Yes, Epi Advisor | | | |
| **MSF research team** | MTL Somali Region Project [wardher-mtl@oca.msf.org](mailto:wardher-mtl@oca.msf.org)  Bashir Ali Field epidemiologist, Somali Region Project [wardher-epidem@oca.msf.org](mailto:wardher-epidem@oca.msf.org)  HP Somali Region Project [wardher-hpo@msf.org](mailto:wardher-hpo@msf.org)  Turid Piening MD PhD (MedCo) ethiopia-medco@oca.msf.org  Birhanu Sahelie (MedCo-Support ) [ethiopia-medco-assist@oca.msf.org](mailto:ethiopia-medco-assist@oca.msf.org)  Jade Pena, Health Advisor  Prince Alfani, Health Advisor  Beverley Stringer, Social Sciences Advisor  Patrick Keating, Epidemiology Advisor  Anna Kuehne, Epidemiology Advisor  Elburg van Boetzelaer, Epidemiology Advisor | | | |
| **Field involvement** | Are national/other field staff informed/included as co-investigators?  No  Yes  Will protocol development include field team input?  No  Yes  Please describe any planned capacity building activities for national staff: The national staff field epidemiologist will be the Principal Investigator on this study/evaluation. The national staff field epidemiologist will be supported by a remote field epidemiologist. The aim is that the evaluation of the surveillance system will be repeated periodically to ensure that the program’s objectives are continued to be met, and that the surveillance system is continuously further improved. One of the objectives of this evaluation is to train the national staff field epidemiologist on how to conduct an evaluation of a surveillance system, so that he can take the lead on further evaluations in the future. Finally, for the qualitative component, different national staff will be trained on qualitative research methods, notably the implementation of focus group discussions. | | | |
| **Health Advisor (HA)**  *Responsible for facilitating study operationally, ensuring desk/field have agreed to study and feeding back to PI/SC.* | Name of relevant HA(s): Prince Alfani  Is/are the HA(s) supporting the study on behalf of the countries they manage?  No  Yes | | | |
| **External partners/MoH**  *Name, position, role of external collaborators.* | **International:**  **Local:** Mohammed Osman (M&E and HMIS officer Somali Regional Health Bureau)  **Community**: *if relevant, describe consultation with a body representing the community.*  Have **resource agreements**, e.g. Open Access publication costs been reached?  No  Yes, namely: | | | |
| **Competing interests** | Members of the research team declare no competing interests | | | |
| **Data management and sharing**  *Contact details of those responsible for ensuring data are managed and shared in accordance with MSF’s Health Data Protection Policy and GDPR* | Name: Patrick Keating  Email: Patrick.keating@london.msf.org  Data management plan: The surveillance data is stored in four password protected data bases and confidentiality will be maintained through the standard procedures in project for such files. The qualitative data (FGD and interview transcripts) will be kept on a password protected computer. The surveillance data and qualitative data will be kept for 5 years, after which they will be destroyed.  Will data be shared with an external partner such as an academic institution?  No  Yes, namely:  *Complete the OCA Data Sharing Agreement and submit for Medical Director signature.* | | | |
| **Opting out**  *All concept papers and/or (ERB approved) protocols are made available on ReMIT and the MSF Field Research website*. | This concept paper and/or accompanying protocol cannot be made available on:  ReMIT; because:  MSF Field research website; because: | | | |
| **Implementation/ impact and dissemination**  Responsibility of the Study Coordinator (unless otherwise noted in roles/responsibilities section) | | | | |
| **Implementation/impact** | Findings of this evaluation will be used by the MSF-OCA Somaliland project in Ethiopia to further strengthen their surveillance system and to further strengthen their ability to early detect and respond to outbreaks. In addition, findings of this evaluation can be used by other MSF project and missions that are working in similar contexts to inform their decision making around surveillance systems. Finally, findings of this study offer a unique comparison of different elements of the surveillance system, namely the event based and indicator based elements, on a number of surveillance system attributes. This will be useful for the broader community of MOH, governments and NGOs to inform decision making around the implementation of surveillance systems elsewhere based on a scientifically sound evaluation and data. | | | |
| **Dissemination**  *Note on journal publication -MSF has an Open Access (OA) journal publication policy. Fee reduction must be requested* ***at article submission.*** *See* [*guidance*](https://msfintl.sharepoint.com/:w:/s/Researchsystem/ERuSJx0O_ZRIkVG8m7lI0gwB_YKjA5jlLrG7mAeN2iiDrQ?e=YbL9X6) *on publication – authorship, how to apply for fee reduction, funding, conflict of interest, and response to journal data deposition requests.*  *Internal reports remain on Sharepoint, not ReMIT.* | **Dissemination of findings:**  MSF – project, mission, headquarters: Study report will be prepared and shared  Participants: Findings will not be shared directly with participants, but will be shared to the larger community which includes the participants, by incorporating key messages from the study findings into ongoing HP activities.  Community: Findings will be shared to community leaders in the local by MSF HPs. Key advocacy messages identified through the work, if any, will be translated into the local language and shared with the local community through ongoing health promotion activities.  In country partners (including MoH): After data analysis is complete, an external report will be prepared and shared with the local and state government.  International dissemination (including WHO and other agencies, scientific publication): If appropriate, an abstract will be submitted to a local and/or international conference and a manuscript will be drafted for journal publication.  **Agreements**  Authorship: TBD  Has the dissemination plan the support of the Health Advisor (HA)?  No  Yes  *Research outputs must be sent in parallel, before wider distribution, to the OCA Research Committee for quality review and to the HA, who will have 1 week to raise any context concerns with the Committee. Context concerns arising since Concept paper approval or quality of output likely the main reasons to postpone outputs.* | | | |

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| **\*Study Reporting Guidelines**  To assist authors in writing up their studies to meet scientific journal criteria | |
| Observational studies – [STROBE](http://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.0040296) ([& extensions](http://www.equator-network.org/?post_type=eq_guidelines&eq_guidelines_study_design=0&eq_guidelines_clinical_specialty=0&eq_guidelines_report_section=0&s=+STROBE+extension&btn_submit=Search+Reporting+Guidelines))  Randomised trials – [CONSORT](http://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1000251) ([& extensions](http://www.equator-network.org/reporting-guidelines/consort/))  Systematic reviews – [PRISMA](http://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1000097) ([& extensions](http://www.equator-network.org/reporting-guidelines/prisma/))  Case reports – [CARE](http://jmedicalcasereports.biomedcentral.com/articles/10.1186/1752-1947-7-223) | Qualitative research – [SRQR](http://journals.lww.com/academicmedicine/Fulltext/2014/09000/Standards_for_Reporting_Qualitative_Research___A.21.aspx) ([& extensions](http://intqhc.oxfordjournals.org/content/19/6/349.long))  Diagnostic studies – [STARD](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4623764/)  Quality improvement studies – [SQUIRE](http://qualitysafety.bmj.com/content/17/Suppl_1/i3.long)  Prediction model studies - [BMJ](http://www.bmj.com/content/350/bmj.g7594.long) |

## Annex 1. OCA Ethics Review Exemption Template

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| **Research exemption proposal**  Template to be filled out and submitted to OCA Research Committee along with a concept paper when requesting exemption from ERB review. See[MSF ERB guidance on exemption criteria](http://fieldresearch.msf.org/msf/handle/10144/618714). Please use the[MSF Research Ethics Framework – Guidance document](http://fieldresearch.msf.org/msf/handle/10144/305288)to answer the questions below. |
| ***Title (same as for Concept paper):*** |
| ***Name of Primary Investigator (PI):*** |
| ***Has a protocol been submitted to or approved by National/ Local Ethics Review Committee(s)?***  No  Yes  ***If not yet submitted, please indicate when and to which committee the protocol will be submitted:***  *Please name the various ERCs.*  ***If not planned to be submitted to local committees please note why:*** |
| **1. Exemption Criteria** |
| * 1. Is the study based on routinely-collected clinical data from pre-existing, established programmes?   No  Yes |
| * 1. Is the study descriptive/evaluative or a targeted evaluation?   No  Yes |
| * 1. Explain here how confidentiality is respected – how you will ensure that no individual patient identifiers are revealed or used? |
| * 1. What are anticipated harms? Ensure you acknowledge any that are relevant or state ‘no harms anticipated’. Can these be kept minimal? |
| * 1. Describe potential benefits to the programme, community, and if publication is the goal, to a wider audience: |
| * 1. Describe any collaborative involvement and, if applicable, authorship from a local authority or partner (Ministry of Health, DHO, other NGO); if relevant and applicable, describe consultation with a body representing the community: |
| **2. Ethics Statement** |
| Once exemption has been granted by the OCA Research Committee, the authors can insert into their article the following statement that has been approved by the MSF ERB:  *“This research fulfilled the exemption criteria set by the Médecins Sans Frontières Ethics Review Board for a posteriori analyses of routinely collected clinical data and thus did not require MSF ERB review. It was conducted with permission from (Medical Director, Operational Centre) Médecins Sans Frontières.”* |

1. # Updated Guidelines for Evaluating Public Health Surveillance Systems https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5013a1.htm

   [↑](#footnote-ref-2)