EAST AFRICAN COMMUNITY

PROTOCOL
ON EAST AFRICAN COMMUNITY REGIONAL COOPERATION ON HEALTH

Preamble

WHEREAS The United Republic of Tanzania, the Republic of Uganda and the Republic of Kenya, the Republic of Burundi and the Republic of Rwanda (hereinafter referred to as the Partner States) have signed and entered a Treaty for the Establishment of the East African Community;

AND WHEREAS the Partner States of the East African Community (EAC), having regard to the interests of and their desire for African unity resolved to co-operate with one another in the area of health as per the provisions of Article 118 of the Treaty for the Establishment of the East African Community;

RECOGNISING FURTHER that the Treaty obliges the Partner States to cooperate in relation to health, the Council of Ministers agreed and decided to develop and operationalise a comprehensive protocol to guide regional cooperation and integration among the Partner States in various fields within the health sector;

NOW THEREFORE the Partner States desirous of addressing issues related to regional cooperation on health;

AGREE AS FOLLOWS:

CHAPTER I:

INTERPRETATION

Article 1
Definitions

1. Unless the context otherwise requires, the terms used in this Protocol shall have the same meaning as ascribed to them in the Treaty for the Establishment of the East African Community.
2. Without prejudice to paragraph (1) of this Article-

"Commissions" means the regional institutions of the Community established under Articles 4 and 5 of this Protocol;

"Community" means the East African Community established by Article 2 of the Treaty;

"Coordination Committee" means the Coordination Committee established by Article 9 of the Treaty;

"Council" means the Council of Ministers of the Community established by Article 9 of the Treaty;

"Commissioner General" means the Chief Executive Officer of the regional institutions of the Community established under Articles 4 and 5 of this Protocol;

"Gazette" means the Official Gazette of the Community;

"Head" means the Chief Executive Officer of a member institution by whatever name called;

"Health" means a state of complete physical, mental and social well being and not merely the absence of disease or infirmity;

"Member Institution" means an institution represented on the governing board of the regional institutions of the Community established under Articles 4 and 5 of this Protocol;

"National Institution" means a body established under the relevant laws of a Partner State mandated to provide health services for and on behalf of the respective Partner State;

"National Focal Point" means a body established by authority of each Partner State to coordinate national activities of each of the regional institutions of the Community established under Articles 4 and 5 of this Protocol;

"Partner States" means the United Republic of Tanzania, the Republic of Kenya, the Republic of Uganda, the Republic of Burundi, the Republic of Rwanda and any other country granted membership to the Community under Article 3 of the Treaty;

"Partnership Agreement" means an agreement signed between the Community and a collaborating development partner interested in promoting regional cooperation on health among the Partner States;

"Secretary General" means the Secretary General of the Community provided for under Article 67 of the Treaty;
"Sectoral Committee" means the Sectoral Committee established by Article 20 of the Treaty;

"Sectoral Council" means the Sectoral Council provided for under Article 14 of the Treaty;

"stakeholder" means a person, legal or natural, governmental or non-governmental conducting business with any of the regional institutions of the Community established under Articles 4 and 5 of this Protocol;

"Treaty" means the Treaty establishing the East African Community and any annexes and protocols thereto.

CHAPTER II:

VISION AND PRINCIPLES

Article 2
Purpose of the Protocol

This Protocol shall govern regional co-operation on health among the Partner States;

Article 3
Vision of the Protocol

The vision of the Protocol is to have a harmonized and integrated health system and services for the improvement of the health and well-being of the peoples of the Community.

Article 4
Mission of the Protocol

The mission of the Protocol shall be to provide legal mechanisms for coordination and integration of health systems and services in order to enhance of the health of the people in the region as spelt out in Article 118 of the Treaty for the Establishment of the Community.

Article 5
Objective of the Protocol

1. The objective of this Protocol is to establish legal mechanisms to guide and govern regional cooperation on health among the Partner States and for related matters in order to improve the health of the citizens in Partner States through

2. The specific objectives for which the Protocol is established shall be to –

(a) strengthen regional collaboration and coordination in the health sector among the Partner States

(b) promote cross-border integrated regional disease prevention and control;
(c) promote and facilitate the development of human resource capacities/skills in health, and databases in all disciplines of health professions;

(d) promote the regional and national health systems development, health services, health research, health policy and practice;

(e) strengthen and enhance mechanisms for collaboration in health research in the Partner States;

(f) facilitate the creation of health research databases to strengthen health policy and practice;

(g) address common intellectual property rights issues of relevance to health in the Partner States;

(h) facilitate strategic planning in health research institutions and others performing health research;

(i) use resources availed to it by the Partner States to implement its core functions;

(j) promote quality assurance processes in order to achieve and maintain international standards in health in the region;

CHAPTER III:

ESTABLISHMENT OF COMMISSIONS

Article 6
Establishment of the East African Community Health Services and Research Commission

The Council hereby establishes the East African Community Health Services and Research Commission which shall be responsible for the coordination of regional cooperation on health among the Partner States.

Article 7
Establishment of the East African Community Medicines and Food Safety Commission

The Council hereby establishes the East African Community Medicines and Food Safety Commission which shall be responsible for regional coordination and management of decentralised regulation of medicines and food safety and quality among the Partner States.

Article 8
Functions of the Commissions
Article 9
Composition of the Commissions

1. The Commission shall comprise the following or their representatives -
Article 10
National Focal Points

The Partner States shall establish National Focal Points as linkages between the Commissions and national stakeholders.

Article 11
Organizational Structure of the Commissions

1. The Commissions shall be institutions of the Community as provided for under Article 9 of the Treaty and shall operate within the existing structure of the Sectoral Council responsible for health.

1. The organizational structure referred to in paragraph (1) is as follows-

   (a) the Sectoral Council;
   (b) the Coordination Committee;
   (c) the Sectoral Committee;
   (d) the Commissions;
   (e) the Secretariats of the Commission.

Article 12
The Sectoral Council

The Sectoral Council shall in relation to this Protocol perform the following functions -

(a) provide overall policy directions and guidance to the Commissions in the formulation and implementation of various health research projects and programmes within the Partner States;

(b) facilitate the Commissions in order to fulfil their respective mandates as provided in Annex I and III;

(c) make regulations, issue directives, make decisions and recommendations and give opinions in accordance with the provisions of this Protocol;

(d) consider and approve the budget and work programmes of the Commissions;

(e) consider and approve measures to be undertaken by the Partner States in order to promote the attainment of the objectives of this Protocol;

(f) adopt annual progress reports of the Commissions from the Coordination Committee; and

(g) perform such other functions as may be directed by the Council.
The Co-ordination Committee shall in relation to this Protocol perform the following functions -

(a) submit reports and recommendations to the Sectoral Council on the implementation of this Protocol;

(b) implement the decisions of the Sectoral Council as it may be directed from time to time;

(c) receive and consider reports of the Sectoral Committee;

(d) assign any Sectoral Committee to deal with any matter relevant to the Commission; and

(e) perform such other functions as may be conferred upon it by the Sectoral Council.

Article 14
Functions of the Sectoral Committee

The Sectoral Committee shall in relation to this Protocol perform the following functions-

(a) be responsible for the preparation of comprehensive implementation of programmes and the setting out of priorities for the Commissions;

(b) monitor and keep under constant review the implementation of the programmes undertaken by the Commissions;

(c) submit from time to time, reports and recommendations of various technical working groups and focal points of the Commissions; and

(d) perform such other functions as may be conferred on it by Co-ordinating Committee.

Article 15
The Secretariat of the Commissions

1. There shall be established respective Secretariats of the Commissions consisting of the Commissioner General and such other officers and staff as the Council may appoint on such terms and conditions of service as the Council may determine.

2. The headquarters of the Commissions shall be determined by the Council.

Article 16
Functions of the Secretariats

1. The functions of the respective Secretariats of the Commissions shall be to-
(a) coordinate and harmonise policies and strategies related to the operations of the Commissions;

(b) initiate regional activities and programmes on health;

(c) convene meetings of the respective Commissions and their technical working groups;

(d) submit reports to the Sectoral Council through the Co-ordination Committee;

(e) generally undertake the administration and financial management of the Commissions;

(f) disseminate information on the respective Commissions to the various stakeholders and the international community;

(g) mobilise resources for the implementation of the projects and programmes of the respective Commissions;

(h) develop a sustainable funding mechanism for facilitating sustainable operations of the respective Commissions;

(i) implement the decisions of the Sectoral Council; and

(j) perform such other functions as may be conferred on it by or under this Protocol.

2. In coordinating the preparation, negotiation and implementation of the national and regional programmes, the Commission shall involve, as appropriate, other parties and relevant intergovernmental and non-governmental organisations in the implementation of this protocol.

Article 17
Commissioner General

1. There shall be a Commissioner General who shall be appointed by the Council.

2. The Commissioner General shall-

   (a) be the Chief Executive Officer of the Commission;

   (b) implement the work of the respective Commissions in accordance with the policy and decisions of the Sectoral Council;

   (c) submit reports on the work of the respective Commissions as well as the audited accounts to the Sectoral Council;

   (d) be the accounting officer of the respective Commission;

   (e) carry out such other functions as are conferred by this Protocol or as may be directed by the Sectoral Council from time to time;

   (f) be the Secretary to the respective Commissions as established by this Protocol;

   (g) perform such other functions as the respective Commissions may direct.
3. The Commissioner General shall serve for a non-renewable period of five years.

4. The post of Commissioner General shall be held on a rotational basis among Partner States.

Article 18
Deputy Commissioner General

1. The Commissioner General shall be assisted by two Deputy Commissioner General appointed by the Council and shall serve on a three year term which shall be renewed once.

2. The two Deputy Commissioner General shall be of nationalities different from that of the Executive Secretary, and the posts shall be held on a rotational basis.

Article 19
Other Officers and Staff of the Commission

1. There shall be such other officers and staff in the service of the Commissions as may be determined by the Sectoral Council.

2. All officers and staff of the Commission shall be appointed on contract and in accordance with staff rules, regulations, terms and conditions of service of the Community.

3. The terms and conditions of Service of the Commission shall be determined by the Sectoral Council.

Article 20
Funding of the Commission

The sources of funds for the Commission shall be from the budget of the Community and shall include stakeholders' contributions, contributions from development partners and such other sources as shall be established by the Council.

CHAPTER IV:

COOPERATION IN DISEASE PREVENTION AND CONTROL

Article 21
Epidemiological Surveillance

Recognizing that early detection of epidemics particularly to those occurring in cross-border epidemiological zones and providing that information to those who need to know
in order to take relevant action is central to the prevention and control of diseases, the Partner States therefore undertake to

(i) Conduct surveillance of all the identified priority diseases in Annex II
(ii) Ensure the cross-border districts report all the identified thirteen priority diseases as indicated in Annex III and any other disease that may be added to the list from time to time immediately, weekly or monthly basis to the relevant unit of the East African Community Secretariat.
(iii) Approve and support the implementation of a mobile phone and web based reporting system to be used for reporting and analysis of cross-border surveillance data.
(iv) Harmonize surveillance and response training materials to include e-reporting, cross-border surveillance, amongst others
(v) Approve the implementation of community based disease surveillance to complement the IDSRe strategy

Article 22
Improving laboratory capacity

Noting that laboratory capacity in the region is still weak and recognizing that laboratory confirmation of the aetiological agent of disease outbreaks is important for their effective control, the Partner States undertake to

(i) Create demand for laboratory services and ensure that the laboratories produce reliable and timely results.
(ii) Ensure that each laboratory shall establish a public health bench within the laboratory in order to ensure that there is close linkage of the lab to surveillance
(iii) Ensure that there are satellite laboratories in the cross-border epidemiological zones with the capacity to detect and confirm all the priority diseases or have direct linkages with other reference laboratories with this capacity
(iv) Ensure harmonization of laboratory standard operating procedures for the 13 priority diseases
(v) Share resources which include laboratory, human resource, facilities, logistics; among others, within the border districts.
(vi) Create and strengthen mechanisms for monitoring the resistance of pathogens to standard drugs

Article 23
Investigation of disease outbreaks

With respect to investigation of disease outbreaks and public health threats, the Partner States undertake to;

(i) Ensure that disease outbreak alert/rumour information is both formally and informally shared among border districts alongside the official national level reporting
(ii) Ensure that a regional rapid response team is in place and facilitated to investigated disease outbreaks and public health threats.
(iii) Take measures to facilitated joint local cross-border rapid response team to conduct joint investigation of outbreaks occurring in the cross-border zones.
(iv) To relay disease outbreak information to the EAC Secretariat within 48 hours of detection within any Partner State
(v) Authorize the EAC Secretariat to communicate to the rest of the Partner States information on disease outbreak in the region immediately upon receipt
(vi)

Article 23
Control of disease outbreaks

With respect to control of disease outbreaks the Partner States undertake to;

(i) Harmonize treatment policies and protocols when necessary;
(ii) Update and disseminate standard case management protocols and train health personnel on their use;
(iii) Assure free access to health care for all at risk populations during epidemics;
(iv) Update and disseminate national mass vaccination strategy documents, according to WHO-recommended standards
(v) Coordinate mass vaccination activities along common borders in terms of timing, social mobilization and target age-groups;
(vi) Supervise and update the skills of the personnel, especially in the organization of vaccination campaigns;
(vii) Determine vaccine storage sites in order to ensure quick provision of vaccines when needed;
(viii) Ensure access of all persons in the target population to vaccinations during epidemics, regardless of financial status.
(ix) Prepare joint epidemic preparedness and response plans for cross-border zones

Article 24
Social mobilization to prevent and control diseases

In order to ensure effective mobilization of the populations for the prevention and control of epidemics, the Partner States undertake to;

(i) Involve political authorities up to the highest levels;
(ii) Mobilize religious, opinion leaders, and private sector to help disseminate correct information;
(iii) Prepare and implement a national social mobilization strategy for the prevention and control of epidemics;
(iv) Produce and disseminate targeted messages;
(v) Use the communication channels that are most accessible to the majority of the population;
(vi) Establish social mobilization committees at various levels and train their members aimed at greater participation of the community

Article 25
Exchange of surveillance and epidemic information
Recognizing that surveillance and epidemic information is best disseminated to those who need to know in order to take action; the Partner States undertake to:

(i) Encourage both formal and informal sharing of disease surveillance information between cross-border district officials
(ii) Recommend that EAC Secretariat develop and disseminate weekly epidemiological reports indicating data on priority diseases occurring in the border districts upon the development of a weekly reporting system
(iii) Approve the posting in the EAC website all weekly epidemiological reports and provide linkage to websites containing similar reports generated by Partner States
(iv)

CHAPTER V:

COOPERATION IN HIV/AIDS CONTROL

Article 26

Article 27

CHAPTER VI:

COOPERATION IN SEXUAL AND REPRODUCTIVE HEALTH RIGHTS

Article 28
Safe Motherhood

Recognizing the persistently high maternal, newborn morbidity and mortality in East Africa, the Partner States undertake to:-

(i) Harmonise Antenatal Care package to offer comprehensive individualized quality care and ensure availability of equipments, medicines and supplies and skilled attendant.
(ii) Ensure availability and accessibility of quality Emergency Obstetric and Newborn Care (EMONC).
(iii) Harmonise Post Natal/Post Partum Care guidelines and strengthen service provision.
(iv) Offer Comprehensive Post Abortion Care.
(v) Ensure availability and accessibility of all Family Planning commodities and services.
(vi)

Article 29
Integration in Service provision
Recognizing the importance of integration of service provision to improve reproductive health, the Partner States undertake to:-

(i) Ensure availability and accessibility of adolescent and youth friendly services.
(ii) Address Sexual and Gender Based Violence including prevention, care, treatment and psychosocial support.
(iii) Ensure availability, accessibility, prevention and treatment of reproductive tract cancers.
(iv) Address infertility including male infertility.
(v) Offer STI/HIV prevention and treatment, FP services and TB screening, diagnosis and treatment as cross cutting in all the above RH services

CHAPTER VII:
COOPERATION IN MEDICINES AND FOOD SAFETY

Article 30

Article 31

CHAPTER VII:
COOPERATION IN HEALTH SYSTEMS RESEARCH AND POLICY

Article 32

Article 33

CHAPTER IX:
GENERAL PROVISIONS

Article 34
Co-operation with Development Partners

The Partner States may establish partnership agreements with development partners to promote the activities of the Commission on the agreed objectives and guiding principles.

Article 35
Dispute Settlement
1) In the event of a dispute between Partner States concerning the interpretation or application of this Protocol, the Partner States concerned shall resolve the matter amicably.

2) If the Partner States do not resolve the dispute amicably, either Partner State or the Secretary General may refer such dispute to the East African Court of Justice in accordance with Articles 28 and 29 of the Treaty.

3) The decision of the East African Court of Justice on any dispute referred to it under this Protocol shall be final.

**Article 36**  
Relationship between this Protocol and the Treaty

This Protocol shall upon entry into force be an integral part of the Treaty and in case of an inconsistency between this Protocol and the Treaty, the Treaty shall prevail.

**Article 37**  
Relationship of the Protocol with other Agreements on Health Research

1. The provisions of this Protocol shall take precedence over any existing agreements relating to health research and where any agreement is inconsistent with this Protocol, the agreement shall be null and void to the extent of its inconsistency.

2. Where the exercise of rights and obligations originating from an existing agreement relating to health research within Partner States, is likely to cause serious damage or threat to the health of its people, the Partner States shall as soon as practicable enter into negotiations or take other measures to remedy the situation.

**Article 38**  
Status, Privileges and Immunities

The Partner States shall grant the Commission the status, privileges and immunities pertaining to the Community in accordance with Article 151 of the Treaty.

**Article 39**  
Dissolution

On dissolution of the Commission all rights, assets, properties and liabilities of the Commission shall vest with the Secretary General.

**Article 40**  
Accession
1. A state which becomes a party to the Treaty, shall become a party to this Protocol by depositing an instrument of accession to the Protocol with the Secretary General.

2. On accession, the Protocol shall enter into force, thirty days after the date of the deposit of the instrument of accession.

Article 41
Amendment of this Protocol

This Protocol may be amended any time by agreement of the Partner States in accordance with Article 150 of the Treaty.

Article 42
Entry into Force

This Protocol shall enter into force upon ratification and deposit of instruments of ratification with the Secretary General by all Partner States, and the publication of the same in the Community Gazette.

IN WITNESS WHEREOF the undersigned have appended their signatures this ___________ day of ___________ in the year Two Thousand and Twelve

| For The United Republic of Tanzania | For the Republic of Burundi | For the Republic of Uganda | For the Republic of Rwanda | For the Republic of Kenya |
Institutional Framework for Cross-Border Integrated Disease Surveillance and Response, in the East Africa Region

July 2nd 2011

There is increasing concern about the occurrence and spread of disease outbreaks as a result of increased international travel, trade, migration, and lack of effective cross-border outbreak coordination mechanisms. This document outlines the activities proposed for improving cross-border surveillance and response in the East Africa Community.
INSTITUTIONAL FRAMEWORK FOR CROSS-BORDER SURVEILLANCE IN THE EAST AFRICAN COMMUNITY

INTRODUCTION

Given the ecological distribution of communicable diseases and the porosity of international borders, it is imperative that countries in the East African Community (EAC) work together to control and eliminate them from the region. The free movement of people and goods across the borders of Partner States in the East African region provides opportunities for cross-border spread of diseases. In addition, in the urban centers located at border points a disaster on one side of the border can easily affect the health of a large number of people on both sides of the borders. It is therefore logical that countries in the EAC engage each other in coordinated and synchronized implementation of interventions so as to control communicable diseases and selected NCDs in the region. Developing a framework for cross-border surveillance in the EAC will therefore provide an opportunity for Partner States to initiate and strengthen priority cross-border activities for disease control, including but not limited to disease surveillance, epidemic preparedness and outbreak control as well as building core capacities to ensure compliance to the International Health Regulations (IHR (2005)).

BACKGROUND

Throughout history, disease outbreaks have been an unwelcome travelling companion of international trade and commerce. In the recent years, the emergence and reemergence of infectious disease combined with the booming international trade and air travel have greatly increased the risk of disease transmission across international borders. There is therefore a global drive for all countries to strengthen mechanisms for effective cross-border surveillance and response.

Measures have already been put in place for EAC countries to ensure that Partner States engage each other in social and economic activities that benefit their citizens and act as regional economic bloc with ease of restricted movement of people, goods and livestock. The process of regional integration is progressing well at the moment as reflected by the encouraging progress of the East African Customs Union, the establishment of one-stop border posts, the signing in November 2009 and ratification in 2010 of the Common Market Protocol by all the Partner States. It is therefore critical that measures are put in place to ensure that cross-border transmission of diseases does not interfere with the current process of establishing a powerful and sustainable East African economic bloc.

Annex 1b of the International Health Regulations (IHR (2005)) mandates countries to establish capacities for disease surveillance and response at designated points of entry to minimize the risk of cross-border disease transmission. Article 57 of the IHR (2005) provides for collaboration of countries in regional blocs like the African Union (AU) and East African Community (EAC) to facilitate joint application of these regulations. Consequently, the African Union developed the Africa Health Strategy (2007 – 2015), which mandates Member States and regional economic communities to strengthen their
surveillance and preparedness plans for health disasters as well as prepare to implement the IHR (2005).

The East African Community Treaty under Articles 108 and 118 mandates the Community to coordinate the control of human and animal trans-boundary diseases. It is in this context that the EAC Partner States developed regional plan of action for the control of human and animal trans-boundary diseases in East Africa (2007-2012). The implementation of the plan is coordinated by the Animal and Human Health Desks of the EAC Secretariat. However, there have been no guidelines developed on how to implement cross-border surveillance in the region.

Other ongoing regional efforts to improve cross-border disease prevention and control in East Africa include the East African Integrated Disease Surveillance Network (EAIDSNet) project and the African Field Epidemiology Network (AFENET).

The “East African Integrated Disease Surveillance Network (EAIDSNet)” was established in 2000 with support from Rockefeller Foundation, as a regional collaborative effort of the national Ministries responsible for human and animal health as well as the national health research and academic institutions of the five (5) EAC Partner States. The goal of EAIDSNet is to reduce morbidity and mortality in the East African region through the generation of quality epidemiological information for early warning and response to impending outbreaks and epidemics and supporting joint planning and implementation of cross-border human and animal disease prevention and control measures. EAIDSNet is currently implementing activities to promote cross-border prevention and control of animal and human diseases as part of a Rockefeller funded project.

AFENET was set up in 2005, with support from CDC to establish a network of Field Epidemiology Training Programs in Africa as well as the Ministries of Health to ensure adequate capacities for disease surveillance and response in Africa.

Earlier initiatives for inter-country collaboration on cross-border surveillance were implemented by countries in the Great Lakes bloc as part of the WHO inter-country surveillance project during the period 2004-2007.

As the EAC embarks on developing a harmonized framework for cross-border surveillance in the region, experiences, expertise and infrastructure from earlier and ongoing cross-border initiatives will be resourceful in operationalizing and strengthening cross-border disease surveillance in the region.

The harmonized framework for operationalising and strengthening cross-border disease surveillance in the EAC will be supported by the East Africa Public Health Laboratory Networking Project (EAPHLN). This project seeks to establish a network of efficient, high quality, accessible public health laboratories for the diagnosis and surveillance of Tuberculosis (TB), and other communicable diseases. The first component of the project aims at improving regional diagnostic and surveillance capacity. To achieve this, the project will complement ongoing regional and global initiatives to improve Integrated Disease Surveillance and Response (IDSR) in the EAC member states. In order to promote cross-border surveillance, the project will reinforce laboratory networking and district capacity (particularly those in border areas) to report, investigate and adequately respond to disease outbreaks.

Disease surveillance efforts in the East Africa region have been hampered by the inability to detect and confirm etiology in a timely manner.
OBJECTIVES

General objective
To establish a harmonized consensus-based collaboration and implementation of cross-border disease surveillance (including other health disasters), joint outbreak investigation and response in border zones at high risk of disease outbreaks within the overall framework of the Protocol on East African Regional Corporation in Health.

SPECIFIC OBJECTIVES

1. Establish mechanisms for sharing surveillance data and epidemiological and other related information through periodic reports, newsletters, bulletins and other methods.

2. Set up cross-border Zonal disease surveillance and response committees to coordinate and implement cross-border interventions.

3. Develop common plans for cross-border surveillance, epidemic preparedness and joint outbreak response to facilitate sharing of information and laboratory and other resources, and synchronized outbreak response interventions within the border zones in the EAC.

4. Establish mechanisms for local community-based trans-boundary integrated human and animal (zoonotic) disease surveillance networks in cross-border settings in the EAC Partner States

5. Organize common training and sensitization sessions on Integrated Disease Surveillance (IDSR), International Health Regulations (IHR (2005)) and cross-border surveillance for HCWs, CHWs and other stakeholders in the identified border zones.

6. Joint designation of ground crossing points for the implementation of the International Health Regulations (IHR (2005)).

PROCEDURE FOR OPERATIONALIZING AND STRENGTHENING CROSS-BORDER SURVEILLANCE

All the cross-border surveillance activities will be moderated by the Regional Surveillance Technical Working Group (RSTWG) and the respective Country Surveillance Technical Working Group (CSTWG). The Health Desk at the EAC secretariat in collaboration with the East Central and Southern Africa Health Community (ECSA-HC) will play an oversight role by providing technical support to coordinate and harmonize implementation in the region.
The EAC technical working group on communicable and non-communicable disease which is a recognized policy development organ had already identified the list of priority animal and human diseases as follows:

<table>
<thead>
<tr>
<th>Epidemic prone diseases</th>
<th>Diseases targeted for eradication or elimination</th>
<th>Other major diseases, events or conditions of public health importance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Acute haemorrhagic fever syndrome*</td>
<td>1. Dracunculiasis</td>
<td>1. Diarrhoea in &lt;5 years</td>
</tr>
<tr>
<td>2. Cholera</td>
<td>2. Neonatal tetanus</td>
<td>2. HIV/AIDS (new cases)</td>
</tr>
<tr>
<td>3. Bacillary dysentery</td>
<td>3. (AFP) Poliomyelitis¹</td>
<td>3. STIs</td>
</tr>
<tr>
<td>5. Meningococcal meningitis</td>
<td>5. Oncocerciasis</td>
<td>5. Rabies (animal bites)</td>
</tr>
<tr>
<td>6. Plague</td>
<td>6. Trachoma¹</td>
<td>6. Pneumonia &lt;5 years</td>
</tr>
<tr>
<td>7. Typhoid fever</td>
<td></td>
<td>7. TB</td>
</tr>
<tr>
<td>8. Yellow fever</td>
<td></td>
<td>b. MDR/XDR-TB</td>
</tr>
<tr>
<td>9. Hepatitis E</td>
<td></td>
<td>8. Selected NCDs</td>
</tr>
<tr>
<td>10. Epidemic typhus</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Ebola, Marburg, Rift Valley, Lassa, Crimean Congo, West Nile Fever, Dengue haemorrhagic fever

Diseases or events of international concern

1. Human influenza due to a new subtype¹
2. SARS¹
3. Smallpox¹
4. Any public health event of international or national concern (infectious, zoonotic, food borne, chemical, radio nuclear, or due to unknown condition

¹Disease specified by IHR (2005) for immediate notification

East Africa Community trans-boundary priority animal diseases

- Highly pathogenic Avian Influenza
- Rift valley fever
- Trypanosomosis
- Rabies
- African Swine Fever (ASF)

It is notable that Rift Valley Fever, Rabies and Trypanosomosis are zoonotic diseases.

The criteria for selection of these diseases into the priority list of diseases was done through a consultative, consensus based processes that involved all the Partner States.
The criteria included the following: epidemic potential, targeted for eradication or elimination and disease of public health importance.

**ESTABLISHMENT OF CROSS-BORDER DISEASE SURVEILLANCE AND RESPONSE TEAMS**

The Technical working Group meeting on Communicable and non-communicable diseases had identified the districts that will collaborate in cross-border community-based animal and human disease surveillance in East Africa as follows:

<table>
<thead>
<tr>
<th>Country</th>
<th>Districts</th>
<th>Zone Number</th>
<th>Name of Satellite lab/s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rwanda</td>
<td>4-Nyagatare, Gicumbi, Musanze, Burera</td>
<td>1</td>
<td>Nyagatare District hospital and Byumba district hospital</td>
</tr>
<tr>
<td>Uganda</td>
<td>3- Kabale, Ntungamo, Kisoro</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uganda</td>
<td>3 - Isingiro, Rakai, Kalangala</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tanzania</td>
<td>10 - Mwanza, Bukoba, Karagwe, Musoma, Ukerewe, Magu, Sengerema, Geita, Biharamulo, Muleba</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Kenya</td>
<td>10 - Machakos, Kwea, Taita, Taveta, Narok South, Loitoktok, Kibwezi, Kajiado, Kuria East, Transmara</td>
<td>1</td>
<td>Machakos</td>
</tr>
<tr>
<td>Tanzania</td>
<td>9 - Lungido, Rombo, Sarne, Lushoto, Mkinga, Pemba, Sina, Tarime, Serengeti</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uganda</td>
<td>10 - Amudat, Napak, Kaabong, Moroto, Nakapiripirit, Kotido</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kenya</td>
<td>7 - Mt. Elgon, Kwanza, Trans Nzoia West, Turkana North, Turkana Central, Turkana South, West Pokot</td>
<td>1</td>
<td>Kitale</td>
</tr>
<tr>
<td>Uganda</td>
<td>14 - Bugiri, Busia, Namayingo, Buvuma, Tororo, Mbaale, Manala, Bududa, Bukwo</td>
<td>1</td>
<td>Busia</td>
</tr>
<tr>
<td>Kenya</td>
<td>12 - Bungoma West, Teso North, Samia, Busia, Bunyala, Ranieda, Bondo, Kisumu East, Kisumu West, Homabay, Migori, Suba</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Rwanda</td>
<td>3 - Nyagatare, Kayanza, Kirehe</td>
<td>1</td>
<td>Nyagatare District Hospital</td>
</tr>
<tr>
<td>Tanzania</td>
<td>3 - Ngara, Karagwe, Biharamulo</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Rwanda</td>
<td>3-Huye, Bugesera, Rusizi</td>
<td>1</td>
<td>Kirundo district hospital</td>
</tr>
<tr>
<td>Burundi</td>
<td>3- Kirundo, Kayanza, Cibitoke</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Country</td>
<td>District</td>
<td>Number</td>
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<td></td>
</tr>
<tr>
<td>Rwanda</td>
<td>1-Kirehe</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Tanzania</td>
<td>Ngara, Kigoma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Burundi</td>
<td>2-Muyinga, Nyanza</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Tanzania</td>
<td></td>
<td></td>
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</tbody>
</table>

From an epidemiological perspective the border population will be considered as one epidemiological zone since diseases do not respect the geopolitical boundaries made by man. It is therefore necessary to have structures for prevention, control and investigation of disease outbreaks occurring across the boundaries. In this regard, Cross-border surveillance committees will be set up in each of the designated cross-border surveillance zones. The committees will be established in the identified border zones and will have the mandate to share and discuss epidemiological information, inform the preparation of district plans for the health sector, plan and coordinate interventions, and share experiences and routine surveillance data.

THE CROSS-BORDER DSR COMMITTEE

The cross-border disease surveillance and response committee will draw membership from all districts in the border zone. Each district under the zone will contribute one technical officer who may be:

- The district focal person responsible for integrated disease surveillance and response
- The district focal person responsible for laboratory services
- The district medical officer of health or his appointee who will be a clinician
- The district focal person responsible for environmental health
- A senior health worker and member of a Hospital Management Team from the biggest health facility in the district

The team will also have:

- One focal person responsible for animal/wildlife health
- One local immigration official
- The local district commissioner or his appointee who will personally attend team meetings for consistency
The committee may co-opt other members depending on the disease profile of the zone and the disease outbreak/public health emergency they are handling. The cross-border disease surveillance committee will receive technical support from the regional authority responsible for health and the CSTWG.

The committees will hold routine quarterly meetings during the inter-epidemic period to review disease trends, other early warning systems, level of preparedness, progress on implementation of recommendations made by CSTWG, organize simulation exercises amongst others. In addition during emergencies the committee will meet as soon as an epidemic is identified and then weekly or fortnightly as the epidemic continues. The activities of the cross-border committees will be moderated by the respective CSTWG. Annex 1 describes the terms of reference for the cross-border surveillance committees. The cross-border surveillance committee will work very closely with the local immigration officials to facilitate movement of staff and equipment whenever necessary.

**DISTRICT RRTS**

Each district within the zone shall have an active RRT. The RRT will comprise of:

- A clinician
- A nurse
- A lab personnel
- A public health educator/officer
- A Health officer
- A veterinary officer
- A water engineer
- A health records officer
- An epidemiologist

The team may co-opt other members from time to time as the need may arise.

**MECHANISMS FOR SHARING EPIDEMIOLOGICAL INFORMATION**

Each of the districts in the identified border zones will select at least two health facilities located within the region and most likely handles patients from within the cross-border zone to be included in the cross-border surveillance. The number of health facilities included in the cross-border surveillance may be increased in a phased approach. These facilities will report on a weekly basis the priority diseases for cross-border surveillance to the district disease surveillance coordinator, who in turn will send weekly reports to the central MOH. The MOH will then submit the reports to the EAC epidemiologist.

Similarly laboratories in the selected health facilities in the border zones and the EAPHLNP supported laboratories will confirm the identified priority diseases and report this to the district disease surveillance coordinator who will then in turn forward these reports with the syndromic surveillance reports as above. This will form the basis of laboratory based surveillance.

In the long-term EAC will work with the countries to permit direct cross-border sharing of information alongside the above means. In the meantime, the cross-border districts shall
share informally disease outbreak/alert/rumour information among themselves and across boundaries.

Building on the well recognized success of Rwanda in ICT, the Republic of Rwanda in collaboration with the EAC will set up a cross-border surveillance database at EAC headquarters in Arusha, Tanzania. The EAC will therefore produce weekly reports on priority diseases that will be shared in all the EAC Partner States. In order to ensure sharing of epidemiological reports in real time, the framework for cross-border surveillance will set up mechanisms to ensure that information is shared rapidly between EAC Partner States. These mechanisms will include but will not be limited to sharing reports using either nationally approved or EAC harmonized reporting tools through periodic (immediate, daily, weekly, monthly or quarterly) reports, newsletters and bulletins. The Protocol for Regional Co-operation on Health should therefore make provisions that would enable rapid sharing of surveillance/epidemiological information with minimal bureaucratic approvals.

Epidemiological information on priority disease conditions will also be shared on a weekly and monthly basis using either nationally or EAC harmonized approved reporting tools and through a feasible mechanism agreed on by EAC member states.

The district disease surveillance coordinator will notify the counterpart in the cross-border zone, province & national levels and EAC Secretariat immediately (within 24 hours) once the alert and/or epidemic threshold for priority diseases have been passed. The means of communication used to notify these levels should be through the fastest and feasible means. Outbreak related information will not only include those reported in the facilities included for cross-border surveillance but rather the whole district. During outbreaks, affected countries will make efforts to avail daily or regular updates to the other EAC counterparts. With the ICT lead from Rwanda, we will explore possibilities of sharing confidential epidemiological information in a secure form among Partner States relevant authorities. This will also included development of a secure web portal for providing discussion forum, sharing information, posting interesting information etc. Quarterly surveillance bulletins will be developed to share epidemiological information as well as show-case work undertaken in implementing collaborative cross-border surveillance and response activities.

A patient with a notifiable disease detected in a country in which the case does not reside will be reported by the country in which the case has been detected; thus will be reported accordingly. A case of binational interest is one with an infectious disease that incubated in another country, or had contacts with persons in another country or a case in which there is need for joint investigations or management. Such cases will be reported in the cross-border surveillance system.

The cross-border surveillance committee in collaboration with the CSTWG will facilitate surveillance officers from a district in one country to short term assignments in the neighboring district in order to gain an in-depth understanding of the surveillance system in the neighboring district. This will include how handling of surveillance data, investigation of alerts, rumours etc.

During the implementation phase, the initial report sharing may be done using the nationally approved reporting formats. Eventually the respective CSTWGs with support
from the RSTWG, ECSA, and the EAC secretariat will meet to harmonize the reporting tools for immediate, daily, weekly, monthly and quarterly reporting. The same meeting will provide guidance on the feasible mechanisms for sharing the reports in real time among member states.

COMMUNITY BASED DISEASE SURVEILLANCE IN THE CROSS-BORDER ZONES

Organized groups of community health workers/units within the catchment area of the targeted health facilities will be identified and trained on community based disease/event surveillance, cross border surveillance and the priority diseases. They will collect information on priority diseases occurring within the community using lay case definitions and report to the disease surveillance focal person at the health facility who in turn forwards the reports to the district disease surveillance coordinator. These reports will then be forwarded through the normal channels that the syndromic and lab based surveillance systems are using. The community health workers will therefore be linked to health facilities. The community health workers will be supervised and trained by identified personnel who could be community strategy coordinator or the disease surveillance focal person/coordinator.

JOINT PLANNING FOR EPIDEMIC PREPAREDNESS, INVESTIGATION AND SYNCHRONIZED RESPONSE

Common plans for surveillance, epidemic preparedness joint outbreak investigation and response will be developed at the designated cross-border zones in the EAC. This activity will be undertaken by the designated cross-border surveillance committees with support from the respective CSTWGs and the satellite laboratory located in the zone. The plans will be financial support will be from the partners within the zone including the EAPHLN project for cross-border surveillance.

The MoHs of the EAC member states will designate IDSR Focal Persons (Surveillance Focal Persons) at district, regional(state, provincial) and national levels. Response to outbreaks will be coordinated by the zonal teams but implemented by RRTs.

Joint Rapid Response Teams will be constituted by the cross-border surveillance committees to ensure that all outbreaks in the designated zones are investigated with participation of experts from both countries. The joint rapid response teams will trained and equipped with outbreak investigation kits to facilitate the implementation of joint outbreak investigations as well as the initiation of synchronized outbreak response interventions on either side of the border.

Countries will also explore and implement mechanisms that will enable patients on long-term treatment who cross borders to access and use services in the country unhindered.

TRAINING DISTRICT TEAMS ON IDSR, IHR (2005) AND CROSS-BORDER SURVEILLANCE

The cross-border surveillance committees will organize common training sessions on Integrated Disease Surveillance (IDSR), International Health Regulations (IHR (2005)),
and cross-border surveillance for the districts located in the cross-border zones with the technical and financial assistance from the EAC.

ADOPTING THE WHO-AFRO IDSR TECHNICAL GUIDELINES (2010) BY MEMBER STATES IN THE EAC

All the EAC member states are using the IDSR strategy to control selected priority diseases. The strategy requires immediate notification of epidemic prone diseases as well as those targeted for eradication or elimination. This protocol in concert with the IDSR strategy and the IDSR technical guidelines and tools will facilitate border districts in the EAC to undertake immediate notification of immediately notifiable events to the national health authorities while at the same time relaying the same information to other members of the cross-border surveillance committee by telephone (messaging or voice call), e-mail, website, fax, or any other means available to rapidly share the information with other member countries in the EAC.

JOINT DESIGNATION OF GROUND CROSSING POINTS FOR IHR (2005) IMPLEMENTATION

The cross-border surveillance zones provide an opportunity for joint designation of ground crossing points for the implementation of the International Health Regulations (IHR (2005)). This will be applicable particularly for cross-border surveillance zones that encompass the EAC designated one-stop border posts in the region. The designated ground crossings will be supported to establish a competent public health authority to oversee the implementation of a set of agreed health interventions in line with the IHR (2005). The competent public health authority at designated ground crossing points will ensure water, sanitation, & food hygiene standards, as well as proper waste disposal. Additionally, first aid & ambulance services as well as screening for and conducting Yellow Fever vaccination will be undertaken. The decision instrument will be used in reporting public health events of international concern.
DECISION INSTRUMENT FOR THE ASSESSMENT AND NOTIFICATION OF EVENTS THAT MAY CONSTITUTE A PUBLIC HEALTH EMERGENCY OF INTERNATIONAL CONCERN

Events detected by national surveillance system (see Annex 1)

- A case of the following diseases is unusual or unexpected and may have serious public health impact, and thus shall be notified:
  - Smallpox
  - Poliomyelitis due to wild-type poliovirus
  - Human influenza caused by a new subtype
  - Severe acute respiratory syndrome (SARS)

- Any event of potential international public health concern, including those of unknown causes or sources and those involving other events or diseases than those listed in the box on the left and the box on the right shall lead to utilization of the algorithm.

- An event involving the following diseases shall always lead to utilization of the algorithm, because they have demonstrated the ability to cause serious public health impact and to spread rapidly internationally:
  - Cholera
  - Pneumonic plague
  - Yellow fever
  - Viral haemorrhagic fevers (Ebola, Lassa, Marburg)
  - West Nile fever
  - Other diseases that are of special national or regional concern, e.g., dengue fever, Rift Valley fever, and meningococcal disease.

Is the public health impact of the event serious?

Is the event unusual or unexpected?

Is there a significant risk of international spread?

Is there a significant risk of international travel or trade restrictions?

EVENT SHALL BE NOTIFIED TO WHO UNDER THE INTERNATIONAL HEALTH REGULATIONS

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1 As per WHO case definitions.
2 The disease list shall be used only for the purposes of these Regulations.
MONITORING OF IMPLEMENTATION

Basing on the priority activities, a set of indicators will be developed and used for tracking progress/identifying gaps, sharing information/knowledge/experiences/expertise among all stakeholders. The proposed indicator will include but will not be limited to the following: number of cholera outbreaks occurring in border districts for with laboratory confirmation; number of outbreaks investigated by the joint rapid response teams; number of quarterly epidemiological bulletins published and shared; and the number of meetings held by the cross-border surveillance committees.

COST ESTIMATES

The table below shows the estimated costs for each part of the proposed project. The estimates cover an implementation period of five years (60 months).

**Summary Budget**

<table>
<thead>
<tr>
<th>PARTICULARS</th>
<th>TOTAL (USD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Sharing of epidemiological information through publication of (weekly,</td>
<td>15,000</td>
</tr>
<tr>
<td>monthly or quarterly) newsletters and bulletins.</td>
<td></td>
</tr>
<tr>
<td>2. Set up cross-border surveillance committees and facilitate them to</td>
<td>80,000</td>
</tr>
<tr>
<td>convene routine quarterly meetings as well as monthly meetings during</td>
<td></td>
</tr>
<tr>
<td>outbreaks.</td>
<td></td>
</tr>
<tr>
<td>3. Establish community based disease surveillance system in the cross-</td>
<td>50,000</td>
</tr>
<tr>
<td>border zone.</td>
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<tr>
<td>4. Facilitate the Joint Rapid Response Teams to conduct cross-border</td>
<td>30,000</td>
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<tr>
<td>outbreak investigations and response.</td>
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<tr>
<td>5. Organize common training sessions on Integrated Disease Surveillance</td>
<td>50,000</td>
</tr>
<tr>
<td>(IDSR), International Health Regulations (IHR (2005)), and cross-border</td>
<td></td>
</tr>
<tr>
<td>surveillance for the districts located in the cross-border zones.</td>
<td></td>
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<tr>
<td>Including supporting countries to adapt IDSR technical guidelines</td>
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<tr>
<td>GRAND-TOTAL</td>
<td>225,000</td>
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</table>

FINANCING OF THE PROTOCOL

This proposal will be financed using funds made available from the project for cross-border surveillance activities.

<table>
<thead>
<tr>
<th>Ref. No.</th>
<th>Activity</th>
<th>Expected Outcome</th>
<th>Indicator</th>
<th>Timeline</th>
<th>Responsible Person</th>
<th>Amount ($USD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Establish cross-border committees for the designated cross-border surveillance zones</td>
<td>1. Cross-border committees established</td>
<td>No. functional cross-border committees</td>
<td>Jan 2012</td>
<td>RSTWG in the EAC</td>
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<tr>
<td>2</td>
<td>Establish community based disease surveillance</td>
<td>1. Identify community health workers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Train community health workers on community based disease surveillance, cross-border surveillance and IDSR</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>3. Print reporting tools for community based surveillance</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>3</td>
<td>Joint designation of ground crossing posts for the implementation of the IHR (2005)</td>
<td>1. Ground crossing ports designated for IHR implementation</td>
<td>No. of designated ground crossing points</td>
<td>June 2012</td>
<td>Respective CSTWG</td>
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<tr>
<td></td>
<td></td>
<td>2. Competent public health authority established to enforce water, sanitation, &amp; food hygiene, proper waste disposal; first aid &amp; ambulance services as</td>
<td>No. of designated ground crossings with competent public health authority</td>
<td></td>
<td>EAC, EAC, ECSA-HC</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Share epidemiological information on immediate, daily, weekly, monthly and quarterly basis</strong></td>
<td><strong>Reports shared between EAC states</strong></td>
<td><strong>- No. weekly reports shared</strong>&lt;br&gt;<strong>- Number of quarterly epidemiological bulletins shared</strong></td>
<td><strong>Cross-border surveillance teams</strong>&lt;br&gt;<strong>Change to designated people</strong></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>4</td>
<td><strong>Annual planning meetings to develop plans for cross-border surveillance and response</strong></td>
<td><strong>Annual planning meeting held</strong></td>
<td><strong>- Annual plan available to guide implementation</strong></td>
<td><strong>Feb 2012</strong>&lt;br&gt;<strong>Cross-border surveillance teams</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td><strong>Quarterly meetings by the cross-border surveillance committees</strong></td>
<td><strong>Quarterly meetings held</strong></td>
<td><strong>- Quarterly performance report</strong></td>
<td><strong>Quarterly</strong>&lt;br&gt;<strong>RSTWG, Cross-border surveillance teams, Regional IDSR FPs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td><strong>Emergency meetings by the cross-border surveillance committees during epidemics</strong></td>
<td><strong>Emergency cross-border meetings held</strong></td>
<td><strong>Minutes of emergency meetings</strong></td>
<td><strong>CSTWG, Cross-border surveillance teams, Regional IDSR FPs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td><strong>Establish joint cross-border outbreak investigation teams</strong></td>
<td><strong>Cross-border RRT established</strong></td>
<td><strong>No. functional cross-border RRTs</strong></td>
<td><strong>March 2012</strong>&lt;br&gt;<strong>CSTWG, Regional IDSR FPs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td><strong>Facilitate the joint cross-border rapid response teams to investigate outbreaks</strong></td>
<td><strong>Outbreak response kits available</strong>&lt;br&gt;<strong>Emergency fund set up</strong></td>
<td><strong>- No. kits procured</strong>&lt;br&gt;<strong>- Amount of funds used for outbreak response</strong></td>
<td><strong>March 2012</strong>&lt;br&gt;<strong>CSTWG, Cross-border surveillance teams, Regional IDSR FPs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td><strong>Establish stockpiles of supplies for outbreak investigation and response</strong></td>
<td><strong>Stockpiles of lab supplies availed</strong>&lt;br&gt;<strong>Stockpiles of outbreak</strong></td>
<td><strong>No. of cross-border zones with lab and drug stockpiles</strong></td>
<td><strong>April 2012</strong>&lt;br&gt;<strong>CSTWG, Cross-border surveillance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>including an emergency fund</td>
<td>response supplies &amp; drugs availed</td>
<td>teams, Regional IDSR FPs</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>11</td>
<td>Organize common training sessions on IDSR, IHR (2005) and cross-border surveillance</td>
<td>Training meetings held</td>
<td>No of training meetings held</td>
<td>May 2012</td>
<td>RSTWG, EAC, ECSA-HC</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>EAC to support countries to adapt the WHO AFRO IDSR technical and incorporate EAC surveillance guidelines</td>
<td>Meetings to adapt the IDSR technical guidelines</td>
<td>- Number of countries supported to adapt IDSR guidelines</td>
<td>May 2012</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
ANNEX 1: TERMS OF REFERENCE FOR CROSS-BORDER SURVEILLANCE COMMITTEES

IDENTIFICATION

Each of the DHTs in the designated cross-border surveillance zones will nominate one member to the joint cross-border surveillance committee. The member will be either:

- The district focal person responsible for integrated disease surveillance and response
- The district focal person responsible for laboratory services
- The district medical officer of health or his appointee who will be a clinician
- The district focal person responsible for environmental health
- A senior health worker and member of a Hospital Management Team from the biggest health facility in the district

The districts will coordinate the nomination of these members to ensure adequate and diverse representation of the relevant health cadres.

The team will also have:

- One focal person responsible for animal/wildlife health
- One local immigration official
- The local district commissioner or his appointee who will personally attend team meetings for consistency

The committees may also co-opt other members from time to time as may be necessary. For proper functioning and continuity, it is desirable that the committee members are nominated as individuals and not the offices they hold.

FUNCTIONS

These will include but will not be limited to:

- Developing annual plans to guide implementation of committee and RRTs activities
- Developing EPR plans
- Carrying out situation analysis of all resources available in the zones and develop a data bank of the resources
- Organizing routine quarterly and emergency meetings of the committee
- Overseeing surveillance and response activities at designated ground crossing points
- Working with DHTs to ensure formation/activation of district RRTs
- Ensuring adequate stockpiles of lab supplies and medicines for outbreak investigation and response
- Sending immediate, daily, weekly, monthly and quarterly reports to the CSTWGs during outbreaks of diseases, conditions and other health events
- Supporting the rapid response teams to undertake outbreak investigation and response activities
- Organising trainings of district teams in collaboration with the CSTWGs

EMOLUMENTS

Members of the cross-border surveillance teams will be entitled to emoluments as per project guidelines and as will be deemed fit by the CSTWG.

REPORTING

The cross-border surveillance committees will report to the respective CSTWGs regarding their activities. This will entail maintaining and availing records of minutes, plans and such other documents as may be needed for monitoring and evaluation.
The members of the regional surveillance technical working group listed below participated in the drafting and revising this document:

<table>
<thead>
<tr>
<th>Name</th>
<th>Designation</th>
<th>Institution</th>
<th>City, Country</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Ssempebwa John</td>
<td>Rep. FELTP Training Program</td>
<td>Makerere University School of Public Health</td>
<td>Kampala, Uganda</td>
</tr>
<tr>
<td>Makumbi Issa</td>
<td>Asst. Commissioner/Head of Epidemiology and Surveillance</td>
<td>Ministry of Health</td>
<td>Kampala, Uganda</td>
</tr>
<tr>
<td>Jennifer Wandawa</td>
<td>District Surveillance Coordinator/SNO</td>
<td>District Health Office</td>
<td>Mbale, Uganda</td>
</tr>
<tr>
<td>Atek Kagirita</td>
<td>Head of Reference Lab/Bio safety Officer</td>
<td>Central Public Health Lab/MOH</td>
<td>Kampala, Uganda</td>
</tr>
<tr>
<td>Robert Downing</td>
<td>Lab Director</td>
<td>CDC</td>
<td>Entebbe, Uganda</td>
</tr>
<tr>
<td>Dr. Bwire Godfrey</td>
<td>Senior Medical Officer</td>
<td>Ministry of Health</td>
<td>Kampala, Uganda</td>
</tr>
<tr>
<td>Dr. Daniel Kibet Lang’at</td>
<td>Assistant Director of Medical Services</td>
<td>Ministry of Public Health and Sanitation</td>
<td>Nairobi, Kenya</td>
</tr>
<tr>
<td>Dr. Willis Akhwale</td>
<td>Head, Disease Prevention Control</td>
<td>Ministry of Public Health and Sanitation</td>
<td>Nairobi, Kenya</td>
</tr>
<tr>
<td>Dr. Jane Wasike</td>
<td>Head, National Public Health Labs Services</td>
<td>Ministry of Public Health and Sanitation</td>
<td>Nairobi, Kenya</td>
</tr>
<tr>
<td>Dr. Chris Masila</td>
<td>Project Coordinator</td>
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<td>Nairobi, Kenya</td>
</tr>
<tr>
<td>Dr. Willie A. Githui</td>
<td>Chief Research Officer</td>
<td>KEMRI</td>
<td>Nairobi, Kenya</td>
</tr>
<tr>
<td>Dr. Omar S. A</td>
<td>PhD Malaria –</td>
<td>KEMRI</td>
<td>Nairobi, Kenya</td>
</tr>
<tr>
<td>Dr. Joyce Onsongo</td>
<td>DPC</td>
<td>WHO</td>
<td>Nairobi, Kenya</td>
</tr>
<tr>
<td>Dr. Mbithi Philip</td>
<td>District Medical Officer of Health</td>
<td>Ministry of Public Health &amp; Sanitation</td>
<td>Kitale, Kenya</td>
</tr>
<tr>
<td>Dr. Joe Oundo</td>
<td>Resident Lab Advisor/Deputy Lab Director</td>
<td>CDC- Kenya</td>
<td>Nairobi, Kenya</td>
</tr>
<tr>
<td>Name</td>
<td>Position</td>
<td>Affiliation</td>
<td>Location</td>
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<tr>
<td>Dr. Wanzala Peter</td>
<td>Research Scientist</td>
<td>KEMRI</td>
<td>Nairobi, Kenya</td>
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<td>Dr. Mutonga David</td>
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<td>Barry Fields</td>
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<td>Charles Njuguna</td>
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<td>Bernard N. Muture</td>
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<td>Florah Mwanjama</td>
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<tr>
<td>Dr. Thierry Nyatanyi</td>
<td>Ag. Director of Epidemic Infectious Diseases</td>
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</tr>
<tr>
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<tr>
<td>Dr. Marie Aimee Muhimpundu</td>
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<td>Tukae A. Lisso</td>
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<td>Leonard E. Mboera</td>
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<td>Sibusiso Sibandze</td>
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<td>ECSA-HC</td>
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<tr>
<td>Dr. Maurice Ope</td>
<td>Disease Surveillance &amp; Epidemiology Officer</td>
<td>East African Community Secretariat</td>
<td>Arusha, Tanzania</td>
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REFERENCES


ANNEX III

List of priority diseases

<table>
<thead>
<tr>
<th></th>
<th>Frequency of Reporting</th>
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<tbody>
<tr>
<td>1</td>
<td>Acute haemorrhagic fevers</td>
</tr>
<tr>
<td>2</td>
<td>Cholera</td>
</tr>
<tr>
<td>3</td>
<td>Yellow fever</td>
</tr>
<tr>
<td>4</td>
<td>Measles</td>
</tr>
<tr>
<td>5</td>
<td>Plague</td>
</tr>
<tr>
<td>6</td>
<td>(AFP) Poliomyelitis¹</td>
</tr>
<tr>
<td>7</td>
<td>Bloody diarrhoea</td>
</tr>
<tr>
<td>8</td>
<td>Cerebro-spinal meningitis</td>
</tr>
<tr>
<td>9</td>
<td>Neonatal tetanus</td>
</tr>
<tr>
<td>10</td>
<td>Rabies (animal bites)</td>
</tr>
<tr>
<td>11</td>
<td>Malaria</td>
</tr>
<tr>
<td>12</td>
<td>Typhoid fever</td>
</tr>
<tr>
<td>13</td>
<td>Diarrhoea in children &lt;5 years</td>
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</tbody>
</table>

¹ AFP: Acute Flaccid Paralysis