CROSS BORDER DISEASE SURVEILLANCE TECHNICAL MEETING BETWEEN THE REPUBLIC OF KENYA REPUBLIC OF SOUTH SUDAN AND REPUBLIC OF UGANDA

EAST AFRICA PUBLIC HEALTH LABORATORY NETWORKING PROJECT (EAPHLNP)

MEETING REPORT

24TH TO 26TH APRIL 2018
ROYAL PALACE HOTEL, NIMULE TOWN, SOUTH SUDAN

Collaboration of the ECSA-HC, EAC and WHO

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1.0 Introduction

All Partner States of the East African Community (Burundi, Kenya, Rwanda, South Sudan, Tanzania and Uganda) implement the WHO-developed Integrated Disease Surveillance and Response (IDSR) strategy. This provides standards for case and outbreak detection, collection and reporting of disease surveillance data on a list of priority diseases from community to national levels; preparedness, investigation; and response to disease outbreaks; and feedback at all levels. The International Health Regulations (IHR2005) are a set of legal provisions that all countries are expected to apply to contain diseases with potential to spread across borders in the states of origin with minimal interference with international travel and trade.

Through the ministries responsible for human and animal health, the EAC partner states are collaborating to implement the "East African Integrated Disease Surveillance Network (EAIDSNet)" which promotes harmonization, capacity-building and exchange of best practices of integrated disease surveillance and response (IDSR) in the region. In addition, the East African Community is collaborating with the EAC Partner States, the East, Central and Southern Africa Health Community Secretariat (ECSA-HC), the World Health Organization (WHO) and the Centers for Disease Control and Prevention (CDC) and other partners in the implementation of the World Bank supported "East Africa Public Health Laboratory Networking Project (EAPHLNP)" which also contributes to the strengthening of the EAIDSNet. The EAPHLNP main purpose is to establish a network of efficient, high quality, accessible public health laboratories for the diagnosis and surveillance of IDSR priority diseases including Tuberculosis (TB) and other communicable disease, with emphasis to cross-border areas.

In 2011, EAIDSNet in collaboration with EAPHLNP demarcated the borders of East Africa into 9 Surveillance Zones. Each comprises of districts or equivalent administrative units from either side of the border. These select a multi-disciplinary and multi-sectoral team that assists to oversee cross-border disease control activities. Through trust-based exchange of both formal and informal information, they help health and administrative systems to respond to health events that could cross borders and constitute Public Health Emergencies of International Concern. The demarcation of cross-border surveillance zones was done before the Republic of South Sudan had joined the EAC; therefore none was formed along the border between the Republics of South Sudan and Uganda; and between the Republic of South Sudan and the Republic of Kenya. The need for demarcation of cross-border surveillance zones and formation of their committees along the border between the two countries is however recognized by all stakeholders.

1.2 Convening of the meeting

The East African Community, ECSA-HC through the East Africa Public Health Laboratory Networking project, the Ministry of Health of Uganda, the Ministry of Health Republic of South Sudan, the Republic of Kenya, and the World Health Organization convened a cross border meeting between the Republic of Uganda, Republic of Kenya, and the Republic of South Sudan in Nimule, South Sudan from 24th to 26th April 2018.

1.3 Meeting Participants

The meeting involved districts/counties and sub-counties in Uganda, Kenya, and South Sudan along the border. The representations involve participants from human, animal, environmental health and immigration. The list of participants is hereto attached as **Annex I.**

1.4 Constitution of the Bureau

In accordance with the Rules of Procedure of the East African Community, all EAC meetings are chaired by the Republic of Uganda and the Republic of Rwanda serves as the rapporteur in the year 2018. Since the Republic of South Sudan was hosting the meeting, the Republic of South Sudan was requested to chair while the Republic of Uganda was the official rapporteur assisted by the EAC and ECSA-HC secretariat. **Dr. Pinyi Nimol,** Director General for

Preventive Health services from the Republic of South Sudan chaired the meeting while **Mr. Atek Kagirita**, Disease Surveillance Coordinator from Ministry of Health Uganda was the official Rapporteur.

1.5 Adoption of the Agenda and Program of the Meeting

The agenda and program of the meeting were adopted with some amendments. The amended program is hereto attached as **Annex II**.

1.6 Opening remarks

South Sudan, Nimule Town

Dr. Augustine Okwahi, Director of Health Nimule Town,

Dr Augustine welcomed the delegates to Nimule Town. He was delighted to host the cross border meeting in Nimule and noted that the people of South Sudan and Nimule in particular were exited that such an important meeting.

ECSA-HC

Dr. Willy Were on behalf of the Director General of ECSA-HC welcomed all the participants to the meeting. He noted that diseases don't know borders therefore neighbouring countries need to work together and strengthen disease surveillance across the borders. He wished the participants fruitful meeting and implementable deliberations.

EAC

Dr. Stanley Sonoiya on behalf of the Secretary General of EAC, commended ECSA-HC for organizing a joint cross border meeting between Kenya, Uganda and South Sudan. He appreciated the state of Torit for waiving visa for the delegates. He indicated that EAC will be donating the mobile laboratory to South Sudan through the Germany funded project and there will be opportunities for laboratory scientists to be trained in Germany. He highlighted the need for exchange visits between the countries to facilitate inter-country learning. He wished participants fruitful meeting and noted that the recommendation will be channeled through the EAC Council of Ministers

World Health Organization

Dr. Joseph Wamala on behalf of the WHO South Sudan welcomed all the delegates to the meeting. He conveyed a message from the WHO Country office, which indicated that, due to increased cross border movement of people, animals and goods the risk of infectious diseases spreading is inevitable. He further noted that infectious diseases have negative impacts economically and socially therefore urged surveillance officer to strengthen surveillance system and conduct evidence based surveillance. He wished the participants fruitful deliberations.

The Republic of Kenya

Dr. Lindah Makayotto, thanked ECSA-HC, EAC, and WHO for organizing the meeting and the republic of South Sudan for hosting. She stated that Kenya is committed to implement the regional collaborative initiatives such as cross border disease surveillance. She appreciated ECSA-HC, EAC and the Regional Disease Surveillance TWG for leading the development of the framework for cross border surveillance and emphasized on the need for EAC countries to find solutions to their own problems.

The Republic of Uganda

Dr. Atek Kagirita, expressed his gratitude to the South Sudan government for hosting the meeting and facilitating smooth entry in the country for the important mission. He underscored the importance of the meeting and further noted that the relationship between Uganda and Southern Sudan has been growing stronger and stronger. He urged countries to work together when targeting disease for elimination.

Official Opening Remarks from the Republic of South Sudan

Dr. Pinyi Nyimol, Director General for Preventive Health Services, Republic of South Sudan

Dr Pinyi acknowledged the importance of the meeting and highlighted some outbreaks that South Sudan has experienced such as Ebola, Rift Valley Fever and called upon countries to establish collaboration and jointly work together to improve disease surveillance across the borders. He noted that South Sudan had inherited weak health systems especially the laboratory services and therefore requested other countries to support

2.0. Meeting objectives

The broad objective is to assessing the current strategies; identify challenges and formulate future plans of improved disease preparedness and response measures between the three states.

2.1. Specific objectives;

1. To discuss country specific strategies for disease surveillance, prevention, preparedness, response, and containment of epidemic prone diseases
2. To assess current national capacities for cross-border disease/ event surveillance and outbreak prevention and response
3. Develop a common plan for cross-border surveillance, epidemic preparedness, and joint outbreak investigation and response
4. To establish inter-country (cross-border) disease surveillance zones and a response committee in each zone to coordinate and implement disease control and management interventions along the border.
5. To establish mechanisms for regular and rapid sharing of epidemiological information and data between counties and districts in the cross-border surveillance zones to facilitate early initiation of investigation, preparedness, and response interventions to prevent widespread cross-border disease outbreaks
6. To orient participants in IDSR/ IHR country requirements for PoE to enhance regional public health security.
7. Present a strategy for enhancing cross-border surveillance, reporting, investigation, and joint cross-border micro planning and vaccination (reactive/SIAs) for polio and measles among international travelers; mobile cross-border populations; unreached/hard to reach border populations.
8. Enhance surveillance and response to neglected tropical diseases in cross-border populations.
9. Explore mechanisms to trace lost for follow-up cases specifically those on ant-TB treatments and on ART who have crossed the border to Uganda and to Kenya.

2.2. Expected Outcomes

1. Country specific strategies for disease surveillance, prevention, preparedness, response and containment of epidemic prone diseases discussed
2. Current cross-border disease/ event surveillance and response capacities and needs assessed using a desk review process
3. Common plan for cross-border surveillance and response developed to facilitate establishment of core capacities for enhanced regional public health security.
4. Inter-country (cross-border) surveillance committees for disease control and outbreak management established in each disease surveillance zone.
5. Participants oriented in IDSR/ IHR country requirements for enhanced regional public health security.
6. A system of networking and regular sharing of epidemiological data among stakeholders in the surveillance zones established.
7. Strategy established for enhancing cross border case based surveillance, reporting, investigation, and response for suspect polio and measles in high-risk cross-border communities.

8. Harmonized strategy for cross-border surveillance and response to neglected tropical diseases in cross-border populations.
9. Mechanism put in place to trace lost for follow-up cases specifically those on ant-TB treatments and on ART in collaboration with the national ministries, WHO, UNHCR, and UNAIDS.

3.0 Consideration of various agenda items

3.1. Overview of EAPHLN Project (Regional Perspective)

The Monitoring and Evaluation Specialist, ***Dr. Mushi Benedict*** made a presentation on the progress made in implementation of the EAPHLN Project at the regional level. The presentation highlighted achievements in the following areas: (i) strengthened laboratory services delivery including accreditation; (ii) Established mechanisms for cross-border disease surveillance and response; (iii) implemented multi-country and national research studies (Malaria, Enteric and TB); (iv) built capacity to deliver high quality laboratory and other health services; v) engaged in more partnerships; vi) developed new platforms for information, knowledge and experience sharing.

The meeting acknowledged the project efforts in strengthening disease surveillance and laboratory Networking in East Africa Region; and noted that;

i. South Sudan laboratories systems requires strengthening to effectively support diagnostic work and disease management as well as surveillance.
ii. Limited capacity of National Public Health Laboratory in Juba, and other levels in South Sudan

Recommended that;

i. EAC and ECSA-HC Secretariat to support South Sudan to put up a concept note for joining the East African Public Health Laboratory Networking Project so that laboratories can be supported to accreditation.

3.2 Country updates and progress in implementing EAPHLNP activities including IDSR

Kenya, Dr. Lyndah Makayotto, Medical Epidemiologist

Constructions of five satellite sites under the old financing have been completed and the laboratories are operational. The construction of MTRH and Marsabit have been awarded and expected to begin in May 2018. An isolation unit for highly infectious cases will be constructed in MTRH (contract awarded). Regional peer assessment was conducted in April 2018 with all the laboratories in the original project attaining 3 stars. National Microbiology Reference Lab received ISO: 15189 Accreditation. A total of 2,692 staff have trained during the course of the project out of a target of 3,879 as of April 2018. The project successfully completed three studies for TB, Malaria and Enterics. Published multiple articles (>10) in journals. Conducted RVF and Avian Influenza Outbreak Simulation Exercise supported by FAO. The country is in the process of developing NAPHS following Joint External Evaluation (JEE) for IHR/GHS held in March 2017. Since 1st Jan 2018, 2,534 cases of cholera and 53 deaths (CFR 1.2%) have been reported nationally. The outbreak was confirmed by lab testing.

Uganda, Atek Kagirita, Surveillance Coordinator

The JEE conducted in Uganda 2017 indicated that the country has developed impressive capacities in surveillance, laboratory, emergency response operations, and risk communication. However there is critical need for continued and expanded multi-sectoral communication and coordination and kick-start the efforts to designate and strengthen IHR core capacities at PoEs. The burden of infectious diseases is still high; particularly cholera has been occurring every year. MDR TB cases in Uganda were reported to have increased between 2012 and 2016, particularly

the North. He highlighted the burden of NCD and NTDs is high: cancer -incidence of 5000 cases registered at UCI per year; diabetes prevalence 2.7% males, 3% females; overweight 18.6% and Obesity 3.9% (WHO). Nodding disease Pader 806, Kitgum 544, Lamwo 339, Gulu 323, Amuru 58 and Lira (*MoH, 2018*). Onchocerciasis is estimated at 1.3M in 2 localised zones.

The meeting noted the following issues:

i. Lack of Port Health Services in South Sudan and Uganda
ii. Limited cross border collaboration in disease surveillance between the EAC Countries and the neighbouring states
iii. MDR TB on the rise in the region especially among the refugee settlements

Recommendations:

i. The Republic of South Sudan and the Republic of Uganda with the support of the EAC and ECSA-HC are urged to establish Port Health Services at various ports of entry
ii. EAC Partner States are urged to enhance control of MDR-TB, including case detection, case management and contact tracing.

3.3. International Health Regulations (IHR) and the need for cross-border disease surveillance mechanisms

Dr Joseph Wamala made a presentation providing orientation on the International Health Regulations (2005). The presentation covered the key fundamental elements of IHR (2005), requirements for Port of entry i.e. core capacity requirements and obligations for airports, ports and ground crossings; Public health measures including technical requirements for Vaccination, prophylaxis and related certificates, technical requirements for conveyance and conveyance operators, special provisions for conveyances and conveyance operators, travelers, provisions for goods, containers and container loading areas. The presentation also highlighted key challenges for points of entry, travelers and conveyance operators.

Issues/concerns raised:

i. Counterfeit certificates for yellow fever vaccination are in circulation across the region
ii. Absence of Quarantine facilities for animals and human at the points of entry (PoE)
iii. Restriction of movement of surveillance officers across borders due to visa requirement may hinder surveillance and other EPR activities
iv. Lack of disease surveillance personnel at points of entry in some Partner States
v. Delayed declaration of disease outbreaks

Recommendation

i. Urge the EAC Partner states urged waive on visa requirements for teams on joint surveillance, emergency preparedness and response missions in order to enhance cross-border collaboration
ii. EAC Partner States urged to establish quarantine facilities for animals and isolation units for humans at the designated border crossing points (Points of Entry).
iii. EAC, ECSA-HC, WHO and other partners to support countries to develop guidelines for declaration of animals crossing borders that may adopted by the Partner States to guide movement on animals across border in light of disease management
iv. EAC Member states should consider establishing a system for more accurate verification mandatory vaccination certificates to avoid counterfeits. Consideration of issuance of electronic certificate documents that may display the details of the traveller and the vaccines the traveller has been covered against.

3.4. Regional Contingency Plan
Dr Willy Were

Due to the many hazards threatening public health in East Africa, the EAC TWG for Communicable and Non communicable diseases recommended to have a regional contingency plan for emergency preparedness and response. With World Bank funding, ECSA-HC, through the EAPHLNP, supported the development of the multi-hazard contingency plan, which aims to provide procedures for a harmonized regional contribution to preparedness against and response to health events. The plan bases on the principle of One Health in dealing with health emergencies in the region. The plan is triggered by the coordinator of national emergency management team of the affected country, who may request for regional assistance from the regional incidence commander—the EAC Secretary General, who through the Regional Coordinator, may then deploy the multi-disciplinary, Rapid Response Team. After the emergency has been brought under control, it is the Secretary General who may de-activate the plan.

Issues:

i. One Heath is easier mentioned than really practiced. While at ministry level officials from different sectors may work together, lower down the scale it is not seen.
ii. There is sometimes confusion on determining the sector that should take the lead during emergencies, especially those of zoonotic diseases
iii. The private sector is not involved in emergencies, yet they should

Recommendations

i. EAC Partner States are urged to strengthen their One Health initiatives. One Health should be seen to be practiced even before the emergencies occur.
ii. EAC Partner States are urged to develop Standard Operating Procedures should be developed to guide response to emergencies.

3.5. Progress in Implementation of IDSR/IHR (2005) in the cross-border districts/sub-counties

Uganda
The burden of infectious diseases is high. Malaria, coughs, pneumonia are high on the list. Some districts have had disease outbreaks in the last year but others did not. While some districts experienced outbreaks of infectious diseases (Adjumani had meningitis and cholera in 2014 and 2016 respectively, while Lamwo did not have any.

Samples from suspected cases are transported to national referral laboratories through the Hub system, and results returned through the same route. Investigations to rule out VHF (1) AFP (9), measles (16) and meningitis (6) were conducted in Lamwo. To strengthen disease surveillance, and cross-border data sharing, training of community health workers in transboundary districts has been initiated.

The challenges faced in disease control included: inadequate system for sharing data across the border; inadequate quantities of medicines, vaccines and supplies as the influx of refugees overwhelms planned quantities; inadequate knowledge and skills of some health workers on IDSR/IHR; inadequate access to ICT and poor culture of use of data at points where the data are collected.

To improve control of diseases in the trans-boundary areas, there is a need to:

i. Develop a comprehensive One Health strategic plan for cross border disease control for the zone, taking care of the needs of the districts, states and sub-counties
ii. Support a plan for capacity building for all cadres of health workers involved in disease control activities. This should include simulations.
iii. Avail more financial resources for disease activities, to implement all planned preparedness, prevention and response activities
iv. Challenges with reliability of power to support electronic IDSR and reliable internet connection.

Kenya, Patrick Kelengwe, Disease Surveillance Officer, Turkana West Sub-county

In this part of Kenya the burden of infectious diseases is very high. Top ones reported are: cholera, dog bites, malaria, tuberculosis, Upper respiratory tract infection (URTI), Urinary tract infection (UTI), Hepatitis B, and diarrhea. Acute malnutrition is also common. Anthrax and brucelossis are common animal conditions. The region also experiences the Neglected Tropical Diseases including: Kala Azar, trachoma, hydatid and myecetoma. In 2016 outbreaks of cholera, scurvy and Hepatitis B were reported.

To control the epidemics, a multi-pronged multi-sectotral approach has been implemented. Interventions have included: strengthened disease surveillance; vaccinations; integrated outreaches; and mass immunization campaigns.

The challenges faced in controlling diseases in this part of the country include: the high mobility of pastoralist communities; inadequacy of health facilities and laboratories in this trans-boundary area; inadequate supply of potable water; inadequate financial resources; poor information sharing on cross border disease control and prevention activities and poor road network.

To have a better system of disease control in this region, it is suggested to:

i. Strengthen cross-border sharing of data and implement joint activities for surveillance, prevention, preparedness and response to health events.
ii. Increase funding for disease control in this border area.

The meeting reviewed the presentations and noted that:

i. The front-line health workers sometimes lack the necessary competencies to control disease outbreaks
ii. Laboratories are very important components of disease control in this trans-boundary region.
iii. Cross-border disease control activities are limited.
iv. There are no joint guidelines/plans for disease control across the border

Recommendations

i. The Ministries of Health and local governments should advocate for increased funding to avail resources to strengthen cross-border disease surveillance. The private sector could be a possible source of resources.
ii. Ministries of Health should step up staff training, that should be continual and targeted to the needs in the local zone
iii. Zonal committees to develop strong mechanisms for sharing data across the borders.
iv. Urged the EAC Partner states are urged engage with energy providers (electricity) and communication to provide reliable supply so as to enhance electronic disease surveillance and sharing of information across borders

3.6. Review of surveillance for AFP, Neglected Tropical Diseases in transboundary areas – Kenya, Uganda, and South Sudan

The Kenya, South Sudan, and Uganda international border areas are endemic to several NTDs including kala azar, trachoma, hydatid disease, onchocerciasis, nodding syndrome, and trypanosomiasis. The zone has also experienced wild polio virus (WPV) outbreaks in 2009 (Turkana district in Kenya linked to strains from South Sudan) and 2011 (Rongo district in Kenya

linked to strains from Eastern Uganda). Kenya is also currently responding to an outbreak of cVDPV2, that was confirmed from an environmental sample in Nairobi. There is an active cholera outbreak in Turkana and West Pokot districts in Kenya since January 2018 with reports of spillovers into Amudat district in Uganda. In addition, the 2014 cholera outbreak in Moyo district was genetically linked to strains from the South Sudan outbreak in the same year. The other cross-border challenges highlighted include Guinea worm, MDR-TB and HIV trends that are on the rise, measles, and zoonotic disease outbreaks of Anthrax and Rift valley fever in Arua, Uganda in 2017.

South Sudan, Dr. Mathew Tut Moses

Highlighted that prior to the 2013 crisis; IDSR was deployed in all former 10 states and 80 counties. In the aftermath of the 2013 crisis; populations were displaced, health facilities were looted and/or destroyed in many parts of South Sudan. EWARN was therefore setup to cater for disease surveillance needs of displaced populations. National surveillance system. EWARN - 7 conflicts affected states - 37 partner supported health facilities. IDSR countrywide 1380 public health facilities. He noted that the country committed to IHR in 2013 and highlighted some of the achievements of the IHR, which included the designated of the National IHR focal point and the IHR focal person. Public Health Laboratory is now functioning with limited capacity, identified, assessed and established two Points of Entry, Juba International airport and Nimule boarder crossing point. Established event information site, which is accessible 24hrs. He also noted that there is a need to strengthen coordination with other relevant sectors and formalize the share information on regular cases and develop guidelines for the case management of food safety events.

Disease burden in South Sudan

Malaria is the top cause of morbidity countrywide accounting for 50% of OPD consultations. ARI and malaria account for 45% of OPD consultations in IDP sites. 80% facility deaths in 2018 attributed to malaria. The top causes of mortality in the IDPs sites in 2018 include malaria, medical complications of malnutrition, pneumonia, perinatal complications, and TB. Cholera has been predominant for the past three years. The highest transmission peaks were associated with outbreaks that affected cattle camps in: Awerial, Yirol East, Duk, Bor, Uror, Ayod, Kapoeta East, Kapoeta South, and Kapoeta North counties. The same locations also reported high CFR due to poor access to health care especially at the onset of the outbreak. Other diseases include Malaria, Measles, Hepatitis E and Kala azar.

Key issues raised

i. There are currently no port health services in South Sudan and Uganda there are currently no cross-border health committees to facilitate regular meetings and information sharing on disease control.
ii. Immunization rates for routine EPI antigens (especially polio and measles) are sub-optimal in the three member states (Kenya, Uganda, and South Sudan) hence the frequent VPD outbreaks in the region.
iii. There is need to adopt the health system approach (using all the building blocks) when supporting countries through the EAPHLNP and other funding streams.
iv. While surveillance, early detection and prevention of communicable diseases has been emphasized as an important aspect of diseases control, No ring-fenced budget to support disease surveillance activities from the National budgets.

Key recommendations:

i. The Republic of South Sudan and the Republic of Uganda should establish Port Health Services to facilitate entry and exit screening, verification of yellow fever vaccination, isolation, and quarantine including vector control.
ii. The Republic of the Republic of Kenya, the Republic of South Sudan, and the Republic of Uganda are urged to work collaboratively to improve microplanning for routine EPI vaccination in cross-border populations.

iii. EAC Partner states urged identify and designate ungazetted entries in order to monitor these entries to reduce disease transmission.
iv. EAC, ECSA-HC and WHO should facilitate and support simulation exercises during the future meeting of the cross-border zone 9 (Kenya, Uganda, South Sudan) cross-border surveillance zone.
v. EAC Partner States urged to strengthen mechanisms to enhance cross-border patient and specimen referral, joint outbreak investigations, and joint public health response to outbreaks and endemic diseases coordinating with the existing mechanisms including NTDs in cross border communities.

3.7. Laboratory Based surveillance – role of the laboratories in supporting disease surveillance and outbreak management

Uganda

Amanziru Mary, Laboratory Manager, Arua Regional Referral Hospital

Arua Regional Reference Laboratory and Lacor Hospital in Gulu have benefited from the support of the East Africa Public Health Laboratory networking project. Some of the key areas supported under the project include:- training of laboratory staff , mentoring to improve the quality of laboratory services and progress towards accreditation, external and internal quality assurance, essential Provided laboratory equipment - refrigerator, hot air oven, autoclave, water distiller and some auxiliary equipment, ICT equipment and internet connection modems, connection to laboratory information systems. The project provides funds to support facility improvement to support activities such as support supervision to the district laboratories, laboratory management reviews, purchase of some essential laboratory supplies for improvement activities and outreach support activities. The laboratory provides support with confirmation of outbreaks by direct testing or packaging and submitting to CPHL for confirmation.

Some challenges have been experienced that included:- delay in disbursement of the funds to facilitate consistent operations; pilot of a courier that traverses the region once a week from CPHL, this is fit for routine HIV viral load and Early Infant Diagnosis (EID) dry blood samples (DBS), but not yet enhanced for microbiology outbreak and emergency samples. The proposed renovation of laboratories in Uganda has delayed.

Kenya,

Henry Ogaro, Laboratory Officer, Kitale Hospital Laboratory Kenya

Kitale County Hospital Laboratory is one of the laboratories in Kenya supported by the EAPHLN Project. The laboratory was able to achieve the following: (i) laboratory quality improvement with current rating at 3 stars; (ii) supporting in disease surveillance and outbreak investigation, took part in investigation of polio outbreak, Marburg virus disease outbreak and suspected measles outbreak (that was confirmed as Rubella disease outbreak); (iii) AMR surveillance - part of AMR surveillance network and microbiology testing services in support of AMR is ongoing and the facility has been selected as one of the two model sites for AMR surveillance pilot for Kenya; (iv) utilizing the video conferencing facilities with ECHO enhancement to build capacity for infection control sessions, TB prevention and diagnosis issues and research implementation discussions among others; (vi) expanded scope of testing (microbiology cultures for AMR, molecular testing; HPV DNA testing); and (vi) operational research - Two studies under implementation, one on antibiotic resistance, molecular characterization of pathogenic E.coli among others.

Issues raised:

i. The satellite laboratories in Arua and Gulu expressed the need to be supported to confirm common outbreaks like cholera and measles.
ii. Construction of the Arua and Lacor laboratory has been awarded and is awaiting NEMA approval to commence the civil works for the construction Arua laboratory and other designated sites under the project.

iii. Kenya satellite sites development seems to have progressed fast and very well covering wide scope of testing including molecular testing, outbreak confirmation and operational research at the site.
iv. While the improvement of capacity for medical laboratories is good progress, capacities for veterinary laboratory needs to be enhanced.

Recommendations:

i. Encouraged the laboratory team to utilize the e-learning portal that has been developed under the project that has currently three modules i.e. operational research, Biorisk management, laboratory management and ICT.
ii. The EAC Partner State urged to support efforts for improvement of capacities of integration and expansion of veterinary samples into the national specimen and results transportation system or network (NSRTS)
iii. ECSA-HC and EAC should work with Partner Countries to facilitate collaborative learning exchange visits for the sites to learn from each other across the countries.

3.8. Update on Institutional Framework for Cross-border Surveillance and Response for East Africa Region

Martin Matu, Project Coordinator

Overview of the institutional framework for cross-border surveillance was provided highlighting the objectives behind developing the protocol including; (i) sharing surveillance data and epidemiological and other related information through periodic reports, newsletters, bulletins and other methods; set up and operationalization of cross-border Zonal disease surveillance and response committees to coordinate and implement cross-border interventions; (iii) develop and implement joint plans for cross-border surveillance, epidemic preparedness and joint outbreak response; (iv) 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; (v) Organize common training and sensitization sessions on Integrated Disease Surveillance (IDSR), International Health Regulations (IHR (2005); (vi) strengthening port health services at all ports of entry (PoEs) in line with the IHR (2005) regulations and interventions to address antimicrobial resistance.

Key issues:

The following key issues were raised:-

i. The protocol was developed before South Sudan joined the EAC and therefore there is need to revise the Framework to include the interests of S. Sudan.
ii. The protocol has not specifically addressed the Port health services (activities)
iii. The challenges on implementing the protocol under devolved system in Kenya;
iv. The need to share information across the borders on surveillance and outbreaks.

Recommended that:

i. The EAC Secretariat in collaboration with the ECSA-HC to revise the Institutional Framework for Disease Surveillance to ensure that S.Sudan is adequately covered including assigning officers to the Regional Rapid Response Team, expansion of the cross-border zones to cover country borders with S.Sudan.
ii. The EAC Secretariat in collaboration with the ECSA-HC to facilitate the revision of Framework to incorporate other emerging disease priorities such as anthrax, Kalaazar, nodding disease, non-communicable diseases, among others.
iii. EAC Partner States urged to provide resources to facilitate operationalization of the cross-border committee and implementation of the joint action plans;
iv. The cross border districts develop common work plans for cross-border surveillance, epidemic preparedness and joint outbreak response to facilitate sharing of information.

3.9. Establishment of Zonal Cross-border committee

Based on the guidelines for the establishment of zonal committees in East African Community Partner States as outlined in the Institutional Framework for Cross-border Disease Surveillance and Response in the East Africa Region (July 2011), it was agreed that Zone 9 (, be established as a Tripartite Zone covering Kenya, South Sudan and Kenya. The zone was divided into three sub-zones as follows:-

Sub-zone	Kenya	South Sudan	Uganda
Sub-zone 1	Turkana West Sub-county Kitale District (Laboratory)	Kapoeta East County Budi County Kapoeta (Laboratory)	Kaabong District Moroto District (Laboratory)
Sub-zone 2		Ikotos County Magwi County Nimule (Laboratory)	Kitgum District Lamwo District Amuru District Adjumani District Gulu District (Laboratory)
Sub-zone 3		Kajo-Keji County Lainya County Morobo County Yei (Laboratory)	Moyo District Yumbe District Koboko District Arua District (Laboratory)

The full Composition of the cross-border sub-zones committee members is attached as Annex **III.**

The team proposed disease surveillance activities to be conducted by the sub zone focusing on the following broad areas:

1. Setting up cross-border zonal disease surveillance and response committees to coordinate and implement cross boarder interventions;
2. Joint training and sensitization sessions on IDSR and IHR (2005) and cross boarder surveillance;
3. Share surveillance data and epidemiology and other related information through periodic reports, newsletters, bulletin and other methods and social media alerts.
4. Joint investigations of outbreaks e.g. ongoing cholera outbreak in Kenya

The detailed planned activities for the year 2018-2019 will be developed during the initial follow up meetings of the sub-zones. Sub-zone 1 will carry out follow up meeting in May as part of joint response to the Cholera outbreak in Kenya.

The following issues were raised:-

i. Visa requirements to cross-between South Sudan and other EAC countries may be a potential barrier to effective cross-border collaboration.
ii. Involvement of the members in the committees need to be formalized. Formal Appointment of members to the sub-committees from the respective ministries.

Recommendations:

i. Bordering countries to consult with respective governments on cross-border collaborative surveillance activities to facilitate waiver of visa on special missions.

Immigration office will be involved in the activities and membership incorporated in each sub-zone and prior advance notification of the immigration office on the planned cross-border missions is given (meetings, outbreak investigations etc).

ii. Countries to provide official appointment of the officers selected as members of the committees with clear terms of reference. The generic TORs provided in the Framework may be customized for that purpose.

iii. The term of office of the sub-zonal committees to be capped for two years but the committee membership may be reviewed based on performance.

iv. Sub-zones to prioritize key activities, cost them and a schedule for implementation be developed for funding through the respective surveillance units of MoH by 30th June 2018.

v. WHO South Sudan will explore how they can support the operations for South Sudan sub-zonal committees as more sustainable financing is sought.

vi. Republic of South Sudan with the support of the WHO to establish a TWG for Disease Surveillance and Response to provide national coordination of the cross-border committees.

Signed on the 26th April 2018 by the respective heads of delegations as indicated hereunder:

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Ministry of Health	**Ministry of Health**	**Ministry of Health**
Republic of Kenya	**Republic of South Sudan**	**Republic of Uganda**

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Annex II: Meeting agenda

Time	Activity	Facilitator	Moderator
Monday 23rd April 2018			
14.00 -19.00 hrs	Arrival of delegates in Nimule, South Sudan		
Day 1: Tuesday 24th April 2018			
08.00 - 08.30 hrs	Arrival and Registration of Delegates	EAC/ECSA Secretariat	**Chair:** Uganda **Rapporteur:** Kenya
08.30 – 08.45 hrs	Introduction	EAC	
08.45 – 10.00 hrs	Opening Remarks: (i) Welcome Remarks by Regional Health Officer (ii) Partner States' heads of delegation: Tanzania and Kenya (iii) ECSA-HC (iv) EAC (v) Ministry of Health SS (vi) WHO Country Representative, SS		
10.00 – 10.30 hrs	Meeting Objectives and the Concept Paper	ECSA/EAC	
10.30- 11.00 hrs	**Health Break, Group Photo**		
11.00 – 11.40 hrs	International Health Regulations and the need for Cross-border disease surveillance mechanisms Overview of EAPHLN Project (Regional Perspective)	WHO Dr. Benedict Mushi	
11.40-12.20 hrs	Overview of EAPHLN Project country progress in implementation of project activities • Uganda • Kenya	Country Representatives	
12.15-12.30	EAIDSNet, Regional Contingency Plan	Dr Were/Dr Sonoiya	
12.30-13.00 hrs	Plenary Discussion		
13.00 – 14.00 hrs	**Lunch Break**		
14.00-15.30 hrs	Progress in Implementation of IDSR/IHR (2005) in the cross-border districts/sub-counties **Kenya**: Turkana West **R South Sudan**: **Uganda**: Koboko, Yumbe, Moyo, Adjumani, Lamwo, Gulu, Kitgum, Kabong, Pader, Amur, Maraha	**South Sudan: District/sub-county representatives**	**Chair:** Kenya **Rapporteur:** Uganda
15.30-16.00 hrs	**Health Break**		
16.00 - 16.30 hrs	Review of Surveillance for AFP, Neglected Tropical Diseases, in trans-boundary areas • Kenya • South Sudan • Uganda	Country Representatives	
16.30-17.00 hrs	Control of cholera outbreaks: the situation in EAC	Dr. Tasiana Mzozo	
17.00-17.30 hrs	Plenary Discussion		
Day 2: Wednesday 25th April 2018			

8.30-8.50 hrs 8.50-9.30	• Frame work for cross-border Disease Surveillance • Cross-Border Surveillance Committees Refugee situation in the cross-border area	Dr Matu UNHCR	**Chair:** South Sudan **Rapporteur:** Uganda
9.30-10.00 hrs	Laboratory based disease surveillance data (Recording, Reporting of laboratory data) • Kitale Hospital Satellite Lab in Kenya • Arua/Lacor lab in Uganda	Satellite Lab Representatives	
10.00-10.30 hrs	Infection Prevention and Control: • Hand washing • Doffing and Donning		
10.30 – 11.00 hrs	Plenary Discussion		
11.00 – 11.15 hrs	**Health Break**		
11.15 – 12.30 hrs	Formation of Surveillance Committee	ECSA-HC/ECA	
12.30 – 13.00 hrs	Work plan of Committee: Group Work and Plenary discussion		
13.00-14.00 hrs	**Lunch Break**		
14.00 – 17.00 hrs	Field Visit to review activities of public health interest. • Visit to Nimule Hospital, Risk assessment for IPC (CDC Tool) • Visit to Nimule ground crossing border post/Water supply system for Nimule City		**Chair:** Kenya **Rapporteur:** Uganda
17.00	**Health Break**		
Day 3: Thursday 26th April 2018			
8.30-10.00 hrs	Field visit report and discussion	ECSA-HC/ECA	**Chair:** Uganda **Rapporteur:** South Sudan
10.00 – 12.00	Report writing		
12.00-13.00	Adoption and signing of report		
13.00 hrs-14.00	**Lunch**		
14.00 hrs	Departure		

ANNEX III: Members of the Cross Border Committees

Sub Zone 1:

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Annex IV: Reports of field Activities

GROUP 1: Nimule Ground Crossing

1. Immigration Department: Visited the ICT room and the visa issuance section

Findings

- **NO** Port Health Services
- Spacious with a large well aerated travelers waiting lounge
- Immigration officials have been forced to take over some of the port health roles i.e. enquiring about yellow fever card, however they are unable to verify authenticity of the cards and also forced to transport sick travelers to hospital
- Travelers without Yellow fever cards are not denied entry/exit but are advised on where to go and have the YF vaccine administered. In addition, the immigration officials also capture the availability/non availability of YF card in their electronic or manual records

Recommendations

- *Short term*
  i. Need to have an MOU with Nimule Hospital to provide ambulance services and emergency medical services to sick travelers
- *Medium term*
  i. Establish port health services at Nimule land crossing providing a minimum package of the very essential port health services.
  ii. Construct temporary structure where the port health services will be provided which should be the first point of call for travelers as they enter South Sudan before proceeding to immigration
  iii. Post a minimum of 3 health workers to man this border post collaborate with Nimule Hospital
  iv. Train the health workers on their roles and responsibilities including, inspection IDSR priority diseases & use of case definitions and Basic Life Support skills
- *Long term*
  i. Establish a One Stop Border Post with designated space for Port Health, Animal health officers and Plant officers
  ii. Ensure you have a temporary isolation/holding room for human cases within the one stop border post building and also have a holding area for animals (livestock/birds/pets etc.) within the vicinity of the border
  iii. Fully implement activities expected at a ground crossing as per IHR 2005

2. River Unyama

- It is generally devoid of visible solid waste. However, the water appears turbid, but this may be due to heavy rains upstream.
- Found locals bathing and washing clothes in the river
- Area around the banks of the river is very bushy. These are breeding sites for mosquitoes and other vectors. This river is in the vicinity of customs where containers are inspected therefore it could be a potential source of spread of vectors to other countries
- Anecdotal report: Is that there is open defecation in the bushes along the river
- We were informed that this river flows into the town's main water source for domestic use

Recommendations

- Need to sensitize local community on proper hygiene and sanitation
- Need to sensitize community on the importance of water treatment at house hold level using chlorine tablets/boiling
- Need to enforce Public Health laws on sanitation
- Clear the bushes on the banks of the river and vector control

3. Customs

Findings

- We were unable to assess the customs department as the leadership had not been informed about our visit and thus were not prepared to receive us.

Recommendations

- Better prior written communication in subsequent cross border field visits

Group2: Nimule Hospital
Located in Nimule Town, in Torit State, in Magwi county. It is an old 174 bed capacity facility providing both primary and secondary health services.
Services provided: Outpatient services, RMCH services, Infectious disease control (MAT), Laboratory diagnostic services, Inpatient services, surgical services, medical services, pharmacy, services and management support services.
Findings:
State: Evidence of good leadership and management; buildings were a mixture of new ,middle aged and old; No water in the reservoir
Services: basic medical and diagnostic equipment in functional state to provide services in points of care visited; Functional lab services with smart staff, Good stock of medicines and health supplies; Service delivery in both out and in patient departments noted.
Personnel: Basic human resources for health (MO,CO,Nurses,laboratory ,pharmacy)
Records: Evidence of good paper based records management
Partner Support: Active partner –Save the children; incentive package from save the children
IDSR: A functional rapid response team in place; personal protection equipment in place (PPE); Staff found in uniforms at work places; No information provided on number of staff trained and providing IDSR services ; no evidence of work plan; no weekly epi reports and charts
Suggested improvements: Improve infrastructure (old dilapidated); strengthen radiology and imaging services; recruit more staff d by a partner on contract (high turn-over rate); preposition supplies for outbreak response; conduct IDSR data analysis and graphs on the site and pin up graphs; improve the main water source.

GROUP 3: River Unyama
Field visit to Water Supply Point along River Anyama: Group/Team 3
Objectives
- To explore resources on the site.
- To interview local authority on the site.
- Suggest possible improvement to the site visited.
- And prepare a written report and present findings of the visit.

Methodology:
The team
- Conducted a walk-through to observe the area
- In the absence of a local authority, a resident, Simon Amoko, provided information:

Findings:

- Men and boys were observed/seen bathing and swimming in the area.
- No Water Supply Point.
- Neither Water Treatment Plant nor Pumps for Water Tankers were present.
- It is said- community and water tankers collect water from this area for households used or businesses, and 6 boreholes around that area.
- No local authority to interview instead, Team Guide Amoko briefed us on the area.
- A building under construction was nearby, it belongs to Egyptian Authority.
- Water Treatment Plant is non-functional.
- Open defecation was observed.

Recommendations:
- An authority for water safety, water treatment is needed in the area.