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**REGIONAL STRATEGY FOR INTEGRATED DISEASE SURVEILLANCE AND
RESPONSE: 2020–2030**

Report of the Secretariat

EXECUTIVE SUMMARY

1. In 1998, Member States adopted the “**Integrated Disease Surveillance in Africa: A Regional Strategy (1999–2003)**”. The strategy was later renamed Integrated Disease Surveillance and Response (IDSR). The IDSR strategy is a comprehensive, evidence-based approach for strengthening national public health surveillance and response systems at all levels.
2. In 2016, Member States endorsed the Regional strategy for health security and emergencies 2016–2020. Based on the Regional strategy for health security and emergencies, all Member States are expected to implement IDSR with over 90% national coverage by 2020. In order to build on these developments and to allow for contemporary evidence as well as innovations in technology, a new IDSR regional strategy for 2020–2030 is required. The new strategy emphasizes the interlinkages within the IDSR as an integral part of health systems strengthening to achieve universal health coverage (UHC).
3. The first objective of the new IDSR strategy is to strengthen national capacity for early detection, complete recording, timely reporting, regular analysis and prompt feedback of IDSR priority diseases, events and conditions at all levels. The second objective is to strengthen national and supranational laboratory capacity to confirm IDSR priority diseases, events and conditions. The third objective is to strengthen capacity for public health emergency preparedness and response at all levels.
4. The new strategy also provides guidance to Member States on strengthening the IDSR in alignment with broader national policies and plans and an integrated supervision, monitoring and evaluation system. Finally, it stipulates milestones, targets and priority interventions to guide Member States.
5. The Regional Committee reviewed and adopted the strategy.

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INTRODUCTION

1. There is increasing recognition of the threat epidemics pose to global health security and the livelihoods of people, beyond their impact on human health. Every one of the 47 Member States within the World Health Organization's (WHO) African Region is at risk of health security threats.¹ Emerging and re-emerging threats with pandemic potential continue to challenge fragile health systems on the continent, exacting an enormous human and economic toll.
2. A 2019 WHO evaluation of disease trends indicates that the risk of emerging infectious diseases has risen.² This is largely attributed to the growth of cross-border and international travel, increasing human population density and the growth of informal settlements. Other factors include climate change, changes in the way humans and wild animals interact and changes in trade and livestock farming.
3. The increased frequency and magnitude of outbreaks in the Region are stark reminders of the need for robust public health surveillance and response systems.³ Moreover, the inadequate health systems are often burdened by events outside the health sector such as: civil conflicts, internally displaced populations and environmental and climate change.
4. In 1998, following delayed responses to major disease outbreaks, Member States adopted the Regional Strategy for Integrated Disease Surveillance and Response (IDSR)⁴ for the period 1999–2003. The IDSR is a comprehensive, evidence-based strategy for strengthening national public health surveillance and response systems at all levels.
5. In 2016, Member States adopted the Regional strategy for health security and emergencies 2016–2020.⁵ The Regional strategy for health security set a very bold target for IDSR; by 2020, all Member States should be implementing IDSR with over 90% national coverage.

SITUATION ANALYSIS AND JUSTIFICATION

Situation analysis

6. A WHO assessment conducted in 2017 demonstrated that the initial momentum in IDSR implementation between 2000 and 2010 was not sustained.⁶ This has been linked to inadequate sustainable domestic financing. In addition, inadequate staffing and high turnover of peripheral staff affected IDSR implementation. Further, limited sharing of surveillance data and information was also observed. In some Member States, inadequate supervision and mentorship, inadequate laboratory capacity and limited availability of communication and transport systems hampered IDSR scale-up.

¹ World Health Organization, Health Emergencies Programme in the African Region: Annual Report 2016. Regional Office for Africa. <http://www.afro.who.int/fr/node/8317> (Accessed on 28 October 2018).

² WHO Regional Office for Africa (2018). The Work of WHO in the African Region - Report of the Regional Director: 2017-2018. Brazzaville. (<https://apps.who.int/iris/bitstream/handle/10665/273743/AFR-RC68-2-eng.pdf>, accessed 25 February 2019).

³ Heymann DL, Chen L, Takemi K, Fidler DP, Tappero JW, Thomas MJ, et al. Global health security: the wider lessons from the West African Ebola virus disease epidemic. *Lancet*. 2015; 385:1884-901.

⁴ World Health Organization. Integrated epidemiological surveillance of diseases: regional strategy for communicable diseases (Resolution AFR/RC48/R2) Harare, Zimbabwe: WHO; Forty-eighth session of the WHO Regional Committee for Africa. 1998.

⁵ World Health Organization. Resolution: Regional strategy for health security and emergencies 2016–2020, Document AF. 2016. <http://www.who.int/iris/handle/10665/252834> (accessed on 18 January 2019).

⁶ Fall IS, Rajatonirina S, Yahaya AA, Yoti Z, Nsubuga P, et al., The Integrated Disease Surveillance and Response (IDSR) strategy in Africa: Current regional status of implementation, lessons learnt and perspectives for the future, *BMJ Global Health* (In press).

7. By 2018, 12 Member States had conducted IDSR training with national coverage of 90% of health workers; 22 Member States had conducted training with coverage between 50%–89% of health workers. Ten Member States had IDSR training coverage of less than 50% of health workers.

8. The IDSR strategy incorporates both indicator-based surveillance (IBS) and event-based surveillance (EBS) systems. Further, IDSR can be implemented at the community level through community-based surveillance (CBS) or at facility level with the use of facility-based surveillance. Finally, IDSR can be paper-based or electronic (eIDSR).

9. By 2018, the proportion of Member States currently implementing EBS was 74%, while the proportion of Member States that had commenced CBS implementation was 68%. Concerning eIDSR, 70% of the Member States report having eIDSR systems. However, 42% of them do not have data on the implementation coverage of EBS, CBS or eIDSR. Ten Member States are currently implementing EBS with 100% national coverage and only seven (15%) are implementing CBS with 100% national coverage. Four Member States have both EBS and CBS with 100% national coverage (Annex 2).

10. As of December 2017, thirty-two Member States had a feedback mechanism through weekly or monthly bulletins, and 34 Member States provided information on timeliness and completeness of IDSR reporting, with 23 of them meeting the timeliness and completeness threshold of over 80%. Among the 23 Member States with good performance on the timeliness of data reporting, 18 had an electronic IDSR system.

11. While addressing health emergencies remains a challenge, commendable progress has been made by Member States in assessing the availability of their IHR capacities using the joint external evaluations (JEEs) and State Party Annual Report (SPAR) since 2016. These assessments have revealed major gaps in IHR capacities. No country in the WHO African Region had the requisite IHR capacities.⁷ Areas for improvement were observed in the following IHR capacities: antimicrobial resistance, biosafety and biosecurity, preparedness, emergency response operations, medical countermeasures and personnel deployment, points of entry, chemical events and radiation emergencies (Annex 3). The above gaps are primarily due to insufficient resources (financial, human and logistics) and fragmented services. Further, limited community engagement; weak health systems; inadequate intercountry collaborations and limited partnerships remain a challenge.

12. Opportunities for improvement exist, such as the revised IDSR technical guidelines (Third Edition). In addition, all Member States except four⁸ have conducted the joint external evaluation (JEE) and are developing or reviewing their national action plans for health security (NAPHS). Furthermore, all the 47 Member States have for the last two years (2017 and 2018) submitted their annual IHR implementation status reports.

Justification

13. Following two decades of implementing the IDSR strategy, there is need for a new strategy that draws on lessons learned. The new IDSR strategy (2020–2030) provides to Member States the current technical guidance and priority interventions to contribute to the WHO Thirteenth General Programme of Work, 2019–2023 (GPW 13) and the triple billion goal of “one billion more people benefiting from universal health coverage, one billion more people protected from health

⁷ Talisuna AO, Yahaya AA, Rajatonirina SC, Stephen M, Oke A et al., Joint External Evaluation of the International Health Regulations (2005) capacities: Current status and lessons learnt in Africa, *BMJ Global Health* (In press).

⁸ Algeria, Angola, Cabo Verde and Equatorial Guinea.

emergencies and one billion more people enjoying better health and well-being”.⁹ It is also guided by the Transformation Agenda of the WHO Secretariat in the African Region, 2015–2020.¹⁰

14. The new IDSR strategy takes into consideration contemporary evidence and innovations, including the prevailing context, and is aligned with strategies for achieving universal health coverage and Sustainable Development Goal 3 (SDG-3). Finally, it is synergistic with strategies for addressing global health security and is underpinned by the “one health” approach.

THE REGIONAL STRATEGY

Aim, Objectives and Targets

Aim

15. To reduce morbidity, mortality, disability and socioeconomic losses due to epidemics and other public health emergencies in the African Region.

16. Objectives

- (a) To strengthen national capacity for early detection, complete recording, timely reporting, regular analysis and prompt feedback of IDSR priority diseases, events and conditions at all levels.
- (b) To strengthen national and supranational laboratory capacity to confirm IDSR priority diseases, events and conditions.
- (c) To strengthen capacity for public health emergency preparedness and response at all levels.
- (d) To strengthen the supervision, monitoring and evaluation system for IDSR.

17. Milestones and Targets

The milestones for 2024 and targets for 2030 are defined against the objectives of the Strategy. *To strengthen national capacity for early detection, complete recording, timely reporting, regular analysis and prompt feedback of IDSR priority diseases, events and conditions at all levels.*

By 2024

- (a) All Member States have mobilized over 80% of the financial resources required for IDSR.
- (b) All Member States are implementing IDSR (indicator, event-based and community systems) with over 90% national coverage.
- (c) Over 80% of acute public health events detected are reported to WHO within 48 hours of detection.
- (d) All Member States publish a regular weekly (or monthly) IDSR bulletin.
- (e) All Member States have capacity to analyse and link data from and between surveillance systems at national and intermediate levels.

⁹ World Health Organization. Thirteenth General Programme of Work 2019–2023 (Accessed 23 January 2019 at: <https://www.who.int/about/what-we-do/gpw-thirteen-consultation/en/> <https://www.who.int/about/what-we-do/gpw-thirteen-consultation/en/>).

¹⁰ World Health Organization. The Transformation Agenda of the World Health Organization Secretariat in the African Region 2010–2020, accessed 18 January 2019 at: <https://www.afro.who.int/regional-director/transformation-agenda>.

- (f) Thirty per cent of Member States have adequate, skilled and competent health personnel for IDSR implementation at all levels.

By 2030

- (a) All Member States have adequate, skilled and competent health personnel for IDSR implementation at all levels.
- (b) All Member States have functional eIDSR with over 90% national coverage.

To strengthen national and supranational laboratory capacity to confirm IDSR priority diseases, events and conditions.

By 2024

- (a) All Member States have access to a robust laboratory system able to reliably conduct at least five of 10 core tests from over 80% of “districts”.
- (b) Over 80% of acute public health events detected have timely laboratory confirmation in accordance with national guidelines and standards.

By 2030

- (a) All Member States have a national quality laboratory standard and mandatory licensing system.

To strengthen capacity for public health emergency preparedness and response at all levels.

By 2024

- (a) All Member States conduct at least one national multihazard emergency risk assessment, risk profiling, and resource mapping, every two years.
- (b) All Member States have an emergency response coordination mechanism and incident management system.
- (c) All Member States have a functional national public health emergency operations centre (PHEOC).
- (d) All Member States test their emergency response systems and decision-making processes for efficient and effective operations once every two years.

By 2030

- (a) All Member States have multidisciplinary national and subnational rapid response teams.

To strengthen the supervision, monitoring and evaluation system for IDSR.

By 2024

- (a) All Member States annually review the performance of IDSR and update the system at all levels in the country.
- (b) All Member States provide quarterly reports on the IDSR key performance indicators (KPIs).

By 2030

- (a) All Member States have demonstrated capacity (level 4)¹¹ for all the IHR capacities based on the annual report.

Guiding principles

18. **Country ownership and leadership:** Enhancing IDSR is the primary responsibility of national governments. Consequently, this strategy urges all Member States to provide technical leadership at all levels. This should take into account the national health, social, economic, health security and political contexts.

19. **WHO leadership and partnerships:** The success of this strategy is contingent on robust WHO Secretariat and partner technical support. Such support should be complementary and synergetic.

20. **Intersectoral collaboration:** Enhancing and optimizing IDSR requires a multisectoral, coordinated strategy based on the One Health approach. This strategy supports planning for IDSR across multiple sectors.

21. **Community involvement:** Effective IDSR optimization requires the active participation of the community. Communities must take ownership of their preparedness and response capacity building.

22. **Domestic financing:** For long-term sustainability, IDSR funding should be from domestic resources. Consequently, arrangements for mobilizing adequate domestic financial resources for IDSR will need to be put in place.

23. **Monitoring results and accountability:** This strategy stipulates the KPIs for monitoring and evaluation. Member States will adapt and use these indicators. Monitoring and accountability need to be institutionalized.

24. **Gender mainstreaming and equity:** IDSR data should be disaggregated by age and sex. Disease trends should be tracked taking into consideration gender-related risks. This should address all populations across the life course, including underserved populations.

25. **Health facility and community focus:** The implementation of this strategy will be at the health facility and community levels with strong technical support from the “district” and national levels.

Priority Interventions

26. **Conducting high-level advocacy:** Reflecting on the current context and recent developments such as the Ebola virus disease outbreaks, there is a need for high-level political commitments across multiple relevant sectors. The success of this strategy requires high-level advocacy at national and subnational levels. All Member States are urged to conduct high-level advocacy for IDSR. Its scale and scope will depend on the decentralization or devolution context.

¹¹ Attributes are in place, sustainable for a few more years and can be measured by the inclusion of attributes or IHR (2005) capacities in the national health sector plan-Score Green.

27. **Ensuring good system design and country ownership:** This IDSR strategy allows for flexibility during planning. Consequently, this IDSR strategy needs to be adapted to the prevailing context. Key considerations during adaptation should include: identification of epidemic-prone diseases, events and conditions for immediate and weekly reporting and those for monthly or quarterly reporting. Further, the political, economic, epidemiological and social setting should be taken into considerations. Finally, for IDSR to be anchored on a sound foundation, country ownership, system design, stakeholder engagement, and a good enabling environment are indispensable and need to be institutionalized.

28. **Optimizing leadership and robust accountability frameworks:** Enhancing and optimizing IDSR requires good leadership and accountability at all levels. Moreover, supervision, monitoring and evaluation are critical for performance improvement and fostering accountability for IDSR implementation. All Member States are urged to scale up implementation of the third edition of the IDSR guidelines which emphasize robust integrated supervision, including the use of electronic supervision. Importantly, Member States are also urged to establish robust national and subnational coordination mechanisms to oversee IDSR implementation at different levels, including designating IDSR focal points at subnational level.

29. **Ensuring consistent availability of skilled health workers:** All Member States are urged to increase the availability of trained human resources by scaling up eLearning. This is a critical success factor for IDSR at all levels, but more so at peripheral facilities and in the community. Noting that workshop-based training might not reach all health workers, eLearning is encouraged.

30. **Institutionalising IDSR training and review of curricula of training institutions:** While eLearning is a solution option, the training gap noted in the situation analysis is a red flag that points to the urgent need for systematic in-service and pre-service training for IDSR. All Member States are urged to institutionalize IDSR training in the training curricula of public health training institutions. The latter option will require a review of the training curricula of all pre-service training institutions. The WHO Secretariat is working with training institutions in select countries to review their curricula to incorporate IDSR. All Member States are urged to adopt this approach to provide a reliable and continuous supply of a well-trained workforce.

31. **Scaling up event-based surveillance:** The IDSR third edition technical guidelines and training modules offer guidance to Member States on how to scale up EBS at all levels. Therefore, all Member States are urged to quickly scale up implementation of the revised IDSR technical guidelines. This is important because the IHR (2005) introduced the notion of “event-based” surveillance (EBS) to address rumours of “unexplained illness or clusters of death” as an event category for reporting. While EBS was added to the second edition of the IDSR guidelines, its implementation has been inadequate. It is important to note that the implementation of EBS requires the involvement of multiple stakeholders, the community, and recourse to media scanning using information technology products and software.

32. **Scaling up high quality community-based surveillance:** To address gaps in CBS, the third edition of the IDSR guidelines has been beefed up. Consequently, all Member States are urged to scale up the revised IDSR guidelines for CBS. It is important to note that CBS is an active process of community participation in detecting, reporting, responding to and monitoring health events in the community. The scope of CBS is not only limited to the systematic ongoing collection of data on events and diseases using simplified case definitions and forms but also reporting to health facilities any unusual events for verification, investigation, collation, analysis and response as needed. Success in CBS requires the participatory engagement of local communities.

33. **Implementing IDSR in complex situations:** Humanitarian crises have affected IDSR performance in several Member States due to the disruption of health and other social services. Based on Member States' experiences, the second edition of the IDSR technical guidelines has been revised to include several key components and lessons learned from implementing IDSR in humanitarian crises. Member States facing humanitarian crises are urged to quickly adapt the third edition of the IDSR guidelines.

34. **Scaling up electronic IDSR:** All Member States are urged to scale up eIDSR nationwide. Electronic surveillance systems are increasingly being adopted for prompt disease detection and response. To support Member States to scale up eIDSR, the third edition of the IDSR technical guidelines and training modules have a section on the implementation of eIDSR. The elements that are required for eIDSR are: political commitment; secure toll-free numbers; piloting before national rollout; periodic data quality assessments; appropriate training; regular feedback and information sharing among relevant stakeholders.¹²

35. **Providing feedback and information sharing:** Under the IHR, all Member States are required to promptly share data (epidemiologic and laboratory) with WHO. Timely, regular and consistent feedback and sharing of IDSR data needs to be improved in all Member States because it facilitates early detection, timely action and leads to better evidence-led decision-making. At the regional level, there is need for continuous information sharing during and after outbreaks. Member States need to leverage existing protocols to strengthen information sharing among regional health and economic communities.

36. **Cross border preparedness and response:** Over the last two decades WHO has supported several ministerial-level meetings on cross-border health issues in the African Region (Kampala, Uganda, 2004; Abuja, Nigeria, 2010; Lusaka, Zambia, 2011; Natitingou, Benin, 2013; and Liberia, 2016). These initiatives led to the signing of protocols of cooperation and memoranda of understanding. These protocols led to improved cross-border coordination, outbreak response and synchronization of public health interventions, and health systems strengthening. However, mechanisms for cross-border information sharing and collaboration to effectively address epidemic and preparedness activities remain weak. In addition, few Member States have established adequate systems for joint planning, joint implementation and joint monitoring and evaluation of strategies for prevention, preparedness, early warning and response at cross-border level. This strategy urges Member States to revitalize these initiatives, taking into account recent developments and frameworks.

37. **Integrating IDSR into broader health information systems:** All functions of IDSR need to be aligned with broader health management information systems (HMIS) of the Member States. All Member States are urged to establish mechanisms that ensure that IDSR is integrated within HMIS.

¹² Thierry N, Adeline K, Anita A, Agnes B, Baptiste KJ, Pamela J, et al. A National Electronic System for Disease Surveillance in Rwanda (eIDSR): Lessons Learned from a Successful Implementation. *Online J Public Health Inform*, 2014, 6:e118.

Roles and responsibilities

38. Member States should:

- (a) Commit adequate resources to support the implementation of this strategy;
- (b) Review structures and systems at national and subnational level to support the implementation of this strategy, including: designating a focal point for IDSR coordination at different levels;
- (c) Strengthen the IDSR coordination mechanism to oversee IDSR implementation, provide guidance on priorities, periodically review progress and build capacity at the sub-national level.

39. The WHO Secretariat and partners should:

- (a) Disseminate the IDSR technical guidelines (Third edition) to support implementation of this strategy;
- (b) Support countries to develop plans that are regularly monitored and evaluated;
- (c) Ensure that the regional IDSR taskforce is operational and serves as a platform for coordinated action, mobilizing resources and forging consensus among partners;
- (d) Facilitate synergy and complementarity in the partnerships for IDSR implementation;
- (e) Establish a regional team of experts to build country capacity.

RESOURCE IMPLICATIONS

40. In 2016, the US National Academy of Medicine constituted a commission on the global health risk framework for the future.¹³ In their report “the neglected dimension of global security: a framework to counter infectious disease crises”, the commission recommended that the incremental financial resources required globally for pandemic preparedness were US\$ 4.5 billion per year.

41. In the WHO African Region, multiyear National Action Plans for Health Security (NAPHS) are being used by Member States to accelerate the implementation of the IHR core capacities. The NAPHS capture national priorities for health security. With WHO assistance, 25 Member States have developed NAPHS. The costs from these 25 Member States were used to derive the WHO African Region investment basket by calculating an average annual cost of preparedness and multiplying it by the number of Member States in the WHO African Region to estimate the Regional costs of preparedness. The cost per capita per annum, also known as the preparedness investment per person, was calculated by taking the Regional investment cost and dividing it by the total population. The investment needed over the next three years is approximately US\$ 9-10 billion or US\$ 3-4 billion per year. This translates into US\$ 2.5–3.5 per person per year, suggesting that the investment case for pandemic preparedness is an affordable public health good. Finally, US\$ 10 million per annum is required for the WHO Secretariat to provide programme support to Member States.

¹³ National Academy of Medicine (2016). *The Neglected Dimension of Global Security: A Framework to Counter Infectious Disease Crises*. Washington, DC: The National Academies Press (<https://doi.org/10.17226/21891>).

MONITORING AND EVALUATION

42. Progress in implementing this strategy by Member States will be tracked quarterly and annually. Data will be collected through IDSR KPIs (Annex 4) and annual IHR reports. Monitoring and evaluation will be adjusted based on the prevailing context. Further, IDSR cost-benefit analyses will be conducted, at least twice during the period of this strategy. Finally, every two years, the Regional Director will report progress in implementing this strategy to the Regional Committee.

CONCLUSION

43. This regional IDSR strategy, if implemented promptly, will improve early detection and reporting of priority diseases, conditions and events, leading to a prompt and effective response. Where IDSR is fully implemented nationwide, it has improved response time and reduced morbidity, mortality and the duration of the outbreaks.¹⁴

44. All Member States are urged to establish an adequate public health workforce. Further, Member States should develop programmes for capacity development, including a paradigm shift from theoretical workshop-based training to approaches that reinforce knowledge, skills, and competencies through simulation exercises and drills. Finally, there is a need to use innovations in technology to strengthen eIDSR such as, mobile telephone-health approaches, eLearning and eTeaching.

45. All Member States are urged to raise the profiles of the units responsible for IDSR at the national and subnational level. Finally, all Member States are urged to prioritize IDSR for funding.

46. The Regional Committee reviewed and adopted the strategy.

¹⁴ Shoemaker TR, Balinandi S, Tumusiime A, Nyakarahuka L, et al., Impact of enhanced viral haemorrhagic fever surveillance on outbreak detection and response in Uganda. *Lancet Infect Dis.* 2018; 18: 373–375.

Annex 1: IDSR implementation status in Member States, 2018

Country	Adapted the 2nd edition of the IDSR Technical Guidelines (TGs)	IDSR Training of Trainers (TOT)	IDSR cascade training up to peripheral level	Total number of districts	Districts with IDSR training between 2015 & 2017 (KPI) (%)	IDSR bulletin produced and disseminated	Timeliness of IDSR reporting (%)	Completeness of IDSR reporting (%)
Algeria	No	NA		--				
Angola	Yes	No	--	166	50 to 89	Yes	--	--
Benin	Yes	Yes	No	77	<50	No	92	100
Botswana	Yes	Yes	No	28	50 to 89	No	82	92
Burkina Faso	Yes	No	--	70	50 to 89	Yes	100	100
Burundi	Yes	Yes	Yes	46	>90	Yes	90	91
Cameroon	Yes	Yes	Yes	189	50 to 89	Yes	72	84
Cabo Verde	No	NA		22				
Central African Republic	Yes	Yes	Yes	30	<50	--	15	75
Chad	Yes	Yes	No	146	50 to 89	Yes	100	100
Comoros	Yes	Yes	Yes	17	>90	Yes	40	60
Congo	Yes	Yes	No	41	<50	No	--	--
Côte d'Ivoire	Yes	Yes	Yes	83	>90	Yes	96	100
Democratic Rep Congo	Yes	No	--	516	50 to 89	Yes	80	95
Equatorial Guinea	Yes	No	No	18	<50	--	--	--
Eritrea	Yes	Yes	Yes	58	50 to 89	--	47	100
Eswatini	Yes	Yes	Yes	4	50 to 89	Yes	85	52
Ethiopia	Yes	--	--	904	50 to 89	Yes	--	--
Gabon	Yes	No	--	51	50 to 89	Yes	99	100
The Gambia	Yes	Yes	Yes	43	50 to 89	--	66	100
Ghana	Yes	Yes	Yes	216	<50	Yes	90	99
Guinea	Yes	--	--	38	>90	Yes	99	100
Guinea-Bissau	Yes	No	No	11	50 to 89	Yes	90	100

Country	Adapted the 2nd edition of the IDSR Technical Guidelines (TGs)	IDSR Training of Trainers (TOT)	IDSR cascade training up to peripheral level	Total number of districts	Districts with IDSR training between 2015 & 2017 (KPI) (%)	IDSR bulletin produced and disseminated	Timeliness of IDSR reporting (%)	Completeness of IDSR reporting (%)
Kenya	Yes	--	--	301	50 to 89	Yes	--	--
Lesotho	Yes	--	--	10	>90	--	--	--
Liberia	Yes	--	No	90	>90	Yes	95	98
Madagascar	Yes	Yes	Yes	114	<50	Yes	54	55
Malawi	Yes	--	--	29	<50	No	--	--
Mali	Yes	--	--	65	50 to 89	Yes	90	97
Mauritania	Yes	Yes	Yes	55	50 to 89	Yes	100	80
Mauritius	No	NA	--	6		--	--	--
Mozambique	Yes	No	No	159	<50	No	52	92
Namibia	Yes	--	--	35	NA	Yes	90	99
Niger	Yes	Yes	Yes	72	50 to 89	Yes	89	98
Nigeria	Yes	Yes	Yes	774	<50	Yes	85	85
Rwanda	Yes	Yes	Yes	46	>90	Yes	78	98
Sao Tome Principe	Yes	Yes	Yes	7	<50	Yes	99	100
Senegal	Yes	No	Yes	76	>90	Yes	96	98
Seychelles	Yes	--	No	26	>90	Yes	--	--
Sierra Leone	Yes	No	Yes	14	>90	Yes	99	98
South Africa	Yes	--	--	52	50 to 89	--	--	--
South Sudan	Yes	Yes	Yes	80	>90	Yes	39	57
United Republic of Tanzania	Yes	No	No	192	50 to 89	Yes	80	100
Togo	Yes	No	Yes	40	>90	Yes	75	75
Uganda	Yes	Yes	Yes	116	>90	Yes	69	70
Zambia	Yes	--	--	105	50 to 89	Yes	--	--
Zimbabwe	Yes	Yes	--	63	50 to 89	--	90	90

--: information not provided

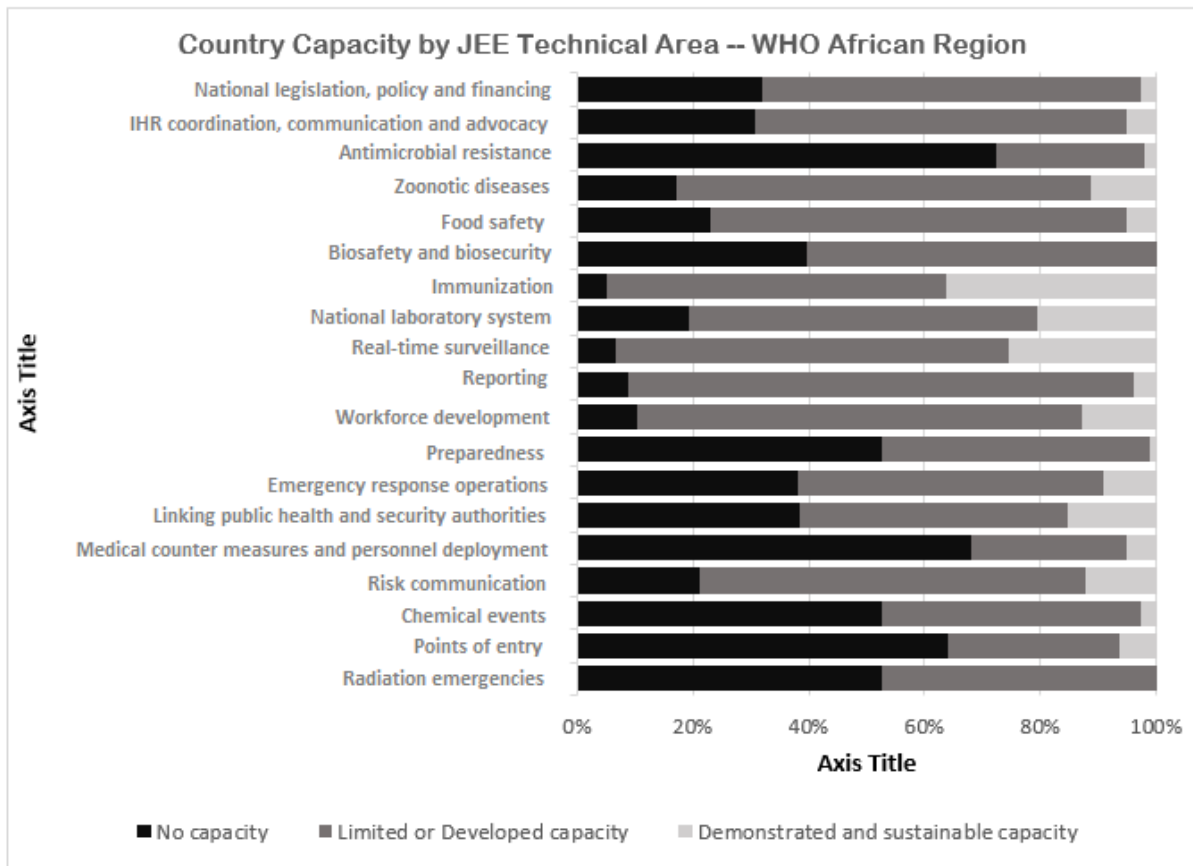
NA: not applicable

*Training conducted in end of 2016

Annex 2: Regional status of IDSR implementation, 2018

Indicator	Status (N = 47)	Percentage achieved
Member States implementing IDSR	44	94%
Member States that have initiated IDSR training at district level	40	85%
Member States that have commenced event-based surveillance (EBS) in the context of IDSR	35	74%
Member States providing information on the timeliness and completeness of IDSR reporting	34	72%
Member States using electronic IDSR systems	33	70%
Member States that have started community-based surveillance (CBS) in the context of IDSR	32	68%
Member States that have achieved the desired target of IDSR timeliness and completeness reporting of 80% or above	23	49%
Member States that have the desired target of at least 90% IDSR implementation coverage at peripheral health facilities	12	26%

Annex 3: Percentage of African Member States in each IHR capacity score level for each of the 19 JEE technical areas (N=43).



Annex 4: Indicators for monitoring the performance of IDSR at Member State level

1. Proportion of health facilities submitting weekly (or monthly) surveillance reports in time to the “district”.
2. Proportion of districts submitting weekly (or monthly) surveillance reports in time to the next higher level.
3. Proportion of cases of diseases targeted for elimination, eradication and any other diseases selected for case-based surveillance that were reported to the district using case-based or line-listing forms.
4. Proportion of suspected outbreaks of epidemic-prone diseases notified to the next higher level within 48 hours of surpassing the epidemic threshold.
5. Proportion of health facilities in which a current trend analysis (line graph or histogram) or spot map is available for selected priority diseases.
6. Proportion of districts that produce a regular weekly (or monthly) IDSR bulletin.
7. Proportion of reports of investigated outbreaks and other public health emergencies that include analysed case-based data.
8. Proportion of investigated outbreaks or events with laboratory results within seven days.
9. Proportion of confirmed outbreaks or other public health emergencies with a nationally recommended public health response within 48 hours.
10. Case fatality rate for each epidemic-prone disease reported.
11. Incidence of priority diseases, events and conditions.
12. Mortality from priority diseases, events and conditions.
13. Number of epidemics detected at the national level that were missed by the “district” level during the last year.
14. Proportion of districts that report laboratory data for diseases under surveillance.
15. Proportion of district laboratories that received at least one supervisory visit that included written feedback from the provincial or national level during the last year.
16. Proportion of districts reporting monthly analysed laboratory data to the national reference laboratory.

“District” for the purposes of this strategy refers to the administrative level next to the national level