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PROGRESS REPORT ON THE IMPLEMENTATION OF THE REGIONAL STRATEGY FOR INTEGRATED DISEASE SURVEILLANCE AND RESPONSE, 2020–2030

Report of the Secretariat

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BACKGROUND

1. The World Health Organization (WHO) African Region is at risk of recurrent health security threats.[1] Emerging and re-emerging diseases continue to challenge fragile African health systems, exacting an enormous human and economic toll.

2. In 1998, Member States adopted the Integrated Disease Surveillance in Africa: A Regional Strategy for Communicable Diseases (1999–2003).[2] The Integrated Disease Surveillance and Response (IDSR) strategy is a comprehensive approach for strengthening national public health surveillance and response systems.

3. In 2019, a revised Regional strategy for IDSR: 2020–2030[3] was endorsed by Member States with the following objectives: (a) strengthen national capacity for early detection, timely reporting, and prompt response to priority diseases, events, and conditions; (b) strengthen national and supranational laboratory capacity to confirm IDSR priority diseases, events and conditions; (c) strengthen capacity for public health emergency preparedness and response; and (d) strengthen the supervision, monitoring and evaluation system for IDSR.

4. This first report summarizes the progress made since 2020 and proposes key next steps. The key achievements are summarized under each of the four objectives.

PROGRESS MADE/ACTIONS TAKEN

5. Of the 45 Member States implementing IDSR, 35 (78%) have incorporated the strategy into their national action plan for health security. To scale up IDSR implementation, national experts from all 47 Member States were oriented on adapting the revised technical guidelines. Subsequently, 41 (87%) Member States[4] adapted the third edition of the IDSR technical guidelines and 33 (70%) of them are implementing electronic surveillance.

6. To improve the skills of health personnel in the districts and health training institutions, three cohorts of virtual trainings to support IDSR roll-out were conducted in 2020–2021. Through these interactive sessions on the district-level training package, 15 000 district health workers across all 47 Member States were trained.

7. In response to the COVID-19 pandemic, all 47 Member States built laboratory capacity to confirm COVID-19. Furthermore, three subregional genomic sequencing hubs were established in Cape Town, South Africa, Dakar, Senegal, and Nairobi, Kenya.

8. Laboratory capacity for confirming other priority threats have also been strengthened. For instance, genomic sequencing capacity to detect viral haemorrhagic diseases (Ebola, Lassa and Marburg) has been developed in the Democratic Republic of the Congo and Guinea. Laboratory capacity for confirming yellow fever, cholera and meningitis was also improved, with the establishment of two additional regional yellow fever reference laboratories.[5]

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1 Talisuna AO, Okiro EA, Yahaya AA, Stephen M, Bonkoungou B, et al., Spatial and temporal distribution of infectious disease epidemics, disasters and other potential public health emergencies in the World Health Organisation Africa region, 2016–2018, Global Health. 2020; 16: 9. Published online 2020 Jan 15. doi: 10.1186/s12992-019-0540-4.

2 Resolution AFR/RC48/8, Regional Strategy for Communicable Diseases: 1999-2003, Regional Committee, Harare, Zimbabwe.

3 Resolution AFR/RC69/6, Regional Strategy for Integrated Disease Surveillance and Response: 2020-2030, Regional Committee, Brazzaville, Republic of Congo, 19-23 August 2019

4 All Member States except Algeria, Gambia, Guinea-Bissau, Mauritius, South Africa, and Zimbabwe

5 Uganda Virus Research Institute in Uganda and Centre Pasteur in Cameroon.

9. All 47 Member States developed costed strategic preparedness and response plans for COVID-19. Thirty-three Member States conducted at least one national multihazard emergency risk assessment. In terms of risk mapping and profiling, 17 (36%) Member States[6] identified to be at risk of Ebola virus disease (EVD) have developed readiness plans. Additionally, all nine Member States[7] bordering the Democratic Republic of the Congo developed contingency plans during the 10th EVD epidemic that occurred in 2018–2020.

10. All 47 Member States have emergency response coordination mechanisms and incident management systems. Of these, 28 Member States have functional emergency operations centres. To test the functionality of capacities to deal with epidemics, 71 simulation exercises have been conducted in 27 (57%) Member States.[8] Further, 10 Member States[9] in the meningitis belt developed or updated their meningitis preparedness/readiness and response plans for the period 2020–2021.

11. The COVID-19 pandemic negatively impacted the implementation of the revised IDSR strategy, resulting in modest progress. Only 21 Member States[10] attained 90% coverage of comprehensive surveillance in the WHO African Region. Nevertheless, the COVID-19 pandemic also created opportunities for reinforcing surveillance and response systems.

12. The implementation of the IDSR strategy has also contributed to overall health system strengthening. However, a lot more needs to be done to build resilient health systems.

13. Low financing has remained a major hinderance to the implementation of the strategy, with only 10 Member States mobilizing over 80% of the finances required for IDSR.

NEXT STEPS

14. Member States should:

(a) conduct high-level advocacy, build strong political commitment, and strengthen technical leadership;

(b) put in place predictable and sustainable financing mechanisms to accelerate strategy implementation;

(c) provide adequate staffing at all levels;

(d) modernize data and information systems including nationwide scale-up of e-IDSR, geographical information systems (GIS) and other digital tools such as Go.Data;

(e) accelerate the improvement of laboratory capacities at national and subnational levels.

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6 Angola, Burundi, Central African Republic, Congo, Côte d'Ivoire, Ethiopia, Guinea, Kenya, Liberia, Mali, Rwanda, Sierra Leone, Senegal, South Sudan, United Republic of Tanzania, Uganda, and Zambia.

7 Angola, Burundi, Central African Republic, Congo, Rwanda, South Sudan, United Republic of Tanzania, Uganda, and Zambia.

8 Burkina Faso, Cameroon, Central African Republic, Chad, Congo, Democratic Republic of the Congo, Eswatini, Ethiopia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Mauritania, Mozambique, Namibia, Niger, Sao Toma and Principe, Senegal, Sierra Leone, South Sudan, United Republic of Tanzania, Togo, Uganda, Zambia, and Zimbabwe.

9 Benin, Cameroon, Chad, Côte d'Ivoire, Eritrea, Ghana, Mali, Niger, United Republic of Tanzania, and Togo.

10 Angola, Burundi, Chad, Comoros, Côte d'Ivoire, Gambia, Guinea, Liberia, Namibia, Niger, Nigeria, Mali, Senegal, Sierra Leone, Togo, Gabon, Lesotho, Rwanda, Uganda, Seychelles, and South Africa.

15. WHO and partners should:

(a) support mapping/updating of risk profiles for the development of evidence-based multihazard preparedness and response plans;

(b) support the integration of IDSR supervision, monitoring, and evaluation into broader sector monitoring systems;

(c) support IDSR implementation by providing updated tools and systems. These should include use of electronic platforms for rapid transmission, analysis and reporting for timely action.

16. The Regional Committee is requested to take note of the progress made and endorse the proposed next steps.