



Enhancing Cross-Border Surveillance, Risk Communication, and Community Engagement for Marburg and other High-Risk Disease Ethiopia, Kenya, Somalia, South Sudan Bishoftu Ethiopia 16th to 18th March 2026



PEACE, PROSPERITY AND
REGIONAL INTEGRATION



Table of Contents

Executive Summary.....	3
Acknowledgement.....	4
Introduction	5
Objectives of the Workshop.....	7
Methodology	7
Key discussions and learnings from the sessions:	8
Marburg outbreak overview of activities; period Nov 25-Jan 26	8
Session: IOM: Risk Mapping and Population Flow Monitoring	9
Session: RCCE Lessons from the Outbreak	10
Session: Summary of Key Lessons Learnt from Ethiopia, Kenya, South Sudan and Somalia.....	13
Session: Cross-border Barrier Identification	14
Session: Cross-border Surveillance and One Health Integration	17
Session: Legal Enablers for Cross-Border Public Health Management	18
Session: SWOT Analysis and workplans	20
Session: Building Resilience in Cross-border Collaborations.....	22
Way Forward and Commitments	25
Conclusion.....	25
Summary of Participant Feedback on the experiences sharing workshop.....	26
Annexes	26

Executive Summary

Following the successful containment of Ethiopia's first Marburg Virus Disease outbreak, declared over on 26 January 2026, the response highlighted the importance of strong coordination while exposing critical gaps in pandemic preparedness, Risk Communication, and Community Engagement (RCCE), community feedback analysis, and cross-border surveillance in a highly mobile and vulnerable region. As Ethiopia transitions from response to recovery, and with neighboring Kenya, Somalia, and South Sudan facing similar structural challenges, the International Federation of the Red cross and Red Crescent Societies (IFRC) convened a regional workshop with governments and National Societies to document lessons learned, strengthen RCCE and Cross-border surveillance as core national capacities, and develop actionable recommendations to enhance early warning, coordination, and community trust for future public health emergencies.

The workshop employed a participatory, multi-method approach including country presentations, group discussions, technical briefings, and plenary sessions to capture experiences, identify gaps, and agree on prioritized actions at national and cross-border levels.

Key Lessons Learned

- **Community engagement and trust are central to early detection and response**, with trusted volunteers, local leaders, and dialogue-based RCCE proving critical in high mobility and border settings.
- **Population mobility mapping is a high-impact preparedness tool**, enabling targeted surveillance, RCCE, and coordination along high-risk corridors and points of entry.
- **Integrated RCCE and surveillance systems are more effective than standalone approaches**, particularly for managing misinformation and translating awareness into behavior change.
- **Cross-border coordination remains uneven**, with gaps in data interoperability, harmonized messaging, and real-time sharing across countries.
- **Legal and governance gaps significantly delay response**, particularly the absence of formalized MoUs, data sharing agreements, and referral protocols at the border level.
- **Strong community -level capacity exists across countries**, but is not consistently matched by institutionalized systems, digital tools, or sustained financing at the border and national levels.
- **Resilient preparedness requires a One Health approach**, integrating human, animal, and environmental health within national and cross-border governance frameworks.
- **Collaborative Partnership Platforms**: Multi-stakeholder, multi-disciplinary platforms that include government leadership and convening regularly are important in building resilient cross-border points.

Overall, the workshop reaffirmed that resilient preparedness in cross-border settings require a shift from short-term, project-based interventions to institutionalized, government-owned systems anchored in community trust. Strengthening RCCE, community feedback, mobility-sensitive surveillance, and legal coordination while reinforcing the auxiliary role of National Societies offers a clear pathway to improved early warning, responsive decision making, and sustained regional resilience. Operationalizing the recommendations using a One Health Approach will require continued political commitment, establishment of formalized cross border frameworks, and sustained investment in community and frontline capacities to prevent and mitigate future public health emergencies.

Acknowledgement

This lessons learned workshop was conducted with the generous support of the Foreign, Commonwealth & Development Office (FCDO), whose funding channeled through the British Red Cross Society (BRCS) enabled critical investments in response recovery, learning, and institutional capacity strengthening following Ethiopia's first Marburg Virus Disease (MVD) outbreak. To leverage the convening of countries and further strengthen the cross-border platform, the Pandemic Preparedness and Response (PREPARE) Program facilitated the participation of additional teams from Ethiopia and Somalia, enhancing regional learning, collaboration, and the complementarity of preparedness investments.

IFRC extends its sincere appreciation to the Government of Ethiopia, particularly the Ministry of Health (MoH) and the Ethiopian Public Health Institute (EPHI), for their leadership, openness, and collaboration throughout the outbreak response and the lessons learned process. Special recognition is given to the Ethiopian Red Cross Society (ERCS) for its pivotal role in community engagement, coordination, and facilitation of this regional learning initiative.

We are grateful to the Governments of Ethiopia, Kenya, Somalia, and South Sudan, represented by officials from Ministries of Health, national public health institutes, One Health coordination mechanisms, and border health authorities, for their leadership, experience sharing, and active engagement in cross-border dialogue and peer learning. We acknowledge the important auxiliary contributions of the Kenya Red Cross Society, Somalia Red Crescent Society, and South Sudan Red Cross Society, and extend appreciation to Africa Centres for Disease Control and Prevention (Africa CDC), International Organization for Migration (IOM), United Nations Children's Fund (UNICEF), World Health Organization (WHO), Intergovernmental Authority on Development (IGAD), the Swiss Red Cross, and UK Health Security Agency/ Foreign Commonwealth & Development Office (UKHSA/FCDO) for their technical expertise, insights, and continued collaboration.

Finally, IFRC acknowledges all workshop participants, facilitators, presenters, and frontline responders whose experiences, reflections, and commitment made this report possible. Their collective contributions continue to shape stronger, community-centered, and resilient systems for cross-border preparedness and response in the region.

Introduction

Following the successful and timely control of the Marburg outbreak, the government of Ethiopia declared the end of the outbreak on 26th January 2026. The Marburg virus disease (MVD) outbreak in Ethiopia was the country's first experience responding to a viral hemorrhagic fever (VHF) emergency. The government attributed the timely response to a well-coordinated effort, supported by key partners. While the outbreak is now over, the risk of future outbreaks of highly infectious diseases remains.

As Ethiopia was responding to the MVD, neighboring countries, namely Kenya, Somalia and South Sudan were on high alert due to high mobility through formal and informal cross-border points. There are uneven pandemic/epidemic preparedness and response capacities across these four countries, as reflected in Joint External Evaluation (JEE) scores for International Health Regulations 2005. There are disparities in infrastructure and health service provision, especially in border areas. Prevalent conflict and security restrictions limit access to health services and disrupt coordination mechanisms. Marginalized cross-border regions often suffer from limited health investments, exacerbating public health issues. Surveillance and port health service efforts are minimal due to low capacity at border areas, leaving the population at the border crossing and the entire community vulnerable. Addressing these issues requires a multifaceted approach, including strengthening health systems, enhancing surveillance, and improving cross-border cooperation.

Risk communication and community engagement remains a critical intervention during an outbreak of a highly infectious disease such as MVD. While response partners in Ethiopia mobilized rapidly and collected community feedback through multiple channels, the outbreak revealed critical structural gaps in national and interagency capacity to systematically analyze, interpret, and operationalize qualitative community data.

As Ethiopia transitions from acute response into recovery, there is a time-sensitive opportunity to document lessons learned from the country's first VHF outbreak and to strengthen pandemic preparedness with RCCE and cross-border surveillance as core national capacities that will be critical for preventing future outbreaks. Without targeted investment now, institutional knowledge risks being lost, and the same gaps in community feedback analysis and use are likely to re-emerge during future emergencies.

The Ethiopian Red Cross (ERCS) received Disaster Response Emergency Fund (DREF) from IFRC for the response and will continue to support activities until May 2026. Additional support for health systems strengthening was received from the Foreign, Commonwealth & Development Office (FCDO) through the British Red Cross Society (BRCS). This funding supports strengthening national response recovery, learning, and institutional capacity strengthening for future VHF outbreaks. The funding provided critical human resources for strengthening inter-agency coordination capacity of MOH, EPHI, and regional RCCE partners. Key activities also include institutionalization of RCCE capacities for community feedback management, qualitative data analysis, and evidence-based decision-making, ensuring that community insights systematically inform outbreak preparedness and response from the outset.

The ERCS, Kenya Red Cross Society (KRCS), South Sudan Red Crescent Society (SSRCS) and Somalia Red Crescent Society (SRCS) are also recipients of the Pandemic Funding, which is disbursed through WHO and IGAD to support cross-border pandemic and epidemic preparedness and response systems strengthening program using a One Health approach.

The IFRC Regional and Ethiopia IFRC cluster convened a three-day regional workshop to document lessons learnt, discuss gaps and challenges in preparedness and response capacities across the four neighboring countries: Ethiopia, Kenya, Somalia and South Sudan. The lessons learnt from Ethiopia's first VHF outbreak and experiences from neighbors were documented and findings will be used in updating national preparedness, response, and recovery frameworks.

The workshop brought together a total of **81 participants including** Africa CDC, the British Red Cross (BRC), the Ethiopian Public Health Institute (EPHI), the Ethiopian Red Cross Society (ERCS), the Swiss Red Cross (SRC), the Somali Red Crescent Society (SRCS), and the IFRC, IOM, the Kenya Red Cross Society (KRCS), the South Sudan Red Cross (SSRC), representatives from the governments of South Sudan, Kenya, Ethiopia, and Somalia, as well as UKHSA/FCDO and UNICEF, reflecting a strong multi-sectoral and cross-border collaboration.



Participants engaging during the workshop

Objectives of the Workshop

The workshop aimed to:

1. Facilitate structured dialogue among government, National Society, and other stakeholders to strengthen cross-border surveillance, risk communication and community engagement (RCCE), community feedback mechanisms and coordination.
2. Facilitate peer learning and exchange of best practices among the 4 countries on community-based surveillance, risk communication, community feedback and trust-building.
3. Review and reflect lessons learnt and make recommendations for Government partner agencies for national, cross-border preparedness response and recovery frameworks (Cross-border surveillance, RCCE and EWS).
4. Identify key gaps in cross-border surveillance, RCCE, community feedback management, and early warning systems and develop a roadmap for capacity strengthening at POE, community, and inter-country levels.
5. Identify the key legal/regulatory and operational barriers to cross-border epidemic surveillance between South Sudan, Ethiopia, Kenya and Somalia, and to agree a government-endorsed coordination package including MoU/SOP annexes, data-sharing and referral protocols.

Methodology

The workshop used a participatory and multi-method approach to capture experiences, lessons learned, and recommendations from the Ethiopia MVD outbreak response and cross-border preparedness efforts. The following methods were used:

1. Funding partners submission on their support to Ethiopia MVD outbreak
2. **Country presentations:** National Societies and government officials delivered PowerPoint presentations on MVD response activities in Ethiopia and preparedness efforts in Kenya, Somalia, and South Sudan, highlighting key actions undertaken during the Ethiopia MVD outbreak.
3. **Country group discussions:** Participants engaged in country-level group discussions using a Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis to identify lessons learned and develop recommendations for sustaining effective practices and addressing gaps
4. **Technical presentations:** Special presentations were delivered to provide additional context and stimulate discussion on key thematic areas, including:
 - Population Mobility Mapping around Ethiopia (IOM)
 - Legal instruments to support Cross-border pandemic preparedness and response
 - Health integration by coordinating human and animal health, sharing zoonotic disease surveillance
 - Review of the community feedback and rumor analysis findings
5. **Panel discussions:** Panel discussions were conducted to explore approaches for strengthening sustainable cross-border collaboration, with a focus on developing and operationalizing Memoranda of Understanding (MOUs) for surveillance, coordination, and data sharing.
6. **Plenary sessions:** Plenary sessions were held to review country draft action plans and consolidate stakeholder recommendations for government, facilitating collective validation, consensus building, and alignment on priority actions.

Key discussions and learnings from the sessions:

Marburg outbreak overview of activities; period Nov 25-Jan 26

The **Ethiopian Public Health Institute (EPHI)** highlighted key milestones and gaps in RCCE during MVD outbreak. The additional funding allowed EPHI to strengthen RCCE and community engagement capacities by assessing evidence and feedback mechanisms, and identifying best practices, challenges, and future priorities.



A presentation session by the Ethiopian Public Health Institute on MVD outbreak response interventions

Community-Based Approaches are Critical for Last-Mile Reach

- Community volunteers are essential for accessing remote and underserved populations. Training and retaining volunteers enhance the continuity, trust, and effectiveness of RCCE interventions.
- In remote border areas where there is low connectivity, innovative solutions (e.g., solar-powered tools) are important to sustain social listening and communication.

Vaccine Hesitancy Requires Targeted, Trust-Based Interventions

- Vaccine hesitancy was observed across populations, including healthcare workers.
- Effective approaches include:
 - Early coordination with Ministries of Health for context-specific strategies
 - Use of role modelling (e.g., vaccinating volunteers first)
 - Community dialogue and engagement with local leaders to build trust and acceptance

Integrated Outreach Enhances Efficiency and Scale

- Coordinating RCCE activities across multiple platforms and partners improves reach and resource utilization.
- Leveraging existing community structures increases credibility and accelerates message uptake.

Mobility Mapping Strengthens Outbreak Preparedness and Response

- Population mobility mapping is a key tool for early detection of disease spread.
- It supports targeted interventions and multi-partner coordination, particularly in high-mobility and cross-border contexts.

Strengthening Data Systems Improves Timeliness and Decision-Making

- Both paper-based and digital systems are currently used; however, digitization is critical to improve:
 - Data timeliness
 - Accuracy and analysis
 - Real-time response actions
- Ongoing efforts to digitize data systems will enhance overall program efficiency.

Bridging the Gap Between Awareness and Behaviour Change

- Awareness campaigns alone are insufficient to drive preventive practices.
- RCCE must incorporate behavioural approaches, including:
 - Dialogue-based engagement
 - Use of trusted influencers and community leaders
 - Tailored, context-specific messaging
- Sustained engagement is required to translate knowledge into action.

Key Implications for Programming

- Prioritize community volunteer systems as a core RCCE delivery mechanism.
- Establish a community feedback mechanism allows the design of interventions that explicitly address cultural norms, beliefs and therefore address vaccine hesitancy through trust-building.
- Strengthen integration and coordination across RCCE platforms and partners.
- Expand use of mobility mapping and data-driven tools for preparedness and response.
- Accelerate digital transformation of data collection systems.

Session: IOM: Risk Mapping and Population Flow Monitoring

The IOM presented findings from the Population Mobility Mapping (PMM) exercise conducted in South Ethiopia. The assessment provided critical insights into how mobility patterns contribute to the risk of public health emergencies, including the recent Marburg Virus Disease (MVD) outbreak. The South Ethiopia Region is characterized by high population mobility, multiple formal and informal Points of Entry (PoEs), and strong cross-border linkages with Kenya and South Sudan. These areas face heightened vulnerability due to their remote location, limited health services, and dynamic movement along corridors.

A rapid response was activated within 24 hours of outbreak confirmation, with partners supporting surveillance, contact tracing, laboratory confirmation, RCCE, and case management. PMM provided a clearer understanding of priority mobility corridors, vulnerable populations, and high-traffic PoEs, which are essential for targeted surveillance, risk communication, and preparedness. The methodology combined participatory mapping, field assessments, flow monitoring, and qualitative consultations with community and border stakeholders.

The findings underscored the importance of mobility-sensitive interventions and reinforced the need for stronger cross-border coordination, evidence-based planning, and integrated surveillance systems. IOM's

contributions, including RRT deployment, PoE screening, capacity building, RCCE interventions, and the installation of screening technologies, played a pivotal role in strengthening outbreak preparedness and response capacity. Overall, the PMM exercise demonstrated that understanding population movement is essential to mitigating multi-hazard risks and enhancing public health resilience in the region.



Dr. Albert Ngetich Kiprotich, Program Manager, Health and Nutrition and MHPSS, IOM during his presentation on Risk Mapping and Population Flow Monitoring.

Session: RCCE Lessons from the Outbreak

The Ethiopian Red Cross and UNICEF shared their experiences of implementing RCCE during Ethiopia's recent Marburg outbreak. Key discussion points include:

- **Trust Barriers and Community Perceptions:**
The Ethiopian Red Cross highlighted major trust challenges that affected response efforts. In Jinja, many community members questioned the existence of Marburg, with widespread rumours undermining risk perception and compliance with public health measures. Additional misinformation framed the outbreak as a curse or as a poison, further complicating engagement and risk communication efforts.
- **Community Engagement and Trust-Building:**
To address these barriers, the National Society worked through trusted community influencers and local leaders to reinforce credible messaging. Volunteers were trained and deployed to engage communities directly and to pre-test communication materials.



Kasahun Tenegu, (On the left) Senior Public Health Specialist, Ethiopia Red Cross Society, making a presentation during Ethiopia's recent Marburg outbreak

- **Community Feedback and Rumor Management**

A Community feedback mechanism was established in the Sidama region and the South Ethiopian region to systematically capture community questions, concerns, beliefs, and suggestions at the branch level. Multiple channels were used, including house-to-house visits, community meetings, hotlines (through the EPHI), and engagement through local leaders and religious leaders. Insights from the Community Feedback Mechanism (CFM) informed rumor management and messaging adaptation.

UNICEF reinforced the importance of timely rumor management, noting that unaddressed misinformation can spread rapidly, erode trust in health authorities, and negatively influence health-seeking behaviors. Rumors may also spill over into perceptions of other diseases and broader health systems. A key operational challenge highlighted by UNICEF was the limited capacity to systematically collect rumors and ensure timely sharing with the appropriate authorities for action.

- **Coordination and Partnerships**

Both IFRC and IOM emphasized that strong collaboration with the Ethiopian Public Health Institute and RCCE partners, which enabled alignment of community engagement strategies and effective use of community insights in the broader outbreak response

Participant example – South Sudan: During the COVID-19 pandemic, vaccine uptake among women was initially low due to rumors that vaccination could cause infertility. To address this, the Ministry of Health organized women-led focus group discussions specifically targeting women in affected communities. These discussions contributed to a shift in attitudes and improved vaccine acceptance. Participants reported greater trust in the information because it was delivered by fellow women, whom they perceived as more relatable and credible messengers.

Participant example – Kenya: During the mpox outbreak, the Ministry of Health deployed nine experts to border areas between Kenya and Somalia, including an RCCE specialist. The team engaged key community structures and stakeholders, such as churches, religious and community leaders, school administrators, and women influencers. They assessed stakeholders’ understanding of mpox and provided training to enable them to disseminate accurate information and promote safe practices for disease prevention within their communities.

Participant example – Ethiopia: The Ethiopian Red Cross Society (ERCS), in collaboration with the IFRC and government health authorities, implemented a comprehensive response to the Marburg Virus Disease (MVD) outbreak, characterized by strong coordination and community-led interventions. A primary pillar of the response was Risk Communication and Community Engagement (RCCE), which used a data-driven approach, including KAP (Knowledge, Attitudes, and Practices) surveys, to tailor messaging. ERCS established robust community feedback mechanisms and sensitized key influencers, including community leaders, religious figures, and youth associations, to foster trust and adherence to public health measures.



Hnin Su Mon, Social and Behaviour Change Specialist, UNICEF Ethiopia, sharing RCCE experiences during Ethiopia's recent Marburg outbreak

Mass communication was amplified through local media outlets like Debub TV and Bansa FM, while over 200 volunteers were deployed for house-to-house outreach, reaching thousands of households with life-saving information. These RCCE efforts were integrated with Community-Based Surveillance (CBS), where trained volunteers conducted active case finding, contact tracing, and screening at 19 points of entry across the Sidama and South Ethiopia regions. The response was further supported by the distribution of IPC/WASH supplies to 50 health facilities, the deployment of ambulances for referrals, and the provision of psychosocial support (MHPSS) to affected families.

Session: Summary of Key Lessons Learnt from Ethiopia, Kenya, South Sudan and Somalia

During this session, government representatives and National Societies from participating countries shared reflections on what worked well and the challenges encountered during preparedness and response efforts. The following cross-cutting lessons emerged:

1. Community Engagement as a Cornerstone of Early Detection

- Strong community engagement, use of trusted local structures, and tailored RCCE approaches significantly enhanced public awareness, acceptance of preventive measures, and timely reporting of suspected Marburg Virus Disease (MVD) cases.

2. Importance of cross-border coordination

- Effective cross-border coordination, especially in high mobility areas, proved essential in reducing the risk of MVD spread. Harmonized approaches, joint mapping, and regular information sharing between countries were highlighted as critical success factors.

3. Strengthened Frontline Capacity and Multisectoral Collaboration

- Investment in training for frontline health workers, border personnel, and community actors improved the quality of surveillance, case detection, and early response.
- Multisectoral and multi-agency coordination accelerated preparedness and enhanced the coherence of interventions across partners.

4. Operational and Systemic Gaps Impacting Preparedness

- Limited logistical capacity, including transport and ICT constraints, weakened the efficiency of surveillance and sample referral systems.
- Inconsistent early messaging and widespread misinformation underscored the need for harmonized communication materials and more robust infodemic management.
- Fragmented reporting structures and limited digital tools for community-based surveillance hindered rapid rumor tracking and linkages to early warning systems.
- Weak laboratory referral pathways and challenges at informal border points further emphasized the need for strengthened PoE systems and cross-border alignment.



Group engagement during the Summary of Key Lessons Learnt from Ethiopia, Kenya, South Sudan and Somalia session.

Session: Cross-border Barrier Identification

Cross-Border Barrier Identification; Surveillance & One Health Gaps: The group identified several critical barriers affecting effective surveillance and One Health implementation at cross-border areas, which collectively limit timely detection, coordination, and response to disease outbreaks:

1. Coordination and Collaboration Challenges

- Weak cross-border coordination contributes to the spread of diseases
- Difficulty in containing outbreaks in border areas
- Absence of formal cross-border coordination structures or committees
- Lack of communication and information-sharing platforms across borders
- Challenges in mobilizing logistics (human resources, supplies, etc.)
- Mobile populations accelerating disease transmission across borders
- Poor road and network infrastructure disrupting early warning and alert systems
- Limited access for volunteers and frontline workers to reach target populations

2. Surveillance and One Health Gaps

- Weak surveillance and reporting systems, including limited or no notification from the community (ground) level and poor information flow from local to national levels
- Delays across the surveillance chain, including alert generation, sharing, escalation, and case confirmation
- Challenges in accessing, verifying, and managing alerts and rumors due to weak rumor management systems

- Weak outbreak detection capacity, including limited active case search and delayed identification of cases
- Poor follow-up and contact tracing, particularly among mobile populations, with disruptions caused by population movement
- Informal cross-border movement with limited screening, documentation, and integration into surveillance systems
- Delays in sample collection, transportation, and access to health facilities, affecting timely response
- Infrastructure constraints (e.g., poor roads and connectivity) limiting surveillance, reporting, and response effectiveness
- Lack of functional One Health coordination platforms in cross-border areas
- Partially functional community-based surveillance (CBS) systems due to limited training, weak supervision, and high turnover of frontline workers and community leaders

3. Infrastructure and Socio-Cultural Challenges

- Poor road and transport infrastructure limiting access to communities
- Weak network connectivity affecting communication and reporting (e.g., hotlines)
- Difficulty accessing and engaging mobile populations
- Low awareness levels among mobile and border communities
- Cultural sensitivities affecting health interventions
- Misperceptions and misinformation about diseases and services
- Language barriers hindering communication and community engagement
- Weak follow-up and contact tracing services

Cross-Border RCCE & Feedback Gaps

The group identified several key barriers affecting risk communication and community engagement (RCCE) and feedback mechanisms at cross-border areas, collectively reducing timely rumor detection, message harmonization, and community accountability.

Coordination Challenges

- Inadequate funding to support cross-border RCCE activities
- Lack of structured systems to capture and track rumors across borders
- Delayed information sharing due to weak coordination mechanisms

Data and Information Sharing Gaps

- Limited capacity to analyze collected data
- Weak ability to harmonize key messages across regions
- Translation and harmonization issues affecting message reach

Systemic and Community-Level Barriers

- Mistrust from communities undermining engagement
- Limited knowledge at the community level, reducing uptake of messages

Legal & Governance Gaps

Focus Areas: MoU limitations, data-sharing barriers, and referral protocol gaps. Prompt: "What legal bottlenecks prevent us from instantly sharing case data or referral protocols between POEs?"

- Participants identified that the main legal and governance barriers to effective cross-border epidemic surveillance and response are the **absence, weakness, or outdated nature of formal cross-border agreements**, especially on data sharing, referrals, and operational coordination. In practice, this means that even where cross-border collaboration is expected, border health and surveillance actors often lack a clear legal basis or agreed procedures to share alerts, case information, screening data, or referral information quickly across points of entry and neighbouring districts. This creates delays in notification, weakens preparedness on the other side of the border, and increases the risk of disease spread before response measures are activated.
- A second major issue raised was **data-sharing restrictions and uncertainty**. Participants noted that health data is often treated as sensitive, with privacy, confidentiality, and sovereignty concerns limiting timely exchange between countries and sometimes even between national agencies. In several contexts, information sharing depends on central government approval, making outbreak alerts highly politicized and slowing operational decision-making. The lack of pre-agreed data-sharing protocols, designated authorities, and interoperable systems means that surveillance data is fragmented, reporting pathways are disrupted, and critical information may not reach relevant actors in time.
- Participants also highlighted **referral protocol gaps** as another barrier. Delays arise where there are no agreed cross-border referral guidelines, no standard procedures for managing suspected cases between border facilities, and no clarity on how patients should be handled regardless of nationality, ethnicity, or place of origin. In the absence of referral protocols, border officials and health facilities may be uncertain about their responsibilities, resulting in delayed assistance, poor continuity of care, and missed opportunities for containment.
- A further theme was **fragmented coordination and limited inclusion of relevant actors**. Participants observed that cross-border coordination is often weak, inconsistent, or concentrated at the national level rather than functioning between border counties, districts, points of entry, and local agencies. Border teams were said to communicate poorly, and surveillance systems often operate in silos. In addition, coordination arrangements do not always sufficiently include all key actors, such as migration authorities, disaster management institutions, local government structures, community leaders, National Society branches, and regional bodies. This limits both early warning and community-level follow-up.
- Participants also emphasised that **operational weaknesses at the border level are closely linked to legal and governance gaps**. Informal crossing points, weak infrastructure, limited staffing, lack of designated key points of entry, technology barriers in border areas, and unclear division of responsibilities all make it harder to implement surveillance and response measures. Without a common framework for collaboration, these challenges contribute to delayed reporting, duplication of effort, weak RCCE and surveillance coverage, and more costly and less effective outbreak response.

Recommendation: Participants highlighted the need for a neutral entity like IFRC to support the convening of governments, especially in conflict-affected countries and their neighbors

Session: Cross-border Surveillance and One Health Integration

This panel discussion examined the current state of cross-border surveillance and health systems integration across Kenya, Somalia, South Sudan, and Ethiopia. Government representatives with expertise in Point of Entry (PoE) health and immigration reflected on operational readiness, community engagement challenges, and regional coordination mechanisms. The discussion underscored the importance of cross-border collaboration in preventing and responding to disease outbreaks, particularly in regions with high population mobility, porous borders, and shared public health risks.



Panel discussion on cross-border surveillance and one health integration

Preparedness and Capacity at Points of Entry

Panelists described varying levels of preparedness and capacity across countries, with Puntland, Kenya, and Ethiopia reporting more structured systems and sustained investment. Puntland highlighted frontline training, refresher courses, cross-sectoral coordination, and functional referral systems. Cross-border committees initially established for tuberculosis were expanded to support broader public health security, including referral pathways to laboratories and health facilities. Kenya reported emergency preparedness plans and routine outbreak-response training at formal PoEs, though preparedness remains focused on formal crossings. Ethiopia described comprehensive measures, including regular training on surveillance and RCCE, simulation exercises, risk assessments, contingency planning, population-mobility mapping, and dedicated preparedness funding. Engagement with community leaders supports traveler awareness and reporting. In contrast, South Sudan reported limited PoE capacity, particularly at the state level. Key challenges include weak coordination, staffing shortages, inadequate remuneration, lack of data-sharing mechanisms, and limited RCCE capacity.

Community Acceptance and RCCE integration

Panelists stressed that technical readiness must be matched by community trust. Kenya highlighted inconsistent information sharing, siloed systems, and RCCE approaches that insufficiently address social and cultural dynamics. Travelers tend to trust familiar local sources more than formal channels. A COVID-

19 example illustrated this risk: opposition from an influential community leader undermined public health measure, contributing to increased transmission and preventable deaths. Participants agreed that RCCE must be locally grounded, socially informed, and better integrated into preparedness systems.

Sustaining Surveillance and Preparedness

Participants emphasized the need to institutionalize preparedness beyond emergency phases. Kenya outlined initiatives targeting high-mobility populations, such as pastoralists, travelers, and refugees, and a partnership with the Kenya Red Cross Society to apply AI tools in surveillance. Efforts are also underway to institutionalize population mobility mapping, reframed as “population connectivity across borders” in collaboration with Africa CDC.

Cross-Border Coordination and Information Sharing

Regional coordination remains uneven. South Sudan called for stronger health infrastructure, cross-border committees, and structured coordination platforms, alongside real-time communication tools for timely information exchange.

Somalia noted low community engagement in preparedness messaging outside active outbreaks and emphasized the need to formalize and standardize information-sharing platforms for improved case tracking.

Key recommendations from panelists

- Strengthen PoE infrastructure and workforce capacity, particularly in under-resourced settings
- Expand preparedness beyond formal crossings
- Integrate RCCE into border health operations
- Institutionalize mobility mapping and surveillance tools
- Formalize cross-border coordination and standardize data-sharing mechanisms

Session: Legal Enablers for Cross-Border Public Health Management

The session emphasized the need for institutionalized, sustainable cross-border systems grounded in national frameworks. It called for states to reflect on international and regional guidance such as the International Health Organization (IHR) 2005, Africa CDC Strategic Framework on Strengthening Cross-Border Surveillance and Information Sharing, IFRC Guidance on Law and Public Health Emergencies, and IGAD Data Health Sharing and Protection Policy Framework. The session also called on participants to reflect on legal enablers being housed in a myriad of instruments rather than one perfect MoU. Participants were encouraged to push for greater political endorsement of cross-border public health management that is implemented through multiple connected operational annexes related to data sharing, and SoPs of public health management at the national, border, and cross border levels. The session also reflected on the importance of institutionalization of the role of National Societies as a trusted community actor through enabling legal frameworks and inclusion of RCCE into legal frameworks.

Participants noted that past mechanisms, such as IGAD TB border coordination committees, collapsed after project closure, highlighting the risk of fragmented, short-term approaches. A central discussion point was the need for mechanisms that allow outbreak alerts to be managed jointly rather than sequentially. This requires pre-agreed coordination structures with clear definitions of who should be involved, spanning different ministries in governments, regional bodies, community actors, National Societies, and other partners.

Participants agreed that effective coordination must be anchored within national systems and supported by:

- Alignment with national legislation, including clear enforcement and escalation pathways
- Strong political commitment
- Integration into national and regional governance frameworks rather than standalone project structures

A recurring gap highlighted was the disconnect between national and cross-border mechanisms, where policies may exist at one level but not be enforced at another. This calls for:

- Bridging national and border-level governance with stronger local engagement
- Establishing responsible bodies for enforcement and follow-up

The discussion also emphasized the importance of:

- Harmonized cross border legal instruments, such as MoUs and SOPs, co-developed by neighboring countries
- Leveraging regional platforms (e.g., IGAD) and international partners (e.g., IFRC) as convenors and technical partners guiding implementation
- Addressing financing gaps by aligning interventions with national budgeting cycles and international frameworks

Key Recommendations / Actions

1. Institutionalize coordination mechanisms within national and regional systems
2. Review and learn from past initiatives (e.g., IGAD TB, RHR) to ongoing programs such as PREPARE implementation
3. Strengthen cross border governance structures aligned with national systems
4. Advocate for and operationalize MoUs and SOPs for data and information sharing
5. Increase awareness and implementation of existing frameworks, especially at border level
6. Integrate community engagement structures into cross border systems
7. Align interventions with national financing and budgeting cycles for sustainability
8. Establish and operationalize One Health governance structures

Another key theme was integrating the One Health (OH) approach by:

1. Institutionalizing OH governance structures at national and cross border levels
2. Ensuring coordination across human, animal, and environmental health sectors
3. Advancing from theoretical concepts to operational, system level implementation, including necessary infrastructure

Session: SWOT Analysis and workplans

During this session, participants were grouped by country to conduct a SWOT analysis of cross-border One Health RCCE, surveillance, policy, and governance systems. The exercise enabled each country team to assess existing capacities, identify gaps, and determine practical opportunities to strengthen cross-border collaboration. These recommendations would inform host governments and partners in prioritising cross-border activity planning for pandemic preparedness and response, and in strengthening cross-border collaboration.



Team Somalia, after successful discussion of the SWOT analysis of cross-border one health RCCE surveillance, policy, and governance



Team South Sudan during SWOT analysis of cross-border one health RCCE surveillance, policy, and governance discussions

Below is the summary SWOT Analysis from the countries.

Category	Kenya	Ethiopia	Somalia	South Sudan
Strengths	Strong RCCE systems, multilingual volunteers, multiple communication channels, active OH committees	National RCCE structures integrated in PHEM; strong outbreak experience; multiple communication channels	Trained volunteers & health workers; functional CEA channels; official IEC materials	Trained community structures; strong partnerships; OH multisectoral mechanism with clear TORs
Weaknesses	Fragmented surveillance; weak border-level coordination; inadequate RCCE teams; funding gaps	Limited RCCE staffing at sub-national levels; weak border communication strategy; limited data sharing	Lack of unified dashboards; limited unified communication across countries; volunteer turnover	Weak data sharing; limited funding; weak feedback mechanisms; high illiteracy
Opportunities	AI for surveillance; inclusion of counties in border committee; regional frameworks (IGAD/EAC)	Growing digital connectivity; stakeholder engagement; joint risk assessments with Kenya	Funding availability; network coverage; functional POEs; existing coordination mechanisms	Africa CDC & IGAD initiatives; OH CBS integration; mobile phone networks
Threats	Porous borders, political instability, frequent outbreaks, climate shocks	High mobility, language barriers, climate disasters, political instability	High population movement, community myths, conflict, funding gaps	Insecurity, donor fatigue, infodemics, high mobility
Overall Pattern	Strong systems + weak harmonization	Strong national systems + weak border engagement	Strong community systems + limited formal structures	Strong partnerships + very fragile operating environment

Session: Building Resilience in Cross-border Collaborations

This panel discussion brought together representatives from the Ministries of Health of South Sudan, Kenya, and Ethiopia, together with the Kenya Red Cross, Somalia Red Crescent Society (SSRC), IOM, and IFRC to examine how resilient cross-border collaboration can be strengthened in practice. The discussion explored how resilience extends beyond emergency response, highlighting the importance of long-term coordination, clearly defined and complementary institutional roles, and sustained investments in systems and capacity. With increasing cross-border mobility and shared public health risks, participants emphasized the need for locally grounded capacity strengthening, community engagement, multisectoral collaboration, and systems that institutionalize preparedness. The plenary offered concrete reflections on the enabling environment required to build and sustain effective cross-border public health resilience. Below are the lessons from the session:



Panel discussion on Building Resilience in Cross-Border Collaborations

1. Understanding Cross-Border Resilience

A core learning from the session is that cross-border resilience is fundamentally community-driven and system-enabled. Stakeholders consistently highlighted that resilience requires:

- Empowering community structures and ensuring continuity of services across borders.
- Strengthening local capacities (CHWs, volunteers, PoE staff) as the first line of defense.
- Moving away from “business-as-usual” by embracing preventive, collaborative approaches.
- Ensuring government ownership to anchor sustainability beyond project cycles.

This reinforces the programme-wide lesson that community systems and government leadership are equally essential pillars in cross-border preparedness.

2. Strengthening Collaboration Across Governments, UN, IFRC and Partners

Panelists emphasized that effective collaboration does not happen organically—it must be formalized and deliberately nurtured. Key learning points include:

- The need for formal frameworks, policies, and legal agreements to guide information sharing and joint action across borders.
- Value of institutionalized coordination platforms bringing together multiple sectors and partners.

- Advocacy as a continuous requirement to ensure workshop commitments translate into leadership decisions.
- Inclusion of a broader set of stakeholders—including migration of actors, pastoralist representatives, and local authorities—to broaden ownership and perspectives.

This demonstrates that alignment and institutionalization are as important as technical interventions in sustaining cross-border action.

3. Systems and Investments That Enable Cross-Border Resilience (5-year horizon)

The panel generated a forward-looking set of practical system investments that can accelerate resilience gains:

- Standardized curricula and scalable training systems for frontline workers that are embedded in pre-service training.
- Interoperable information systems, common data-sharing protocols, and real-time dashboards.
- Strengthened infrastructure at Points of Entry, including laboratory, screening, and isolation capacities.
- Technology-driven solutions, including the use of AI for early detection.
- Mobile and community-based health services tailored for pastoral and migratory populations.
- One Health multisectoral approach, linking human, animal, and environmental health.

These lessons reinforce the importance of systems thinking, not just activities.

4. Operational Learning: What Works in Practice

Across multiple contexts, the following emerged as critical enablers:

- Functional referral pathways and cross-border tracking systems.
- Community-led RCCE, especially for mobile populations.
- Activated and functional cross-border committees with clear TORs.
- Integration of cross-border activities into national development and preparedness plans to ensure continuity.
- Consistent capacity building before, during, and after outbreaks.

A recurring learning is that interoperability—across systems, sectors, and borders—is central for real-time action.

5. Barriers Identified and What They Teach Us

The discussion surfaced several systemic barriers that continue to constrain cross-border collaboration:

- Delays or lack of timely information sharing.
- Absence of legal frameworks governing cross-border health action.
- Differences in digital systems (paper-based vs DHIS2) are hindering interoperability.
- Insufficiently trained PoE staff and limited tools/equipment.
- Political sensitivities, particularly in contested borders.
- Varied levels of willingness and capacity among member states.

The learning here is clear: technical solutions alone cannot solve cross-border challenges—policy alignment and political will are equally important.

6. Opportunities and Strategic Recommendations

Panelists identified strong opportunities that can be leveraged across the programme:

- Use of neutral humanitarian networks (IFRC/RCRC) to sustain dialogue where political processes slow down.
- Leveraging regional frameworks (IGAD, EAC, IOM) to anchor cross-border collaboration.
- Governments budgeting for cross-border preparedness within development plans.

- Expanding innovation, research, and structured knowledge sharing.
- Holding regular cross-border forums to sustain collective action.

These insights underscore the need for multi-level coordination—community, national, and regional—to strengthen readiness and resilience.

7. Key Takeaways Demonstrating Learning in Action

Participants committed to:

- Advocating internally to ensure workshop recommendations are implemented.
- Enhancing coordination across surveillance, RCCE, and One Health sectors.
- Applying lessons from recent outbreaks (Mpox, MVD) to strengthen preparedness.
- Prioritizing high-impact, low-cost interventions that anticipate outbreaks.
- Scaling community-centered, equitable, and context-specific solutions.

This session demonstrated a shift from dialogue to action-oriented learning, a major outcome of the session.



Kasahun Tenegu, Senior Public Health Specialist, Ethiopia Red Cross Society, during the closing session of the workshop

Way Forward and Commitments

- At the country level, institutionalize and sustain One Health RCCE and interoperable surveillance systems as core PPR pillars.
- Strengthening coordination, harmonization, and cross-border alignment of One Health RCCE frameworks, and surveillance systems among Member States (training, SIMEX, 7-1-7 approach, data management & sharing, etc.).
- Advocate for the development of One Health policies and governance frameworks that align national, border, and cross-border level coordination.
- Cross-border One Health risk mapping, and population mobility mapping to inform PPR action plans.
- Evidence generation, documentation, and dissemination across Member States for cross-learning, experience sharing, and advocacy.
- Advocacy for sustainable financing for joint cross-border OH RCCE interventions- domestic (government & private sector) and donor funding.
- Advocate for the designation of eligible cross-border points of entry that are not currently designated to attract government funding and resources to man the borders. Support existing designated cross-border points of entry with necessary equipment and supplies for pandemic preparedness and response.
- Conduct a comprehensive mapping of cross-border One Health workforce in the IGAD countries and maintain an updated list of the available cadres across PPR technical areas for rapid emergency response deployment.

Conclusion

This workshop, which brought together key stakeholders and partners, provides the IFRC and NS with an opportunity to scale up cross-border surveillance and interventions in the Africa region, using lessons learnt and recommendations made.

Summary of Participant Feedback on the experiences sharing workshop

Participant feedback indicates a high level of overall satisfaction with the training. Across all days, participants consistently rated the sessions as relevant, well-structured, and applicable to their work in cross-border preparedness and response.

Most participants (over 75%) reported that the training content was highly relevant to their roles and addressed key operational priorities, particularly in surveillance, coordination, and RCCE integration. Facilitation was also strongly rated, with participants highlighting clear delivery, effective moderation, and inclusive engagement that enabled knowledge sharing across countries and institutions.

83% of participants indicated they were confident in applying tools and approaches introduced during the training. The interactive format, including panel discussions and practical exercises, was particularly valued.

Areas for improvement:

1. Requests for more time for discussion, additional practical and scenario-based exercises, and broader inclusion of subnational and operational-level stakeholders to strengthen implementation.
2. Overall, the training was seen as impactful and well-organized, contributing to strengthened collaboration, shared understanding, and commitment to advancing cross-border resilience. Participants expressed a strong interest in follow-up engagements focused on implementation and action planning.

Annexes

- [Agenda](#)
- [Presentations](#)
- [Link to the photos](#)

Annex 1: List of Participants

No	Full Names	Organization
1.	Dr. Aniekeme UWAH	Africa CDC – HE DID NOT ATTEND
2.	Sarah Harvey-Kelly	BRC
3.	Christina Mangunda	British Red Cross
4.	Shiferaw Negash	EPA
5.	Temesgen Lemi	EPHI
6.	Yibeyin Muluarem	EPHI
7.	Belayien Kokobe	EPHI
8.	Ashendfi Sisang	EPHI
9.	Etsehiwot zemenak	EPHI
10.	Aster Tarfa	ERCS
11.	Gashaw Dagne	ERCS
12.	Kassahun Tegegne	ERCS
13.	Tifist Tamirat	ERCS
14.	Abebe Gelona	ERCS
15.	Zelalem Enyew	ERCS - Gambella BO
16.	Temesgen Robel	ERCS - Jinka BO
17.	Husen Mahad	ERCS- Moyale BO
18.	Catherine Kamatu	IFRC
19.	Elisabeth Ganter	IFRC
20.	Elizabeth Gonese	IFRC
21.	Hanna Mekonnen	IFRC
22.	Hellen Kariuki	IFRC
23.	Henry Musembi	IFRC
24.	Michael Aiyabei	IFRC
25.	Stella Barasa	IFRC
26.	Stella Ngugi	IFRC
27.	Gemechisa Mustefa	IFRC
28.	Lucy Ndombi	IFRC Ethiopia
29.	Matt Baden	IFRC Ethiopia
30.	Mignot Admassie	IFRC Ethiopia
31.	Misrak Mersha	IFRC Ethiopia
32.	Robi Wambura Gikaro	IFRC Ethiopia
33.	Sahal Abdi	IFRC Ethiopia
34.	Tesfa Adugna	IFRC Ethiopia
35.	Yves Stephane NGALEU	IFRC Ethiopia

36.	Abdinasir Ali Mohamoud	Immigration and Border Control Office
37.	NGETICH Albert Kiprotich	IOM
38.	Audrey Nasirumbi	KRCS
39.	Marian Noor Yarow	KRCS
40.	Paul Olale	KRCS
41.	Roy Kimtai Bett	KRCS
42.	Mawlid Mustafe Ahmed	Ministry of Environment and Climate Change
43.	Mohamed Hassan Ahmed	Ministry of livestock and Rural development
44.	Abadit Mifuse	MOH
45.	Dr.Ermicas Gebre	MOH
46.	Hamse Ali Mohamed	MoH - Development
47.	George Giathi Kamau	MOH-KNPHI
48.	Michelle Sagalla	MOH-KNPHI
49.	Samuel Kadivane Kazi	MOH-KNPHI
50.	Wycliffe Matini	MOH-KNPHI
51.	Ariath Them Buoi	MOH-SS
52.	Deng Santino Ngong Garang	MOH-SS
53.	Obat Denis Mary Denis	MOH-SS
54.	Turuk Gatjang Gatdep Gorong	MOH-SS
55.	Dr Roba Jilo	One Health Actors
56.	Dr. Feyisa Regassa	One Health Actors
57.	Shiferaw Negash	One Health Actors
58.	Melka Mesfin	S/Ethiopia BO
59.	Robel Orsango	S/Ethiopia BO
60.	Abebe Wana	Sidama BO
61.	Demelash Wachamo	Sidama BO
62.	Abdiket Ahmed	Somale BO
63.	Bekene Dagni	SRC
64.	Abdikani Said Hassan	SRCS
65.	Abdirashid Mohamed Ali	SRCS
66.	Abdiwahab Abadir Hirsi	SRCS
67.	Abdulahi Abdikafi Hersi	SRCS
68.	Ahmed Bashir Bulshale	SRCS
69.	Hussein Mohamed Osman	SRCS
70.	Mahad Yusuf Jama	SRCS
71.	Mahamoud Mohamed Hussein	SRCS
72.	Muhyadin Abdillahi Ali	SRCS

73.	Mustaqim Mohamed Mohamoud	SRCS
74.	Gori Joseph Lukak Charles	SSRC
75.	Gune Rebecca Alum William	SSRC
76.	Kiringen Konyi Yoman	SSRC
77.	Namurihono Lodura Charles Kamilo	SSRC
78.	Amitabh Sharma	Swiss Red Cross
79.	Bayad Noland	UKHSA/FCDO
80.	Osman Dar	UKHSA/FCDO
81.	Hnin Su Mon	UNICEF