REPORT

FOREIGN AID AND ONE HEALTH IN A CHANGING CLIMATE:

WHERE DO WE GO FROM HERE?

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Sumner M. Redstone Global Center for Prevention & Wellness
THE GEORGE WASHINGTON UNIVERSITY

coregroup

SUMMARY OF A ROUNDTABLE DISCUSSION

On May 27, 2026, the Sumner M. Redstone Global Center for Prevention and Wellness and the CORE Group co-hosted a hybrid roundtable at the George Washington University Milken Institute School of Public Health in Washington, D.C.[1] The convening brought together 31 leaders and experts spanning academia, multilateral agencies, government bodies, and non-governmental organizations to address a critical challenge: optimizing the efficiency and impact of zoonotic disease prevention and control through a One Health lens, amid escalating climate risks and tightening global health financing. Prior to the roundtable, participants received a comprehensive pre-read briefing document to guide and frame key discussion topics.

This report presents the key insights, participant recommendations, and curated resources emerging from the discussion.

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[1]The roundtable was conducted before the quadripartite organizations extended the implementation period of the Joint Plan of Action from 2022–2026 to 2029.

TABLE OF CONTENTS

I. Climate Change as a Systemic Driver of Zoonotic Disease Risks	04
II. Community-Level Capacity and Trust as a Bedrock	05
III. Governance, Financing, and Political Economy Challenges	07
IV. Impacts on Vulnerable Pastoral Populations and Their Livelihoods	11
V. Persistent Imbalance Across One Health Sectors	12
VI. Gaps in Surveillance, Data Systems, and Early Warning and Response Systems	13
VII. Opportunities for Integration, Innovation, and Coordination	15
VIII. Actionable Recommendations for One Health Operationalization	17
Conclusion	19
List of Participants	20
Annex - One Health Resources Table	22

I. CLIMATE CHANGE AS A SYSTEMIC DRIVER OF ZOONOTIC DISEASE RISKS

The roundtable opened with an analysis of the direct relationship between climate variability and zoonotic disease emergence, highlighting recent severe climate shocks that have impacted disease transmission (e.g., the recent prolonged drought across the Greater Horn of Africa has contributed to increased risks of cholera, measles, and malaria outbreaks). Participants emphasized that climate change serves as a primary, accelerating driver of health threats across the human-animal-environmental interface. For example, despite contributing less than four percent of global greenhouse gas emissions, the African continent suffers a disproportionate burden of climate hazards, with nine of the world's ten most climate-vulnerable nations.

Shifting Disease Ecology & Vector Dynamics

Rising temperatures, altered precipitation patterns, and extreme weather events are fundamentally reshaping disease ecology. These shifts are driving vectors and reservoir hosts into previously low-risk regions, including higher altitudes and expanding latitudes, while altering vector behavior, survival, and seasonal transmission dynamics. Consequently, vector-borne diseases such as malaria, Rift Valley fever, and dengue are expanding into novel geographic corridors. At the same time, the tools that prevent these diseases are being disrupted: in an April 2025 survey conducted by the World Health Organization (WHO) of 64 malaria-endemic countries, more than half reported moderate or severe disruptions to malaria services, and more than 40 percent of planned insecticide-treated net campaigns were delayed or at risk (WHO, Departmental update, 2025). Simultaneously, acute environmental disruption is intensifying human-wildlife contact; for instance, post-drought rodent incursions into domestic spaces have driven surging Lassa fever incidence. El Niño phenomena can further intensify and increase risks of extreme weather, with both increased and decreased precipitation, leading to more severe health impacts on climate-vulnerable populations. Furthermore, climate-induced shifts in pastoral migration routes and soil disturbance directly exacerbate endemic zoonoses including anthrax, brucellosis, and trypanosomiasis.

Compounding Feedback Loops & Systemic Risk

Climate change operates through complex feedback loops with socioeconomic and institutional systems, compounding health risks across three major dimensions:

- **Livelihood Disruption:** Climate stress forces shifts in agricultural production, livestock management, and asset loss, altering human-animal interaction patterns.
- **Population Mobility:** Forced displacement and altered migration pathways heighten human and animal exposure along transit routes and within informal settlements.
- **Governance & Service Strain:** Fragile delivery systems are overwhelmed by concurrent shocks, degrading public and animal health infrastructure.

Together, these interlinked factors drive both primary pathogen spillover caused by ecological disruption and secondary disease amplification linked to informal or small-scale livestock production shifts.

Implication: Given the transformation of ecological and climatic conditions, traditional, static disease surveillance models are insufficient. Effectively assessing and managing the evolving biological threat landscape will require dynamic, integrated, and adaptive bio-surveillance and risk governance frameworks. These frameworks should facilitate the development, evaluation, and enhancement of tools, methods, and guidance for zoonotic disease prevention, detection, diagnosis, and control.

The article, **"One Risk: Strengthening Regional Risk Modelling Capacity and Collaboration,"** serves as a best-practice model for mitigating systemic drivers of zoonotic disease risks, including those exacerbated by climate change and environmental degradation through localized capacity building and quantitative analytics (Costard, 2025). Implemented across West and Central Africa by EpiX Analytics in partnership with the World Organisation for Animal Health (WOAH) and the U.S. Department of Agriculture Animal and Plant Health Inspection Service (USDA-APHIS), the One Risk initiative trained 55 multidisciplinary professionals across 12 countries to translate complex epidemiological, ecological, and trade data into actionable, stochastic risk models using open-source tools. By combining a 12-month mentorship framework with cross-sectoral collaboration, the program bridged the gap between basic ecological science and applied policy, successfully producing evidence-based strategies for zoonotic threats like anthrax, brucellosis, and avian influenza. Ultimately, the initiative demonstrates that institutionalizing regional, data-driven modeling capacity enables low- and middle-income countries to move from reactive crisis management to proactive, climate-resilient risk forecasting and disease prevention.

II. COMMUNITY-LEVEL CAPACITY AND TRUST AS A BEDROCK

A central theme of the roundtable was the essential role of communities and frontline actors in health security. As one participant emphasized, "*Outbreaks start and end in these communities.*" Participants stressed that communities must serve as co-designers and decisionmakers in zoonotic disease prevention, rather than passive beneficiaries or downstream consultation targets. Engaging local actors early builds trust, a prerequisite for effective disease surveillance, rapid reporting, and sustained behavior change. Conversely, a lack of trust creates an information vacuum that enables misinformation and compromises outbreak response efforts.

Recognizing and Resourcing the Frontline Workforce

Community-rooted actors, such as Community Health Workers (CHWs), Community Animal Health Workers (CAHWs), and formal and informal local networks, constitute the primary defense against emerging threats and serve as first and last responders in hard-to-reach areas. Their value extends beyond service delivery: as trusted members of their communities, they can facilitate early detection and reporting, strengthen community acceptance of health information and interventions, and provide an essential link between communities and formal health and veterinary systems. Despite providing essential primary health, veterinary, and early warning services where formal infrastructure is weak, these workers remain chronically under-compensated and under-recognized within national systems.

Promising Models for Community-Based Action

Participants highlighted several operational models that effectively integrate local actors into One Health frameworks:

- **Integrated Service Delivery Hubs:** Single-entry facilities or mobile platforms combining primary human healthcare, nutrition, and veterinary/livelihood support.
- **Community-Based Surveillance (CBS) Networks:** Local reporting channels that capture real-time health anomalies at the human-animal-environment interface.
- **Institutional Partnerships:** Engagement with faith-based, traditional, and educational leaders to mobilize communities, counter misinformation, and facilitate service linkage.

Strategic Priorities for Localized One Health Systems

Operationalizing a truly community-centered model requires moving beyond informal engagement to systemic institutional alignment:

- **Cross-Disciplinary Frontline Training:** Update CHW and CAHW training curricula to build cross-sectoral competencies, enabling workers to recognize syndromic indicators and community-based case definitions of zoonotic threats in both humans and livestock. Capacity enhancement of frontline workers should reference the WHO's Competency for One Health Field Epidemiology framework and the FAO/WHO/WOAH online coursework for joint responses to zoonotic disease outbreaks.
- **Integrated Syndromic & Climate Surveillance:** Establish lightweight, community-led surveillance frameworks that connect localized early warning indicators (e.g., unusual animal mortality, climate anomalies) with national health monitoring architectures.
- **Institutionalization of Local Intelligence:** Reform national surveillance protocols to systematically receive, validate, and respond to community-level alerts and informal reporting streams.
- **Incentives:** Local communities and frontline community workers should receive fair compensation and recognition for their engagement and contributions to surveillance efforts.

Implication: Treating communities as equal collaborators, rather than passive recipients, requires structural investment in frontline workforce capacity, integrated surveillance tools, and governance frameworks that value and act upon local intelligence. Sustained community trust is essential to making these systems effective.

The article **"One Health activities to reinforce intersectoral coordination at local levels in India"** (Taaffe et al., *Frontiers in Public Health*, 2023) highlights local community-level capacity and trust as the foundational bedrock for operationalizing One Health frameworks. The authors demonstrate that while national-level governance structures exist, effective zoonotic disease prevention, surveillance, and response depend heavily on formalizing day-to-day intersectoral coordination among sub-district health, veterinary, and environmental actors. By establishing ground-up trust, through community-tailored education targeting rural farmers and school children, cross-sector laboratory diagnostic sharing, and joint outbreak investigations, the study illustrates how empowering local frontline networks bridges the gap between high-level policy and real-world field implementation, turning community intelligence into proactive health security.

The paper, **"One Health approaches require community engagement, education, and international collaborations—a lesson from Rwanda"** (Henley, Igihozo, & Wotton, *Nature Medicine*, 2021) provides a real-world blueprint for operationalizing community-level capacity and trust as the primary bedrock of One Health. Drawing on implementation experiences at the University of Global Health Equity in Rwanda, the authors demonstrate that sustainable health security cannot be achieved through top-down mandates alone; it requires deep community immersion, transdisciplinary workforce education, and cross-border partnerships. By co-designing educational and field initiatives directly with local populations, training future health professionals to recognize human-animal-environmental linkages, and cultivating trust through transparent engagement, the paper proves that empowering frontline communities turns local knowledge into early detection and builds lasting health system resilience.

III. GOVERNANCE, FINANCING, AND POLITICAL ECONOMY CHALLENGES

Participants identified governance and financing structures as the primary bottlenecks to operationalizing One Health frameworks globally. While conceptual consensus around One Health exists, translation into sustained field-level implementation is severely hampered by institutional fragmentation, political instability, and misaligned financial incentives.

Institutional Silos and Governance Deficits

- **Ministerial Fragmentation:** Sectoral mandates naturally drive health, agriculture, environment, and finance ministries into institutional silos, preventing joint planning and resource pooling.
- **The Subnational Execution Gap:** National One Health coordination platforms often exist only on paper, failing to establish operational mechanisms, reporting pathways, or authority at subnational and community levels.
- **Complex Emergencies and Fragility:** Political instability and active conflict severely impede health access and outbreak containment. For example, ongoing security crises in the Democratic Republic of the Congo (DRC) continually disrupt surveillance infrastructure and delay containment efforts for Ebola and mpox outbreaks.
- **Absence of Local Spatial Governance:** Current governance frameworks rarely address land-use planning or the spatial regulation of small-to-medium intensified livestock production, particularly in high-risk zoonotic hotspots. For example, the 2026 Bundibugyo Ebola outbreak was first recognized as a cluster of deaths in an artisanal gold-mining zone in Ituri, DRC, although the spillover event has not been identified (Zhang et al., Infectious Medicine, 2026).

> **Operational Benchmark — Zambia's National One Health Strategic Plan:** Participants highlighted Zambia as a strong example of operational One Health governance (Hamoonga et al., *One Health Cases*, 2024). Its multisectoral framework has supported coordinated mobilization and response during concurrent health and climate-related emergencies, including anthrax outbreaks and severe drought.

Financing Imperatives: From Extractive Surveillance to Sustainable Services

Financing gaps extend beyond simple resource scarcity; they represent a fundamental failure to build self-sustaining, community-anchored models.

- **Sustainability Trap:** The most critical gap in One Health is not recent funding shifts, but the long-standing dependency of community-level interventions on transient donor financing.
- **Incentivizing Local Surveillance:** Integrated CHW and CAHW networks, paired with smartphone-based reporting, show immense promise for early warning. However, these systems frequently collapse when donor funds for basic operational costs (e.g., mobile data credit) expire.
- **Non-Extractive, Value-Adding Models:** Effective surveillance must not be purely extractive (collecting local data for central databases without returning value). To be sustainable, surveillance must be tied to cost-recovering local health and veterinary services that address immediate community priorities. For instance, digital reporting tools should instantly connect farmers with care providers or automated diagnostic guidance.
- **Farmer-Led Biosecurity Models:** Programs like the Food and Agriculture Organization's (FAO) African Swine Fever biosecurity models demonstrate that smallholder farmers will invest in and maintain biosecurity protocols when they yield direct, measurable economic, and herd-health benefits.

Geopolitical Realities and the Retrenchment of Global Health Security

Shifting donor dynamics and geopolitical realignments pose severe threats to the future of integrated One Health governance.

- **Prioritization of Funding for Public Health Response over Prevention:** Chronic resource competition inherently favors reactive public health initiatives over preventive actions and investments in the animal health/veterinary and environmental sectors. High-profile human disease outbreaks (e.g., Ebola, Marburg) consistently trigger reactive funding in human health infrastructure, leaving animal health systems chronically underfunded. The 2026 Bundibugyo Ebola outbreak followed this pattern: within a week of a Public Health Emergency of International Concern being declared, the U.S. Department of State announced $23 million in bilateral assistance and $50 million through UN pooled funds for treatment clinics. At the same time, U.S. funding for the International Rescue Committee's outbreak preparedness work in eastern DRC had largely ended in March 2025, according to the organization (Kent & Hansler, CNN, 2026). Smaller investments in animal health also tend to favor reactive over preventive measures, such as the response to the 2024 H5N1 avian influenza outbreak (Mostafa, Nogales & Martinez-Sobrido, *npj Viruses*, 2025).
- **The Pivot to Bilateralism:** The growing donor trend towards bilateral agreements and strict national security framing is shifting global health priorities. Current bilateral funding streams predominantly target Ministries of Health, largely bypassing gaps that Joint External Evaluations repeatedly flag in capacities that depend on the animal health, agriculture, and environment sectors, such as antimicrobial resistance and biosafety and biosecurity (Gupta et al., *Journal of Global Health*, 2018). Published summaries of the 35 bilateral health agreements signed under the U.S. Department of State's America First Global Health Strategy (as of September 2026) center largely on HIV, tuberculosis, malaria, maternal and child health, polio, and human-health surveillance and outbreak response (KFF, 2026).
- **Erosion of Multisectoral Incentives:** As funding concentrates on public health mandates, the political and financial incentives ("carrots and sticks") that previously drove the establishment of national One Health platforms, common data architectures, and joint outbreak investigations are evaporating, threatening to reverse a decade of progress, even as the WHO Pandemic Agreement adopted in May 2025 calls for a One Health approach to pandemic prevention, preparedness, and response (Article 5).
- **Disincentivizing Regional Cooperation:** The transition away from multilateral and multi-country platforms (e.g., WHO, which the United States formally exited on January 22, 2026, and the Global Health Security Agenda) towards isolated bilateral agreements undermines vital regional mechanisms. Prior gains in regional data sharing, cross-border capacity building, and joint response frameworks, particularly within bodies like the Association of Southeast Asian Nations (ASEAN), the Pan American Health Organization (PAHO), and Africa CDC, are increasingly at risk, compounding global vulnerability to future pandemic threats.

Implication: Effective One Health implementation requires integrated governance structures, sustainable domestic and international co-investment and co-financing, and proactive policy engagement. To overcome systemic barriers, the scientific and technical community must expand its influence beyond academia to actively engage policymakers, counter anti-science sentiment, and re-establish public trust in evidence-based decision-making.

Furthermore, global health security frameworks must evolve beyond a strict dependence on traditional, public-good grant funding. Stakeholders should explore market-driven, cost-recovering One Health models, such as farmer-funded biosecurity interventions and marketable diagnostic technologies. At the same time, One Health investments should align strategically with the economic, national security, and diplomatic priorities of major international donors, including the U.S. Department of State, whose America First Global Health Strategy sets a goal of detecting outbreaks with epidemic potential within seven days of their emergence. For zoonotic threats, meeting that target depends on animal health and community-based surveillance, which gives One Health a concrete entry point into bilateral agreements (see the 7-1-7 approach in the Annex).

Kenya has worked to operationalize One Health at the subnational level by establishing **County One Health Units (COHUs)** across its 47 counties (COHESA, 2023). Managed by the national Zoonotic Diseases Unit, this initiative aligns closely with Kenya's decentralized health governance, placing essential tools directly into the hands of local authorities who are closest to public health threats. By equipping local personnel to coordinate responses, detect outbreaks, confirm pathogens, and manage risks independently, the COHU model addresses critical health vulnerabilities, particularly in remote, arid regions. Historically, these areas have experienced severe climate-driven zoonotic events, such as Rift Valley fever outbreaks, which inflict devastating human and economic tolls. Decentralizing capacity is specifically designed to foster closer engagement with pastoralist populations, building local ownership and strengthening community trust from the ground up. Operationally, this decentralized model drives multisectoral integration and surveillance innovation by encouraging flexible communication pathways across departments. For example, informal data-sharing mechanisms, such as localized WhatsApp networks in Isiolo County, have successfully bridged animal and human health sectors to accelerate early threat detection. Despite facing ongoing governance and financing challenges at the subnational level, COHUs have demonstrated an impact across Kenya. The Kenyan government expects COHUs to serve as a vital mechanism for mitigating diverse health risks, including zoonotic spillover, antimicrobial resistance, and food and water safety threats.

IV. IMPACTS ON VULNERABLE PASTORAL POPULATIONS AND THEIR LIVELIHOODS

Roundtable participants highlighted that underserved and pastoralist communities face a disproportionate burden from climate hazards. In Kenya, for instance, pastoralists have suffered severe livestock losses of up to **70 percent during major droughts**. Floods have also contributed to livestock losses through increased waterborne disease risk. Despite generating a primary share of East Africa's livestock production and regional trade, **over 40 percent of pastoralists live in poverty**. Their close, daily interactions with animals and changing environments create heightened exposure to emerging zoonotic threats.

Beyond infectious disease risks, climate stress cascades across multiple socioeconomic dimensions, driving the rapid depletion of core household wealth. For example, disease outbreaks in camels can be devastating to household livelihoods, as they can be valued between US$1,000 and US$2,000 per head. Climate-induced drops in milk and meat production also exacerbate acute malnutrition and food insecurity. These economic and nutritional pressures frequently trigger social disruption, escalating conflicts over shrinking natural resources and heightening displacement risks. These multi-dimensional vulnerabilities are further compounded by severe infrastructure gaps in remote pastoral regions. Extreme geographic distances prevent access to functional human and veterinary health facilities, supply chain fragilities lead to chronic stockouts of essential medicines and vaccines, and systemic neglect forces communities to rely almost entirely on informal market actors or under-resourced community volunteers.

Implication: Among pastoral communities, human health, animal health, food security, and poverty are inextricably linked. Effective solutions for this high-risk population require cross-sectoral, system-wide solutions that reinforce local health architecture and are tailored to the specific needs of pastoral communities.

The **"Kimormor" approach in Turkana** is a community-centered innovative mobile One Health model that delivers integrated livestock health services alongside maternal and child healthcare to nomadic pastoralist communities in Kenya (Ollinga, Amref Health Africa, 2025). Operating in remote areas far from health facilities, the program strategically leverages livestock health, a primary cultural and economic priority, as an initial draw for community members. Once on-site, families receive public health interventions, including antenatal and postnatal care, routine vaccinations, nutritional screenings, and civil registration services. This multisectoral strategy has achieved a dramatic reduction in maternal mortality, from 1,594 down to 381 per 100,000 live births, by building community trust and adapting clinical care to local customs, such as utilizing traditional birth stools and re-envisioning traditional birth attendants as trusted "companions." (Continue next page)

Beyond direct clinical care, the initiative relies on real-time digital data collection via the Electronic Community Health Information System (eCHIS) to empower community health promoters and directly inform county-level decision-making. To maximize outreach, the model also demonstrates the value of integrating health clinics with high-demand civil services, such as national identity card issuance. Ultimately, the long-term sustainability and impact of the Kimormor model stem from strong governance and alignment of political and economic strategies. A highlight of this political engagement was the Turkana County government codifying the Kimormor integrated health strategies into law through the Community Health Services Act of 2018.

V. PERSISTENT IMBALANCE ACROSS ONE HEALTH SECTORS

One Health is an integrated, unifying approach that aims to sustainably balance and optimize the health of people, animals, and ecosystems (One Health High-Level Expert Panel et al., *PLoS Pathogens*, 2022). This concept recognizes that the health of humans, domestic and wild animals, plants, and the broader environment are intrinsically linked and interdependent. By mobilizing diverse sectors, disciplines, and communities across all levels of society, a One Health approach fosters holistic well-being and mitigates complex health threats while simultaneously advancing climate action, food and water security, sustainable energy, and broader equity goals.

However, a fundamental systemic challenge within One Health implementation is the disproportionate focus on human health, which drives chronic underinvestment in the animal and environmental health sectors. For instance, animal health receives as little as 0.6 percent of global health spending and at most 0.02 percent of global climate finance, compared to approximately four percent allocated to agriculture (WOAH, 2026; HealthforAnimals; WBG, 2024) . Laboratory capacity building, surveillance infrastructure, and operational funding remain overwhelmingly skewed towards public health systems, neglecting veterinary and environmental monitoring networks. For example, a scoping review of 77 programs implementing One Health strategies reported that none of the programs involved the environment sector and its impact on human or animal health (Milazzo et al., *One Health*, 2025).

This funding disparity obscures our understanding of how ecosystem degradation and animal dynamics drive climate-amplified zoonotic threats. Furthermore, limited veterinary capacity hinders effective animal health measures. In Latin America for example, outbreaks of rabies in humans and other animals are intimately tied to livestock vaccination status, but resource limitations and limited veterinary services can make this type of preventive immunization

impossible. Because nearly 75 percent of emerging infectious diseases in humans originate in animals, continuing to prioritize reactive human health measures over upstream spillover prevention compromises global health security (CDC, 2025).

Implication: Without rebalancing investments equitably across the human, animal, and environmental sectors, One Health surveillance frameworks and zoonotic disease prevention efforts will remain fundamentally fractured and ineffective.

VI. GAPS IN SURVEILLANCE, DATA SYSTEMS, AND EARLY WARNING AND RESPONSE SYSTEMS

Participants consistently noted continued systemic weaknesses in surveillance and data integration that have worsened over the past year. Issues around fragmented systems include poor interoperability across human, animal, and environmental data systems and limited cross-border and inter-institutional data sharing. The sector also struggles with insufficient infrastructure. Surveillance systems are weak or absent in many low- and middle-income countries (LMICs), particularly fragile and conflict-affected contexts. While human and veterinary laboratory capacity is improving across many LMICs, environmental diagnostics capacity remains limited.

Another challenge specific to zoonotic disease prevention relates to misaligned incentives in the livestock sector. Livestock producers often lack incentives to report outbreaks or do not perceive a return on investment for doing so. This challenge leads to significant data gaps in zoonotic disease surveillance.

To address these gaps, participants mentioned the following issues that need to be addressed:

- National and regional frameworks and policies have not been consistently translated into action at the community level.
- Data flows do not extend beyond reporting to support decision-making within government structures and at the community level. A participant noted that *"Surveillance isn't supposed to be extraction but information for action."*
- Foreign assistance cuts have made it difficult for trained specialists to keep their jobs in laboratory surveillance. As one participant stated, *"A year ago [technicians] were working in the lab, and now they are driving a taxi in Kinshasa."*

Recent technological advances in laboratory surveillance have produced new high-speed genomics tools that can improve global sensitivity to crossover events and outbreaks. However, these tools require training and dedicated personnel to operate them. One participant described these surveillance technologies as *"either planned centralized service or sustainable remote systems — lab in a bag."*

Participants also called attention to promising advances in Early Warning and Response System (EWARs) that leverage AI and predictive modeling to anticipate and protect people across multiple hazards. However, these systems face implementation gaps and need to be co-designed with end users to ensure they are acceptable, appropriate, feasible, and sustainable to operate in resource-constrained environments.

Despite these challenges, **examples of success** include:

- Laboratory collaboration between the DRC and Uganda during the ongoing 2026 Bundibugyo Ebola outbreak supported cross-border data sharing and sequencing within days. After a Zaire-specific GeneXpert test in Bunia returned a false negative, the Institut National de Recherche Biomédicale (INRB) in Kinshasa identified the virus using a pan-filovirus assay and genome sequencing, and the Uganda Virus Research Institute rapidly confirmed imported cases in Kampala (WHO, Disease Outbreak News, 2026; Zhang et al., *Infectious Medicine*, 2026). Uganda contained its outbreak after 20 cases, and the outbreak was declared over on August 25, 2026. In contrast, transmission went undetected for several weeks in the DRC and confirmed cases exceeded 8,600 by early October 2026 (ECDC, 2026).
- Community-based surveillance has effectively integrated mobile technologies and social networks, like the FARMER crowdsourcing app in Thailand (CDC 2024). Farmers, local volunteers, and human and animal health officers can report zoonotic disease events through the app, allowing local One Health teams to rapidly respond and control potential outbreaks.
- Municipal-level efforts have established multi-hazard early warning systems for a holistic approach to climate-informed, emergency preparedness and response.
- Meteorological and other ecological or environmental data have been integrated into surveillance systems for decision-making, although this process has been inconsistently applied and underutilized.

The case of the 10-year Rift Valley fever One Health research project in South Africa (2016–2024) was discussed as a good example of cross-disciplinary integration. Veterinarians, epidemiologists, climate scientists, soil scientists, wildlife practitioners, vector ecologists, and economists worked at the research level, with defense, agriculture, and public health departments engaged at the decision-making level and farmers involved at the local level.
Implication: Surveillance should shift from extraction-oriented systems to actionable, locally useful information systems that benefit communities, producers, and other stakeholders in both the private and public sector.

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An example of successful One Health integration was the **early detection of and response to a dengue case in Indonesia** (Resolve to Save Lives, 2022). In this community-led approach, local Red Cross volunteers trained in community-based surveillance conducted a home visit to confirm a suspected dengue case and escalate it to the village midwife and submit the case report through a mobile data collection platform. The same volunteers led risk communication and community engagement efforts to remove standing water and take other preventive measures to reduce dengue transmission risk. This integrated, community-based model proved highly successful. Across 31 surveyed community-based surveillance alerts from 2019–2020, all but three were successfully confirmed by laboratory diagnosis.

Another example is the **development of a One Health-based community surveillance system** (Parai et al., *Frontiers in Public Health*, 2026) to determine risk factors, transmission dynamics, and prevalence of leptospirosis, brucellosis, and scrub typhus in Odisha, India. The protocol includes mixed methods to collect data on disease prevalence, health behaviors, and environmental risk factors. Findings related to zoonotic disease patterns, modifiable risk factors, and transmission pathways will inform tailored interventions, such as community awareness messaging and animal vaccination campaigns.

VII. OPPORTUNITIES FOR INTEGRATION, INNOVATION, AND COORDINATION

Participants identified multiple opportunities to strengthen One Health systems.

Government-led Efforts

- **Multisectoral Governance & Coordination:** Identify opportunities to establish or strengthen existing national and sub-national Multisectoral Coordination Mechanisms (MCMs) for One Health integration. These mechanisms must expand beyond traditional health sectors to systematically engage finance ministries, the private sector, and academia, including public health, veterinary, and social scientists, to ensure sustainable financing and evidence-based policy.
- **Integrated Service Delivery:** Deliver holistic services directly to communities by establishing "one-stop" service hubs that integrate human health, animal health, and agricultural/livelihood support. To maximize adoption and impact, these models must be designed around community-defined priorities and the socio-economic factors driving care-seeking behavior.
- **Workforce Integration & Institutional Alignment:** Governments should facilitate cross-ministerial collaboration to align the mandates, scopes of practice, and referral pathways of CHWs, CAHWs, and agricultural extension agents. Institutional alignment must be paired with adequate resourcing, cross-training, and continuous supervisory support.

Scientific, Academic, & Technical Leadership

- **Data Integration & Interoperability:** Adapt and standardize data architectures to facilitate seamless integration across climate, ecological, epidemiological, and socioeconomic datasets. Institutionalizing cross-domain data interoperability is critical for holistic threat analysis and joint surveillance.
- **Emerging Technologies & Predictive Analytics:** Leverage the responsible use of emerging technologies including generative AI, machine learning, and advanced analytics to accelerate multi-source data processing, automate anomaly detection, and enhance early warning systems for emerging zoonotic and environmental health risks.
- **Integrated Research & Risk Modeling:** Incorporate ecological, climatic, and socioeconomic variables directly into disease risk and transmission models. Research agendas must intentionally bridge basic science (e.g., wildlife ecology and vector biology) with applied public health and veterinary practice to translate empirical insights into actionable field interventions.
- **Social Science Research Collaboration:** Beyond quantitative data for analytics, social science concepts, including traditional knowledge, should be included and emphasized more in zoonotic disease prevention. Understanding behavioral risk factors and contextual knowledge, such as cultural practices and beliefs, are critical for informing ethical and locally appropriate disease prevention interventions.

Implication: Stronger integration across service delivery, data systems, and emerging technologies shifts global and national health security from reactive containment to proactive risk mitigation. By linking frontline workforce capabilities with advanced predictive science, countries can prevent spillovers at the source, shorten response timelines, and safeguard both community livelihoods and public health.

Strong examples of effective integration across One Health sectors are the **Prioritizing Zoonotic Diseases for Multisectoral One Health Collaboration workshops** in Honduras and Colombia (CDC 2023). These multistakeholder workshops based on the U.S. CDC's One Health Zoonotic Disease Prioritization model convened stakeholders from local, national, and multilateral agencies and universities with expertise in public health, food safety, ecology, agriculture, and conservation. Through a participatory process, representatives prioritized zoonotic diseases of highest concern in Honduras and Colombia and developed action plans to collaboratively address priority diseases. The action plans identified next steps, indicators, and responsible sectors for achieving objectives related to One Health coordination, surveillance capacity, laboratory capacity, preparedness and planning, outbreak response, prevention and control, workforce capacity, and zoonotic disease research.

VIII. ACTIONABLE RECOMMENDATIONS FOR ONE HEALTH OPERATIONALIZATION

To translate One Health principles into sustainable, resilient practices capable of mitigating climate-amplified zoonotic threats, roundtable participants formulated the following strategic recommendations for governments, multilateral partners, donors, and technical institutions:

A. Strengthen Interoperable Systems & Infrastructure

- **Advance Cross-sectoral Surveillance:** Invest in co-located, joint surveillance architectures bridging human, animal, and environmental health monitoring.
- **Harmonize Data & Indicators:** Build standardized, interoperable data platforms and shared metrics across technical ministries to facilitate cross-domain analysis.
- **Deploy Localized Early Warning Networks:** Scale dynamic, early-warning frameworks tailored to community, municipal, and regional risk hotspots.
- **Mainstream Climate-Health Intelligence:** Routinely incorporate climatic, ecological, environmental, and meteorological variables into disease risk modeling and health sector planning.

B. Rebalance Investments Across One Health Pillars

- **Equitize Sectoral Funding:** Address chronic financing disparities by allocating dedicated capital to under-resourced animal and environmental health systems.
- **Integrate One Health into Climate Policies:** Formally embed One Health strategies and targets within national climate plans, including Nationally Determined Contributions and National Adaptation Plans.
- **Build Integrated Laboratory Networks:** Expand diagnostic infrastructure to support joint processing and environmental testing capabilities.

C. Institutionalize Community Leadership & Frontline Capacity

- **Resource and Empower Frontline Workers:** Formally align, cross-train, and sustainably compensate CHWs, CAHWs, and agricultural extension agents.
- **Strengthen Local Surveillance & Risk Communication:** Leverage trusted local actors to lead community-based early warning and culturally resonant risk messaging.
- **Close the Community-to-Policy Loop:** Establish direct feedback mechanisms ensuring community-level data actively informs regional and national policy decisions.

D. Optimize Multisectoral Governance & Financing

- **Operationalize Coordination Platforms:** Move MCMs from conceptual frameworks to sustainably funded, sub-nationally empowered governance bodies.
- **Engage Economic Leadership:** Partner directly with Ministries of Finance to frame One Health investments around fiscal resilience, trade security, and macroeconomic stability.

- **Demonstrate Economic Impact:** Generate empirical Return-on-Investment data and quantify the "cost of inaction" to justify proactive funding for spillover prevention.

E. Shift Priority to Upstream Prevention & Local Resilience

- **Rebalance Investment between Containment and Prevention:** Direct additional resources towards primary, upstream spillover mitigation while maintaining essential preparedness and response capacity.
- **Reinforce Primary Systems:** Strengthen foundational human and veterinary healthcare systems, alongside environmental surveillance and monitoring capacity.
- **Support Cross-Border & Regional Platforms:** Deepen multilateral cooperation, regional data exchange, and joint outbreak response networks (e.g., ASEAN, PAHO, the African Union Interafrican Bureau for Animal Resources).

F. Enhance Data Governance, Analytics, & Emerging Innovation

- **Facilitate Strategic Information Sharing:** Prioritize real-time information and intelligence exchange, even in contexts where raw data sharing faces regulatory constraints.
- **Build LMIC Analytical Capacity:** Invest in specialized workforce development, prioritizing bioinformatics, quantitative modeling, and data science training in LMICs.
- **Leverage Predictive Technologies:** Safely deploy AI, machine learning, and digital tools to automate anomaly detection and forecast disease risk. Beyond identifying hotspots, forecasting can help identify and monitor harmful environmental exposures (e.g., extreme heat, flooding) and their cascading impacts.

G. Ensure Programmatic Sustainability & Market Realities

- **Design for Long-Term Continuity:** Move away from short-term donor grant cycles towards self-sustaining, cost-recovering operational models.
- **Scale High-Impact Models:** Document, evaluate, and systematically replicate proven localized initiatives (e.g., farmer-led biosecurity, integrated service hubs).
- **Foster Communities of Practice:** Cultivate peer-to-peer technical networks with clear professional incentives, multisectoral mentorship, and inclusive participation.

H. Address Broader Socio-Ecological Determinants & Policy Translation

- **Address Structural Risk Drivers:** Factor social inequities, gender dynamics, behavioral norms, and cultural contexts directly into risk assessments.
- **Incorporate Spatial Dynamics:** Integrate water security, rapid urbanization, land-use change, and population displacement into One Health spatial planning.
- **Bridge Science, Policy, & Public Trust:** Strengthen translation pipelines connecting scientific research to policy formulation, while actively communicating evidence to counter misinformation and disinformation.

CONCLUSION

The roundtable underscored that One Health challenges are increasingly compounded by climate change, systemic inequities, and underfunded, fragmented institutions. While technical capabilities and successful pilot initiatives are well-established, the primary barrier to progress lies in operational integration, sustainable financing, governance, and localized implementation.

To address these challenges, discussions consistently highlighted four core imperatives:

- **Shift focus and resources upstream:** Reallocate capital and policy attention towards primary prevention and early threat mitigation before spillover events occur.
- **Center communities and local systems:** Anchor One Health initiatives in community priorities, leveraging local leadership and existing sub-national structures for long-term sustainability.
- **Unify sectors and data systems:** Institutionalize cross-sectoral collaboration and advance cross-domain data interoperability across human, animal, and environmental health sectors. Increase support and focus on animal and environmental health to ensure they receive equal importance in relation to human health.
- **Reframe the value proposition:** Position One Health not merely as a health security measure, but as a critical economic driver essential for fiscal resilience and sustainable development.

Operationalizing these priorities is essential to building resilient, equitable, and functional One Health systems capable of adapting to accelerating global change and preparing to address emerging and reemerging risks. These tools will help equip the global health workforce to work collaboratively with community stakeholders and contribute to the development of timely interventions, policies, and other decision-making activities.

ROUNDTABLE PARTICIPANTS

The individuals in the table below agreed to be listed as participants in the roundtable discussion.

Participant	Title	Affiliation
Adugna Yimam	Senior Technical Advisor for Health and Nutrition	Action Against Hunger
Assaf Anyamba	Senior Research Scientist / Dr.	UMBC/NASA Goddard Space Flight Center
Bernard McCaul	Executive Director	GOAL USA
Chadia Wannous	Head of the One Health and Global Frameworks Department	World Organisation for Animal Health (WOAH)
Christine Jost	Senior Independent Consultant	
Colleen GallagherThomas	Global Medical Advisor	Relief International
Dianna Darsney	Director of Global Initiatives	Global Food Institute at the George Washington University
Ekta Patel	Scientist	International Livestock Research Institute (ILRI)
Erica Nelson	Co-Director: Humanitarian Geoanalytics Program; Associate Director: Emergency Health Systems, HHI; Attending Emergency Medicine MD: MGB	MassGeneral Brigham; Harvard Humanitarian Initiative, Harvard University
Helena Chapman	Professorial Lecturer	GW Milken Institute School of Public Health (GWSPH)
Hibret Tilahun	Global Project Director	World Vision
Ian Frye	DrPH Student	GWSPH
Innocent Rwego	Technical Director for Global Health Security	World Vision US
Jackson Wachira	Research Fellow	Centre for Humanitarian Change
Jenny Munhofen	Veterinarian	GWSPH

Participant	Title	Affiliation
Jonathon Gass	Assistant Professor	Tufts University School of Medicine
Joshua Glasser	Expert	Independent
Justin Pendarvis	Public Health Consultant	Independent
Lisa Hilmi	Executive Director	CORE Group
Matthew D. Brown	Health Diplomacy Strategist; former senior official, NIH, HHS/OGA, CDC, and U.S. Department of State	Independent
Maya M. Rao	Senior Center Specialist	Redstone Global Center, GW Milken Institute School of Public Health (GWSPH)
Paige Van de Vuurst	Visiting Assistant Professor	Columbian College of Arts and Sciences, Department of Geography and Environment, The George Washington University
Ricardo Echalar	Consultant	Independent
Robert Salerno	Senior Health Specialist	The Pandemic Fund / World Bank Group
Ron Waldman	Professor Emeritus	GWSPH
Sarah Dumas	Research Scientist	Redstone Global Center, GW Milken Institute School of Public Health (GWSPH)
Saskia Hendrickx	Scientist	University of Florida
Steven Hansch	Adjunct Faculty	GWSPH
Tamara Chikhradze	Global Practice Lead for PHC	International Rescue Committee
Timothy H. Holtz	Professor, Redstone Chair and Director	Redstone Global Center, GW Milken Institute School of Public Health (GWSPH)
Yewande Alimi	One Health Unit Lead	Africa CDC

Annex – One Health Resources Table

One Health Resources that can be used and adapted for One Health implementation and planning at various levels:

Resource/Title	Author	Description	URL
Risk Mapping			
Climate and Health Risk Index (CHRI)	World Bank Group	The CHRI describes how climate hazards, national and subnational population vulnerability, and health system readiness contribute to health risks in a country. The index includes risk components, such as exposure, sensitivity, and adaptive capacity	https://climateknowledgeportal.worldbank.org/global/chri
Strategic Toolkit for Assessing Risks (STAR)	WHO (Quadripartite)	STAR provides guidance for developing appropriate risk assessments to better prevent, prepare, for, and respond to a health emergency or disaster. This participatory approach consolidates existing evidence to describe the risks in a country following six key steps: 1. Identify country hazard(s) and describe the most likely scenario to require activation of national response 2. Assess the likelihood of the risk occurring; 3. Estimate the impact of the risk to the country 4. Determine the estimated level of risk 5. Draft key recommendations and priority actions based on the risk ranking 6. Integrate recommendations into the national and subnational action planning process	https://www.who.int/publications/i/item/9789240036086
One Health Risk Analysis System (OHRAS)	COHESIVE, a One Health European Joint Programme project	OHRAS is a combination of six activities centered around One Health: signaling, risk assessment, feasibility assessment, risk management, coordinated communication and governance. The design and implementation of activities is flexible and can be adapted and applied to the needs of a country's specific context.	https://www.ohras.eu/page/home https://onehealthejp.eu/wp-content/uploads/2021/06/COHESIVE-OHRAS-infographics.pdf
One Health Zoonotic Disease Prioritization (OHZDP) Process	U.S. Centers for Disease Control and Prevention	The OHZDP uses a multisectoral approach to prioritize and jointly address endemic and emerging zoonotic diseases of major concern to jurisdictions. The OHZDP tool is flexible in scale and can be applied at the regional, national, or subnational level and adapted to various infectious diseases and One Health issues. The tool is applied in a participatory workshop to inform assessments, planning, resource allocation, and strategy development in five steps:	To request information on the OHZDP tool, contact OneHealth@cdc.gov https://www.cdc.gov/one-health/php/prioritization/index.html

		1) Preparation and Logistics, 2) Criteria Development, 3) Question Development; 4) Ranking and Scoring the Zoonoses, and 5) Next Steps and Action Planning.	
Resource/Title	**Author**	**Description**	**URL**
Community Engagement & Trust			
Guide to Community Engagement and Accountability (CEA)	International Federation of Red Cross Red Crescent National Societies (IFRC)	This guide provides staff and volunteers across the International Red Cross and Red Crescent Movement with a common approach to build CEA systematically into its ways of working. It includes an overview of CEA approaches and activities that can be applied to any program or operation across all stages of the program cycle.	https://www.ifrc.org/document/cea-guide
Community Engagement and Accountability (CEA) Toolkit	IFRC	This toolkit equips National Red Cross and Red Crescent Societies and other organizations with tools to assess, design, implement, monitor and evaluate community engagement and accountability activities in support of programs and operations.	https://www.ifrc.org/document/cea-toolkit
One Health Governance			
A generalizable one health framework (GOHF) for the control of zoonotic diseases	Ghai, R.R., Wallace, R.M., Kile, J.C. et al.	The GOHF provides a structure for applying a cross-sectoral One Health approach to zoonotic disease programs at local, sub-national, national, regional, or international levels. It includes a toolkit of resources coupled with recommendations for capacity building and implementing a One Health approach for zoonotic disease prevention and control in laboratory, surveillance, preparedness, response, and other technical domains.	https://www.nature.com/articles/s41598-022-12619-1
A Strategic Action Model for Understanding, Designing, and Achieving Community-level One Health Implementation	Mohanty, N.	This article presents a comprehensive roadmap for community-level One Health implementation developed through synthesis of published literature, global frameworks, and case studies. The authors identify community health priorities, describe mixed-methods needs assessment approaches, outline implementation barriers, recommend evidence-based strategies, and define essential competencies for community-based One Health workforce development.	https://esmed.org/community-level-one-health-strategies-for-implementation/

Resource/Title	Author	Description	URL
One Health Monitoring Tool (OHMT)	FAO (Quadripartite)	The OHMT assesses the status of One Health institutionalization and national operationalization covering all One Health areas (food safety, AMR, zoonotic diseases, environment, biosafety and security, etc.) and includes three sets of criteria: 1) communication, coordination, collaboration; 2) multisectoral disease response; and 3) sustainability. These criteria are scored at five capacity levels, ranging from no capacity to sustainable capacity.	https://www.atlantis-press.com/proceedings/isessah-19/125927943
Incorporating One Health into Policy & Technical Guidance Toolkit	U.S. Agency for International Development (USAID) Preparedness & Response Project (DAI)	This toolkit guides users through the process of integrating One Health into new or existing policy and technical guidance documents, including guidelines, standard operating procedures, protocols, and plans, as part of broader One Health policy advocacy and multisectoral preparedness and response efforts.	https://drive.google.com/file/d/1ey4k9LL9_JpTZovFDRxYUg150B72Wwi_/view
One Health Policy Advocacy Toolkit	USAID Preparedness & Response Project (DAI)	This toolkit aids in developing a policy advocacy strategy to guide the National One Health Platform in advancing messages to gain decision-makers' support, identifying advocacy tools and events to strengthen collaboration and policies, and cultivating alliances and champions for the One Health cause.	https://www.onehealthcommission.org/documents/filelibrary/resources/toolkits/Policy_Advocacy_Toolkit_Overview_E017344A8907E.pdf
One Health Policy Model (OHPM) Toolkit	USAID Preparedness & Response Project (DAI)	This technical guide describes a policy modeling tool to describe the complex dynamics at the country level between livestock and human populations in terms of zoonotic disease transmission and its implications. The guide is divided into two parts: 1) an instruction manual for creating an application of the OHPM; 2) the calculations underlying the model.	https://drive.google.com/file/d/1BnP6eoZVdpK_1blL6UwMR9uitsFYsLha/view
One Health Stakeholder Mapping Toolkit	USAID Preparedness & Response Project (DAI)	This toolkit guides users through the process of planning and executing stakeholder mapping. It also contains helpful tips and important considerations in the text boxes placed throughout the document.	https://www.onehealthcommission.org/documents/filelibrary/resources/toolkits/Stakeholder_Mapping_Toolkit_Overvie_DE335616F9C8C.pdf

Resource/Title	Author	Description	URL
Private Sector Engagement in One Health Toolkit	USAID Preparedness & Response Project (DAI)	This toolkit guides users through identifying potential entry points for private sector engagement in One Health activities. It also includes tools to develop and communicate the business case for public-private partnership to platform members and the private sector.	https://www.onehealthcommission.org/documents/filelibrary/resources/toolkits/PrivateSectorEngagementToolkit508_F2FED959BAD5F.pdf
One Health Coordination			
Tripartite Zoonoses Guide (TZG) Multisectoral, One Health, Coordinating Mechanism Operational Tool (MCM OT)	WHO, FAO, WOAH (Quadripartite)	The TZG MCM OT provides countries a stepwise process to address 18 technical elements critical for establishing or strengthening a government-led multisectoral, One Health coordination mechanism.	https://www.who.int/initiatives/tripartite-zoonosis-guide/multisectoral-coordination-mechanism-operational-tool
IHR-PVS National Bridging Workshop (NBW)	WHO, WOAH (with FAO)	The NBW brings national human health and animal health services together to review their International Health Regulations (IHR) and WOAH Performance of Veterinary Services (PVS) Pathway assessment results, identify gaps in collaboration on zoonotic diseases, food safety, and antimicrobial resistance, and agree on a joint national roadmap.	https://www.woah.org/en/what-we-offer/improving-veterinary-services/pvs-pathway/one-health-capacity-building/
One Health Systems Mapping and Analysis Resource Toolkit (OH-SMART)	University of Minnesota (U.S. Department of Agriculture)	This 6-step toolkit has been used in 18 countries to tackle ongoing and emerging One Health challenges, ranging from emerging and endemic zoonotic diseases to disaster preparedness and antimicrobial resistance action planning. OH-SMART offers a practical, easy-to-use, transferable framework to tackle human, animal and environmental cross-disciplinary challenges.	https://oh-smart.umn.edu/
Organizational Structure and Terms of Reference Toolkit	USAID Preparedness & Response Project (DAI)	This toolkit provides guidance on the creation and organization structure of National One Health Platforms.	https://www.onehealthcommission.org/documents/filelibrary/resources/toolkits/Org_Structure_and_TOR_Toolkit_Overv_6BBE6042A4D04.pdf

Resource/Title	Author	Description	URL
Leading Change Toolkit	USAID Preparedness & Response Project (DAI)	This toolkit serves as an advocacy guide to inform and influence decision-makers on the One Health approach.	https://www.onehealthcommission.org/documents/filelibrary/resources/toolkits/Leading_Change_Toolkit_Overview_D40BDF9F9BFEA.pdf
One Health Strategic Plan Development Toolkit	USAID Preparedness & Response Project (DAI)	This toolkit provides guidance and an orientation on One Health organizational development.	https://www.onehealthcommission.org/documents/filelibrary/resources/toolkits/One_Health_Strategic_Plan_Toolkit_O_DDFD4C3A013A1.pdf
Sustainable Funding Strategy for One Health Toolkit	USAID Preparedness & Response Project (DAI)	This is a fundraising guide to support long-term One Health sustainability.	https://www.onehealthcommission.org/documents/filelibrary/resources/toolkits/Sustainable_Funding_Strategy_Toolki_94FF070EE16F0.pdf
One Health Gender Integration Toolkit	USAID Preparedness & Response Project (DAI)	This toolkit includes guidance in integrating and achieving higher gender equity with One Health interventions.	https://www.onehealthcommission.org/documents/filelibrary/resources/toolkits/Gender_Integration_Toolkit_Overview_8A0960CBB8B8C.pdf
Surveillance, Data Systems, Early Warning			
Tripartite Zoonoses Guide (TZG) Surveillance and Information Sharing Operational Tool (SIS OT)	WHO, FAO, WOAH (Quadripartite)	The TZG SIS OT supports national authorities in establishing or strengthening a One Health multisectoral coordinated surveillance and information sharing system for zoonotic diseases. This tool includes a stepwise assessment for evaluating existing in-country capacity and identifying activities, ultimately creating a roadmap and a workplan to establish or strengthen coordinated surveillance and information sharing systems. For each activity, the SIS OT recommends a curated array of tools and resources. Designed for nations across the spectrum of surveillance capabilities, the SIS OT helps those without a foundational system to establish one, while also aiding countries with mature systems to further refine their processes. The tool package includes a guidance document with annexes and an Excel-based workbook.	https://www.fao.org/documents/card/en/c/cc0716en https://www.who.int/initiatives/tripartite-zoonosis-guide/surveillance-and-information-sharing-operational-tool https://www.woah.org/app/uploads/2022/09/af-sis-eng-woah-web.pdf

Resource/Title	Author	Description	URL
Event-Based Surveillance (EBS) Resources	Africa CDC	The EBS Framework and Manual offers guidance to health practitioners seeking to implement EBS in their countries, including methods, such as hotline EBS, media scanning EBS, facility EBS, community EBS, monitoring and evaluation, and data management.	https://africacdc.org/download/africa-cdc-event-based-surveillance-framework-2/
Community-based Surveillance Training Manual for targeted Diseases and signals	CORE Group	This manual provides community volunteers on best practices for delivering effective and efficient surveillance of vaccine-preventable poliovirus, measles, and neonatal tetanus, and the animal-to-human disease detection and reporting of rabies, anthrax and brucellosis. The manual also provides instruction on facilitating family dialogue on healthy behaviors and practices and includes strategies for engaging caretakers in increasing child vaccination uptake. It also includes guidance on the tracking and referral of pregnant women, newborns and defaulters to nearby health facilities for vaccination.	https://coregroup.org/wp-content/uploads/2019/12/CBS-ENGLISH-Training-Manual-CGPP_Ethiopia_.pdf
7-1-7	7-1-7 Global Alliance	The 7-1-7 approach uses a simple set of three timeliness metrics to assess and improve real-world performance of early detection and response systems: 7 days to detect a suspected public health threat; 1 day to notify a public health authority responsible for action; 7 days to complete early response actions.	https://717alliance.org/digital-toolkit
Epidemic Control Toolkit	IFRC	The Epidemic Control Toolkit provides guidance on evidence-based methods to prevent and control the spread of epidemics at the community-level, and guidance on appropriate referral and basic care for the sick.	https://epidemics.ifrc.org/

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