

CAPACITY/CAPABILITY ASSESSMENT

ECDC country visit to Bosnia and Herzegovina to discuss surveillance of communicable diseases

ECDC Accession Support to Western Balkans and Türkiye

Introduction

The European Centre for Disease Prevention and Control (ECDC) is cooperating with countries in the Western Balkans and Türkiye to improve their infectious disease prevention and control systems and public health workforce in order to prepare them for their future participation in the Centre's work.

Through its technical cooperation with the Western Balkans and Türkiye [1] ECDC aims to support their capacity to implement EU rules on communicable diseases, improve the 'One-Health' response to antimicrobial resistance (AMR) and enhance surveillance of laboratory-confirmed severe acute respiratory infections (SARI). The project is funded by the European Commission's European Neighbourhood Policy and Enlargement Negotiations (DG NEAR) [2] under the Instrument of Pre-accession Assistance (IPA) [3].

The project is structured around three technical work streams. Work Stream 1 encompasses preparatory measures to enable IPA beneficiaries to enhance communicable disease surveillance and control capacities, improve health emergency preparedness and support public health laboratory systems development [1]. This will enable national health authorities to fulfil ECDC prerequisites for disease data submission at the minimum level required by the EU. The expected results of this stream are:

- enhanced EU-level data so that communicable disease surveillance data are more comparable, timely and reliable;
- long-term expansion of ECDC scientific and surveillance outputs, covering a broader geographical area within Europe that includes the Western Balkans and Türkiye; and
- improved response to public health threats from infectious diseases at the national level, with early detection of and response to serious cross-border threats at EU level.

In the context of Work Stream 1, ECDC conducted a technical visit to Bosnia and Herzegovina to obtain additional information on the country's national surveillance system, including its operation and governance. The aim of this initiative was to provide ECDC with a comprehensive overview of the needs, vulnerabilities and strengths of the surveillance system. To help ECDC ensure consistency of the visit and follow-up of progress, an assessment tool was used [4]. This tool included eight topics seen as core areas for successful communicable disease surveillance and control which were used as guide for discussion. The insights gained within the assessment mission were used to identify areas where surveillance operations could be further strengthened, and other aspects that could benefit from ECDC's technical support or guidance.

Background

ECDC's technical cooperation with the Western Balkans and Türkiye has enabled participating countries to report mutually agreed diseases to The European Surveillance System (TESSy) since 2016 (2015 data), attend ECDC meetings, network with colleagues and participate in some ECDC surveillance activities.

The Centre has incorporated capacity-building activities in the Western Balkans and Türkiye into the [ECDC strategy 2021–2027](#) and the [long-term surveillance framework 2021–2027](#).

In 2022, ECDC analysed the quality of data reported to TESSy by the Western Balkans and Türkiye. Virtual bilateral meetings were then arranged with EU enlargement countries to discuss challenges and technical issues related to reporting, identify needs for future ECDC support in strengthening national surveillance, and plan the next steps for joint surveillance activities.

National public health authorities in the Western Balkans and Türkiye have established, or are in the process of establishing, digitalised surveillance of notifiable diseases. They are also implementing the lessons learned from the COVID-19 pandemic.

However, specific and detailed knowledge of how the national surveillance systems are organised is needed in order to develop tailored capacity-building activities in the Western Balkans and Türkiye, including the possible expansion of routine national reporting to TESSy for additional diseases.

To this end, ECDC stressed the need for technical country visits to the Western Balkans and Türkiye as an immediate priority during bilateral meetings and a meeting with national correspondents and observer National Focal Points (NFPs) for Surveillance in November 2022.

ECDC prepared an [Assessment tool for national communicable disease surveillance systems](#) to accompany the offer of a technical visit to Bosnia and Herzegovina. The offer was accepted and the agenda for the visit was developed jointly with the Ministry of Civil Affairs of Bosnia and Herzegovina (Annex 1). During the visit, findings for all areas of surveillance were discussed and an assessment tool was filled out in collaboration with colleagues from the country.

Purpose and objectives

The purpose of ECDC's technical visits to the Western Balkans and Türkiye is to identify areas in the surveillance of communicable diseases that may require further work, and possible ECDC support. This will enable the countries to fulfil ECDC prerequisites for data and information submission, including completeness and timeliness, at the minimum level required by the EU. The visits also serve to meet the broader objectives of Work Stream 1, as set out above.

Specific objectives

The specific objectives of technical visits to the Western Balkans and Türkiye are:

- to better understand the existing structures, systems, tools and processes involved in the national surveillance of communicable diseases, as well as any planned changes;
- to identify needs, vulnerabilities, strengths and areas for improvement related to the surveillance of communicable diseases, including aspects that might benefit from ECDC's technical support;
- to document the current situation concerning the strengths, vulnerabilities, needs and potential action plans;
- to discuss and potentially agree upon next steps, as well as setting priorities for further surveillance activities that ECDC could support with technical guidance and assistance.

1. Surveillance system description

Communicable disease surveillance in Bosnia and Herzegovina consists of three surveillance systems: one in the Federation of Bosnia and Herzegovina, one in the Republika Srpska and one in the Brčko District of Bosnia and Herzegovina. Communicable disease surveillance is coordinated with veterinary surveillance, food safety and environmental surveillance (service water and wastewater monitoring). In addition, information from immunisation and cancer registries can also inform communicable disease surveillance. The list of notifiable diseases is regulated by the Law on the Protection of the Population from Infectious Diseases of the Federation of Bosnia and Herzegovina (FBiH) [5], the Law on the Protection of the Population from Communicable Diseases of the Republika Srpska (RS) [6-8] and the Law on the Protection of the Population from Infectious Diseases of the Brčko District (BD) [9], and ranges from 84 diseases in the FBiH to 58 diseases in BD.

Explicit disease surveillance objectives exist for influenza, polio, measles, rubella and monkeypox surveillance. These objectives are shared with data providers. Disease surveillance is primarily passive, albeit with some exceptions and differences between Republika Srpska and the Federation of Bosnia and Herzegovina (e.g. in the FBiH acute facial paralysis, measles and rubella have active surveillance, whereas in RS some diseases have active surveillance on demand, depending on the epidemiological situation). In the FBiH there are no additional voluntary surveillance schemes, while in RS and BD diseases that were historically important can still be notified voluntarily (e.g. scabies).

Even if there is a comprehensive surveillance scheme implemented for most notifiable diseases, and all healthcare providers (public and private) have a legal requirement to report, under-reporting persists. This is known to be the case for sexually transmitted infections, particularly in the private sector. Sentinel surveillance of influenza-like illness (ILI) is in place in the FBiH and RS, and sentinel surveillance of acute respiratory infections (SARI) is in place in the FBiH, RS and BD to monitor respiratory infections (influenza, COVID-19, respiratory syncytial virus - RSV) during the influenza season (October through May). At present, catchment populations are not available, or are difficult to estimate and therefore all-cause consultations (in the RS) and all-cause admissions (in the FBiH and RS) are being used as denominators for ILI and SARI surveillance, respectively.

Procedures for external and internal evaluation of surveillance systems for communicable diseases have not been established, however the FBiH did carry out an internal evaluation of HIV/AIDS surveillance in 2011 [10].

2. Data collection

The FBiH and BD are using EU case definitions from 2018 [12] for the reporting of communicable diseases, while RS uses EU case definitions from 2012 [13]. Guidance on how to report cases of communicable diseases is detailed in the Rulebook on the Method of Reporting Infectious Diseases for the FBiH [14], in the Rulebook on the Method of Reporting, Content of Records and Content of Reporting on Communicable diseases for the RS [15] and in the Rulebook of the Reporting Methods, Content of Records and Content of Reports on Infectious Diseases for the BD [16] (electronically available, on the websites of the respective public health institutes or through official legal documentation outlets).

Notifiable communicable diseases are reported to cantonal and regional public health institutes in FBiH and RS, respectively, by medical doctors (in primary care institutions, hospitals, clinical centres, reference laboratories, or hygienic-epidemiological services). Cantonal public health institutes report disease cases to the Public Health Institute of the FBiH. The Public Health Institute of the RS, and Public Health Institute of the FBiH report information to the Ministry of Civil Affairs (MoCA). In the BD, cases of disease are reported by hygienic-epidemiological services directly to the Sub-department of Public Health, which is responsible for conveying public health information to the MoCA. The MoCA aggregates information and oversees reporting to the international level (respiratory virus surveillance, West Nile virus (WNV) infection and mpox to The European Surveillance System (TESSy) [17], HIV, tuberculosis, polio, measles, leprosis, yellow fever, and respiratory virus surveillance to the World Health Organization (WHO) and zoonoses and foodborne outbreaks to the European Food Safety Authority (EFSA)). Reporting forms for some diseases (e.g. respiratory virus surveillance) in the FBiH include all variables required for reporting to TESSy, but the same does not apply to the RS and BD. For example, in the BD, laboratory data are not included in reporting forms and therefore additional information required for TESSy reporting is collected by email or phone.

Data for surveillance of notifiable diseases are primarily collected using a paper-based system and then inserted manually into computerised databases in the FBiH, RS and BD. Electronic databases pertaining to disease surveillance are not linked to other surveillance system databases or between FBiH, RS and BD. All data are collected in a case-based format, except for ILI/SARI surveillance (FBiH, RS and BD) and chickenpox (FBiH).

3. Data quality

Neither the administrative entities nor Brčko District have identified parts of the country or population segments that are systematically missing from surveillance data. There are four temporary migrant reception centres in FBiH, which submit regular health reports to the MoCA. In RS and BD, there are no temporary migrant reception centres and therefore the RS and BD do not submit regular information to MoCA on disease surveillance in migrants. However, RS submits regular information to MoCA regarding healthcare provided at the border and, consequently it is expected that this population group is included in the respective disease surveillance systems.

In both administrative entities and Brčko District, there is some validation of routine surveillance data. However, most of this validation consists of confirmation of cases with data providers (e.g. for measles surveillance), confirmation of case classification, or monitoring of trends with the aim of detecting outliers. The validation process is not automated and feedback on data quality to data providers is provided annually (FBiH), on an ad-hoc basis during specific events (e.g. immunisation week in the RS), or not at all (BD).

Timeliness of reporting is assessed for some diseases, with active disease surveillance, such as measles and rubella. In these circumstances, reporting delays are not an issue, as data providers are called when they fail to provide information. Medical staff are often reminded to report notifiable diseases with passive disease surveillance, but it is thought that paper-based reporting causes delays.

Although there are no defined minimum thresholds for data completeness and there is no monitoring of missing or unknown data for most diseases, high data completeness (~80%) is ensured for diseases reported to WHO, such as measles [18]. The proportion of laboratory-confirmed cases is also measured for these diseases. The extent of possible under-ascertainment (i.e. under-diagnosis and/or under-reporting) has never been estimated, but it is believed to be high in sexually transmitted diseases due to the fear of stigma and discrimination.

4. Data management

As data are stored on local computers in the Federation of Bosnia and Herzegovina, Republika Srpska and the Brčko District of Bosnia and Herzegovina, a unified and comprehensive view of surveillance data is not available for all users at all levels through a centralised database. This hinders the possibility of tracking and merging disease data across health sectors. For three years, during the COVID-19 pandemic, a federal web-based real-time database was in place, with a comprehensive view of SARS-CoV-2 disease surveillance for the Department of Epidemiology of the FBiH Public Health Institute, designated laboratories and cantonal public health institutes in the FBiH, however this was discontinued due to cost sustainability [19].

Even though there is no automatic integration between clinical data and laboratorial results, data providers are able to reconcile this information, using the citizen number for Bosnian nationals, or a combination of the first name, last name and date of birth for tourists or migrants. For HIV, data is anonymised and the citizen number is replaced by a unique identifier, in accordance with WHO recommendations for data security and confidentiality [20]. However, the guidelines of the EU General Data Protection Regulation (GDPR) [21] are not implemented in Bosnia and Herzegovina.

Data validation checks are performed as mentioned above, however these checks are performed by epidemiologists and data managers are not involved.

5. Data analysis

Epidemiological analysis of surveillance data, including trend monitoring for relevant diseases, is performed on a routine basis, using population data as a denominator to compute incidence rates. For most diseases, rates are not compared to those for the EU. The analyses are not automated and are mainly performed using basic graphic visualisation techniques – e.g. Microsoft Excel.

Information from routine surveillance is used to advise strategies for prevention and control of disease, such as stopping hospital visits when influenza incidence reaches pre-defined thresholds (set by federal public health institutes), implementing non-pharmaceutical measures during the COVID-19 pandemic in the FBiH, or moving patients and taking swabs from surfaces at hospitals in the event of an outbreak of sepsis in the RS.

Risk factor studies, such as research on the predictors of *Legionella* spp. presence at tourist facilities in the FBiH [22]; on risk behaviour related to the prevalence of HIV and other sexually transmitted infections (STI) (hepatitis B, hepatitis C, syphilis) within the Roma population in the FBiH [23]; assessing the risk of HIV infection in sex workers in the RS [24], or analysing the connection between the spatial occurrence of WNV infection cases and the location of flooded areas in the RS [25] have also been used as a means of building the scientific body of evidence on communicable diseases and informing public health decision-making.

6. Dissemination of surveillance data

Dissemination of surveillance outputs differs between Federation of Bosnia and Herzegovina, Republika Srpska and the Brčko District of Bosnia and Herzegovina, but there are no automated reports, bulletins or dashboards. There are no surveillance outputs at a central level.

For a subset of diseases, monthly and annual epidemiological reports are shared by the FBiH Public Health Institute with public health institutes at cantonal level, and/or with the Federal Ministry of Health. In addition, several surveillance outputs are available for the general public on the FBiH Public Health Institute website, including daily and weekly bulletins on the epidemiological situation for measles [26, 27], and monthly or annual reports on communicable diseases [28, 29]. Surveillance bulletins on the epidemiological situation at cantonal level are also published by the respective public health institutes on their dedicated websites [30, 31].

The Public Health Institute of the RS prepares monthly and annual reports with an overview of the epidemiological situation for infectious diseases. In particular, the annual report is delivered to all healthcare institutions (primary, secondary and tertiary) and the Ministry of Health and Social Welfare of the RS. In addition, an annual report on the status of the population's health in the RS, containing a chapter dedicated to communicable diseases, is published online [32]. Bulletins on ILI and SARI surveillance are also disseminated on a weekly basis to relevant stakeholders and the media, and weekly bulletins on the epidemiological situation for COVID-19 and measles are published online [33, 34].

The Sub-department of Public Health of the BD prepares weekly, monthly and annual reports on the epidemiological situation for measles and rubella. However, only the weekly measles report is published online [35]. In addition, the Sub-department of Public Health shares a monthly bulletin on infectious disease activity in the BD with the Public Health Institute of Tuzla Canton and the Public Health Institute of the RS.

7. Outbreak detection

Routine surveillance data are used for outbreak detection, with specific criteria applied to each disease. For example, a >10% positivity rate in respiratory samples collected from sentinel sites is used to indicate the start of the seasonal influenza epidemic (following ECDC guidelines [36]), whereas $\geq$ five measles cases (with dates of rash onset occurring 7–21 days apart) that are epidemiologically linked is used to indicate a suspected measles outbreak (according to WHO guidelines [37]). Examples of detected outbreaks in 2024 are measles (FBiH, RS and BD), pertussis (FBiH) and *Salmonella* (RS).

Even though automated signal detection is not implemented, monitoring of disease trends and comparison with historical data is systematic. For ILI surveillance the Moving Epidemic Method - MEM [38], based on data from the last five years, is used as an indicator of the level of influenza activity.

Outbreaks are reported by healthcare institutions to respective cantonal public health institutes in FBiH and subsequently to the FBiH Public Health Institute, or to the Public Health Institute of the RS and subsequently to the RS Ministry of Health, in accordance with the Rulebook on the Method of Reporting Infectious Diseases for the FBiH [14], and with the Rulebook on the Method of Reporting, Content of Records and Content of Reporting on Communicable diseases for the RS [15], respectively. However, not all information regarding outbreak detection at local level seems to be conveyed to federal level, as it was mentioned that a hepatitis A outbreak detected at cantonal level was not reported to the FBiH Public Health Institute. In the BD, hygienic-epidemiological services in healthcare centres are responsible for reporting outbreaks of disease to the Sub-department of Public Health, according to the Rulebook of the Reporting Methods, Content of Records and Content of Reports on Infectious Diseases [16]. There is informal communication between BD, FBiH and RS for detection and monitoring of outbreaks, however information sent to the MoCA is submitted for international reporting purposes only.

In all entities there is an early warning system (ALERT – Early Warning and Emergency Response System) that is triggered whenever there is deemed to be a risk of an infectious disease outbreak that constitutes a public health emergency [14–16]. Even though the system stipulates specific time limits (<24h) for medical doctors to report cases of disease to public health authorities, there is no 24/7 duty.

Molecular surveillance for detecting clustering cases and outbreaks of disease is not implemented (RS and BD) or is routinely implemented only for respiratory viruses (FBiH). However, the FBiH is planning to expand molecular diagnosis to WNV, *Legionella*, and enteroviruses.

8. Capacity

Diagnostic confirmation and pathogen identification is not available for some diseases (e.g. polio, serotyping for pneumococcus infection in the FBiH, or measles in the BD), or is dependent on existing reagents. There is an agreement in place with the Istituto Superiore di Sanità in Italy to enable confirmation of polio, but no formal cooperation with laboratories from other countries has been established for other viruses.

For the FBiH and RS, training for communicable disease reporting, analysis and outbreak investigation is mostly dependent on international cooperation (e.g. US Centers for Disease Control and Prevention (US CDC) or WHO). If surveillance procedures are updated for a specific disease, or a new disease emerges, training is tentatively organised, albeit contingent on overcoming financial and technical issues (e.g. venue availability). However, training on ILI/SARI surveillance is offered on an annual basis to participant sentinel sites in the FBiH before each influenza season, and information on how to report measles cases is provided to paediatricians during the annual immunisation week in the RS. In the BD, training on disease surveillance is not currently offered to healthcare professionals reporting cases of disease, and the last workshop offered was in 2008 for TESSy reporting.

There is lack of surveillance staff, especially in the Ministry of Civil Affairs of Bosnia and Herzegovina (e.g. no epidemiologists working at the MoCA), but also data managers and administrative staff in the Federation of Bosnia and Herzegovina, the Republika Srpska and Brčko District of Bosnia and Herzegovina. Bioinformatics capacity and availability of statistical software for data management and analysis of surveillance data is scarce. In addition, although microbiology capacity is deemed by the FBiH and the RS to be good, lack of financing or regular training sessions are challenging for communicable disease surveillance.

Conclusions and recommendations

This country visit triggered a comprehensive discussion on national communicable disease surveillance in Bosnia and Herzegovina and enabled the ECDC team to review the current situation. Surveillance of communicable diseases in Bosnia and Herzegovina is regulated through three specific pieces of legislation in the Federation of Bosnia and Herzegovina, the Republika Srpska and the Brčko District of Bosnia and Herzegovina, albeit with minor differences (e.g. list of communicable diseases under mandatory surveillance, or use of EU disease case definitions for surveillance). Surveillance involves extensive manual work, individual effort and burden on medical doctors, which may not be sufficient to face potential challenges (e.g. emergence of a new disease with a high impact on the population and healthcare services). The sustainability of the human and technical resources allocated to communicable disease surveillance is questionable, as these resources seem to be limited in terms of the scope of activities and workload. There is also a lack of funding for implementing improvements in surveillance systems, including diagnostic confirmation for all diseases under surveillance and regular training for doctors and microbiologists involved in disease surveillance. Finally, it is unclear whether all information regarding disease surveillance is relayed from local to entity-level and eventually to federal level. This is particularly relevant for smaller outbreaks where the potential consequences may be underestimated.

There are, however, areas of good practice and evidence of change for the better. Examples include dissemination of surveillance outputs to health authorities and the public, use of disease surveillance data to detect outbreaks and plans to increase molecular capacity in the FBiH. These good practices and the staff who strive to achieve them need to be supported and resourced. Strengthening laboratory capacities, leveraging knowledge on statistical computing, and fostering strong collaborative relations among public and private surveillance stakeholders could also be vital for improving the timeliness of the surveillance systems and outbreak detection. This assessment has led to the following recommendations being proposed by the ECDC team as concrete steps to improve disease surveillance.

Harmonise case definitions with EU legislation

The most recent EU legal framework for disease case definitions should be applied in Federation of Bosnia and Herzegovina, Republika Srpska and the Brčko District of Bosnia and Herzegovina (Commission Implementing Decision (EU) 2018/945 on the communicable diseases and related special health issues to be covered by epidemiological surveillance as well as relevant case definitions) [12]. It should be noted that a revised list of diseases notifiable at EU/EEA level is expected in 2025.

Improve communication across administrative levels

The creation of a central system linked to surveillance systems in BD, FBiH and RS would help provide an overview at country level. In addition, the creation of a surveillance steering group, including representatives from the Public Health Institutes of BD, FBiH and RS would help coordinate surveillance activities at country level. This would help ensure that information and action are relayed to all levels in a coordinated manner and improve implementation of public health interventions.

Decrease surveillance burden for data providers

Consider automatic integration of clinical and laboratory data, focusing on digitalisation and reducing the burden of notification and the risk of human error.

Promote participation of private healthcare providers

Consider solutions to strengthen relationships and collaboration with private health institutions on the surveillance of communicable diseases. One solution could be collaborative agreements and nominated contact points in private public health institutions to facilitate communication and dissemination of surveillance guidelines.

Strengthen laboratory capacity

Reference laboratories should support diagnostic laboratories in standardising their methodologies and providing an external quality assurance scheme. Ideally, diagnostic confirmation should be available for all diseases to be covered for epidemiological surveillance listed in the European legal framework [12]. However, for rare diseases agreements could be set up to send samples to laboratories in other EU countries, where necessary.

Improve IT and data analytics

It is recommended that available IT expertise is channelled and supported with investment in systems and programmes that leverage surveillance data collected by surveillance units. In particular, ECDC recommends strengthening R [39] programming capacity among data managers and epidemiologists, with the aim of automating data validation, compiling surveillance dashboards and performing statistical analysis. ECDC could provide training activities.

Comply with General Data Protection Regulation

Since most disease surveillance data are personal data, we recommend complying with the requirements set out by the General Data Protection Regulation (GDPR).

Assess surveillance data quality

Although there are some existing data quality checks, ECDC would recommend making them more systematic and possibly automated (e.g. variable completeness or reporting timeliness).

ECDC would also recommend assessing the level of possible under-ascertainment by looking at other data sources.

Consider disseminating outputs at central level

For diseases notifiable at EU level or in all administrative entities and the Brčko District, the publication of outputs from all surveillance data would provide an overview for Bosnia and Herzegovina and help promote good practices.

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Annex 1. Practical arrangements for the assessment process

This annex describes the main practical arrangements of the country visit to Bosnia and Herzegovina that took place in Mostar from 25 to 27 September 2024.

Country visit agenda

Day 1, Tuesday, 24 September 2024		
University of Mostar, Organizational Unit, Faculty of Medicine (1 st Floor)		
Kralja Petra Krešimira IV bb, 88000 Mostar, Bosnia and Herzegovina		
Time	Topic	Speaker/topic owner
13:00-13:30	Welcome and introduction to the meeting MoCA, MoHFBiH, MoHSWRS, IPHRS, IPHFBiH	Assistant Minister, MoCABiH Assistant Minister, MoHFBiH Senior Public Health Associate, MoHSWRS Director, IPHRS BDBiH Director of IPHFBiH
13:30-14:00	Surveillance of infectious diseases at EU/EEA level and strengthening surveillance in Western Balkans (30')	ECDC
14:00-15:00	Description of infectious disease surveillance system in Bosnia and Herzegovina Communicable disease surveillance system in Federation of Bosnia and Herzegovina Communicable disease surveillance system in Republika Srpska	IPHFBiH IPHRS
15:00-15:30	Break	
15:30-16:30	Description of infectious disease surveillance system in Bosnia and Herzegovina Communicable disease surveillance system in Brčko District of Bosnia and Herzegovina Discussion	BDBiH IPHFBiH, IPHRS, BDBiH, ECDC
16:30-18:00	Data collection Data collection in Republika Srpska Data collection in Federation of Bosnia and Herzegovina Data collection in Brčko District of Bosnia and Herzegovina	MoCABiH IPHRS IPHFBiH BDBiH

Day 2, Wednesday, 25 September 2024**University of Mostar, Organizational Unit Faculty of Medicine (1st Floor), Mostar, Bosnia and Herzegovina**

Time	Topic	Participants
09:00-09:10	Wrap-up of the first day	ECDC team
09:10-10:50	Data quality	IPHFBiH, IPHRS, BDBiH, ECDC
10:50-12:30	Data management	IPHFBiH, IPHRS, BDBiH, ECDC
12:30-13:30	<i>Lunch break</i>	
13:30-15:30	Data analysis Dissemination of the communicable disease surveillance data Dissemination of data in Republika Srpska Dissemination of data in Federation of Bosnia and Herzegovina Dissemination of data in Brčko District of Bosnia and Herzegovina	IPHFBiH, IPHRS, BDBiH, ECDC
15:30-16:00	Break	
16:00-16:30	Outbreak detection	IPHFBiH, IPHRS, BDBiH, ECDC
16:30-17:00	Capacity	MoCABiH, IPHFBiH, IPHRS, BDBiH

Day 3, Thursday, 26 September 2024**University of Mostar, Organizational Unit Faculty of Medicine (1st Floor), Bosnia and Herzegovina**

09:00-09:10	Wrap-up of the second day	ECDC team
09:10-10:30	Discussion on selected diseases reported to ECDC	MoCABiH, IPHFBiH, IPHRS, BDBiH, ECDC
10:30-11:00	Break	
11:00-12:30	TESSy reporting training Reporting of existing diseases, Q&A Additional topics, Q&A	ECDC MoCABiH, IPHFBiH, IPHRS, BDBiH
12:30-13:00	Debriefing session: Draft conclusions and way forward	ECDC, MoCABiH, IPHFBiH, IPHRS, BDBiH

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