National Policy

On

Integrated Disease Surveillance And Response (IDSR)

Federal Ministry of Health
Abuja, Nigeria.

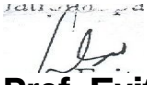
September, 2005.

Foreword

In most developing countries, communicable diseases are the most common causes of death, illness and disability. These diseases include Malaria, Measles, Cerebrospinal meningitis, Cholera, Yellow fever, Lassa fever, Tuberculosis, HIV/AIDS, Diarrhoea and Pneumonia, etc. The Federal Ministry of Health has enunciated programs for the elimination, eradication prevention and control of these diseases, with technical support from development partners. The Ministry, through the Integrated Disease Surveillance and Response (IDSR) Technical Advisory Committee is also responsible for mobilizing and deploying resources for disease surveillance and out break response.

Presently, the existing surveillance system is insensitive as it is incapable of detecting early warning signs of outbreaks. The resultant effect of the poor surveillance system is high mortality, morbidity and disability, with attendant suffering of our people. In recognition of the defect in the disease surveillance and notification situation, Nigeria and other member States in the WHO African Region endorsed Integrated Disease Surveillance and Response strategy at the 48th Regional Committee meeting held in Harare, Zimbabwe, in September, 1998. Nigeria has embraced the new IDSR strategy and has also introduced it in all the States of the Federation and Federal Capital Territory (FCT). This strategy will integrate multiple surveillance systems, so that personnel and other resources can be used more efficiently and effectively. A functional disease surveillance system will equip health workers to set priorities, plan interventions, mobilize and allocate resources and provide early detection and response to disease outbreaks.

The long term goal of the IDSR policy is to ensure good and quality health for all Nigerians by contributing to the reduction of the burden of these communicable diseases, which is one of the health millennium development goals (MDGs) and also one of the thrusts of the on going Health Sector Reform (HSR). This statement of policy supports comprehensive national guidelines for IDSR with details of sectoral responsibilities and also allocates specific roles for each tier of the health system. The core sections include background and situation analysis, specific IDSR objectives, training, core indicators for monitoring and evaluating IDSR, resource mobilization, laboratory field support and operations research. It is expected that with the adoption of this policy, disease surveillance and response activities will be well integrated in the country leading to a more judicious use of scarce resources and better outcome. This IDSR policy document was developed with technical support from our local and international partners namely, WHO, UNICEF, MSF, USAID, PATHS and NEMA.



Prof. Eyitayo Lambo.
Hon. Minister of Health.

Acknowledgement

The IDSR Policy Drafting Committee wishes to express profound gratitude to all those who contributed in making the development of this very important document a reality. We especially acknowledge the leadership role and the encouragement of the Hon Minister of Health, Prof. Eyitayo Lambo in the formulation of this IDSR policy.

Our gratitude also goes to the Director, Public Health, Dr. Edugie Abebe mni, for her inputs and the special attention she accorded this project.

We also wish to acknowledge the untiring efforts and technical inputs of the World Health Organisation.
Finally, we wish to thank our other colleagues who have contributed in one way or the other towards the development of the policy document.

List of Acronyms

AIDS Acquired Immunodeficiency Syndrome

CFR Case Fatality Rate

DHPR Department of Health Planning & Research.

DSN Disease Surveillance and Notification

DSRC Disease Surveillance and Response Committee

EPR Epidemic Preparedness and Response

FMOH Federal Ministry of Health

HF Health Facility

HIV Human Immunodeficiency Virus.

IDSR Integrated Disease Surveillance and Response

LGA Local Government Area

MSF Medecins Sans Frontieres

NBE Nigerian Bulletin of Epidemiology

NEMA National Emergency Management Agency

NGOs Non Governmental Organizations

NHMIS National Health Management Information System

NPHCDA National Primary Health Care Development Agency.

NPI National Programme on Immunization

PATHS Partnership for the Transformation of Health Sector

PHC Primary Health Care

RRT Rapid Response Team

SMOH State Ministry of Health

SOPs Standard Operating Procedures

STI Sexually Transmitted Infection.

TAC Technical Advisory Committee

UNICEF United Nations Children's Fund

WHO World Health Organization.

TABLE OF CONTENTS.

TABLE OF CONTENTS. 6-7

1.0. Background

1.1 Introduction.

The disease surveillance system in Nigeria was introduced in 1988 following a major outbreak of yellow fever in 1986/87, which affected ten out of the then nineteen States of the Federation. The magnitude of the outbreak was attributed to weak or non-existent disease surveillance and notification system in most States. As a result of this, a task force was established by the Federal Ministry of Health to review disease surveillance and notification in the country.

Between 1988 and 1989, a disease surveillance and notification system for the country was developed. Forty diseases of public health importance in the country were identified and designated for routine (monthly) notification out of which ten epidemic prone diseases were selected for immediate reporting. Standard reporting forms (DSN 001 for immediate reporting, and DSN 002 for Monthly routine reporting) were also introduced. The methodology for information flow between the various levels was also prescribed. In 1989, the National Council on Health approved the adoption of Disease Surveillance and Notification (DSN) in the country.

Varying degrees of success have been recorded in the implementation of the disease surveillance system. However, the effectiveness and efficiency has been a cause for concern over the years, as it has not been able to produce the required information needed for timely response. Furthermore, some disease control programs have continued to maintain vertical surveillance systems and the involvement of laboratories in surveillance has not been satisfactory. This unsatisfactory situation was more or less the same in other countries in the African Region. In view of this, the World Health Organization Regional Committee for Africa in her 48th session in September 1998, met in Harare, Zimbabwe and advocated for the assessment and strengthening of the surveillance system by member States and the adoption of an integrated diseases surveillance system (IDSR) by countries in the region.

1. 2. Situation Analysis.

1.2.1 IDSR in Nigeria

In 1998, Nigeria along with other member nations at the Regional committee meeting in Harare, endorsed the Integrated Disease Surveillance and Response strategy as a means of strengthening communicable disease surveillance and response with a view to making it more sensitive at all levels. In Nigeria the IDSR implementation process started in June 2000, with an orientation workshop held to sensitize national program managers of

vertical programs and partners on IDSR. In January 2001, a steering committee on IDSR was inaugurated to steer the implementation process.

In June 2001 the steering Committee carried out an assessment of the surveillance system with a view to obtaining baseline information on the existing disease surveillance system in the country and securing consensus on a list of priority diseases. The findings of the assessment include the following.

- Vertical surveillance by some disease programmes
- Multiplicity of reporting forms and format
- Incomplete and untimely reporting
- Inadequate pre-positioned medicines and vaccines
- Lack of communication equipment
- Absence of case management protocols
- Inadequate Laboratory facilities and involvement of existing ones
- High prevalence of communicable diseases e.g. Malaria, Diarrheoa, Pneumonia, Measles, Tuberculosis and HIV/AIDS
- Inadequate funding

Based on these findings, recommendations were made for improving the IDSR system which include

- Development of National standard case definitions and management protocols for priority diseases,
- Relevant trainings for IDSR
- Provision of budget line for IDSR

1. 2.2. Surveillance structure

The current IDSR structure is based on the three tier system of Government i.e Local State and Federal levels. Focal persons are designated at each level to carry out IDSR activities

1.3. Justification.

Currently, most disease control and prevention programmes in Nigeria are vertically implemented with the result that scarce resources of personnel, funds and materials are duplicated to the detriment of synergy, coverage and efficiency. Many programmes have established vertical surveillance systems with specialized and sometimes complex data collection formats. Reporting is often incomplete and untimely, Medicines, vaccines and other relevant supplies are often inadequately pre-positioned to the detriment of appropriate response. The will to ensure functional and effective integrated disease surveillance system has informed the formulation of this national policy by the Federal Ministry of Health.

2.0. Scope of the Policy.

The policy shall guide and provide the necessary environment for the planning, implementation, monitoring and evaluation of an integrated disease surveillance and response system by all tiers of government, including parastatals, private health sector, non-governmental organizations and partners. The following are the selected priority diseases for IDSR:

2.1. List of Priority Diseases.

- **Epidemic prone diseases**
  CSM, Cholera, Measles, Lassa fever and Yellow Fever.

- **Diseases targeted for Elimination and Eradication**
  Neonatal Tetanus, Leprosy, Lymphatic Filariasis, Guinea worm and Poliomyelitis.

- **Other diseases of public health importance**
  - Diarrheoa without blood
  - Malaria
  - Plague
  - Tuberculosis
  - Pertussis
  - Onchocerciasis
  - Pneumonia
  - Diarrhea with blood
  - HIV/AIDS
  - Sexually Transmitted Infections.
  - Hepatitis B

2.2. Legal Frame Work.

This policy is set within the framework of the National Health policy and is subject to the provisions of the National Health Act. The policy shall be reviewed every 5 years or as deemed fit by the Honourable. Minister of Health in consultation with the National Council on Health..

2.3 Policy Declarations.

The Federal Ministry of Health recognizes the need for the implementation of an integrated disease surveillance and response system (IDSR), which will ensure integration of multiple surveillance systems, where personnel, materials and other resources could be used more effectively and efficiently. All tiers of government and the people with the following declarations in accordance with the National Health Policy hereby adopt this policy document:

1. That all the tiers of government recognize and agree that the IDSR will contribute to a better quality disease surveillance, and response in the country and will lead to reduction in deaths, illnesses and disability among our people.

2. That all the States and Local Government health personnel shall participate actively in the planning, implementation, supervision, monitoring and evaluation of IDSR activities

3. That the people of Nigeria strongly agree that the National policy on IDSR shall be complementary to the National Health policy and its strategies to achieve quality health care for all Nigerians.

4. That sustainable frame work that will enhance the sensitivity of our Disease Surveillance and Response system shall be established.

5. That compliance by all the tiers of government and individual with all relevant policies and laws that support integrated disease surveillance will be ensured.

6. That the policy when adopted shall be made available to all the States, LGAs including Medical and Health institutions and implemented without delay.

2.3.0 To this end, Government shall:

2.3.1 Establish a sustainable framework to facilitate the implementation of effective integrated disease surveillance system in the country.

2.3.2 Ensure compliance by all tiers of government and communities with all the relevant policies supporting the establishment and implementation of a sound and effective IDSR programme.

2.3.3 Establish appropriate mechanism for the review of relevant curriculum and training manuals of medical and health institutions in order to incorporate IDSR strategies in their curriculum.

2.3.4 Provide adequate funding for integrated disease surveillance and response programme through increased financial provision for IDSR activities in the budget.

2.3.5 Strengthen the capacity of the National Health Management Information system NHMIS in order to adequately address the issue of integrated disease surveillance.

2.3.6 Ensure the establishment of functional Disease Surveillance and Response Committees and Rapid response team equipped with adequate facilities at all levels.

2.3.7 Ensure the establishment of functional public health laboratory networks in the country and strengthen the capacity of the Central Public Health Laboratory.

2.3.8 Ensure the improvement of communication between Federal, State and LGA, through the provision of modern communication facilities that will encourage two-way feedback mechanism.

2.4 Policy Goal.

The policy goal is to ensure good health of all Nigerians, through the provision of necessary framework and guidance for the strengthening of skills, provision of resources, and the prevention, early detection and timely response to diseases and conditions that cause high rates of death, illness and disability.

2.5. Broad Objective.

The broad objective of the IDSR is to contribute to reduction of mortality, morbidity and disability from diseases through accurate, complete and timely information with respect to data gathering and transmission for effective control and prevention of communicable diseases in the country.

2.6. Specific Objectives.

The specific objectives of the IDSR are:

- To integrate vertical surveillance systems, so that personnel, materials and other resources could be used more efficiently and effectively.
- To establish functional national disease surveillance system that is able to detect epidemics early enough for timely response.
- To support the strengthening of surveillance data management and utilization of information for disease control activities for planning, implementation, monitoring and supervision and resource mobilization at all levels.
- To strengthen the capacity and involvement of laboratories in disease surveillance as well as establishing laboratory network for IDSR at Federal, State and LGA levels.
- To support the establishment of effective communication network for transmission of surveillance data and epidemiological information at all levels.
- To support training and retraining of health workers on IDSR at all levels using adapted training modules and inclusion of IDSR into the training curricula of health institutions.
- To conduct continuous advocacy to policy and decision makers at all levels to mobilize resources and support for IDSR activities

- To create awareness and mobilize the communities to promptly report suspected epidemic prone diseases and disasters to the local health authorities

- To ensure regular monitoring and supervision of IDSR activities at all levels

- To strengthen the surveillance and data reporting mechanism of both public and private health institutions to the local health authorities

3.0. Strategies for the Implementation of IDSR.

The IDSR shall be implemented in phases at the community, health facility, LGA, State and Federal level, utilizing the LGA as the lowest administrative unit within the national health system. The strategies for effective implementation of IDSR include:

3.1. Advocacy and Sensitization

Continuous advocacy shall be conducted for effective IDSR implementation, to ensure the support of policy makers, opinion leaders and partners. Advocacy visits shall be conducted to these categories of people on a regular basis. Advocacy will be used for resource mobilization and funding for IDSR. In addition, sensitization workshop shall be carried out at all levels. Sensitization of the opinion leaders and leaders of thought at the community level shall be carried out to enlist their support for the programme. Health professionals and other private professional bodies shall be sensitized on IDSR approach in order to secure their support and participation in its implementation.

3.2. Programme Management and Coordination

A focal unit for IDSR shall be identified in all health facilities, LGA PHC departments, State ministries of health and the Federal Ministry of Health. A focal person shall be assigned to this unit. A multi-agency coordinating committee shall be established to coordinate IDSR implementation at LGA, State and Federal Level. The committee will comprise program managers of priority diseases, partners and experts in public health, particularly in Epidemiology and Laboratory Science. This group will also serve as an advisory body to the government. The committee shall meet on quarterly basis to review and monitor IDSR activities.

3.3 Strengthening Communication Capacity.

Basic communication apparatus shall be available at all levels. At minimum telephones (land and mobile), facsimile, high frequency radios and e-mail should be made available at LGA, State and Federal levels. Federal, State and LGA IDSR units and laboratory service offices, shall be equipped with computers.

3.4 Capacity Building

A set of core trainers shall be established at Federal Ministry of Health with partners who would periodically conduct training and retraining of health workers program officers and IDSR focal persons at all levels, utilizing the WHO generic IDSR training modules which had been adapted for Nigeria. Training would be conducted using the training of trainers' mechanism. These core facilitators will be utilized to provide technical support for States, LGAs and health facilities training activities. The training will incorporate all aspect of disease surveillance, laboratory diagnosis, epidemic preparedness and response (EPR) and data management. Since the Federal Ministry of Health has the responsibility of ensuring sustained and high quality training, skill reinforcement supervisory visits and follow-up shall accompany these training within 8 weeks of conducting the training. Pre-service training for health workers shall be introduced to ensure sustainable IDSR implementation. Heads of medical and health training institutions shall be sensitized on IDSR to facilitate inclusion of IDSR in their curriculum.

3.5 Strengthening Data Management

The National IDSR unit shall develop a comprehensive database of the 21(twenty) priority communicable diseases and will provide data management guidelines for use at all levels. Standard case definitions of priority diseases shall be produced, and circulated to all implementing health facilities, LGAs and States. Workshops shall be conducted to sensitize decision-makers on the use of data generated for decision-making and policy formulation. Data will be disseminated through a two-way feedback process, such as monthly newsletter at all levels and the quarterly National Bulletin of Epidemiology (NBE) at the Federal level. Surveillance officers at all levels shall be trained in data management. Partners shall be expected to provide technical and financial support for training and development of database and relevant software recommended by WHO. States and LGAs will be linked to the National IDSR Unit through Internet and facsimile facilities to ensure rapid transmission of surveillance data.

3.6 Establishment of Sentinel Sites

Sentinel sites shall be established to promote active surveillance and to generate more detailed disease data disaggregated by sex, smaller age grouping and classification for specific target diseases of public health significance, such as cholera, measles, poliomyelitis, cerebrospinal meningitis, viral hemorrhagic fever (Lassa Fever), yellow fever, HIV/AIDS, malaria, diarrheoa diseases, acute respiratory infection, guinea worm, onchocerciasis, tuberculosis and leprosy. The sentinel surveillance sites will be expected to function with IDSR. Data collection format, guidelines and manual will be developed for sentinel surveillance activity in collaboration with the various programmes or any other programme that wishes to establish one. At the sentinel sites, active case search of priority diseases shall be introduced and intensified.

3.7 Epidemic Preparedness and Response (EPR)

EPR committees shall be established at all levels and strengthened where available. The committee shall meet on quarterly basis and when deemed necessary, with defined terms of reference, plan of action and operational guidelines. Rapid response teams equipped with adequate resources and logistics for rapid intervention shall be established at all levels. Adequate funds shall be provided to secure Federal, State and LGA contingency stocks of medicines, vaccines and supplies and for the pre-positioning of emergency stocks, particularly in epidemic prone States.

The existing epidemic management protocol and Standard Operating Procedures (SOPs) shall be updated and made available to health personnel at all levels.
Weekly reporting and collation of data on epidemic prone diseases by LGA shall be introduced to facilitate prediction of impending epidemics.

3.8 Strengthening Laboratories and Case Management

Laboratory network shall be established for IDSR at States, Central and reference laboratories and guidelines shall be developed for efficient laboratory services. Training of laboratory personnel shall be a continuous process, to ensure regular availability of well-trained and skilled manpower. Mechanism for prompt and proper disposal of laboratory waste shall be put in place at Federal and State levels. Adequate mechanism shall also be established for communication with LGAs for the collection and transportation of specimens and feedback of results. Budget line for public health laboratory services shall be created at Federal and State levels, to ensure regular availability of reagents and other supplies. Reference laboratories shall be strengthened for confirmation of special pathogens and also act as quality control for State laboratories.

3.9 Case - based Surveillance.

Cased based surveillance shall be conducted when there is a suspected case of an epidemic prone disease or disease targeted for elimination, eradication and accelerated control such as polio, neonatal tetanus or measles or during out break of these diseases, as such health workers shall conduct case based investigation to learn more about the specific disease pattern. In such cases health workers shall use the epidemiological case definition to identify suspected cases and proceed to line list the suspected cases by age, sex, vaccination status (where applicable), home address and date of onset and take appropriate specimen for laboratory confirmation.

4.0 Roles and Responsibilities of Stakeholders.

4.1 Role of Federal Ministry of Health.

The Federal Ministry of Health with the support of partners shall:

- Be responsible for coordinating the implementation of IDSR.
- Conduct training and provide technical, supervisory, monitoring and evaluation support for IDSR activities.
- Provide technical guidelines, set up regulations and ensure quality control for laboratory services in the country.
- Organize annual IDSR review meeting in collaboration with stakeholders.
- Provide prompt and efficient response mechanisms for emergencies including epidemics and notify appropriate authorities.
- Analyze IDSR data and disseminate to all levels for planning purposes.
- Provide feedback to States and the stakeholders involved in disease surveillance.
- Mobilize resources for IDSR activities.

4.2 Role of IDSR Technical Advisory Committee

The IDSR Steering Committee shall be renamed **IDSR Technical Advisory Committee (TAC)** and shall exist at the Federal level**.**

The TAC shall:

- Provide technical advice on IDSR to the Federal Ministry of Health.
- Provide technical support to, and build capacity of States and LGAs on disease surveillance and response.
- Monitor IDSR implementation at all levels.
- Review periodically health-related data to determine the frequency of occurrence of communicable diseases particularly epidemic prone diseases.

- Provide feedback through quarterly epidemiological bulletin, monthly newsletter and meetings.

4.3 Role of Agencies/Parastatals

4.3.1. National Primary Health Care Development Agency

- Shall assist in the collection and collation of disease surveillance data in the LGAs.

- Shall mobilize the community for integrated disease surveillance and response activities.

- Shall assist in the investigation and control of disease outbreaks in the LGA levels.

- Shall assist in the training and supervision of LGA staff.

4.3.2. National Program on Immunization (NPI)

The NPI with the support of the Federal Ministry of Health shall:

- Be responsible for strengthening routine immunization and effective control of vaccine preventable diseases.
- Ensure that adequate and potent vaccines are available for supplemental immunization including epidemic response activities at all levels.
- Collaborate with the Federal Epidemiological Division to monitor Vaccine Preventable Diseases and contingency stock of vaccine for epidemic prone diseases.

4.4 Role of State Ministry of Health

The State Ministry of Health shall:

- Conduct training and provide technical support for planning, implementation and monitoring of disease trends at the LGAs.
- Establish a Disease Surveillance and Response Committee.
- Establish a public health laboratory to support surveillance activities.
- Ensure timely receipt and analysis of IDSR data from all LGAs in the State and prompt transmission to FMOH.
- Coordinate all IDSR activities in the LGAs and provide timely response and support to LGAs in emergency situation.
- Ensure proper pre-positioning of adequate vaccines, medicines and supplies.

- Mobilize resources for IDSR for states and LGAs through advocacy to policy and decision makers.
- Reproduce and provide training materials, IDSR reporting forms and guidelines to LGAs.
- Provide regular feedback to LGAs through monthly newsletter and review meetings.
- Create a budget line for IDSR activities.

4.5. Role of State Disease Surveillance and Response Committee

- Provide technical advice on IDSR to the State Ministry of Health.
- Provide technical support to, and build capacity of LGAs on disease surveillance and response.
- Monitor IDSR implementation at LGA level.
- Review periodically health-related data to determine the frequency of occurrence of communicable diseases particularly epidemic prone diseases.
- Plan and coordinate epidemic response activities.
- Mobilize resources for IDSR activities.
- Establish an Epidemic Rapid Response Team.
- Review response plan where necessary
- Provide feedback through monthly newsletter and review meetings.

4.6. Role of LGAs

The LGA is the primary level of IDSR implementation and shall:

- Create a budget line for IDSR activities.
- Report on weekly basis, cases of epidemic prone diseases, and monthly for all other priority diseases.
- Monitor disease trends and detect impending epidemics within the LGA.
- Ensure that IDSR forms, medicines and other supplies are available to health facilities.
- Establish LGA Disease Surveillance and Response Committee.
- Notify the State immediately of any disease outbreaks within 48 hours of detection.
- Conduct training and retraining of health personnel on IDSR.
- Provide feedback to the health facilities and communities.
- Ensure collection of data from all public and private health facilities within the LGA.
- Provide logistics support and communication facilities for IDSR operations in the LGA.

4.7 Role of Health facilities

All Tertiary, Secondary and Primary health facilities shall:

- Ensure timely and regular provision of disease data to the LGA where they are located using approved IDSR reporting format
- Conduct training and retraining of health personnel on IDSR
- Assist in Laboratory diagnosis and effective case management using sandardised management guidelines
- Provide technical and logistic support for epidemic response.
- Provide regular routine immunization services
- Provide regular feedback to the communities

4.8 Role of National Health Management Information System (NHMIS)

IDSR is an integral part of the overall NHMIS. The current NHMIS expects bi-annual returns from States, whereas disease surveillance returns are rendered monthly and weekly for epidemic prone diseases.

Data on disease surveillance shall be fed into the NHMIS system for effective health planning, implementation, monitoring and evaluation of programme, policy formulation, evidence based decision making and research. There shall be proper streamlining of data management between the NHMIS and Federal Epidemiology Division to avoid duplication of efforts.

The NHMIS shall:

- Collate, analyze IDSR data on a National basis.
- Monitor progress towards stated goals and targets of IDSR.
- Provide feedback to other levels.

4.9 Role of Partners

The role of partners in IDSR implementation amongst others shall be to:

- Provide technical and financial support.
- Support the establishment of IDSR resource center at the Federal and State Ministries of Health.
- Support research on new trends in IDSR.
- Serve on the IDSR Technical Advisory Committee and Disease Surveillance and Response Committee.
- Collaborate with all tiers of government for improving disease surveillance activities.
- Mobilize resources from other interested parties to support IDSR implementation,

4.10 Role of Private Health Sector

The private health sector shall be involved in the delivery of immunization services and disease surveillance in the country.

In collaboration with government, the private health sector shall perform the following roles in IDSR:

- Ensure that disease data generated from their facilities are rendered to Local Government health offices on a regular basis, using IDSR reporting format.
- Participate in routine immunization services by collecting vaccines from LGA cold stores and making proper returns on its utilization to the LGAs.
- Collaborate with the States / LGAs in the areas of training of health personnel for IDSR.
- Complement government laboratories in the diagnosis of suspected cases of priority diseases in their catchment's area using approved format.

5.0 Partnership Coordination.

The Federal Ministry of Health shall be responsible for the coordination of the activities of all partners involved in IDSR implementation and resource mobilization.

6.0 Monitoring and Evaluation.

The success of the National integrated disease surveillance policy will depend on how well the provisions of the policy are implemented. The Federal level shall regularly monitor the implementation of IDSR. Standardized monitoring checklists shall be developed and distributed to all levels by the FMOH. Appropriate mechanisms shall be put in place for monitoring and evaluating performance of IDSR.

- ♦ Monitoring and evaluating IDSR shall be conducted using the core indicators which shall form the major tools for measuring IDSR performance periodically.
- ♦ The Federal Ministry of Health in collaboration with the State Ministry of Health and partners shall evaluate performance and progress through annual review meetings.
- ♦ A full evaluation of IDSR with technical support from partners shall be undertaken every 5years.

7.0. Operations Research.

The Federal Ministry of Health and partners shall encourage and support basic and operations research that will facilitate effective implementation of IDSR policy. Government shall provide the financial and technical support to encourage such research activities especially in the areas of priority diseases review. Other priority areas of support shall include disease surveillance and notification formats, IDSR core indicators, emergency preparedness and response rapid test kits for confirmation of outbreaks.

8.0 IDSR Core Indicators.

S/N	IDSR Activity	Indicators
8.1	**Routine reporting (IDSR 002, 003 forms)**	Proportion of health facilities submitting weekly or monthly surveillance reports on time to the LGA.
8.2	**Reporting outbreaks from the LGA to National level**	Proportion of reported outbreaks of epidemic prone diseases notified to the next higher level within 2 days of surpassing the epidemic threshold.
8.3	**Case-based reporting**	Proportion of cases of diseases targeted for elimination/eradication and any other diseases of public health importance, which were reported using case-based forms or line list.
8.4	**Case-based data analysis.**	Proportion of reports of investigated outbreaks that include analyzed case-based data.
8.5	**Data analysis**	Proportion of health facilities/LGAs that have current trend analysis (line graphs) for selected priority diseases..
8.6	**Laboratory support**	Proportion of reported outbreaks of epidemic prone diseases that occurred in the **Past year with laboratory confirmation of results**
8.7	**Outbreak response**	Proportion of confirmed outbreak with appropriate ***and timely*** response (48-72 hours) at the LGA level during the last 12 months.
8.8	**Case fatality rate –CFR**	Number of Deaths X 100% Number of Cases
8.9	**Attack rate**	Total No of Cases x 100% **T**otal Population exposed.

Annexes

Annex A

Definition of Terms

Epidemic: An Epidemic is defined as the occurrence of a disease in a geographic area clearly in excess of expected or known rate for given area and time period.

Epidemiology: The study of the distribution and determinants of diseases and health related events in human population, and the application of the knowledge for the prevention and control of health problems.

Surveillance: A system of constant monitoring and watchfulness over all aspect of the occurrence and spread of diseases and the use of information gathered for the purpose of designing preventive and control measures.

Monitoring: Is a process of measuring, recording and collation of information oln project performance on a continuous basis, to assist management in decision making.

Evaluation: Is the measurement of achievement in relation to set goals for a project over time.

Incidence rate: $\frac{\text{Number of New Cases}}{\text{Total popn. at risk}} \times 100\%$

Active Surveillance: Surveillance where public health officers seek report in the surveillance system on a regular basis, rather than waiting for the reports to be submitted at the discretion of participating facilities.

Annex B

Steps in Epidemic Investigation

- Verify existence of the epidemic
- Prepare resources and logistics
- Confirm diagnosis
- Start treatment based on clinical diagnosis
- Identify all additional cases contact tracing
- Analyze data and interpret results
- Develop an explanatory hypothesis
- Implement and evaluate control and preventive measures
- Prepare and disseminate report.

Annex C.

State Disease Surveillance and Response Committee

Membership/Composition

The DSRC shall be composed of:

- Hon. Commissioner for Health
- Director PHC/Public Health
- Director Hospital Services
- Director of Pharmaceutical Services
- Director of Nursing Services
- Director Medical Laboratory Services
- State Epidemiologist.
- Representative of partner agencies

Terms of Reference of Disease Surveillance and Response Committee.

- Plan and coordinate surveillance and epidemic response activities
- Resource mobilization.
- Meet regularly with the Epidemic Rapid Response Team.
- Monitor and evaluate response interventions.
- Review response plan where necessary.

State Rapid Response Team (RRT) Composition

- Director PHC/Public Health
- State Epidemiologist.
- Medical Laboratory Scientist.
- Public Health Nurse
- Environmental Health officer
- Health Education Officer
- DSN Officer
- Representative of partner agencies

Terms of Reference of Rapid Response Team.

- To verify any report of disease outbreak in the State
- To carryout outbreak investigation
- To propose and plan appropriate measures for containment of the epidemics to the State Disease Surveillance and response Committee
- To participate actively in implementation of epidemic prevention and control strategies
- To provide technical support to LGAs during outbreaks.

Annex D.

LGA Disease Surveillance and Response Committee

Membership/Composition

- LGA Chairman
- Supervisory Councilor for Health
- PHC Coordinator/Medical Officer of Health
- Environmental Health Officer
- Health Education Officer
- DSN Officer
- Zonal Technical Officer (NPHCDA/NPI)
- Community Physician/Medical Directors in charge of General Hospitals
- Representative from NGOs/Agencies available in the LGA
- Representative from the community
- Nursing Officer from private hospital
- Representatives from the Armed forces/ Police

Terms of Reference of Epidemic Management Team.

- Plan and coordinate epidemic response activities.
- Resource mobilization.
- Meet regularly with the Epidemic Rapid Response Team.
- Review response plan where necessary.

LGA RRT

- PHC Coordinator/Medical Officer of Health
- Environmental Health Officer
- Health Education Officer
- DSN Officer
- Representative from NGOs/Agencies available in the LGA
- Representative from the community
- Nursing Officer from private hospital

Terms of Reference of Rapid Response Team.

- To verify any report of disease outbreak in the LGA
- To carryout outbreak investigation
- To propose and plan appropriate measures for containment of the epidemics to the LGA Disease Surveillance and response Committee
- To participate actively in implementation of epidemic prevention and control strategies
- To provide technical support to LGAs during outbreaks.

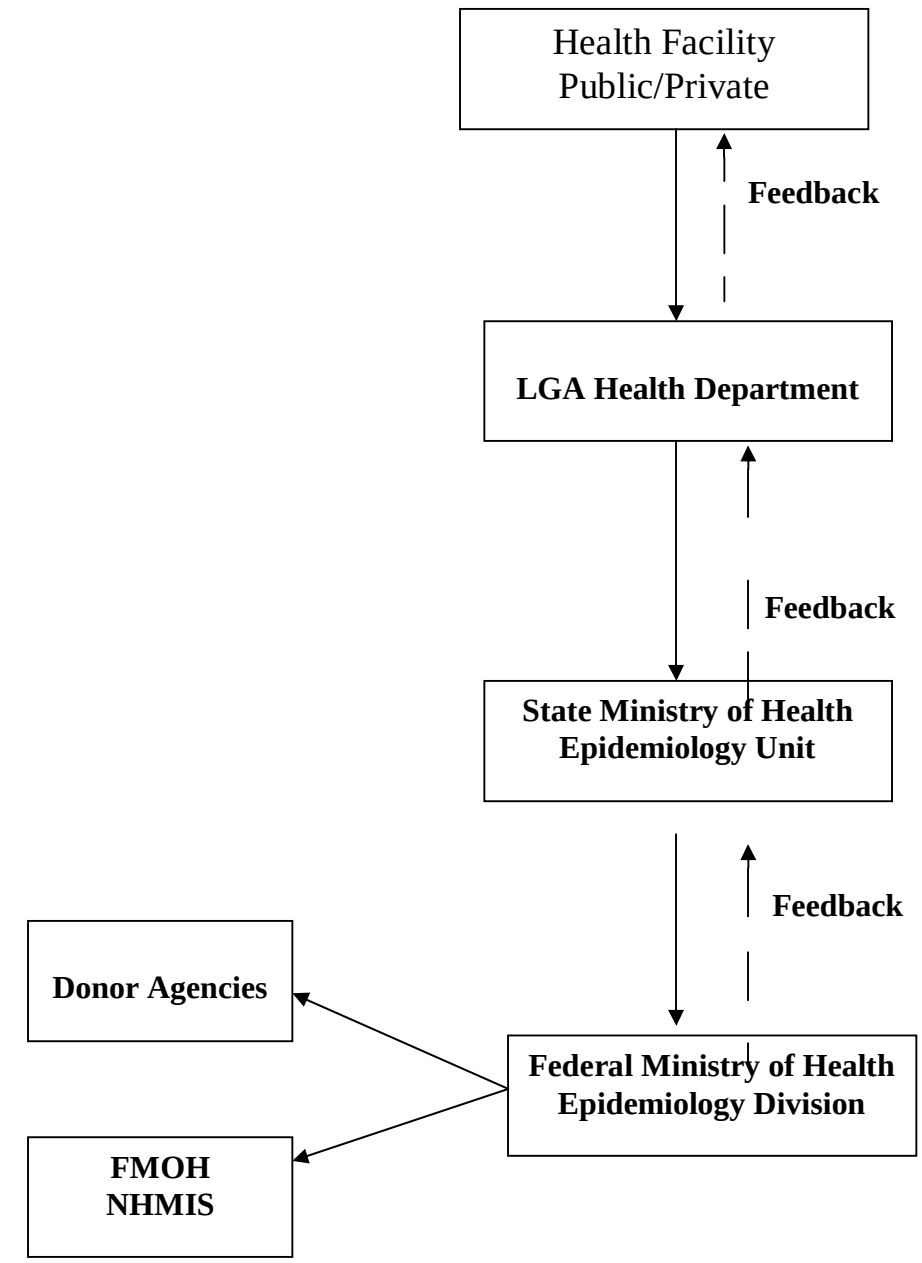
Annex E.

Alert and epidemic thresholds of epidemic prone diseases.

S/N	Disease	Alert Threshold	Epidemic Threshold
1.	CSM	5 cases per 100,000 inhabitants per week in a pop. greater than 30,000. 2 cases per 100,000 inhabitants per week in a popn. of 30,000 or less.	15 cases per 100,000 inhabitants per week in a pop. greater than 30,000. 4 cases per 100,000 inhabitants per week in a pop. of 30,000 or less.
2.	Yellow Fever	If a single case is suspected.	If a single case is confirmed.
3.	Measles	5 or more suspected cases reported from a district/health facility in a month.	3 or more measles IgM+ confirmed cases in a district/health facility in a month.
4	Viral Haemorrhagic Fever (Lassa Fever)	If a single case is suspected.	If a single case is confirmed.
5	Cholera		Doubling of cases per week.

Annex F

Information flow on IDSR in Nigeria.



- **Collect data on Standard IDSR format**

- **Receive forms from HF**
- **Collate and forward to SMOH**
- **+.**
- **Analyze and feedback to HF**

- **Collate data and forward to FMOH**
- **Analyze and feedback to LGA**

- **Collate data and forward to (NHMIS)**
- **Analyze and feedback to SMOH.**

Feedback is in Reverse order.

REFERENCES

1. National Technical guidelines for IDSR, 2002, pg 6, pg 41

2. Report of the assessment on DSN by the IDSR Steering Committee. 2001

2. WHO Immunization Policy. 1995, pg 3

3. Disease Surveillance and Notification Training Manual. 1988

3. National Immunization Policy and Standard of Practice, 1995, pg 42, pg 43.

4. Draft National Health Bill, 2004, pg 15 of 43.

5. Revised National Health Policy, 2004. pg 41.

6. Control of Communicable Diseases in Man. Abram S. Benenson.1990 pg 507.

7. WHO/Country Cooperation Strategy (NHMIS Health Profile).2005 ed. pp 6.