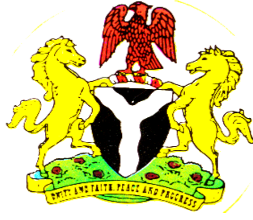

National Policy

On

Integrated Disease Surveillance and Response (IDSR)

Federal Ministry of Health
Abuja, Nigeria.

December, 2010

Foreword

Communicable diseases are the commonest causes of illness, disability and death in most developing countries. These diseases include malaria, measles, cerebrospinal meningitis, cholera, yellow fever, lassa fever, tuberculosis, HIV/AIDS, diarrhoea, pneumonia, etc. The Federal Ministry of Health has initiated programs for the elimination, eradication, prevention and control of some of these diseases with the technical support of development partners.

The current surveillance system is yet to meet our target of detecting early, warning signs of outbreaks, conditions and events. In recognition of this gap in the disease surveillance and notification situation, Nigeria and other member States in the WHO African Region endorsed Integrated Disease Surveillance and Response (IDSR) strategy at the 48th WHO Regional Committee held in Harare, Zimbabwe, in September, 1998. In April 2006, the IDSR strategy was approved by the Federal Executive Council. This strategy is being implemented in all the States of the Federation and the Federal Capital Territory (FCT).

The epidemiologic transition of diseases has made it imperative to review the policy to capture the new trend in the IDSR strategy. A functional disease surveillance system would equip health workers to set priorities, plan interventions, mobilize and allocate resources and provide early detection and response mechanism to disease outbreaks, conditions and events.

The long term goal of the IDSR policy is to ensure quality health for all Nigerians by contributing to the reduction of the burden of these communicable diseases, conditions and events. This is more so with the epidemiologic transition which has resulted in non-communicable diseases contributing significantly to morbidity and mortality in Africa including Nigeria. Consequently, the list of priority diseases for notification in the country was reviewed to include non- communicable diseases such as diabetes mellitus, high blood pressure, cancer and sickle cell disorders. Neglected Tropical Diseases (e.g noma, burulli ulcer) and emerging and re-emerging infectious diseases such as H5N1, H1N1 and SARS were included in the list.

It is expected that with the adoption of this reviewed policy, disease surveillance and response activities would be well integrated in the country leading to a more judicious use of scarce resources and improved health outcomes.

This IDSR policy document was reviewed with technical support of our local and international partners namely WHO, UNICEF and NEMA.

Finally, with the revised International Health Regulations (IHR 2005) adopted at the 58th World Health Assembly in 2005, the list of the notifiable diseases was expanded to include conditions and events of international concerns.

I approve the use of this policy to all stakeholders in the health sector.

Prof. C. O. Onyebuchi Chukwu
Honourable Minister of Health.
December, 2010

Acknowledgement

The IDSR Policy Review Committee appreciates the immense contributions of the following persons/organizations towards the successful completion in reviewing the IDSR policy.

The Honorable Minister of Health, Prof. C. O. Onyebuchi Chukwu, is highly appreciated for the leadership role played in making the IDSR Policy review a success.

Our profound gratitude goes to the Permanent Secretary, Mr. Linus Awute, mni for the special attention given to the review of the IDSR Policy.

The contribution of the National Emergency Management Agency (NEMA) and the National Primary Health Care Development Agency (NPHCDA) is equally noted. We also wish to thank all the consultants from the various Federal Health institutions for their technical support.

Our appreciation also goes to our Development Partners (WHO, UNICEF etc) for their unflinching support.

We also wish to acknowledge the contributions of our colleagues from the Department of Health Planning, Research and Statistics (DHPRS) and other divisions in the Public Health Department.

Finally, we thank the Almighty God for the grace and privilege given to us all to be part of the review of this very important document.

Dr. Henry Akpan.
Chief Consultant Epidemiologist
December, 2010

List of Acronyms

AIDS	Acquired Immunodeficiency Syndrome
CFR	Case Fatality Rate
DHPR	Department of Health Planning & Research.
DSN	Disease Surveillance and Notification
EPR	Epidemic Preparedness and Response
FMOH	Federal Ministry of Health
HF	Health Facility
HIV	Human Immunodeficiency Virus.
IDSR	Integrated Disease Surveillance and Response
IHR	International Health Regulations
LEMC	Local Government Emergency Management Committee
LGA	Local Government Area
MSF	Medecins Sans Frontieres
NAFDAC	National Agency for Food and Drugs Administration and Control
NBE	Nigerian Bulletin of Epidemiology
NEMA	National Emergency Management Agency
NGOs	Non Governmental Organizations
NHMIS	National Health Management Information System
NIMET	Nigerian Metrological Agency
NPHCDA	National Primary Health Care Development Agency.
PATHS	Partnership for the Transformation of Health Sector
PHC	Primary Health Care

PHEIC	Public Health Emergency of International Concern

RRT Rapid Response Team

SEMA State Emergency Management Agency

SMOH State Ministry of Health

SOPs Standard Operating Procedures

STI Sexually Transmitted Infection.

TAC Technical Advisory Committee

UNICEF United Nations International Children's Education Fund

WHO World Health Organization.

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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 have been a cause for concern over the years, as the system has not been able to produce the required information needed for timely response. Furthermore, some disease control programmes 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 (IDS) strategy by countries in the region. The diseases addressed under this strategy were mainly those that were targeted for eradication and elimination, epidemic prone diseases and some communicable diseases of public health importance.

With the epidemiologic transition, non- communicable diseases are now contributing significantly to morbidity and mortality in Africa including Nigeria. To this end the list of priority diseases for notification in the country has been increased to include non- communicable diseases such as Diabetes mellitus, High blood pressure & sickle cell disorders. Also included are Neglected Tropical Diseases (e.g Noma, Burulli Ulcer) and emerging and re-emerging infectious diseases such as H5N1 and SARS

Furthermore, with the revised International Health Regulations (IHR 2005) adopted at the 58th World Health Assembly in 2005, the list of the notifiable diseases has been expanded to include conditions and events of international concerns. This revised International Health Regulations entered into force on 15th June 2007.

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 (IDSR) 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 programme managers of vertical programmes 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 under utilization 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 Surveillance 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

A recent assessment carried out in 2009 shows that implementation of IDSR at the operational level has made some progress, but there is still a lot to be done to improve surveillance system for effective prevention & control of diseases and other public health risk.

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 (including IHR 2005) activities.

1.3. Justification.

Currently, most disease control and prevention programmes in Nigeria are vertically implemented with the result that scarce resources are duplicated at the expense 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 increase in morbidity and mortality as a result of non-communicable diseases, the neglected tropical diseases as well as the inclusion of IHR 2005 and the will to ensure functional and effective integrated disease surveillance system has informed the revision of this national IDSR policy by the Federal Ministry of Health.

2.0. Scope of the Policy.

This revised policy shall guide and provide the necessary environment for the planning, implementation, monitoring and evaluation of IDSR strategy by all tiers of government, including parastatals, private health sector, non-governmental organizations and partners. The following are the selected priority diseases, conditions and events for IDSR:

2.1. List of Priority Diseases, conditions and events

Epidemic-Prone and IHR recommended Diseases, conditions and events	
Epidemic prone	**IHR**
1. Cholera 2. Diarrhoea with blood (Shigella (Sd1)) 3. Measles 4. Meningitis 5. Viral hemorrhagic fevers (Lassa fever) 6. Human influenza (caused by a new Subtype) 7. Yellow Fever	8. SARS 9. Smallpox 10.Dengue 11.Anthrax 12. SARI

Diseases targeted for Elimination or Eradication

1. Poliomyelitis 2. Dracunculiasis 3. Leprosy	4. Neonatal tetanus 5. Lymphatic Filariasis 6. Tuberculosis

Other diseases of public health importance

Communicable	**Non-Communicable**
1. Diarrhoea (children <5 years) 2. Pneumonia (children <5 years) 3. HIV/AID 4. Malaria 5. Onchocerciasis 6. Sexually transmitted infections (STIs) 7. Trypanosomiasis 8. Buruli ulcer 9. Plague 10. Trachoma 11. Typhoid 12. Hepatitis –B 13. Pertussis 14. Human Rabies 15. Schistomiasis 16. Noma	17. Asthma 18. Diabetes mellitus 19. Epilepsy 20. High blood pressure 21. Sickle cell disease 22. Malnutrition

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 IDSR strategy, 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 IDSR will contribute to a better quality disease surveillance and response in the country and will lead to reduction in deaths, illnesses and disabilities among our people.

2. That all States and Local Government health personnel as well as the communities 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 framework that will enhance the sensitivity of disease surveillance and Response system shall be established.

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

6. That the policy when adopted shall be made available by FMOH to its agencies/parastatals, states, LGAs and partners.

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 curricula and training manuals of all health institutions in order to incorporate IDSR strategies.

2.3.4 Provide adequate funding at all levels for IDSR activities. .

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 Epidemic Preparedness and Response (EPR) Committees and Rapid response teams 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 effective communication between Federal, States and LGAs, through the provision of modern communication facilities.

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, prevention, early detection and timely response to diseases, conditions and events that cause high morbidity, disability and mortality.

2.5. Broad Objective.

The broad objective of IDSR is to contribute to reduction of mortality, morbidity and disability from diseases and PHEIC through accurate, complete and timely information/ data gathering and transmission for effective prevention and control.

2.6. Specific Objectives.

The specific objectives of IDSR are to:

- Integrate vertical surveillance systems, so that personnel, materials and other resources could be used more efficiently and effectively.
- Establish functional national disease surveillance system that is able to detect epidemics early enough for timely response.
- Support the strengthening of surveillance data management and utilization of information for planning, implementation, monitoring, and supervision and resource mobilization at all levels.
- Strengthen the capacity and involvement of laboratories in disease surveillance as well as establishing public health laboratory network for IDSR at Federal, State and LGA levels.
- Support the establishment of effective communication network for transmission of surveillance data and epidemiological information at all levels.
- 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.

- Conduct continuous advocacy to policy and decision makers at all levels to mobilize resources and support for IDSR activities.

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

- Ensure regular monitoring and supervision of IDSR activities at all levels.

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

- Ensure timely and complete reporting of disease conditions and events using IDSR forms/formats.

- Assess all reports of urgent events within 48hours and notify WHO immediately through the National IHR focal point when the assessment indicates the event is notifiable.

2.7. Targets by the Year 2015

Specific Target for Year 2010 – 2015

1. Establish a functional IDSR system for priority diseases in all the States with at least 80% of the LGAs implementing IDSR.

2. Strengthen the capacity for Data Management for effective monitoring of diseases, epidemic trends and PHEIC in all the States and at least 80% of the LGAs.

3. Train a critical mass of at least 80% of relevant health workers at all levels for the implementation of IDSR.

4. Establish a contingency stock of vaccines, medicines and essential supplies in all the States and LGAs.

5. Establish functional EPR committees and rapid response teams equipped with adequate facilities at national, all states and LGAs.

6. Establish a network of public health laboratories in at least 80% of states with the central public health laboratory and reference laboratories.

7. Develop, operate and maintain EPR plans in all the states and LGAs.

8. Provide appropriate means of transportation for IDSR activities at all levels.

9. Provide effective means of communication between the Federal, States and LGAs.

3.0. Strategies for the Implementation of IDSR.

The IDSR shall be implemented at the community, health facility, LGA, State and Federal levels, 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

Advocacy shall be undertaken for effective IDSR implementation to solicit the support of policy makers, opinion leaders and partners on a continuous basis. It will also be used for resource mobilization to support IDSR.

Sensitization on IDSR approach should be conducted for the opinion leaders at the community level as well as for health professionals (both public and private) and relevant professional bodies in order to enlist their support and participation in its implementation. Sensitization workshops shall be conducted at all levels.

3.2. Programme Management and Coordination

A focal unit and focal person shall be identified and supported for IDSR activities in all health facilities, LGA PHC departments, State Ministries of Health and the Federal Ministry of Health.

A multi-sectoral coordinating committee shall be established to coordinate IDSR implementation at LGA, State and Federal Levels. The committee will comprise programme managers of priority diseases, conditions and events, 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 a quarterly basis to review and monitor IDSR activities.

3.3 Capacity Building

A set of core facilitators comprising officers of the Federal Ministry of Health and partners will periodically conduct training and retraining of IDSR focal persons and programme officers at all levels, utilizing the IDSR training modules based on the National Technical Guidelines.

The training will incorporate all aspects of disease surveillance, especially laboratory diagnosis, EPR and data management. These core facilitators in addition will provide technical support for States, LGAs and health facilities for IDSR activities.

The Federal Ministry of Health shall conduct regular supportive supervisory visits to the States, LGAs and health facilities on IDSR activities.

Pre-service training on IDSR shall be introduced in all Health institutions to ensure sustainable IDSR implementation. Heads of medical and health training institutions and the regulatory bodies shall be sensitized to facilitate inclusion of IDSR in their curricula.

3.4. Communication

In order to ensure timely transmission of information, basic communication equipment shall be made available at all levelsTelephones (land and mobile), facsimile, high frequency radios, internet facilities and computers shall be made available at Federal, State and LGA IDSR units and laboratory service offices.

3.5 Strengthening Data Management

The National IDSR unit shall develop a comprehensive database of the 40(forty) priority diseases as well other Public Health Events of International Concern (PHEIC) and will provide data management guidelines for use at all levels. Standard case definitions of priority diseases and decision instrument for PHEIC (Annex) shall be produced and circulated to all implementing health facilities, LGAs and States.

Sensitization workshops shall be conducted on the use of data generated for decision-making and policy formulation.

Data on IDSR shall be reported to the various levels in accordance with the IDSR technical guidelines as follows:

- Health facilities shall report suspected cases of immediately reportable diseases to the LGA within 24-48 hours.

- Weekly reports
    - from health facilities to LGA, data shall reach the LGA on Monday of the following week
    - from LGA to state, data shall be collated and reach the State by Wednesday of the following week
    - from state to Federal, data shall reach the Federal Epidemiology Division by Monday of the second week after the reporting week
- Routine monthly reports
    - From Health Facility to LGA, data shall be reported by the first week after the reporting month
    - From LGA to State, data from all health facilities shall be collated and forwarded to State by the second week after the reporting month
    - From State to Federal, data from all LGAs shall be collated and forwarded by the third week after the reporting month
    - The state Epidemiology unit shall send copies of the report to the HMIS unit of the Department of Planning, Research and Statistics of SMOH
    - The Federal Epidemiology Division shall share their report with the NHMIS division of the FMOH department of health planning, research and statistics

Data shall be analyzed and disseminated through a feedback process, using channels such as meetings, 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 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/Strengthening of Sentinel Sites

Sentinel sites shall be established and strengthened to promote active surveillance and generate detailed disease data disaggregated by sex, age groups and other relevant variables for specific target diseases of public health significance.

Data collection format, guidelines and manuals will be developed for sentinel surveillance activities in collaboration with the various programmes.
At the sentinel sites, active case search of priority diseases shall be introduced and intensified. Data generated at such sentinel sites shall be incorporated into the IDSR database.

3.7 Epidemic Preparedness and Response (EPR)

EPR committees shall be established at all levels and strengthened where available with defined terms of reference, plan of action and operational guidelines. The committee shall meet on quarterly basis and when deemed necessary.

Rapid response teams equipped with adequate resources and logistics for rapid intervention shall be established at all levels. Adequate funds shall be provided at all levels to secure contingency stocks of medicines, vaccines and supplies and for pre-positioning of emergency stocks.

Epidemic management protocol and Standard Operating Procedures (SOPs) shall be made available to health personnel at all levels.
The EPR committee shall monitor LGA weekly data on epidemic prone diseases to facilitate prediction of impending epidemics.

3.8 Establishment/Strengthening of public health Laboratories

States and reference laboratories shall be established/strengthened for IDSR and guidelines shall be developed for effective public health laboratory services. These shall be networked to the central public health laboratory. The central public health laboratory and other reference laboratories shall be strengthened for confirmation of specific pathogens and also act as quality control for State laboratories.

Training of laboratory personnel shall be a continuous process to ensure the availability of well-trained and skilled manpower.

Adequate communication mechanism shall be established for the collection and transportation of specimens and feedback of results. Budget line shall be created at Federal and State levels, to ensure effective delivery of public health laboratory services.

3.9 Case - based Surveillance.

Case- based surveillance shall be conducted for diseases targeted for elimination, eradication and accelerated control such as neonatal tetanus, poliomyelitis and measles.

4.0 Roles and Responsibilities of Stakeholders.

4.1. Government Ministries and Departments

The Federal Ministry of Health will coordinate activities of all partners and stakeholders in the implementation of IDSR strategies.

4.1.1 Roles 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 meetings in collaboration with stakeholders.
- Provide prompt and efficient response mechanisms for emergencies including epidemics and notify appropriate authorities.
- Build core capacities for the implementation of IHR 2005 at all levels of operations
- Establish a mechanism for the assessment of PHEIC
- Ensure coordination of timely response to public health risks, disease outbreaks and PHEIC.

- Promote Public Private Partnership (PPP) to ensure sustainable and effective implementation of IDSR and disease control.
- Analyze IDSR data and disseminate to all levels and stakeholders for planning purposes.
- Ensure provision of seed quantities of IDSR reporting tools to State Ministries of Health and encourage same to reproduce these when necessary while adhering strictly to the generic format
- Provide feedback to States and stakeholders involved in disease surveillance, response to disease outbreaks, and other health related conditions and events.
- Mobilize resources for IDSR activities.
- Periodically review health-related data to determine the frequency of occurrence of communicable diseases with emphasis on epidemic prone diseases.
- Regularly monitor and evaluate IDSR implementation at all levels of operation.

4.1.1.1 Roles 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.

4.1.2 Roles of Federal Ministry of Environment

In collaboration with FMOH, the Federal Ministry of Environment shall:

- Maintain an active surveillance of possible environmental hazards in Nigeria
- Regularly update the list of possible locations of environmental hazards and share same with FMOH and other stakeholders
- Ensure proper environmental sanitation (waste management, transportation and sanitary disposal of human and animal remains in situations of disease outbreaks, control of air pollution, food safety etc).

4.1.3 Roles of Federal Ministry of Water Resources.

The Federal Ministry of Water Resources shall:

- Ensure provision of alternate sources of potable water during water associated epidemics.
- Collaborate with FMOH to ensure that adequate measures are taken to forestall spread of communicable diseases associated with irrigation systems, dams and other water bodies.

4.1.4 Roles of Federal Ministry of Agriculture

The Federal Ministry of Agriculture shall:

- Maintain active surveillance regarding unwholesome activities related to food and animal products.
- Collaborate with FMOH to carry out surveillance and response activities for the control of zoonotic diseases.
- Collaborate with FMOH to maintain cross border surveillance for trans border animal related diseases.

4.1.5 Role of Federal Ministry of Finance

- Shall ensure adequate financial appropriation and timely release of funds for IDSR activities.

4.2 Roles of IDSR Technical Advisory Committee

The IDSR Technical Advisory Committee (TAC), formerly the IDSR Steering Committee, shall exist at the Federal level**.**

The TAC shall:

- Provide technical advice on IDSR to the Federal Ministry of Health.
- Provide technical support through the FMOH to States and LGAs on disease surveillance and response.
- Periodically review policy issues related to IDSR in consonance with current health related data and events.
- Commission periodic independent assessment of IDSR implementation.

4.3 Roles of Agencies/Parastatals

4.3.1. National Primary Health Care Development Agency (NPHCDA) shall:

- Provide technical and appropriate interventions to the LGAs and communities on IDSR implementation.
- Assist in the collection and collation of disease surveillance data in the LGAs and communities.
- Collaborate with LGAs to mobilize the community for IDSR activities.
- Assist in the investigation and control of disease outbreaks in the LGAs and communities.
- Assist in the training and supervision of LGA and community based workers on IDSR.
- Be responsible for strengthening routine immunization and conducting supplemental immunization activities to effectively control vaccine preventable diseases.
- Ensure that adequate and potent vaccines are available for supplemental immunization including epidemic response activities at all levels.
- Collaborate with the FMOH and relevant stakeholders to monitor vaccine preventable diseases and contingency stock of vaccine for epidemic prone diseases.

- Undertake effective resource mobilization and management for IDSR implementation at the LGA and community levels.
- Establish and promote appropriate collaboration with other health interventions and disease control programmes for effective implementation of IDSR activities.
- Promote Public Private Partnership (PPP) to ensure sustainable and effective implementation of IDSR activities.

4.3.2. **National Agency for Food and Drugs Administration and Control (NAFDAC)**

NAFDAC shall:

- Carry out laboratory assessment of quality and safety of medicines, food and other regulated products.

- Support assessment of facilities' suitability for storage of thermo labile regulated products such as vaccine and test kits.

4.3.3 **National Emergency Management Agency (NEMA)**

NEMA shall:

- Coordinate other service support Agencies in the preparedness and response to emergencies.
- Support awareness creation on early warning mechanisms for Epidemics
- Facilitate prompt and effective response mechanism for emergencies including epidemics.
- Support resource mobilization for implementation of IDSR activities.
- Collaborate with FMOH on regular monitoring and evaluation of IDSR implementation at all levels of operations
- Monitor the state of preparedness of all organizations or Agencies that may contribute to disaster management including IDSR implementation
- Collate data from relevant Agencies so as to enhance forecasting, planning and field operations
- Support FMOH on the IDSR annual review meeting.
- Function at the State and LGA levels through State Emergency Management Agency (SEMA) and Local Government Emergency Management Committee (LEMC) respectively.

4.3.4 Nigerian Meteorological Agency (NIMET)

NIMET shall:

- Provide meteorological data and information to enhance IDSR implementation
- Support emergency response by deploying the use of Geographical Information System

4.4 State level Ministries

At the state level, two ministries are crucial for the effective implementation of IDSR activities namely: the state ministries of Health and of Local Government and Chieftaincy Affairs. However, the state ministry of health takes the lead and coordinates IDSR implementation at the state level.

4.4.1 Roles 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 Epidemic Preparedness and Response Committee.
- Establish a public health laboratory to support surveillance activities.
- Ensure production and availability of adequate stock of IDSR reporting tools for use at State, LGAs and health facilities according to the standardized format.
- 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 other supplies for emergency response.
- Mobilize resources for IDSR for States and LGAs.
- Reproduce and provide training materials, IDSR reporting forms and guidelines to LGAs.

- Provide regular feedback to LGAs through monthly newsletter and review meetings.
- Create budget line and provide funds for the implementation of IDSR activities.

4.4.2. Roles of State Ministries of Local Government and Chieftaincy Affairs

- Mobilize support for the implementation of IDSR at the LGA level
- Ensure adequate logistics and financial support for IDSR implementation at the LGA level
- Provide a legal framework for LGA Chairmen to support the implementation of IDSR activities.

4.5. Roles of State Epidemic Preparedness 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.
- Periodically review health-related data for planning and appropriate response on IDSR related issues.
- Advocate and mobilize resources for IDSR activities.
- Establish an Epidemic Rapid Response Team.
- Regularly review response plans as appropriate
- Provide feedback through monthly newsletter and review meetings.

4.6. Roles of LGAs

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

- Create a budget line and appropriately fund IDSR activities at LGA and community levels.
- Report cases of epidemic prone diseases, other priority diseases and public health emergencies as recommended.
- 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 Epidemic Preparedness and Response Committee.
- Notify the State immediately or within 48 hours of occurrence of any disease outbreak.
- Ensure appropriate cold chain management of vaccines and other consumables for routine immunization.
- 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 support for logistics, communication and data management for IDSR operations in the LGA.

4.7 Role of Health facilities

All Tertiary, Secondary and Primary health facilities shall:

- Ensure timely and complete submission 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 the identification of early warning signs through regular analysis and review of health data.
- Assist in Laboratory diagnosis and effective case management using standardised management guidelines.
- Provide technical and logistic support for epidemic response where applicable.
- Participate in response to disease outbreaks
- Regularly review and maintain up-to-date records of diseases and health events and conditions occurring in their facilities.
- Provide routine immunization services.
- Provide regular feedback to the communities.

4.8 Role of Communities

- Ensure there are functional Ward and Village/Neighborhood development Committees
- Work closely with health facilities to identify, report and contain disease outbreaks.
- Act as vanguards against disease, health conditions and events in the Communities and report appropriately
- Manage and ensure proper use of infrastructure in the communities e.g., safe water sources
- Provide the necessary support for effective functioning of Village Health Volunteers

4.9 Role of Partners

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

- Collaborate with all tiers of government to improve disease surveillance and response activities by providing technical and logistic support.
- Support the establishment of IDSR focal points at all levels.
- Support research on IDSR.
- Serve on the IDSR Technical Advisory and Epidemic Preparedness and Response Committees.
- Mobilize resources from other interested parties to support IDSR implementation.

4.10 Roles of Private Health Sector

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

- Ensure appropriate cold chain management of vaccines and other consumables for routine immunization.
- Collaborate with the States / LGAs in the areas of training of health personnel on IDSR.
- Complement government laboratories in the diagnosis of suspected cases of priority diseases.
- Support case management during disease outbreaks

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 Supportive Supervision

- Federal Ministry of Health in collaboration with relevant stakeholders shall conduct regular supportive supervision using appropriate checklists at all levels.
- Other levels (States &LGAs) shall also carry out regular supportive supervision.
- Appropriate documentation of all supportive supervision activities and findings shall be maintained at all levels of IDSR implementation.

7.0 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 regular monitoring and evaluating the performance of IDSR.

- Monitoring and evaluation of 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 other relevant stakeholders shall evaluate performance and progress through annual review meetings.
- A full evaluation of IDSR with technical support from partners shall be undertaken every 5years.

8.0. Operations Research.

The Federal Ministry of Health and partners shall encourage and support basic and operations research that will facilitate efficiency and improvement in IDSR implementation especially in the areas of review of priority diseases and current trend.

Annexes

<u>Annex. A</u>

IDSR Core Indicators.

S/N	IDSR Activity	Indicators
1	**Routine reporting (IDSR 002, 003 forms)**	Proportion of health facilities submitting complete weekly or monthly surveillance reports on time to the LGA.
2	**Reporting outbreaks from the LGA to National level**	Proportion of suspected outbreaks of epidemic prone diseases notified to the next higher level within 2 days of surpassing the epidemic threshold.
3	**Case-based reporting**	Proportion of cases of diseases targeted for elimination, eradication or accelerated control which were reported using case-based forms.
4	**Case-based data analysis.**	Proportion of reports of investigated outbreaks that include analyzed case-based data.
5	**Data analysis**	Proportion of health facilities/LGAs/States that have current trend analysis (line graphs) for selected priority diseases.
6	**Laboratory support**	Proportion of reported outbreaks of epidemic prone diseases that occurred in the past year with laboratory confirmation of results
7	**Outbreak response**	Proportion of confirmed outbreak with appropriate ***and timely*** response (48-72 hours) at the LGA during the last 12 months.
8	**PHEIC**	**Proportion of states and LGAs with Public health risks** **Proportion of States and LGAs resources mapped.** Proportion of LGAs and states with identified Information sources for public health events and risks.

Annex B

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

Case fatality rate – CFR: $\frac{\text{Number of Deaths}}{\text{Number of Cases}} \times 100$

Attack rate $\frac{\text{Total No of Cases}}{\text{Total Population exposed.}} \times 100$

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.

Event: a manifestation of disease or an occurrence that creates a potential for disease.

Public health risk:
the likelihood that an event that may adversely affect the health of human populations, with an emphasis in the IHR for events that may spread internationally or may present a serious and direct danger to the international community.

Feedback:
the process of sending analyses and interpretations of surveillance data regularly through all levels of the surveillance system so that all participants can be informed of trends and performance.

PHEIC: Public health emergency of international concern:
an extraordinary event which, as provided in the IHR 2005, is determined (i) to constitute a public health risk to other States through the international spread of disease and (ii) to potentially require a coordinated international response public health risk". It implies the likelihood that an event may adversely affect the health of human populations, with an emphasis on events which may spread internationally or may present a serious and direct danger to the international community.

Zoonosis: an infection or infectious disease transmissible under natural conditions from Vertebrate animals to humans, e.g., rabies, plague etc.

Geographic information system (GIS):
an organized collection of computer hardware, software, geographical data and personnel designed to efficiently capture, store, update, manipulate, analyse and display all forms of geographically referenced information

Annex C.

State Epidemic Preparedness Response Committee

Membership/Composition

The DPRC 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
- Executive Secretary, SEMA
- State Epidemiologist.
- Representative of partner agencies

Terms of Reference of State Epidemic Preparedness 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 Epidemic Preparedness Response Committee

Membership/Composition

- LGA Chairman
- Supervisory Councilor for Health
- Chairman, LEMC
- PHC Coordinator/Medical Officer of Health
- Environmental Health Officer
- Health Education Officer
- DSN Officer
- Zonal Technical Officer (NPHCDA)
- 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
- Pharmacist/Chemist/Patent Medicine Dealer
- Representatives from the Armed forces/ Police

Terms of Reference of LGA Epidemic Preparedness Response 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
- Rep of LEMC

Terms of Reference of LGA Rapid Response Team.

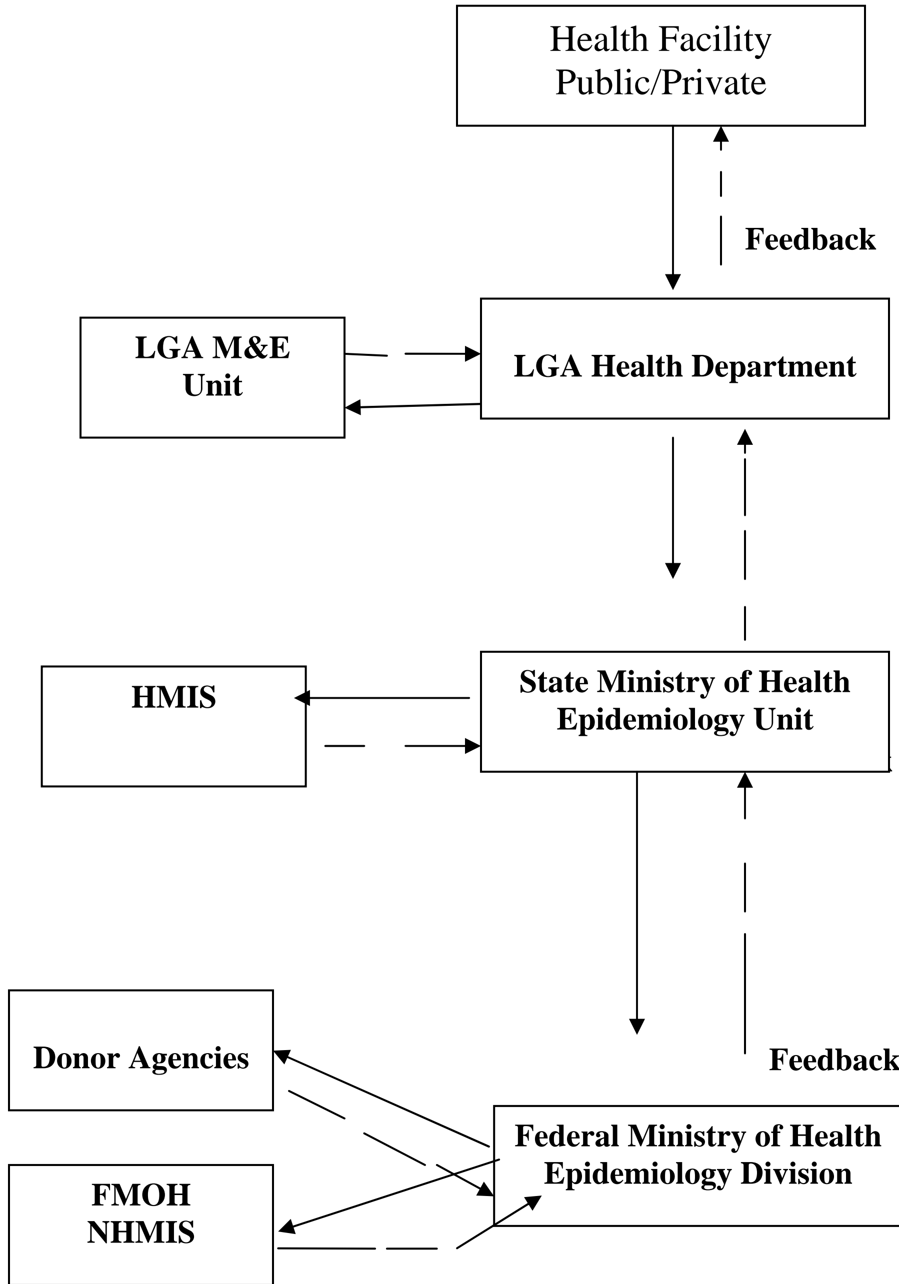
- To verify any report of disease outbreak in the LGA
- To carryout outbreak investigation
- To propose and plan appropriate measures for containment of the epidemics to the LGA Disease Surveillance and response Committee
- To participate actively in implementation of epidemic prevention and control 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 population greater than 30,000. 2 cases per 100,000 inhabitants per week in a population of 30,000 or less.	10 cases per 100,000 inhabitants per week in a population greater than 30,000. 4 cases per 100,000 inhabitants per week in a population 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**

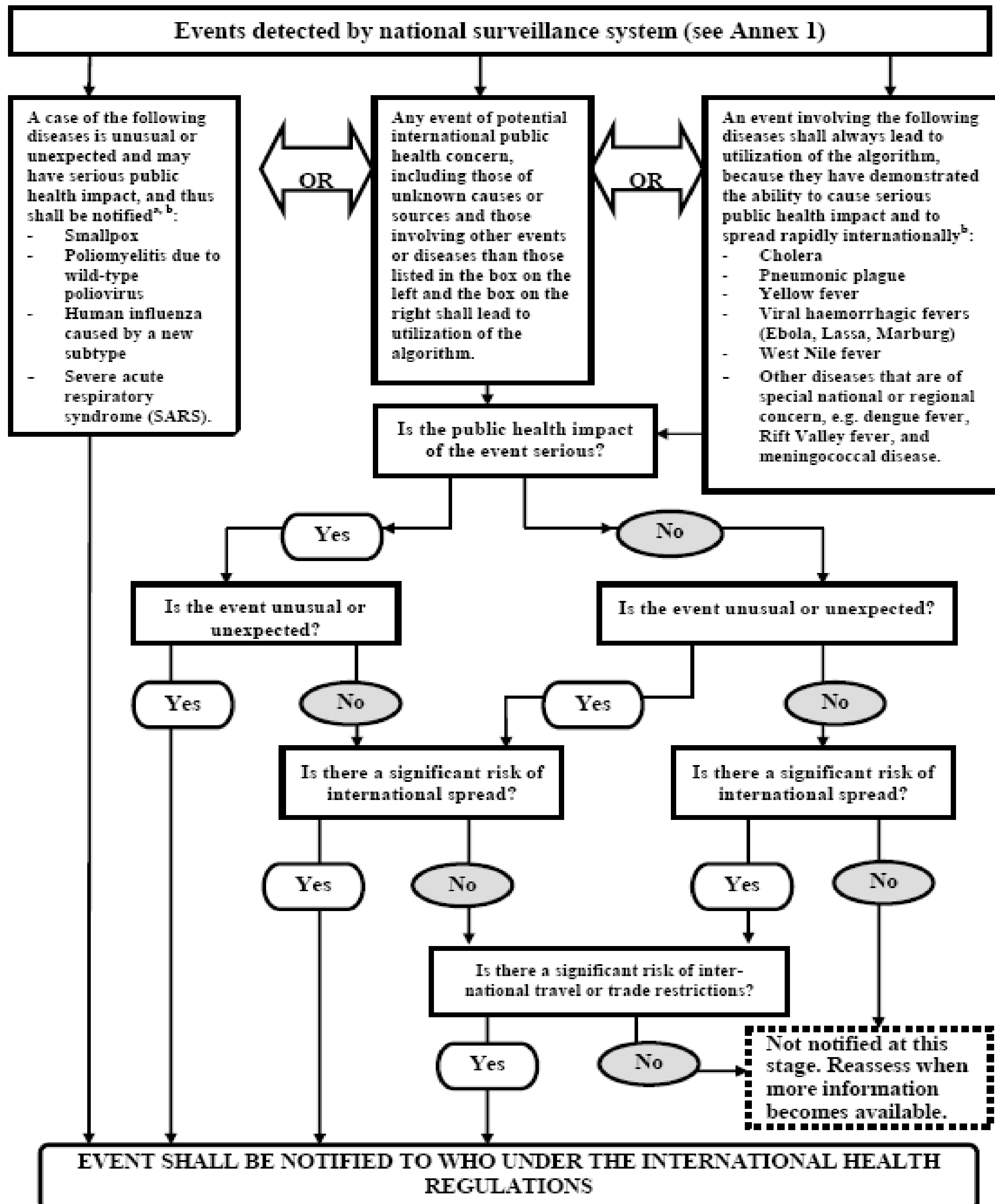
- **Collate data and forward to FMOH**
- **Analyze and feedback to LGA**

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

Feed forward ————▶
Feedback - - - - - - - -▶

ANNEX G

DECISION INSTRUMENT FOR THE ASSESSMENT AND NOTIFICATION OF EVENTS THAT MAY CONSTITUTE A PUBLIC HEALTH EMERGENCY OF INTERNATIONAL CONCERN (Annex II of IHR)



[a] As per WHO case definitions.
[b] The disease list shall be used only for the purposes of these Regulations.

ANNEX H

LIST of Review committee

S/N	NAME	ORGANIZATION
1	Dr. Henry Akpan	Epid., FMoH, Abuja
2	Mrs O. E Ojo	Epid., FMoH, Abuja
3	Mr. J. A. Kehinde	Epid., FMoH, Abuja
4	Dr. Oyari Felix	EBSUTH Abakaliki
5	Mrs. Etta Jeanette Nneka	NCD, FMOH, Abuja
6	Mr. Durojaye A	Epid., FMOH, Abuja
7	Mr. Bosah N.C.	Epid., FMOH, Abuja
8	Dr. Promise Abuwa	UNIPORT, Port Harcourt
9	Dr. Lawanson A.	Port Health Services, FMOH, Abuja
10	Adebayo W.A. (Mrs.)	NHMIS, FMOH, Abuja
11	Mrs. I.N. Anagbogu	NIGEP/HAT, FMOH, Abuja
12	Mrs. S.B. Oladejo	EPID, FMOH, Abuja
13	Ms. Onyeneke Judith	EPID,FMOH, Abuja
14	Mrs. Ifeoma Anudike	EPID, FMOH, Abuja
15	Mrs. Gbadegesin S.O.	EPID, FMOH, Abuja
16	Mr. R. A. Usani	EPID, FMOH, Abuja
17	Mr. Ekwueme Prince M.	EPID, FMOH, Abuja
18	Dr. A. O. Adebiyi	UCH, Ibadan
19	Dr. Kehinde T. Craig	WHO, Abuja
20	Chief Chris Elemuwa	NPHCDA, Abuja
21	Dr. Obi. Ejezie	EPID, FMOH, Abuja
22	Ms. Mercy Akpabio	EPID, FMOH, Abuja
23	Mrs. Elsie Ilori	EPID, FMOH, Abuja
24	Mr. Musa Abdul-Razaq	NEMA, Abuja
25	Dr. Saheed Gidado	N-FELTP, FMOH, Abuja
26	Mrs. Lilian S. Maina	AI Lab., Asokoro, FMOH, Abuja
27	Mr. Okoh F. O.	NMCP/FMOH
28	Mr. Alhassan Nuhu	NEMA
29	Obinna Idika	UNICEF

REFERENCES

1. National Technical guidelines for IDSR, 2002.

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

3. WHO Immunization Policy. 1995, pg 3

4. Disease Surveillance and Notification Training Manual. 1988

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

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

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

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

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

10. National IDSR Technical Guidelines revised 2008

11. National IDSR Policy. 2005

12. IHR 2005