Update: Integrated Diseases Surveillance and Response implementation in Ethiopia.

Effective Communicable diseases control relies on effective surveillance and response system that promote better coordination and integration of surveillance function. Recognizing this, the initiative to strengthen the disease surveillance system that promotes the integration of surveillance activities in Ethiopia was started in 1996. Later in 1998 the WHO/AFRO, following the resolution of the 48th assembly, started promoting Integrated Disease Surveillance and Response (IDSR) for all member state to adopt as the main strategy to strengthen national disease surveillance system.

Ethiopia as a member state adopted this strategy, which is district centred and outcome oriented. And based on the steps recommended by the strategy, the FMOH of Ethiopia and its development partners did an assessment of the country’s surveillance system in October 1999 and subsequently prepared a five-year national plan.

Currently Ethiopia is categorized among the countries, which have made a tremendous achievement in the implementation process of Integrated Diseases Surveillance and Response. Following is a summary of activities accomplished so far:

- Ethiopia completed assessment of the existing surveillance system in October 1999. On the basis of this assessment it has developed a five-year and two-year plans of action in 2000. Strengthening of IDSR team at national level was initiated along with establishment of task force in 2001.

- First and second round of TOTs conducted and a total of 84 facilitators were trained in 2002. These were:
  - Surveillance officers
  - Regional disease prevention and control officers
  - Public health graduates
  - Clinicians, academicians in the field of medicine and public health/epidemiology.

- Most sensitization activities have occurred at the national and regional levels. National and regional level officials were aware of this strategy and had played active roles in its implementation.

- Technical guidelines have been adapted, 2002. The technical guidelines have been used to develop a separate, smaller booklet focused on surveillance for epidemic-prone diseases. Twenty Two diseases are grouped in four categories:
  - Epidemic prone diseases (Cholera, Dysentery, Measles, Meningitis, Relapsing fever, Typhoid fever…)
  - Diseases targeted for eradication /elimination (AFP, Neonatal tetanus, Dracunculiasis, and leprosy) and
  - Diseases of public health importance (Pneumonia in less than 5, Diarrhea in less than 5, Tuberculosis, HIV/AIDS, STI, Onchocerciasis)
Training modules have also been adapted, with examples changed to the Ethiopian context using real data from past occurrences. Since one of the strategic orientations for implementing the activities of IDSR is giving in-service training at the District level, the National IDSR team conducted the training at District level for a total of 704 District and zonal surveillance focal persons between January –August 2003 with strong support from the Regional Health Bureaus, and covered all the Districts in the regions.

Awareness and use of IDSR indicators improved: Such as use and interpretation of Case fatality ratio,
  ✓ Timeliness and Completeness of reporting and
  ✓ Use threshold for selected epidemic-prone diseases.

Efforts of integration and coordination between IDSR and Vertical Programs initiated at National and Regional level.
  • EPI and AFP: integrate data, resources, transport and communication.
  • Feed Back: The federal Ministry of Health has a quarterly bulletin, which is produced with support from WHO. In its early phase, the bulletin was focused on Polio and EPI. Its subsequent issues, however as an initiation for a move towards an integrated approach have incorporated sections on integrated disease surveillance and response.

Establishment of National Emergency Response Task force.

A major input of the IDSR to the laboratory system is the initiation of the process of national assessment on the capacity of public health laboratories for surveillance, which was conducted in October 2002 at 10 Regional laboratories. The objective of this assessment was to identify the needs to strengthen laboratories for surveillance and response.

IDSR National Guide line distributed in all Regions up to the District level.
The new IDSR reporting format is finalized and distributed to regions as of October 5, 2003.
Initiation of IDSR training at health facility level. As part of strengthening the process of IDSR implementation at District level, Regions started to conduct the training on IDSR at the health facility level, which constitutes the surveillance front line. The Amhara National Regional state took the first step and gave the training for 128 health workers.
Surveillance information is needed to act as an early alert system that can trigger rapid responses to outbreaks of communicable diseases before they get out of control.

**Surveillance – “Information for Action”**.