A role for the private sector in poliomyelitis surveillance?

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In order to identify all cases of acute flaccid paralysis as quickly as possible, most countries need to include private health providers in their poliomyelitis surveillance systems. Ways of achieving this are considered below.

In order to eradicate a disease it is necessary to have a surveillance system that can identify virtually every case rapidly enough to allow immediate intervention. For poliomyelitis this can be accomplished by reporting all cases of acute flaccid paralysis and by having more reporting sites and increasing public awareness of the disease.

The experience of the smallpox eradication programme and of current projects indicates that the private sector could make a vital contribution to poliomyelitis surveillance. This sector includes private physicians, pharmacists, traditional healers and hospitals, nongovernmental organizations and private voluntary organizations involved in development work, and women’s, students’ and religious groups. Because of the extensive ramifications of the medical private sector in many countries, its participation is essential if reporting is to be complete. The non-medical private sector, including certain nongovernmental organizations, could also make a significant contribution. However, before any expansion of a surveillance system is made it is necessary to improve governmental activities in this field and then put methods of investigating cases and outbreaks into effect.

Non-reporting by the private sector

Private physicians may fail to report cases of infectious diseases because of a lack of knowledge of why or how to do so and because they feel that reporting is too time-consuming. Yet many of the reasons why these physicians often do not report such cases are the same as those leading to underreporting in government systems. At the community level, patients may not seek medical care if they feel that their illness is mild, that access to care is difficult, or that the available care is of poor quality. Community health workers may be overburdened with paperwork, and may receive little supervision. At the regional and district levels, understaffing and underfunding commonly make it difficult to achieve rapid analysis and feedback.

Private physicians rarely contribute to national disease surveillance, particularly if they provide only outpatient care. International nongovernmental organizations and private voluntary bodies often act autonomously within countries, and may not participate in government health programmes. In some countries they are intentionally
excluded from routine reporting systems because of government inability to provide supervision.

Even in countries where disease surveillance is a legal requirement, it often happens that doctors' ignorance of reporting requirements and methods leads to underreporting. Some physicians may feel that the reporting of an infectious disease violates confidentiality.

Clearly, doctors can only contribute to surveillance if they know what to report and if patients seek their help. Educational activities that expand the knowledge of both the medical profession and the general public can greatly increase both case-finding and reporting.

Private doctors have little motivation to report if there is no reward for doing so, no supervision or feedback, and little evident response when cases are reported. It is rare for laws on the reporting of diseases to be enforced, and administrative obstacles in hospitals may hinder reporting.

International nongovernmental organizations and private voluntary bodies collect data of interest to themselves as well as information required by the host countries. This may lead to excessive workloads and failure to report cases as required.

Where private providers do not play a significant role in the care of patients with acute flaccid paralysis, efforts to achieve improved surveillance are best concentrated on social mobilization and community education.

**Strategies for developing private sector surveillance**

The amount, type and location of care provided by the private sector should be estimated on the basis of surveys and of records kept by ministries of health, the Expanded Programme on Immunization, medical schools, local government agencies, medical associations, hospitals, and international donors. Once this has been done, efforts should be made to bring private sources gradually into the surveillance system. The sources most likely to identify and report cases of acute flaccid paralysis are large hospitals, and they should be the first to be incorporated; private physicians come next, and finally other health care workers should be brought in. While the system is being expanded, reports of acute flaccid paralysis from the private sector should not be disregarded; indeed, they should be investigated as quickly as possible to encourage further reporting. Malaria workers and other employees of official agencies can assist in identifying cases, and local government leaders can act as reporting points and can educate and motivate the populations they serve.

The non-medical private sector plays an important role in surveillance. Thus Rotary International has developed a plan whereby its members can participate in a range of activities, including:

- strengthening surveillance laboratories;
- assisting with the transportation of stool specimens to laboratories;
- providing personnel, supplies and transport in support of national immunization days and action against outbreaks;
- promoting community participation and lay reporting through workshops, pamphlets, posters and other means;
- providing inducements to report new cases;
- increasing the participation of private physicians and traditional healers through seminars, pamphlets and awards;
- encouraging the business sector to become involved in the eradication effort;
- identifying key persons in areas lacking a reporting infrastructure, e.g., teachers and private physicians;
- collecting reports and forwarding them to area health officers;
- making communication equipment available so as to assist the reporting process;
- facilitating the distribution of feedback reports.

In 1992, Rotary International sponsored and helped to run nine surveillance workshops in India, during which local Rotarians, managers of the Expanded Programme on Immunization and health care workers received training on improved surveillance techniques.

There are possibilities of using in-country private voluntary organizations. In Haiti, for example, a group of such bodies chose an area with a population of approximately 10,000 for improved surveillance. The villages in the area provided a community health worker to register the population, monitor health events and organize health days. A physician, specially trained in community health and surveillance, acted as supervisor and data coordinator. This project identified high-risk groups, educated and motivated the people, and improved immunization and contraceptive coverage.

There is also scope for involving industry in surveillance work and for using lay people. A method has been devised for the lay reporting of categories of disease symptoms (1).

Educational programmes on poliomyelitis eradication should not be limited to health workers and physicians; community involvement is desirable, since increased awareness of the subject among the general public encourages people to seek care for paralysis, increases the demand for immunization, and motivates lay reporting of cases. In countries where surveillance systems cannot be expanded, reporting by members of communities may offer the only prospect of finding cases in remote areas. The mass media present the best means of educating all groups of people.

Obstacles to reporting should be eliminated, and only data of immediate value should be collected. Reporting forms should be designed as checklists and should require the minimum amount of information for the identification of cases. In the absence of electronic means of communication, messengers are usually speedier than mailing systems. Sometimes the police, the military and businesses are willing to make their communication equipment available for case-reporting.

Private physicians should report to clearly identified persons, for instance the nearest government health workers or public health officials at the district or provincial level. Only cases of acute flaccid paralysis should be reported; there is no point in making negative reports. A notifiable disease list should be drawn up, and case investigation methods should be functioning before private-sector reporting begins, so that all cases reported can be investigated.

The best form of feedback, and therefore the best way to encourage reporting, is the demonstration to health workers that reporting leads to investigation and intervention. Furthermore, following up a case report with a visit, letter or telephone call is more effective in stimulating reporting than is a periodic surveillance newsletter.

Private doctors can be encouraged to report by offering incentives such as awards made
through their professional societies, or by providing them with free vaccines, posters, pamphlets, journal subscriptions, and so on.

There should be a legal requirement to report certain infectious diseases. Where this is so, health care workers generally comply and their concerns about breaches of confidentiality are diminished.

People should be educated so that they are motivated to seek care and report their own disease problems. The mass media and other means of social mobilization can be used to encourage community-based reporting.

Active surveillance is an essential part of disease eradication programmes, identifying far more cases than passive systems (2). It has been shown that simple reporting forms and a feedback newsletter alone are not sufficient to make reporting more complete, whereas actively contacting reporting sources has the desired effect (3). The active collection of data from private physicians stimulates them to report and improves the quality of the material obtained. Active surveillance, the relatively high cost of which can be contained to some extent by using volunteers and voluntary organizations for the collection of data, should initially be used in areas of greatest need and/or easiest access, or where voluntary bodies are willing to help.

In order to identify all cases of acute flaccid paralysis as quickly as possible, most countries need to include private health providers in their poliomyelitis surveillance systems.

Before bringing the private sector into these systems it is necessary to improve their efficacy. The population, including private health providers, then has to be educated about the importance of poliomyelitis eradication. The mass media probably offer the best means of doing this, and can be an effective motivational tool for increasing community participation in case-finding and reporting.

Efforts should be made to educate private practitioners about reporting needs and methods, to motivate them to become involved on a voluntary basis, and to remove obstacles that make reporting difficult.

Non-medical voluntary bodies can assist in the development of surveillance by the private sector by educating their own members and providing money, manpower, transport and means of communication. These organizations can provide a valuable link between managers of the Expanded Programme on Immunization and the private health care sector.

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References

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