INTEGRATED DISEASE SURVEILLANCE PROJECT

TRAINING MANUAL FOR STATE & DISTRICT SURVEILLANCE OFFICERS

PRIVATE SECTOR PARTICIPATION IN DISEASE SURVEILLANCE

Module -4

CONTENTS

1. INTRODUCTION

Integrated Disease Surveillance Program (IDSP) is expected to provide essential data to monitor progress of on-going disease control programmes and detect early warning signals of impending outbreaks so as to initiate an effective response in a timely manner. Integrating and decentralizing surveillance activity is one of the main components of the programme. Since more than 70% of the health care is provided by the private sector overall, (more in some states and in urban regions), a strategy for the participation private health providers in the formal and informal sector is crucial to the success of the programme.

Polio surveillance is an example of successful public private partnership among the disease surveillance programmes. There are also pilot projects in the country in the private sector where private sector contribution to surveillance activity have been successfully demonstrated as in NADHI project conducted by CMC, Vellore and pilot project of district surveillance in Kerala. It is expected to make use of lessons learned from these existing surveillance systems to develop a strategy for wider participation from both formal and informal health providers in the state under IDSP. It is expected that this will have many generalizing characteristics, which could be incorporated in strategy for improving disease surveillance in other states where IDSP is being initiated. It is expected that in all districts Selected Sentinel Private hospitals, Institutions and Practitioners will provide partnership with the public sector for surveillance activities under IDSP.

2. SPECIFIC INSTRUCTIONAL OBJECTIVES

At the end of the session the participants would be able to:

1. List the four reasons why private sector participation is important in disease surveillance in India

2. Describe the methodology of selection of Sentinel private practitioners at the district level.in IDSP

3. Enumerate the activities at the district level, which will help to integrate the SPPs to IDSP activities carried out by the public sector health institutions.

4. Discuss the methods adopted to have an effective rumor registry in IDSP.

5. Describe the role of RMPs and Indian System of Medical practitioners in IDSP

6. List the factors in the surveillance method adopted to improve quality of reporting from Selected Sentinel Private-practitioners (SPPs).

7. Enumerate at least 5 issues that are likely to impact on sustainability of partnership with private sector.

3. MODULE STRUCTURE AT A GLANCE

Duration of Session **1 Hour**

Unit No	CONTENT	METHODOLOGY	TENTATIVE DURATION	TEACHING AIDS
1	Strategy for Private Sector Participation in IDSP	Lecture Module Reading	20 Minutes 20 Minutes	Training Modules / Over Head Projector / Power point. Handouts and Reading Materials
2	Group Exercises	Brain storming Session	20 Minutes	Training Modules Exercises

4. GROUP ACTIVITIES

Brain Storming Points

Diseases and Syndromes

1. What do you think are the Strengths and limitations in including private sector in disease surveillance?
   - ☞ Strengths
   - ☞ Limitations
2. What should be done to Integrate SPPs to IDSP?
3. What should be done at the district to identify SPPs?
4. What should be done to sustain their partnership?
5. How will the SPPs report disease in IDSP?
6. To whom will private sector send the reports?

Role-Play

Objective: To Influence the attitude of IDSP officers regarding collaboration with private sector

Role-play of 2 situations where a child with acute diarrheal disease and adult with STD are being seen in a public health facility (PHC).

- ☞ Availability of personnel
- ☞ Confidentiality
- ☞ Availability of drugs and medicines

Highlight potential responses of patient and relatives to high light the problems of care faced by subjects in different situations.

5. SALIENT POINTS TO REMEMBER

1. State Surveillance officer should specify the number and criteria for selection of SPPs required in each state from Hospitals, Nursing homes and Health Clinics

2. DSO/SSO should develop a master list of private health providers in each district using existing database from current list available with directorate of public health, IMA and IAP. Conduct Rapid assessment if necessary in each district

3. DSO should finalize the list of SPPs at each district using the master list based on criteria through consultation initiated with district level office bearers of IMA and IAP. Written understanding with each SPPs must be ensured regarding the diseases under surveillance by the unit and method of reporting by the provider.

4. DSO should ensure quality of reporting by private sector by initiating training of all partners through short training programmes and availability of operations manual. The training may be taken up by the association themselves for their members with supervision and evaluation.

5. State Surveillance Office should specify the role of Health inspectors / Leprosy inspectors in integration of SPPs with public health system. Instructions to this effect must be sent to Health inspectors in the field.

6. DSO should distribute pre-paid post cards through sensitization meetings on IDSP to wider groups of health providers in formal and informal sector to report unusual health events and changing trends of disease to increase sensitivity of private sector participation.

7. SSO/DSO should ensure that partnership is sustainable and mutually beneficial by regular feedback, privacy, respect of partners, and timely re-imbursements of costs & Incentives as agreed in the programme.

8. SSO /DSO should ensure that internal and external evaluations of private sector participation in IDSP is carried out in time and feed back provided to all stake holders of the programme.

6. FREQUENTLY ASKED QUESTIONS

1 There is legal provision that all notifiable diseases should be reported to the government. Why should this not be enforced instead of identifying Sentinel level practitioners for lesser output?

2 The reliability and validity of reporting from most private sector is less controllable by the DS officer. How will the IDSP handle this difference when the reporting occurs?

3 Can private laboratories be part of the private sentinel-reporting center?

4 If SPPs does not consistently report as promised. What should be done?

7. HANDOUT ON PRIVATE SECTOR PARTICIPATION IN IDSP

7.1 Need for Private Sector Participation in IDSP

1. Health care services largely depend on the private health providers in most states. Nearly 90% of the health facilities and most of the patients are seen by the Private sector and without private sector involvement disease surveillance cannot be performed effectively.

2. There is increasing evidence from published literature that the preferred first contact physician is private practitioner rather than doctors working in public sector. This is even more so for some diseases like STD. The advantages include better accessibility, privacy and lack of facilities in the public sector units. While in theory public sector units provide free medical service, in practice both private and public sector units provide services on payment as out of pocket expenses.

3. In the event of an emerging epidemic, it is likely that the private sector units rather than public health sector units feel the early warning signs.

4. There is reasonable public sector infrastructure for performing disease surveillance in the rural regions of the state (CHC, PHC and sub centers). However such infrastructure and necessary personnel are not present in the urban regions. Private hospitals, Nursing homes and clinics meet most of the curative needs of the urban centers. Traditionally NGOs and private sector units cater to the health needs of urban slums in many parts of India

7.2 Conditions Selected for regular surveillance by the Private Sector:

Limited number of condition based on disease are expected to be under surveillance by IDSP both at private and public sector and this includes communicable and non-communicable diseases. However private sector health providers will only participate in regular sentinel surveillance of the following conditions. As specified in the national Project Implementation Plan private practitioners will participate in the regular surveillance of the following conditions both as core conditions and as state specific diseases.

1. Malaria
2. Acute Diarrheal Disease
3. Typhoid
4. Tuberclosis
5. JE
6. Dengue
7. Measles
8. Polio
9. Plague
10. Unusual syndromes causing death and hospitalisation

7.3 Flow of Information

The programme is district centered and most of the inputs in the IDSP at data gathering will take place at the sub district and district level.. The district surveillance unit is manned by team of personnel lead by District Surveillance Officer who will coordinate the data collection from the private and public health systems. The private sector inputs will be from the following units

7.4 Private Health Sector Reporting Units:

Sentinel Private Practitioners at the rural level	15-45 / 100,000 population from the rural regions reporting to Block Level PHC / CHC or DSO
Sentinel Private Hospitals/ Nursing Home	15-30 / 100,000 population from the urban centers reporting to District Surveillance Officer
Private Medical Colleges	Reporting to District Surveillance Officer
Sentinel Laboratories	Reporting to District Surveillance Officer
Other Private Practitioners and Informal Sector	Through Rumor registry at the CHC, District Hospital / DSO

7.5 Initiating Partnership with Private Sector in IDSP

I	**Initiate partnership with private health providers for disease surveillance in IDSP**	**Develop MOU with IMA & IAP at the Central and state level for partnership in IDSP**

1 Discussions with the IMA and IAP at the state level revealed that Memorandum of Understanding with the organizations are necessary both at central, and state levels for effective participation at the district level.

2 Directorate of Public Health should request the Central Surveillance Unit to develop a MOU with the National Office bears of IMA and IAP as the initial step. An official letter of invitation for partnership is needed from the MOHFW to initiate this process both at the central and state level.

3 The state branch of IMA and IAP will enter into separate MOUs on participation in IDSP. This MOU should specify the number of units of SPPs that is expected from each of the state and districts of the country and specify that the final selection may be made in consultations based on criteria of selection.

7.6 Criteria for Selection of Private Sector Units

II	**Criteria for selection of SPPs** **Type of Health Facility suitable to function as sentinel surveillance Unit** **a) Hospitals b) Nursing homes** **c) Clinics**	**a) Wherever available the choice of the institutions can be prioritized based on the number of patients of specific interest to surveillance seen. Usually Hospitals see the largest, then nursing homes and then clinics.** **b) Where this is not available Indian system of medicine private health providers and RMP need to be recruited** **c) Ensure geographical coverage**

1. There is need to include both inpatients and outpatients in the surveillance since severe presentations and mortality will be reflected in the inpatients and milder and earlier disease will be reflected in the outpatient surveillance data.

2. Though health clinics overall see the bulk of the outpatient load. However per unit recruited it is less efficient than larger nursing homes and hospitals regarding outpatient and inpatient services. Since IDSP is focusing on sentinel level surveillance from the private sector. Efficiency (number of cases of general practice, Medical and paediatrics) would be the primary criteria to choose a reporting center.

3. However health clinics are found even in places where nursing homes and hospitals are not present.

7.7 Method For Identifying Partner Health Facilities

Method of Selecting the Sentinel Surveillance Unit for IDSP	**a) DSU should verify list of health facilities and health providers with** **■ IMA & IAP** **■ Directorate of Public Health** **■ Department of environment and sanitation** **b) If such lists are not available, the state could initiate a rapid assessment** **c) The final selection of the participating units should be in consultation with the district chapter of IMA or IAP so that the associations take responsibility and ownership of the reporting unit.**

1. Information may be available with IMA, IAP, Directorate of Health and Department of environment and sanitation regarding the list of health providers in each district and this list could be effectively used in the selection of SPPs

2. If there is insufficient information in any district then rapid assessment of private health providers may be initiated in this district to obtain information on the providers.

3. Selection of Individual units from this master may be made by the district surveillance officer based on criteria and in consultation with district level office bearers of IMA and IAP.

4. It is important that the medical associations take responsibility for the choice of centres so that they have an ownership for the programme and take responsibility for quality of the output from these units.

5. District Surveillance Officer will choose additional centres as required based on specific situational analysis in the district. This would include, geographical representation, tribal areas, urban slums etc.

6. There are some tribal and rural areas with sufficient number of health clinics manned by qualified health care providers are not available. In these areas there are informal private health providers (RMPs) and qualified providers under Indian systems of medicine who can be chosen to function as sentinel sites.

7.8 Expected Number of Sentinel Sites

Number of Sentinel Surveillance Units in each state	• **Recruiting the units can be initiated in a phased manner. Total number of units in a phase-1 limited to 15 -45 / 100,000 population in the rural regions and 15-30 /100,000 in the urban regions. This can be increased over the next phase of recruitment.** • **Effectively doubles the total number of recruiting units per state**

1. The PIP plan of recruiting total of 30 sentinel sites is based on the calculation that all the selected conditions required to be under surveillance will be covered by all the SPPs. This is unlikely to be so since a pediatrician is not likely to report on leprosy and general medical practitioners are unlikely to be reporting on Acute Diarrheal Disease which is primarily a childhood problem.

2. Where hospitals are fewer (rural areas in some districts) it is likely that more than 15 SPPs will need to be identified (health clinics) while in other districts where sufficient hospitals and nursing homes are available this may be limited to 15 units from rural and 15 from urban. (Total of 30 as planned in the PIP). It is proposed that for 100,000 population there should be at least 15 hospital **or** 30 Nursing homes **or** 45 private clinics depending on availability.

3. In a state with approximately 30 health district, it is estimated that there will be apox. 13501 rural sentinel sites mostly of the category of clinics and some nursing homes while in the urban regions of the state there are large number of Nursing homes and hospitals.

4. In metros of the country there is no dearth of hospitals. There will be at least 20 sentinel hospital selected from each city / municipal limits as SPPs.

5. Thus effectively there would be double the number of reporting units per district/ state due to participation of private sector. In a state with an average of 30 districts total of more than 2200 sentinel sites will be recruited in the first phase of the programme.

6. There will be a phased increase in the induction of SPPs in the programme. In the second year, the total number of SPPs will be doubled from rural and urban region of the blocks and 40 SPPs from each of large metropolis cities will be included.

7.9 Facilitating Data Collection

Data Collection and Transmission	**a. Regular Weekly report** **b. Nil reports mandatory** **c. Simplified formats for reporting** **d. Number of conditions under surveillanc will be decided in consultation with DSO** **e. A choice of methods for transmission of data to the district level will be given to SPPs.**

1. All selected Sentinel sites should provide weekly reports on the conditions under surveillance agreed upon with the district surveillance officer

2. If no cases are seen Nil report is mandatory from the SPPs.

3. Sentinel surveillance unit can be given freedom to choose and limit the conditions under surveillance by each unit. Hospitals would be encouraged to report all diseases of interest but nursing homes and health clinics may choose from the list of diseases under surveillance.

4. Flexibility will be provided in the method of reporting by the SPPs. Each PHC may choose an optimal method that is suitable in the situation. The method of sending the report will be finalized appropriate for each reporting unit so that if there is delay in reporting this can be quickly addressed and will be noted at the appropriate level. Any of the following methods may be used:

- ☞ Telephone followed by mailing of IDSP format by hard copy
- ☞ Fax or Electronic Mail to DSO
- ☞ Courier
- ☞ Direct contact with Health Worker if necessary

Telephonic reports will be encouraged during epidemic situations so as to avoid delay. MO Block PHC / computer entry person / District Surveillance Officer will be able to receive information from the periphery.

7.10 Simplified formats for reporting (Form P) will be used to identify cases on a weekly basis. If no cases are seen '0' will be marked against the corresponding disease and the results submitted to the DSO or MO PHC/CHC

7.11 Integrating Private Sector in IDSP

INTEGRATION OF PRIVATE SENTINEL REPORTING UNITS	• **The SPPs will act primarily as an afferent arm of surveillance in data collection.** • **Health inspectors from PHC, CHC, District Hospitals will function as the link person between SPPs and Public sector units responsible for surveillance action.** • **Available Public health personnel should be integrated into role of surveillance inspectors and take on the role of integrating the activities of private sector reporting units.**

1 Many states in India are already doing routine surveillance of acute water diarrhea, leprosy, polio, Dengue, JE and Leptospirae. This work involves selected sentinel sites in the private sector. The Health inspector is currently the key integrating person. This could be expanded under IDSP.

2 It is important that each of the sentinel private sector unit participating in the surveillance is under the supervision of one health inspector. On a regular basis the HIs visit sentinel sites in different regions and facilitate collation of information on the cases of interest. This hand holding will be very important in the early phase of the programme.The routine allows once a week/fortnightly visit to each of the sentinel sites.

3 The health inspectors are expected to the phased out over the next 5 years. Currently most of the HIs are senior level staff and expected to retire over the next 5 years and their posts are not likely to be filled up.

4 However there are a number of young HIs under leprosy programme that are educated and motivated. With training these personnel could be the integration factor between private and public health system at the rural and urban levels of the state.

7.12 Increasing Sensitivity of Reporting From SPPs

Increasing Sensitivity of reporting in IDSP	• **Develop wider participation of private health providers in the rumor registry through a system of paid post cards which can be mailed in when changing trends in disease of interest is noted as demonstrated by NADHI and District Surveillance System in Kerala.** • **Encourage a wider group of RMPs and Indian system of medicine doctors also to participate reporting unusual trends in disease through prepaid post cards.**

- There have been some pilot projects, which has shown partial success in integrating private health providers in sentinel surveillance. The lesions from NADHI and Kerala district surveillance model could be used to increase the sensitivity of reporting in IDSP.

- Pre-paid post cards will list the names of the diseases/syndromes of interest. The health provider is encouraged to mail the cards to the DSU as and when he feels that there is a change in trends of disease or some unusual syndromes in the locality.
- Since this is similar to the rumor registry but with better organization the DSU or PHC/CHC medical officer will undertake epidemic investigations as warranted to confirm changing trends or emerging outbreaks.
- There is no insistence on zero reporting and a wide spectrum of private health providers can effectively participate in this programme
- To be effective active distribution of pre-paid post cards will need to be carried out. Feed back need to be provided to participating health providers by the DSU.

7.13 Quality Control

Maintaining quality of Reporting.	• **Ensure Availability of Operations Manual** • **Training of SPPs on IDSP should be provided.** • **Each SPPs should state the diseases of interest which will be under surveillance and mode of transmission of this data to the next level** • **Health Inspectors / Leprosy inspectors may need to visit the units at regular intervals to facilitate regular reporting** • **Feed back from DSO is very important for maintaining quality of reporting**

1. All the private health providers who participate in the programme as SPPs should have the hard copies of operations manuals provided by the district surveillance team. This along with training should ensure quality of reporting.

2. Private health providers are busy during regular working time and short duration half-day training programmes particularly during weekends are suitable for improving their knowledge, attitudes and skills under IDSP. These programmes need to be separately arranged from the health workers and unqualified private health providers.

3. The respective associations may be requested to organize this activity in which the district surveillance officer and the district training team can participate.

4. The training should include

a) An overview of the IDSP and its objective

b) Data collection

c) Specimen collection

d) Reporting formats and frequency

e) Trigger levels and type of public health measures

f) Feed back

g) Feed back from the District surveillance officer should specify the accuracy of reporting, the timeliness and regularity to individual SPPs at monthly intervals.

7.14 Sustainability

Sustainability of Partnership	• **Incentives** • **Maintain Confidentiality in sensitive information.** • **Consider SPPs as equal partner in the programme** • **Feedback** • **Full time District Surveillance Officer**

There seems to be general agreement that financial incentives for SPPs are not possible for their participation. Experience with NADHI surveillance system in Vellore and Kerala Model of District based surveillance have shown that the following incentives are sufficient for private sector participation. These include:

- Actual cost of participation be re-imbursed without delay as done in polio programme. This may be postal or telephone charges.
- Support time for a person in large private hospital /Institution for collation of reports.
- Inclusion of name in the network directory.
- Representation in the District surveillance committee
- Certificate of recognition and participation for participating in National IDSP.
- Access to IDSP computer web reports.
- Quarterly bulletins on health status of the region from District Surveillance Officer.
- Feedback on surveillance from the district surveillance officer on a regular basis.
- Membership in village health committee meetings on rotatory basis.

Continuing Medical Education Session:

One of the important felt needs of the private practitioners is method to improve their patient care by updating the current knowledge about management options. The IMA meeting and IAP meeting this factor emerged as an important incentive to be a part of the sentinel surveillance unit. The association may be provided support money to conduct once a year CME session at the state capital to their members participating in IDSP. These CMEs should be allowed to be organized and conducted by the organizations themselves and be seen as a clear incentive for their participation in the programme. The choice of the subjects for CME and also the choice of the resource persons invited for these CMEs should be primarily decided by the respective associations. The state IDSP committee could facilitate participation of the medical colleges and other experts. The forum could also be used to give feed back on the role of SPPs in IDSP and provide further reinforcement on the methodologies in surveillance.

Other Determinants of Sustainability

1. In the discussions with IMA members regarding their experience with participating in government programme, one of the most important factors that determine success was listed as respect for the private sector. There is lot of good being performed by both private and public health sector for the health of the country and there are a number of success stories where true partnership has shown a new way of success. There is need to highlight these success stories in the training programmes for IDSP.
2. There should be mutual respect and consideration as equal partners rather than as junior officers of the government service which, since independence is the most important reason why private providers remain as private providers.
3. The participating units and doctors has to feel that they are benefiting the society through the activity and at the same time gain regarding pattern of diseases in the community. Both these factors can be achieved through a proper feed back mechanism, which has to be built in as part of private sector partnership.
4. Printed quarterly reports will be sent to all participating SPPs from the district surveillance unit. This bulletin will list all the SPPs who are contributing to the programme in the district and the number of cases reported by them I-n each quarter.
5. The experience of NADHI has shown the importance of a motivating person or group, which is needed for successful sustainability of the programme. There is need for hand holding and constant support and encouragement from this person or group for the private practitioners. In IDSP the district surveillance office necessarily have to take on this responsibility of bringing together and integrating the private and public health systems in the region.

7.15 Evaluation

Evaluation	**External Evaluation will be conducted on the level of success of private sector participation in IDSP.**

The district and state surveillance officers will make internal assessment of private sector participation every year which include

Process Indicators

- ☞ Number of SPPs identified and participating in the programme
- ☞ Percentage of SPPs completed training for IDSP
- ☞ Percentage of SPPs reporting with more than 80% regularity
- ☞ Timeliness of reporting by SPPs
- ☞ Total number of interactions of Health inspectors with SPPs
- ☞ Number of feedback reports received by the SPPs from DSU
- ☞ Number of CME programmes conducted with support from IDSP

The strategy of private sector participation will be evaluated at the end of 2 years to assess the status of functioning. The indicators for evaluation will include the following in addition to the process indicators mentioned above

Performance Indicators

- Number of outbreak investigations carried out in response to information from SPPs
- Number of pre-paid cards received by DSO from private sector health providers
- Number of disease outbreaks detected through private sector reporting
- Feedback from partners on

8. EVALUATION QUESTIONS

1. The private sector will not take part in IDSP
   - ☞ Data Collection
   - ☞ Surveillance response
   - ☞ Analysis of data
   - ☞ Rumor registry
2. There is increased reliance of private sector in
   - ☞ Rural regions
   - ☞ Urban Slums
   - ☞ Tribal areas
   - ☞ Border areas

6. Sentinel Private Practitioners
   - ☞ Will perform surveillance in selected diseases
   - ☞ Will use modified simple format for reporting
   - ☞ Will provide nil reports at weekly intervals
   - ☞ Will be provided feed back from District Surveillance office
   - ☞ All the above