Reviewer's report

Title: Polio Eradication Initiative in Africa: Influence on Other Infectious Disease Surveillance Development

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Reviewer: Guenael Rodier

Level of interest: not specified

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General comment

This paper is one of the few which try to addresses a specific but key public health issue is resource-poor countries: do vertical programmes such as polio eradication contribute to strengthening or weakening national health systems?

Infectious disease surveillance strengthening, particularly in Africa, is acknowledged to be currently a very important public health issue, particularly in the context of the increasing needs for early detection of epidemics and/or emerging infections (re. WHA Resolution on Global Health Security, Epidemic Alert & Response, May 2001). A unique infrastructure and trained workforce have successfully been developed to achieve the specific goal of polio eradication. As the polio eradication initiative in Africa will hopefully been successful and come to an end in 2005 (initial target was 2000), the question about the future of this unique capacity become more acute every day, increasingly raised by a number of public health authorities and donors. In this perspective, this paper is timely.

The actual impact of vertical programmes such as the polio eradication initiative has never been measured. To my knowledge, this is the first attempt to measure the influence of the polio eradication initiative in Africa on other programmes. This make this paper, in its intent, interesting

However, the paper contains some weaknesses, mainly related to the method used.

The questionnaire used is not really described and a sample of it as an annex would be very useful.
The definition of the "key informant per country" who answered the questionnaire is rather fuzzy since
the paper says that it included "Ministry of Health officials and WHO country assignees". In fact the abstract refers only to "WHO-AFRO staff assigned to the 38 countries that regularly report polio activities to WHO". This is a key point since it raises the possibility of an important bias in answering the questionnaire: in effect, the future employment and/or career development of the respondents, after the polio eradication is over, will likely depend on their capacity to support other control programmes. Although this may be an incentive for really being involved in non-polio activities and positively contributing to other programmes, this is a likely bias in answering the questionnaire. It is surprising that this point in not mentioned among the "certain limitations" in the discussion section.

. How is it possible that, in a six-month long survey targeting people who "regularly report polio activities to WHO", that "In certain countries, we could not contact possible respondents because of difficulties in communication"? This was the case for 6 countries out of 38.

In the result and discussion sections, it would have been interesting to know more about the "other diseases"
. it would have been quite interesting to know if the fact that some polio medical officer/staff are also involved in other diseases in due to a natural implication simply for practical reasons, in a bottom-up approach, or if this is the result of a national or WHO policy, formally designed, endorsed, and implemented in AFRO.
. Information related to the quality of non-AFP surveillance done in addition to AFP surveillance is missing even if the need for indicators is acknowledged. At least, it would have been interesting to have some sense of the quality of these non-AFP surveillance activities, and not only to know if involved or not involved. In this perspective, reference to the work done by AFRO and CDC on indicators for the IDSR approach would have been useful in the discussion.
. One of the key question for today's decision makers, particularly the donor community, is the cost to maintain and sustain, after the eradication of polio, the workforce and infrastructure of the polio eradication. Such information, even if only cost estimate, would have added much to the discussion. In this perspective, it is disappointed that the survey did not attempt to quantify such a cost. The paper refers only to "lack of funds", "lack of vehicle" etc.
. Although the paper focuses on surveillance, the response component for non-AFP events (e.g. cases of outbreak of measles, cholera, meningitis, yellow fever) is not sufficiently addressed. Even if not done by polio officers if would have been interesting to know more about their implication in the response (there are in fact a number of very positive stories). This is quite important as the scope of the IDSR is surveillance and response.
. A last point would be about the suggestion that "other disease-specific programs might consider investing in general infectious disease surveillance following the polio example". Although this is right in principle, the authors do not seem to see the special commonality between AFP-surveillance and response with the surveillance and response to other vaccine-preventable and/or epidemic-prone diseases (i.e. detection, investigation, specimen collection, laboratory diagnosis, outbreak containment) compare to the TB or AIDS control programmes, more care oriented, and much less field and outbreak containment oriented. However, possible synergies with some other diseases, communicable or non-communicable, could be possibly identified for TB and AIDS. "Following the polio example" may just require more caution/nuances.

Competing interests:

None declared.