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THE ROLE OF BASIC HEALTH SERVICES IN TUBERCULOSIS CONTROL

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1. Introduction

Throughout the history of modern medicine TB doctors have been the forerunners of a progressive public health approach such as: the creation of dispensaries, the emphasis on social and preventive aspects of the tuberculosis problem and a combined curative and preventive activity. Therefore, even the concept of integration has been early appreciated, studied, recommended and applied in TB control programmes.

Integration is very clearly defined theoretically, but it seems that the practical implementation is not so simple. The principle that the "National TB Programme must be integrated in the community health structure" (Ninth Report, WHO Expert Committee on Tuberculosis, 1974) has been widely recognized and accepted and attempts at implementation are underway in practically all developing countries. However, the implementation is far from rapid and successful, in spite of beneficial effects which could be obtained from integration. Results of integration differ much between country to country, or even province to province, and it is apparent that the human factor plays a much bigger role than objective conditions.

The experience in Afghanistan will be instrumental in demonstrating the difficulties and, possibly, generate proposals for the practical implementation of a national TB programme integration into the general health services.

2. National TB Programme in Afghanistan

Up to 1969, TB services in Afghanistan were provided only by one specialised TB centre in Kabul (established in 1954, with WHO assistance). Some short-term field activities were undertaken from the centre during the 1962/69 period. Subsequent to an international seminar on tuberculosis held in Kabul in 1969, and organised with the assistance of WHO and the International Children's Centre in Paris, the Government decided to create a national TB programme, integrated into basic health services. A Directorate of the National TB Programme (DNTP) was created in the Department of Preventive Medicine.

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At that time, the situation with general health services was the following: in provinces one or more hospitals existed in the capital of the province, under the direction of the Department of Curative Medicine. The Directorate of Basic Health Services (BHS) has been just created and the establishment of basic health centres was at an initial - pilot - stage. It is important to mention that at that time there existed a very well organized, country-wide Malaria Eradication Programme and a Smallpox Eradication Programme, but both have been kept as separate vertical programmes and not included into a new plan for general health services.

As the essential prerequisite - an organized infrastructure of basic health services - did not exist, the Directorate of the National TB Programme started its activities in the light of the circumstances: establishement of TB control services at the level of provincial hospital, with a planned gradual expansion of the programme into basic health services whenever and wherever they would be created. A training programme has been envisaged, and the emphasis put on BCG vaccination to be done by general health services vaccinators.

Later on, after the proclamation of the Republic things started to move faster: the DNTP merged with Kabul TB Centre and the National TB Institute (NTI) has been created as a part of the National Institute for the Communicable Diseases Control (CDC). Regional TB Centres - intermediate level - have been planned and two created up to date. At the provincial level, TB Centres were created at the provincial hospital, with two or three fulltime auxiliary personnel (nurses, senior vaccinators or sanitarians) and the coverage of the country has been achieved at the present time. Those provincial TB centres will introduce TB control services on a fully integrated base into basic health centres whenever these would be deemed able to carry-on the programme. A national BCG vaccination mass campaign has been organized, combined with simultaneously done smallpox vaccination.

Basic health centres will be organized, one for every district (Woleswali) of the country, thus altogether 176 basic health centres (BHC) have been planned and today 106 of them have been created.

Every BHC should have 3-5 subcentres, some of these even to be upgraded to a health centre. The creation of subcentres is going on slowly. All established BHCs are not evenly functional, for lack of personnel, equipment and supplies, and TB control services could not be introduced in all of them. Therefore, today only 32 BHCs exist where TB control services are provided to some extent.

The supervision and supply line goes from NTI through provincial TB centres to BHCs. Reporting follows the same pattern in the opposite direction.

Thus, the role of these various levels started to be significant only after 1969, when provincial TB centres started to produce results and were followed by BHCs. The following table shows the participation of all levels as it is now (second quarter 1975).

Table 1.

Participation of various institutions in NTP

(Second quarter 1975)

	Kabul TB Centre		Prov. TB Centres		Basic Health Centres		Mass Campaign		Total
	No	%	No	%	No	%	No	%	
Number of patients under treatment at the end of June 1975	3286	24	8589	62	1925	14			13,798
Number of sputa exam'd during the second quarter 1975.	3104	35	3952	45	1785	20			8,841
Number of BCG vaccin. during the second quarter 1975	87000	22	66,000	17	21,000	5	222,000	56	396,000

As is apparent, the contribution of basic health services to all aspects of the NTP is still very limited. This is the result of the low degree of functionality of those centres. However, if the yield of provincial centres and BHCs would be added together, the contribution of the non-specialised part of the programme is high and shows definite progress from 1969 on.

Thus, the concept of integration started to be implemented six years ago. As the stage of development of basic health services was in its initial phase, TB planners were forced to start the implementation of the programme in the field by the utilisation of existing provincial health services (hospitals) and they planned later gradual integration into basic health services. At that time existing vertical programmes, Malaria and Smallpox, had not been included into the integration programme. However, the Director of the Malaria Institute agreed lately to assist NTP in defaulter tracing. Malaria field workers on their monthly visits to the villages take with them the list of defaulters and interview them, trying to convince them to visit the TB centre again. This cooperation has already materialized in some parts of the country. The Smallpox Eradication Programme terminated the vaccination campaign successfully and only in the last two years has a combined programme on simultaneous BCG/smallpox vaccination been launched, first on a pilot programme base and now as a country-wide mass campaign, covering the 0 - 15 age group of the population with BCG and 0 - 4 age group with smallpox vaccination.

Outputs in the vaccination programme increased remarkably: from below 200 000 vaccination in the whole of 1969 to nearly 400 000 vaccinations in the second quarter of 1975 only. The contribution of general health services is about 20% of the total output. The number of vaccinations done by BHCs has increased gradually from 1969 on. Present discussions about the permanent general vaccination programme, to follow the mass campaign, will probably result in increasing the responsibility and participation of BHCs in that programme.

Case-finding programme expanded gradually more and more. From the negligible number of sputum microscopies in 1969 -1 408 done exclusively by Kabul TB Centre, it increased up to 7 903 examinations only in the second quarter of 1975. The contribution of general health services (both provincial and basic health centres) went up from zero in 1969 up to 5737 in the second quarter of 1975. The contribution of BHCs is still small, due to the scarcity of laboratory technicians, assistants and equipment. Training and utilisation of microscopists has not been approved by the Ministry of Public Health (MPH).

The treatment programme is following the same pattern. Patients in 1969 were registered only in Kabul City (total 1468), and at the end of June 1975 we had 13 798 registered patients in the whole country, 76% of them being registered outside Kabul. Contribution of BHCs is improving from year to year even though their activity is not uniform.

The pattern of performances and evolution according to presented figures seems uniform. However, it changes when we examine reports from individual provincial or basic health centres. There, the periods of activity have been, sometimes, followed by a complete stop of services, due mainly to the local inadequacies.

3. Difficulties and proposals

In this chapter we will try to discuss the main problems in the process of integration in Afghanistan and to offer some proposals and conclusions to be applied generally.

3.1. Premature decisions on integration

The first and most important prerequisite for any integration is the existence of a horizontal programme into which a vertical programme can be integrated. In Afghanistan, basic health services did not exist at the time when the concept of integration was accepted. The existing and active vertical programmes (Malaria and Smallpox) have not been considered as potential nuclei for the integration or building-up of basic health services because of the fear that integration would possibly threaten these successful, fixed-in-time programmes.

Therefore, a survey on existing conditions of general health services should precede the decision to integrate. Whenever possible, the integration should start within existing facilities, which should be utilised as the initial point for the expansion of an integrated programme (example: Malaria and Smallpox Programmes). Moreover, the principle of stratified organization in the process of integration of national TB programmes should be applied in all developing countries: specialised management at the central level - NTI or DNTP; specialised teams on a regional level; auxiliary personnel on a provincial level; and a fully integrated programme at the peripheral level - basic health centres and subcentres.

3.2. Lack of understanding and training

The concept of integration has to be very flexibly applied according to the existing situation. One of prerequisites is the understanding and acceptance of the integration by health workers combined with the ability to perform the duties of an integrated programme. In Afghanistan, the medical profession in general did not fully understand and accept the concept of integration and was not even adequately trained to implement such a programme in many instances. Moreover, lack of any personal benefit influenced their attitude. Finally, there are doctors who do not accept the participation of paramedical personnel in the simplified methodology of diagnosis and treatment, or who believe that standardised treatment, which is not 100% effective, is therefore too simplified and is at the expense of some individual, complicated cases.

Therefore, a careful public health educational activity has to support and coincide with the decision on integration. Carefully prepared training courses, conferences in the field, lectures at medical schools and postgraduate training, manuals etc. etc. are the instruments of this education. Adequate utilisation of short conferences in the field, where all BHS and other medical officers from one or two provinces participate, training courses for auxiliary personnel of provincial centres, lectures at Public health schools for nurses, sanitarians, laboratory technicians etc., short courses for medical students before or immediately after graduation, manuals and permanent direct contact with the field institutions have been instrumental and successful when applied in Afghanistan.

In countries where the salaries are low and resources scarce there should be a financial incentive. Unfortunately, it has not materialised yet in Afghanistan.

3.3. Transfer

Most health workers in Afghanistan (similarly to all other Government officials) are transferred every two years. Therefore, the continuity of an established programme is not protected because often the substitute does not arrive (lack of personnel, etc.) or arrives late. Another difficulty is

that transfers are decided and take place only at one period of the year. The consequence is that approximately two months around this date proper work in health institutions is disrupted because the activity of a health worker is more devoted to transfer problems.

As the transfer itself in Afghanistan is unavoidable (there are areas where the work conditions are very poor and the personnel has to be entitled to a transfer after a determined period), the only possible solution is to change the system, extending transfer activities evenly throughout the year and to order the transfers in close consultation with the relevant services (the personnel trained in NTP should, in his new position, join again TB services).

3.4. Supplies and transportation

The problem of supplies and transportation is a common one in developing countries. Added to the lack of respurces is also the lack of proper organization of the ditribution of supplies. The ideal integrated distribution of supplies to the periphery is not yet established in Afghanistan and, in the meantime, the supplies for the NTP have been distributed from the NTI to provincial centres, and from there to BHCs.

The organization of a general delivery system from central stores to the periphery has to be organised on a fully integrated basis. The adequate provision of supplies and transportation is still unachieved by many developing countries. International assistance is imperative for a longer period. Operational assistance (transportation expenses, maintenance, per diem etc.) is also necessary for some additional period to the least developed countries.

3.4. Supervision, assistance and evaluation

It is the experience in Afghanistan as well as in other countries that without a close supervision and assistance to the field, as well as a proper evaluation of the programme, it usually collapses very soon. In Afghanistan, when it was clear that the central Institute cannot cover the whole country with a good supervision, regional TB centres have been planned and slowly organized. These centres shall have responsibility mostly for supervisory and evaluation activities in their region.

It seems clear that the future of an integrated TB programme depends directly on the supervision from the central and regional management.

The implementation of a good supervision, assistance and evaluation is still a big problem in developing countries. There, international assistance should exist for a longer period and it should include advisory assistance as well as the operational one. It seems that national health institutions in many instances need the continuance of such an assistance.

4. Conclusion

The integration of the National Tuberculosis Programme into general health services, as recommended by WHO, is the best organizational approach for all countries with small resources. The experience in Afghanistan shows that the integration is realisable even under difficult circumstances. Careful evaluation of existing facilities and a flexible approach to all problems is a precondition for success. The main point, based on the experience in Afghanistan, have been presented and discussed and solutions sought. The importance of continued international assistance, both in advisory and material support, has been emphasised.