# WHY INTEGRATED TUBERCULOSIS PROGRAMMES HAVE NOT SUCCEEDED AS PER EXPECTATIONS IN MANY DEVELOPING COUNTRIES—A COLLECTION OF OBSERVATIONS[1]

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**Summary :** Hard work is still needed to make integrated tuberculosis services, and integration in general, acceptable to health workers and to improve all the support systems for integrated tuberculosis services to the extent that the envisioned fruits are borne simultaneously with the introduction of these services through primary health care.

Now that case-finding and treatment for tuberculosis are being considered for introduction into primary health care, it is relevant that the experience gained from integration of vertical tuberculosis programmes into the general health service be reviewed critically. It would be unwise to let the problems and weaknesses of integrated national tuberculosis programmes (NTP) flow into the new emerging primary health care system without batting an eyelash.

It could be stated at the outset, and with due emphasis, that there really is no alternative to an integrated tuberculosis service, all its drawbacks notwithstanding. The point at issue is that the present form of integrated TNPs need not necessarily be the basis of application of tuberculosis control technology through primary health care.

**Success with integration has been patchy so far**

In the 1960s, when WHO started recommending NTPs, especially for developing countries, the epidemiological, socio-economic and operational reasons in its favour were indeed compelling (W.H.O. 1964, 1976). After over two decades, it cannot be truthfully said that NTPs have succeeded; nor that they have failed. The old justifications have not changed since, but the manner in which integration was brought about has provided a fresh perspective.

It is true that a tuberculosis patient out in a village has a much greater chance today than before of being diagnosed and treated, but the proportion being missed, misdiagnosed and improperly treated is uncomfortably large. And, it appears, nothing much is being done by the integrated health services to correct the situation. True again, that a newborn baby, infant, or school entrant has a far greater probability of getting BCG vaccinated under the integrated health services, compared with the BCG mass campaign days. But, vital aspects like maintaining the potency of the vaccine and proper vaccination technique were neglected by general health workers to the extent that some special programme aspects had to be reintroduced under the Expanded Programme on Immunization to make BCG meaningful.

In some countries even voluntary/private agencies have joined hands with the government's integrated NTP but specialized institutions, both under public and private sectors, still maintain that they purvey a much superior kind of tuberculosis service compared with what general health institutions have to offer. A degree of competition exists between general and specialized health institutions in securing preferential attention of the public, despite free-flowing bilateral referral provided under the NTP. This should be enough to confuse the health workers and the public alike.

**Integration is great to talk about**

Health officials and workers often talk about integration knowingly and with enthusiasm but, like the talk about weather, nobody does anything about it. The number who "know" what is wrong with integration is legion. But it is not for them to find out the reason thereof and do something, albeit at their own levels.

Compartmentalized thinking, attitudes, and functioning abound at all the levels of the health infrastructure. Strangely enough, those presently charged with primary health care do not appear to be above all this. To many, it is the newest health technology and those not directly involved could be kept at arm's length. Is primary health care gradually and unconsciously being regarded as a new speciality?

**Philosophy of integration is understood but not really accepted**

Integration is most visible in the grassroots level rural health institutions because that is where in the estimation of most health

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officials, integration is most suited and needed. In cities and higher levels of the health organization, integration is either missing or cosmetic, because it is regarded as unnecessary there. Despite the welcome success of integration in rural health institutions the attitudes and practices of rural health staff are not always helpful. Poor attitudes could be the reason for the sizeable misdiagnosis and mistreatment in respect of tuberculosis under the integrated health service. By training and the examples of peers, health workers face serious problems in forming the needed attitude towards integration. Besides, integration conceptually is not meant for rural areas alone. Attitudinal and functional changes have to take place at all levels of the health infrastructure, for success even for the most peripheral level (W.H.O. 1965 and D.G.H.S. 1967).

The widespread covert non-acceptance of integration at all levels is there, perhaps, because integration cuts across the present-day medical sociology and health services politics. The apprehensions, insecurity, and confusion generated by integration among health workers are just too many. The absence of a strong logical support to the fears is what is making the non-acceptance covert and non-vocal.

Highly placed officials, who often exercise disproportionately large influence on account of expert clinical services rendered by them to those in political power, are the ones espousing the idea that integration needs to be confined only to the rural health institutions; that people need and are demanding the establishment of many more specialized and prestigious centres and that no country can afford to lower its medical expertise and not have at least a few centres equal to the best in the world. In this way they try to meet the "threat" posed by integration to their positions/prestige acquired through a different system. The element of truth in their statements conveniently is not put in the perspective that could often be achieved only by denying the simplest health services or rendering second-class services to the millions to provide what is first-class to a few. It is done perhaps because it is a question of survival for them.

The purpose of the above suggestion is not to denigrate but to ascribe the often noted "weak" political will behind many a public health programme, the re-separation after the passage of some years of departments, bureaux, posts and functions that had been integrated earlier, the continued opening of new tuberculosis hospitals and centres when their non-essentiality has been amply demonstrated, etc. to just one causation, namely, non-acceptance of integration. None can afford to be overly critical or cynical. It is those, who are either pushing forward integrated health services, primary health care, etc. or have to sit in judgment over their success, that must search their minds. Must planning for the better health of the people brush aside the felt-needs of the professional staff who have to carry out the plans?

### Need for acceptability studies

At the time when integration of health services was being recommended, a pilot project or two in every country helped to demonstrate to the local workers that the strategy is feasible and works well. The mental walls appeared much later. One after another even promising NTPs got bogged down with difficulties. The pilot project approach is also being used to promote primary health care, to attain the goal of "Health for All by Year 2000". This is good, but when will we learn that what is feasible is not necessarily acceptable?

Time and effort must be spared *now* for acceptability studies regarding integration. No sooner had difficulties arisen with integration in respect of NTP than health services research should have examined its pragmatic basis. Pragmatically planned programmes are essentially short-term expedients, but for one reason or another they succeed in eluding scientific scrutiny for varying periods. If this note is regarded as overly critical or unrealistic, pragmatism will win once again.

This is not to suggest that nothing should be done until the studies are completed. There is also no denying that a long time is needed to bring about a major change from specialization/high technology of the vertical programmes involving concentration of "line" and "staff" functions in the hands of the same persons, to the people-oriented integrated services with stress on decentralization, prevention and cost-benefit. The points being made are that a quarter of a century has elapsed and we do not have unlimited time at our disposal since primary health care services have to be pushed forward now and that we are in a stalemate with regard to integration and do not have sufficient awareness as well as knowledge about what to do.

### There was inadequate preparation

A part of the blame for the poor attitudes and practices among general health workers





must be borne by those who had the responsibility for bringing about integration. Compared with what was demonstrated to them in pilot projects, the preparations they made for the extension phase were either deficient or grossly inadequate, in order perhaps to attain the set extension targets. Some programme extensions comprised merely an administrative order and despatch of supplies. Training quite often was improperly organized with the result that untrained staff rendering the services, some trained staff awaiting equipment and supplies long enough to forget their training, and microscopes lying around in packing cases for years, were observed quite frequently. The seminars/workshops that were organized for training laid far more stress on technology and too little on the change of attitudes. The people in general were hardly prepared for the integrated services and its enshrined referral system. It is not clear how during the pilot phase the comparative inadequacy of organizational/training capabilities, available generally to tackle the enormous task of extension, was not foreseen and something done about it. It is hoped that history will not repeat itself when it comes to extension in respect of primary health care.

### Other observations

Besides poor acceptability of integration, and inadequate preparation for its implementation, there is :

(a) unexplained, almost paralyzing, lack of sustained interest/enthusiasm among general health workers in respect of tuberculosis services; perhaps some other programmes as well. Compared with acute diseases and physical injuries, the beneficial results from tuberculosis services do not become visible quickly, which may lead to a general state of disinterest. But, in some cultural milieu, the apathy tends to disappear when a family member, friend, or a person with a "letter of reference" approaches for the service, suggesting that a part of the explanation is insufficient social consciousness among health workers. Therefore, the apathy needs looking into and not merely explained away.

(b) Health workers are prone to regard the functions connected with their "category training" for entry into service as "legitimate duty" and other duties given to them as multipurpose workers merely as "extra work". This psychology of extra work perhaps is behind persistent demand for "incentive pay" when other duties are entrusted to them in the wake of integration, on the grounds that they are overworked. A number of studies has demonstrated that all categories of health staff in rural health centres, including medical officers, are in fact under-utilized. Yet the myth of overwork continues to thrive, and is generally accepted. No sooner are more hands provided to help reduce the overwork, than the staff tend to revert to the unipurpose system of work, sometimes by private arrangements among themselves. If supervisors would not allow it openly, they are ready to turn a blind eye towards it.

Under some health programmes the grant of incentive pay is permitted on the grounds that health workers in most developing countries get poor salaries. There is no reason why health workers should get less salary than comparable other categories, but linking this up with the aim of achieving higher targets in respect of a high priority health programme, which indisputably leads to neglect of other activities and duties in health institutions, borders on the undesirable. Ironically, in spite of the incentive pay the achievements may turn out to be fictitious if supervision is lax or cannot be exercised for a period. Primary category training as "multipurpose health worker", to cover all the integrated health duties as the terms of service at entry, better salary, and good supervision may resolve the problem.

(c) One of the reasons for NTPs not succeedings as per expectations could be that the expectations are unrealistic. After all, these expectations are those of the overseeing specialized workers who are not really familiar with the structure and dynamics of a general health service. Replacement of population/prevalence-based targets with operational ones within the reach of multipurpose health workers might provide the answer.

(d) The "oil crisis" facing the world, especially the developing countries, may yet prove a blessing in disguise for the integrated services. Parenthetically, transport is an essential prerequisite for implementors/supervisors of a public health programme. The role of transport

as an image builder of health workers, however, became apparent when attempts were made to apply management principles leading to the optimal use of all roadworthy vehicles belonging to any health programme in an area. Marked reluctance was observed for programme functionaries to travel by public transport when necessary, share the vehicle with others from sister health programmes, and agree to the allocation of roadworthy transport according to optimal utilization and not merely status of those using them. The most frequent reaction to "pooling of vehicles" practice was for the supervisors to forego supervision duty on one plea or another. Now, with increasing problems of maintenance of vehicles and rising price of gasoline, coupled with insufficient budgets for supervisory travel, a pattern of small radius supervision exercised from each successive level in a step-ladder fashion might help resolve the problem.

(e) The supervision of NTPs by general health workers has been decidedly infrequent, and at times even incorrect, making it altogether grossly insufficient. Quite often, there is great enthusiasm at the time of introduction of integrated tuberculosis services in a health centre, but very soon hardly any case-finding or treatment are left to be seen, as if the service had never been introduced at all. The specialized "staff" officers in the higher levels often try to correct the situation by exercising supervision at all levels, which is obviously an impracticable proposition. If proper supervision of integrated tuberculosis services by the general health service "line" officers cannot be expected at present, it would take a long time to make tuberculosis services meaningful under primary health care.

## Not by studies alone

An impression might have been given that nothing could be done to correct the present not so satisfactory position of NTPs until the operational studies have been completed. That technology of tuberculosis control has reached the peripheral level is a gain which should not be thrown to the winds while awaiting scientific studies. Until then, the status quo should continue with whatever could be done to improve poor attitudes, weak programme support systems, inadequate training and supervision, and the general climate of confusion and apathy. No cut-and-dried solutions for the interregnum are offered on purpose, not because it is not possible to offer some suggestions. The temptation has been resisted. If the earlier pragmatism and successful pilot projects did not quite succeed, more time should not be lost in trying some new pragmatic solutions, thus tinkering with the problems instead of tackling them systematically.

## Tuberculosis control technology and philosophy of primary health care

However, there is one basic point between NTPs and the primary health care systems that needs a pragmatic rationalization now. Under the philosophy of primary health care, people have the right and duty individually and collectively to participate in the planning and implementation of their health care activities. It has to be remembered, however, that at times people's perception of the health "threats" facing them and their participation in meeting the hazards has to be moulded through health education. Tuberculosis and leprosy have a long history of "stigma" which even today makes individuals and families deny that the hazard exists for them. They may agree to these diseases being a community problem, to which they may accord a low priority. True, comparatively fewer persons in the community are afflicted with tuberculosis, but those few suffer a lot more than others having most other diseases (Nagpaul et al, 1966). And, before dying, they infect healthy contacts—about ten in the case of tuberculosis—who may develop the disease much later. There has to be a kind of understanding, at this stage, on the point of educating the public suitably, because faced with the enormous and difficult task of ushering primary health care in the context of a low perception of tuberculosis as a health hazard, whatever gains NTPs have already registered, may be allowed to wither away. That would mean a real failure of integration.

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