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SMALLPOX SURVEILLANCE IN AFGHANISTAN

by

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1.0 Introduction

Afghanistan is a mountainous country with a population of about 15 million which includes nearly two million nomads called "kuchis". The climate is dry with wide variations in temperature and frequent snow falls in winter. Main towns can be reached by motor vehicles; however, access to remote villages, especially in mountainous areas, is difficult.

Smallpox has been prevalent in the country for centuries. In late 1968, the government seriously viewed the problem and decided to undertake an eradication programme. Accordingly, a mass vaccination campaign with concurrent assessment was launched on 1 April 1969 in the Kandahar zone. The Central Directorate and the remaining three zones were subsequently established. From Table 1 and figure 1, it will be noted that whereas only 500 000 vaccinations were done during 1969, nearly 2.5 million vaccinations had been carried out by 1 October 1970. Priority for vaccination has been accorded to the provinces bordering Pakistan, where the danger of importation of the disease exists. Figure 2 graphically represents the current status of the vaccination programme.

2.0 Surveillance

Although the vaccination programme was started in a planned and organized manner in April 1969, we were not able to give much attention to the surveillance aspect of the eradication programme until the beginning of September 1969.

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2.1 Notification of cases

First, an attempt was made to improve the reporting of suspect cases. Past experience showed that notification was extremely poor and that perhaps only one out of a hundred cases was ever reported.

The following measures were taken:

1. During an orientation course for Provincial Senior Medical Officers, all aspects of the Smallpox Eradication Programme were explained and the importance of developing a network of reporting sites in the provinces was stressed. It was agreed that the provincial medical officers would report suspect smallpox cases by telephone or telegram to the Zonal Headquarters or to the Central Directorate of the Smallpox Eradication Programme and also would continue to submit weekly reports on notifiably diseases, including smallpox, to the statistical section of the Ministry.

2. A detailed directive under the signature of the Health Minister was issued to all chief medical officers of the provinces outlining their tasks such as early reporting of cases and immediate containment action.

3. The President of the Malaria Institute sent instructions to his regional officers and through them to all the surveillance workers requesting their cooperation in early reporting of all suspect cases.

4. The programme staff began regular visits to the provincial hospitals, health centres and MCH clinics all over the country to explain the need for prompt regular reporting and to distribute educational material such as smallpox picture folders, posters and so on.

Notification of cases improved considerably but was still by no means complete. An example is an outbreak of 14 cases in a village only a few kilometers from the provincial hospital in Zabul province and of which the chief medical officer had no knowledge.

One problem is the lack of health centres. Of the 326 woleswalis and alaquadaries in the country, only 69 have health units, of which only 47 have medical officers. Because of this, we have had to resort to additional measures for obtaining reports of cases.

2.2 Additional measures taken to obtain reports of cases

As Health Centres are few and far between and Malaria surveillance workers are not ubiquitous, we decided to contact village leaders, who usually know immediately of cases or illness among their people. The leaders, known as Maliks or Arbabs, are frequently in contact with the sub-governors, who are the woleswali chiefs. The leaders thus could inform the sub-governors of any suspect cases and the sub-governors could transmit the information by telephone to the provincial medical officer.