Paramedical Personnel in National Tuberculosis Programme

Mrs. J. L. MONGA

Introduction

Tuberculosis, once a dreadful disease, now pronounced a curable disease, still presents many complicated problems. The prevalence, incidence, mortality and morbidity rates of tuberculosis seem to be static. With all our advanced science and technology the proper diagnosis and successful treatment of Tuberculosis mostly depends on patient compliance.

The paramedical staff who have the responsibility of helping in diagnosis, motivation and retrieval could contribute, to a large extent, in improving the patient compliance provided they are given proper orientation, guidance and supervision.

The paramedical staff are the link between the health services and the community and they play the key role in Tuberculosis control programme.

The expected staff to be posted as per the National Tuberculosis Programme at district level are District Tuberculosis Officer, Treatment Organiser, Pharmacist, Lab. Technician, X-ray Technician and Statistical Assistant. The additional staff may be a second Medical Officer, Health Visitor, Lab. Attender, Dark Room Assistant, Clerk, Peon and a driver, if a vehicle is provided.

The expected staff to be posted at the level of Primary Health Centre for Tuberculosis programme are Medical Officer, Treatment Organiser, Pharmacist, Lab Technician and X-ray Technician if x-ray facilities are available. Many places do not have the sanctioned staff for Tuberculosis activities.

The importance of paramedical staff in the comprehensive health care system is increasingly recognised but timely technical support and supervision are lacking.

The National Tuberculosis Institute has defined the guidelines and procedures for implementation of National Tuberculosis Programme but the implementation varies from state to state, district to district.

The district is the basic administrative unit of the National Tuberculosis Paogramme. Under the District Tuberculosis Programme the districts are divided into Taluks and further subdivided into Community Development Blocks with a Primary Health Centre in each block.

The author is Nursing Officer, T.B. Research Centre, Madras.

The Primary Health Centres may be small referral centres or may be microscopic centres with facilities for sputum examination or microscopic and X-ray centres with facilities for both X-ray and sputum examination.

In the actual practice the general health workers are already overloaded with priorities such as family planning, malaria control, child welfare, etc. So, they are not able to give top priority to Tuberculosis activities. Most of them tend to feel that Tuberculosis Programme and treatment are not part of their routine duties but additional responsibilities forcibly added without any compensation or relief.

To integrate Tuberculosis Control Programme and treatment through the Primary Health Care system is more beneficial and economical if proper orientation and process of integration are well planned and organised.

The fact remains that the government and the TB specialists realize that the control of Tuberculosis deserves a high priority in the list of national health activities on a par with family planning activities but how to achieve them with the allocated staff and available resources are the factors to be planned, organised and implemented by the Tuberculosis specialists.

What is Expected from Paramedical Personnel in National Tuberculosis Programme ?

Case finding : Identifying symptoms from the individuals or through their relatives and referring them to Tuberculosis Centres for diagnosis and treatment.

The next step is sputum examination. It has been pointed out by experts that the laboratory services at the level of Primary Health Centres are often ineffective and unsatisfactory in developing countries.

As per the National Tuberculosis Programme the diagnosis and treatment is based on one positive smear of sputum test. Therefore, the proper collection of sputum from the patient not saliva, use of proper techniques for sputum test by trained personnel are all important factors in effective case holding.

Case Holding : Motivating the patient for regular treatment should start from the very first day of starting the treatment. Motivation means to create confidence in the patient. This can be achieved better if the family is also involved to give moral support to patient.

To get better cooperation from the patient selection of drugs is another important factor which the Medical Officer has to determine. In general, the policy should be to give cheaper, potent, oral drugs which are less toxic and the period of treatment is short and the number of patients' attendances are few. But in practice the medical officer has no choice except to give the avilable drugs.

To recognise adverse reaction of drugs and take prompt action as per the prescribed procedures and detect defaulters and take retrieval action per the defined policy are all part of case holding mechanism.

Health education: To create public awareness about the symptoms and seriousness of the disease, to give information about the facilities available for free diagnosis and treatment and to teach simple preventive measures. To advise contacts examination.

Record keeping: To maintain lists of patients under treatment, to enter issue of drugs in treatment cards, to keep record of defaulter action and transfer of cases and despatch treatment cards to the respective clinic, to maintain drug stock, etc.

These are the main duties of the paramedical personnel in case finding, case holding and control programme of Tuberculosis. Unless a constant, meticulous supervision of each activity of the programme of Tuberculosis at *D.T.C.*s and at *PHC*s are ensured, we cannot expect good performance and satisfactory results. Proper coordination and correlation of all the Tuberculosis activities and periodical evaluation of the programme are essential.

I have so far mentioned some of the expected duties of the paramedical personnel in the National Tuberculosis programme. But the following things are to be ensured to expect the staff to perform their duties efficiently.

1. The working conditions must be conducive to carry out their duties properly.

2. Posting of sanctioned number of trained personnel and periodical reorientation of staff involved in Tuberculosis activities and arrange for substitutes for the staff on long leave.

3. To ensure regular pay, travelling allowances, chances for promotion as other health workers.

4. To avoid frequent transfers of staff. This disorganises the programme, makes the work ineffective and the staff becomes inefficient and indifferent.

5. Periodical supervision and evaluation of the work.

6. Regular supply of medicines, chemicals, equipments, linen, stationery items ensured.

7. Maintenance and prompt repair or replacement of equipments.

8. To allot sufficient financial resources for these activities.

9. To organise mass media information campaigns through radio, TV and advertisements on par with the family planning programme. We only hear about Tuberculosis programme for one week in a year during the TB seal sale campaign, whereas the family planning propaganda is a routine daily programme on TV and Radio.

10. Full involvement of community, family and the patient in Tuberculosis treatment and control programme, to be encouraged by sustained efforts and more interest by all health workers.

We think that almost at every National Tuberculosis Conference we discuss, suggest and expect development and improvement in our fight against TB but we are not sure how far we have succeeded in controlling Tuberculosis effectively. Unless determined national commitment and community involvement are there the situation will be the same.

I hope and wish that the TB Association will continue to include paramedical staff for participation in National Tuberculosis Conferences. I was the one who fought in 1958 and got the regular chances for paramedical personnel to participate in National Tuberculosis Conference and I was the first one to present a paper at Jaipur in 1959. I am in the Tuberculosis field since 1948. I have witnessed the days the patients used to count their days in their death-bed with agony and misery without any hope of survival and I am also witnessing the days now that the patients can be cured in 6 months with regular and proper chemotherapy. I wish that more importance is given to Tuberculosis Control Programme to eradicate Tuberculosis from our country.

I am due to retire next year and I would still like to contribute whatever is possible to help eradicate Tuberculosis even after retirement. On my part, if the Tuberculosis Association would like I can prepare the caption words in Tamil for mass media communication in Tamil Nadu semething like what we hear daily about family planning. I think the same can be done in all local languages.

I am sure that this would create public awareness and pave the way for more case finding, prevent initial defaulters and help in better case holding and prevention of infection.

This is the text of the paper read by the author at the Tuberculosis Conference at Shillong recently.

Articles in Hindi

We invite articles in Hindi for publication in the *Journal*. It is our desire to make the Hindi Page a regular feature.

EDITOR, NJI
