ROLE OF A HEALTH VISITOR FOR T.B. PATIENTS IN THE COMMUNITY

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TB is a major public health problem in India. It kills more adults in India than any other infectious disease. Every day more than 20,000 people become infected, 5,000 people developed diseases 40% of the adults are infected with the TB bacillus. Nearly 5 lakh persons die each year. 1000 people a day - one every minute - die of TB in our country.

The goal of the Revised National Tuberculosis Control Programme (RNTCP) is to cure at least 85% of new sputum smear positive patients detected, and to detect at least 70% of all such patients from the community but only after the desired cure rate has been achieved .

DOTS (Directly Observed Treatment Short Course) the global strategy for TB control now used in more than 120 countries, is to a large extent a product of the Research done in India. DOTS programme investigations and anti TB drugs are provided to all patients free of costs at all Government Hospitals and treatment is decentralized.

The Nurse has a creative role to improvise and support care in home- environment- to create awareness among the family members and in the community.

METHODOLOGY

TB Research Centre(T.R.C)is rendering medical services through out patient department. Doctors, Nurses, Social Workers, Public Health Nurses and Health Visitors are functioning as a team to control TB.

In TRC, smear positive patients with age more than 18 years are admitted for various randomized clinical trial. For the sake of effective functioning,, Chennai is divided into 14 sectors. Each Health visitor is responsible for one sector, one team consists of 4 health visitors, one medical officer, one social worker and one PHN. 4 health visitors were responsible for 171 patients in the period of Aug.2003.

Role of Health Visitors in TRC set up
Home visits - initial
Health education
Defaulter visits
Other visits
Case detection, documentation and reporting.

Home visit initial

At first, contact with the patient and his family members in the clinic, the HV establishes rapport with the patient and his family, tries to get maximum information regarding his disease. After admitting the patient for research study depending upon the willingness of the patient the first visit is made by the health visitor. The HV is responsible for the patients hailing from her sector. Apart from these patients some of the MDR TB-HIV TB who hail from out side our area of

intake, also do come under the care of the concerned health visitor. In each team 2 health visitors will visit the patients in the allotted sectors daily. Since many patients object home visits due to social stigma, depending upon patients willingness home visits will be done to their respective home after these patients are admitted into our research trials.

During the initial home visit, health visitors will verify their given address, the distance between their homes to treatment centre and T.R.C. mode of transport, assess socio-economic condition, literacy level, previous history of TB in the family. Family contacts will be listed and interact to strengthen the rapport. Based on the above particulars, health education is given.

METHOD OF HEALTH EDUCATION

Health Education is a crucial component of TB control, The different target groups which need to be addressed are patients, their relatives and the community. It should reinforce positive attitudes and eliminate negative ones. Individual and family health education are given in personal interviews at the Clinic environment and also in the home environment. In working with individuals the Health Visitors must first create a good rapport with the patients and their family, allow the individual to talk as much as possible. By careful listening we can discuss, argue, and persuade the individual to change their attitude, towards the disease. Any intervention which facilitates interaction among the patient and family members like providing health education, emotional and social support will help to reduce the stigma. Health education through personal interaction method provides opportunities to ask questions and get doubts cleared.

Health education is given regarding causation, nature of illness and personal and environmental hygiene. It is emphasized that TB is almost 100% curable with adequate treatment. Directly observed treatment with standardized short course chemotherapy (DOTS) as per the recommendations, is the key to cure TB. If treatment is not taken as per recommendations it is likely that the disease may become incurable as the patient will acquire drug resistance . Such a patient can spread an incurable form of the disease in the household and community. So the patients and their family are made aware of the risk of irregular or incomplete treatment. TB transmission is mainly through inhalation of droplet nuclei which are discharged in the air when a patient with untreated TB cough or sneezes. Hence the patients are educated to cover the mouth nose, and also not to spit sputum everywhere. They are instructed to spit in the sunlight if they are away from the house. Preventive measures include the importance of taking TB drugs regularly on schedule, for the full duration of treatment. Otherwise the disease may become incurable. The patients are advised that disappearance of symptoms does not mean the cure of the disease. Possible side effects due to the drugs are also informed to the patient to make them not to be alarmed. The patients are also advised to bring their close contacts especially below 5 years for investigations.

DEFAULTER VISITS

TB has three kinds of problem unlike other infectious disease. It needs long standing treatment, certain amount of social stigma ,relapse which is common due to drug resistance if patient did not take regular treatment in RNTCP. Patient who misses a dose are contacted and put back on treatment through home visit. HV visit the patient the day after the patient was due to come for treatment. She discusses problems with the patient and helps him to prevent him from

default and convince that cure depends upon regular intake of drugs. The message is also convinced to the relatives and family members so that they take interest and ensure the patients regularity. Some of the reasons for defaulting are asymptomatic, pressure of work, lack of money, lack of transport, indifference, dependence of alcohol and drugs and domestic preoccupation

Apart from the initial home visit and defaulter retrieval visits supervisory visits also undertaken by the health visitors in order to check whether the patient takes the anti-TB drugs regularly by checking the empty pill covers. If the patient does not take the drug unused drugs will be brought to the centre. Visits are also made to collect urine specimens and handover to the lab for testing acetyl INH. Besides the follow-up case visits will be made every month before periodical monthly check up one bottle issued for sputum specimen collection and remind the patient for monthly checkup. Sputum will be tested every month to find out whether TB is controlled or not. Patients not willing for home visit and migrated from Chennai to other places are contacted through letted/phone .

RESULTS.

Period - August2003

Total No. of patients due for visits	: 171
Total no. of visits done by 4HV	: 138 (80.7%)
Unwilling for home visit	: 33
Defaulter visit	: 69
Patients who turned up after visits by HV .	: 63(91.3%)
Other visits	: 69

CONCLUSION:

The success of TB control requires the combined efforts of the team which includes the nurses and HVs. Committed nursing care providers at the community level is a vital factor. Health Visitors are able to establish good rapport with the patient and their family and are able to retrieve majority of defaulters and deliver health education to patient and family.

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