

Public awareness about tuberculosis , prevention, transmission and default in tuberculosis treatment

INTRODUCTION:-

As you know tuberculosis is a potentially serious infectious bacterial disease that mainly affects the lungs.

The bacteria that cause TB are spread when an infected person coughs or sneezes. So, The government of India has initiated a program in 1962 , named National Tuberculosis Control Programme. In spite the program was launched still it was not able to control the number of infectious people in the country.

The Government of India has formed the plan to eliminate TB from India till 2025. The major limiting factor in this are the people who even do not know about T.B as in rural area, how T.B spreads and major contributions from those who leave the treatment in between. This may lead to development of TB drug resistance and failure to achieve the target till 2025. Hence it is very important to completely aware these people and find the cause why these people leave T.B treatment in spite the treatment is being free so that the TB will be completely eradicated from India and hence "T.B. HATEGA AUR DESH BACHEGA "

AIM:-

To assess the knowledge of general public regarding the tuberculosis, Defaulters, prevention and transmission of disease.

OBJECTIVE:-

- To know how many people know about tuberculosis.
- To know how many people know regarding Treatment and prevention of tuberculosis.
- To know the general public opinion regarding the defaulters of tuberculosis treatment.

ROL:-

• Communication

The behaviour and attitude of the TB health visitor (TBHV) towards the patients has an important bearing on the ability of the patients to continue treatment generally six of the 40 defaulters stated that they had defaulted because of the poor communication skills of the health workers, who were described as being rude or unhelpful.

• Lack of attention and support received at the clinics/DOT centres

A related problem was the lack of attention or support sometimes given by the TBHV when patients experienced side-effects.

It is important to stress that not all patients had bad experiences. Cases in which the TBHV strove diligently to find ways of supporting patients to enable them to continue treatment were also found. These examples are important in themselves, but also in so far as they underscore more generally the importance of support and care for patients, the effectiveness of this approach, and its feasibility within programmes.

- **Barriers to re-entry after default**

Non-participant observation at the DOT clinics revealed the existence of barriers to re-joining treatment after a period of interruption. Having defaulted, these patients became labelled as

'unlikely to comply' who could no longer be trusted to complete their treatment, and who were thus deemed likely to 'spoil the results of a TB centre'. In other cases returning patients were asked to produce a guarantor from the community who could vouch for their ability and willingness to complete their course of treatment. Obtaining such a guarantor can be difficult if not impossible for those who are poor and/or relatively new to the city.

- **Alcoholism**

It is important to note, however, that practicalities were not the only blocks to treatment completion described by the patients and family members interviewed. For example, 11 of 40 interviewees described default due to alcoholism. Some of these individuals were simply uninterested in treatment, and were not amenable to suggestion or persuasion. These patients often get labelled as a difficult case by the health workers, and comments from family members sometimes concur with this label.

Material and method:

METHODOLOGY:-

The study was conducted over a period of 1 month from 8 March 2023 to 8 April 2023. A cross sectional study survey using a validated, self administered questionnaire was designed for this study. The sampling frame was general public living in bhagpatipur village, Bareilly city, Uttar Pradesh. The target sample size was thus calculated to be _____

Inclusion and Exclusion criteria:-

People willing to participate in the survey and aging 18 years with cognitive impairment are excluded

The questionnaire consist of 18 questions which covered the following areas. First part of questionnaire consists of 7 questions that focuses on socio demographic details. Second part of questionnaire focuses about knowledge about TB transmission. Third part contains general information about TB. Final part consists

items that highlight knowledge about TB prevention. All items in questionnaire were framed using 3 possible answers [yes, no and I don't know]

Descriptive statistics were applied to compute demographic characteristics of the respondents.

QUESTIONNAIRE:-

1. Do you know about Tuberculosis? (Yes / No)
2. What is the source of information ? (A. Television / B. Newspaper/ C. Family/ D. Others)
3. Do you think there is a taboo related to tuberculosis ? (Yes / No)
4. Do you think the treatment for tuberculosis is necessary? (Yes / No)
5. Is tuberculosis a communicable Disease (Yes/No)
6. If yes, what is the mode of transmission? (A. Thorough Touch / B. Sneezing/Coughing/ C. Unclean Water / D. Hereditary)
7. What do you think which age group either male/female is more likely to be involved in default ? Age group- A- 10-20 yrs .B-20-40 .C-40-60 D. -60 above.
8. Do you know the side effects during the treatment of tuberculosis? (Yes / No)
9. Do you think constant flu like symptoms , abdominal pain, nausea is the reason for the default? Yes /No
10. Do you think improper behaviour is the reason for default in treatment for tuberculosis? (Yes / No)
11. Do you think long treatment is the reason for default? (Yes / No)
12. Do you think lack of education causes default in treatment for tuberculosis ? (Yes / No)
13. Do you think the occurrence of PHC ,far away is the reason for default? (Yes / No)
14. What do you think the reason for being default in T.B treatment is either involvement of more -(MALE /FEMALE)
15. Do you think the reason for default is being likely the involvement of more no. of HIV patients than normal one ?(yes /no)
16. Do you think the prolonged treatment and progressive slow cure rate is the reason for being default ?(yes /no)
17. Do you think multi drug resistance during repeated treatment is the reason for default?- (Yes/No)
18. Do you think the initiative programme, campaigns and television advertisements has impacts in reducing the cases of T.B or defaults ? (Yes/No)

Study design

Descriptive study (cross section)

Result:-

Discussion:

Table. 1: Socio demographic characteristics and Knowledge scores (n=1000).

Characteristics	Frequency	Percent age
Family Type		
Nuclear		
Joint		
Gender		
Male		
Female		
Education Level		
Intermediate		
Higher		
Illiterate		

Residence

Rural

Urban

Age

18-30 Years

30-59 Years

>60 Years

Monthly Income

>185895 Rs.

92951-185894

69535-92950

46475-69534

27883-46474

9308-27882

<9307

: General knowledge and sources of information about TB.

Question	Yes (%)	No (%)
<i>Have you ever heard about a disease called TB?</i>		
<i>What is your source of TB information?*</i>		
Television		
Family members		
Health Professionals		
Radio		
Magazines		
Internet		
Newspapers		
Others**		

Question
Public Opinion about if treatment for T.B is necessary
Question
Is T.B a communicable disease.
Questionsion
Public opinion regarding the long treatment is the reason for default in T.B treatment

Characteristics Defaulter Non-Defaulter

- Sex
- Female
- Male
- HIV
- Negative
- Positive
- New
- Re-treatment
- Alcoholic
- Non-Alcoholic
- Employed
- Unemployed
- Age group (years)
- < 19
- 20 -39
- 40 -59
- >60
- Age ± SD (yrs)

Question	Frequency	Percentage
Opinion about the ways to prevent T.B		
A) Healthy Diet		
B) Avoid Alcohol		
C) Using Face Mask		

D) Drinking Boiled Water		
Question	YES	NO
Public opinion regarding the prolonged treatment and progressive slow cure rate being the reason for default		
Question	YES	NO
Public opinion regarding Govt. camapaigns and advertiments has role in reducing cases and default in T.B treatment		

References:

- *Andersen S (1962) Some aspects of the economics of tuberculosis in India. Indian Journal Tuberculosis.*
- *Balasubramanian VN, Oomme K & Samuel R (2000) DOT or not? Direct observation of anti-tuberculosis treatment and patient outcomes, Kerala state, India. International Journal of Tuberculosis Lung Disease*
- *Banerji D & Andersen S (1963) A sociological study of awareness of symptoms among persons with pulmonary tuberculosis. Bulletin World Health Organisation*