Home > Enabling Female Health Workers to Identify Tuberculosis

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Afghanistan is one of the most high burden tuberculosis (TB) countries in the world. TB affects women there two times more than men (female/male ratio is 2:1), and this is a unique phenomenon in the world. According to the National TB Control Program, in 2009, there were 26,358 TB cases diagnosed 17,044 (65%) of them were female. However, female health workers were not originally trained on TB case detection, diagnosis, and treatment so they were unable to help provide treatment within their own communities. Considering Afghanistan's cultural sensitivity, female clients prefer to be visited by female health workers and most women avoid visiting male health workers. Most female clients were left un-screened for TB because the female health workers at clinics were not trained on TB case detection, diagnosis, and treatment.

The US Agency for International Development (USAID) TB Control Program (TB CAP) [1], with support from Management Sciences for Health (MSH), trained 475 female health workers from nine provinces from October 2010 to March 2011. They were trained on TB case identification, referral to DOTS (Directly Observed Treatment Short course, the internationally recommended strategy for TB control) room and lab room for sputum smear collection, examination, treatment initiation, and counseling. This training increased the knowledge of female health workers and enabled them to help identify TB cases that had been missed prior to the training.

Sima, a female doctor, had been working for Bibi Aina Clinic for four years before she was trained on TB case detection diagnosis and treatment in December 2010 by TB CAP. She applied the new knowledge from the TB CAP training by sharing with community health workers (CHWs) and community health supervisors (CHS). She trained 18 female and 19 male CHWs in December 2010. Sima referred 64 TB suspects in the subsequent quarter of 2011, of them 1 patient was diagnosed with an active form of pulmonary TB. She said,"I am satisfied with the new knowledge I got during the training and I am practicing it during my day-to-day interaction with female clients. I am pleased it has assisted me to identify TB patients correctly and get clients appropriate care."

TB CAP aims to decrease morbidity and mortality by increasing case detection and treatment success of pulmonary TB patients in USAID priority countries. Within TB CAP, MSH makes a

unique contribution by addressing constraints such as poor management and lack of sustainable leadership, weak laboratory services and failure of drug supplies, inconsistent drug quality and inadequate drug policies, lack of information systems, weak monitoring and evaluation, and overwhelmed health systems. MSH helps TB CAP by aiding in the development and implementation of the International Standards for Tuberculosis Care TB control, guidelines for TB control in prisons, and institutional capacity building.

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Links
[1] http://www.msh.org/global-presence/tb-cap.cfm