

A Dissertation
on

**A study on Health seeking behaviour of Kala Azar patient :
Health Providers and Patients Perspective**

In
CARE India

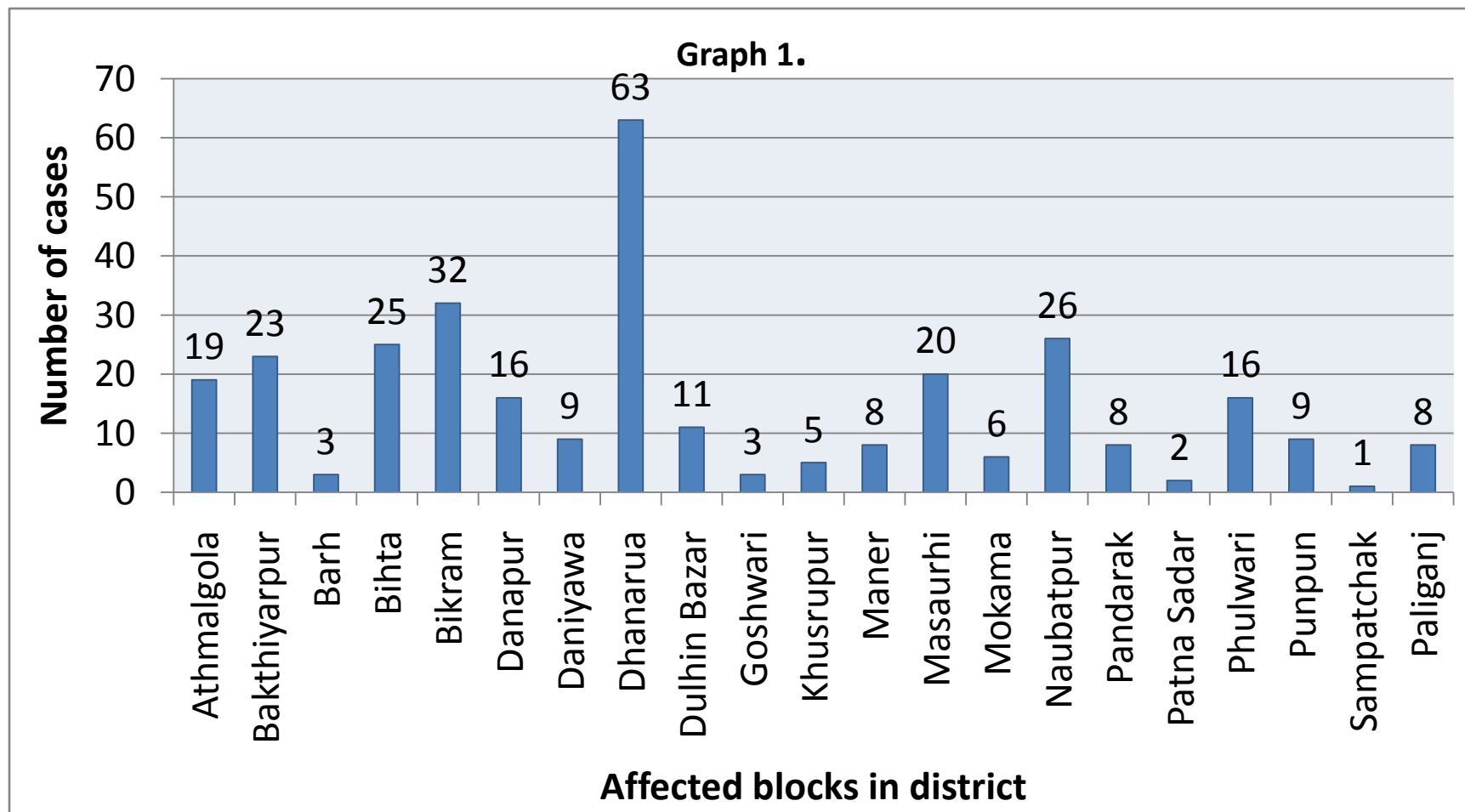
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Literature review.

- Joshi (2008) cited that out of total cases of KA reported in India annually, 90% comes from Bihar alone. Focal and sporadic cases of KA have been occurring regularly in many districts of Bihar since 1977.¹
- Kumar Narendra *et al* (2011) mentioned that presence of kala-azar cases in the family might aid the transmission of this disease in the presence of sand fly vectors and other conditions favorable for completion of transmission cycle within the house.²
- Sundar et al (2008) showed a clear need to revise control approaches if early and more exhaustive case detection is to be achieved. Waiting in poorly attended public health clinics will not bring disease spread to a halt. There is a need for a much more active approach, and it will need to consider the available human resources that could potentially be mobilized for the effort.³

Block wise KA cases in Patna



Rationale of study

- Patna , having its 21 district affected by Kala Azar out of 23.
- Treatment and program awareness.
- Patients attitude toward facility

Research Questions

- What all services are being provided by health facilities under KA program?
- What are the perspective of health providers for KA and its patients?
- What are the treatment seeking behavior of Kala Azar patients? If there are defaulters, what are the related reasons?

Objectives

- To study the type of services being provided under the Kala Azar Program.
- To study the attitude and practice of health providers towards Kala Azar.
- To know the health seeking behavior of patients.
- To identify the defaulters and the reasons behind defaulter's non compliance for the treatment.

Methodology

- **Study area**

Dhanarua block in Patna district, highest among the 21 block affected by KA

- **Study duration-** 3 months (15th February – 15th May'2014)

Methodology cont'd.....

Sampling

- Selection of blocks – purposive sampling
- Selection of HSC – stratification by endemicity.
- Selection of villages (2/HSC) – simple random sampling
- Sample Size – collected from 7 villages

Health Providers

Respondents	Sample
Medical officer in-charge	1
ANM	4
ASHA	7 (one ASHA not in position)

Methodology Cont'd...

- **Patients**

From the line list of patients, the sample selected was 54.

Additional 13 cases were identified during field visit, whose name were not in the list, hence sample size increased to 67.

But interview could only be conducted for 52 patients.

Respondents	Sample
KA Patients / Relative/ Immediate care taker	67

Methodology Cont'd...

Data collection tools and techniques

- Both qualitative and quantitative methods of data collection were used.

Qualitative data

- Discussion guidelines for in-depth Interview with Medical officer, ANM and ASHA .
- Observations – Non-participant observation

Quantitative data

- Face to face interviews with KA patients using Semi-structured interview schedule.

Analysis approach

- The collected data was analyzed using SPSS 16 package. The data was edited and coded.
- Uni-variant analysis - form of frequency and percentage by tables and graphs.
- Bi-variant analysis – 2*2 contingency tables.
- Test of significance – Chi-square test, to see the association.

Findings

Qualitative Study

Supply side “health providers”

Analysis Result

1. Government programmes for KA.

- Diagnostic services
- Drug availability at PHC
- Khoj camp
- IRS round
- Incentives for Patients and ASHA
- Referral services

*(None of ANM were knowing about the Khoj camp and the drug name also
Not a single ASHA have not got incentive)*

2. Factors contributing for occurrence of KA

- All the ASHA and ANM were aware of the vector causing KA
- Maximum of the respondents mentioned about the
 - Unhygienic living condition
 - Migration
 - Illiteracy and poverty
 - Less awareness about KA

3. Socio-demographic Characteristic :

- Disease affect almost all the age groups.
- Mushar and Manjhi community are the most affected caste group due to their practices and local culture.
- No relation with any type of occupation.

4. Community behaviour and gender Discrimination :

- No stigma attached with KA.
- No gender discrimination , female gets full support treatment by family members.
- Only issue that was high lighted was “ *as they have to look after family and other works , hence they delay few days for seeking health advice*”

5. IEC/BCC activities and IRS spray

- Lack in IEC activities, lead in refusal from community for spraying.
- Medical officer in charge mentioned that the *“bridge between flow of information to community can be reduced by an active play by ASHAs as the funds available are not much for miking to be done every day before Khoj camp or IRS round.”*
- For complete eradication, the ASHAs and ANMs mentioned community awareness about KA through
 - Nukkad Nataks
 - IPC
 - Electronic media

Finding
Quantitative Data
“Demand side”

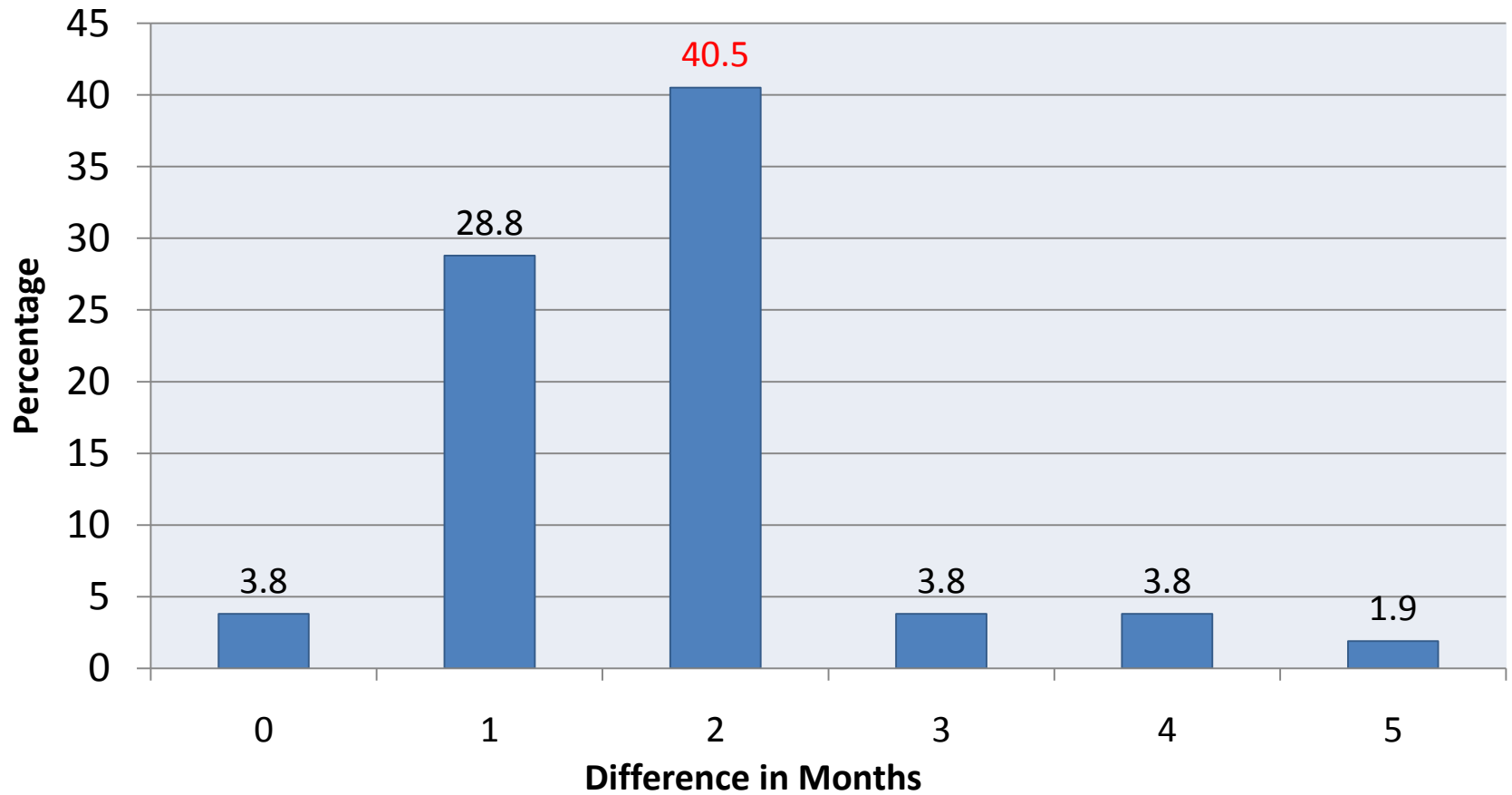
Background characteristics of patients

- When analysed about the occupation of the respondents family. Maximum, with 33% of response came for Farm Labour and 31% from those who do seasonal work in different jobs.
- Around 98% respondents were Hindu by Religion 79% belonged to schedule caste maximum from Manjhi and Ravi Das.
- Number of Dead Patients

Total Respondents	52
Alive respondents	94 %
Death	6 %

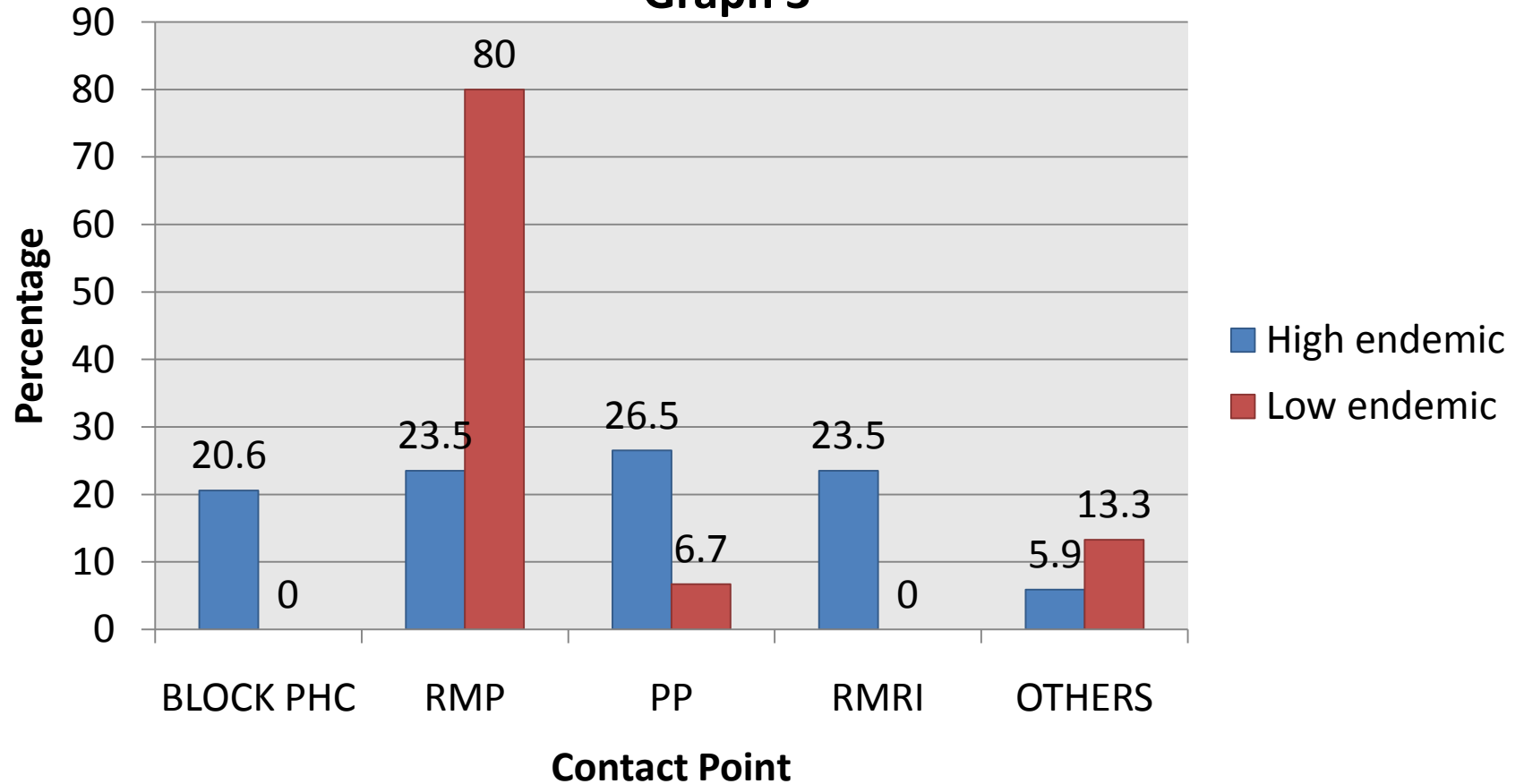
Delay in diagnosis

Graph 2



First point of contact by endemic zone

Graph 3

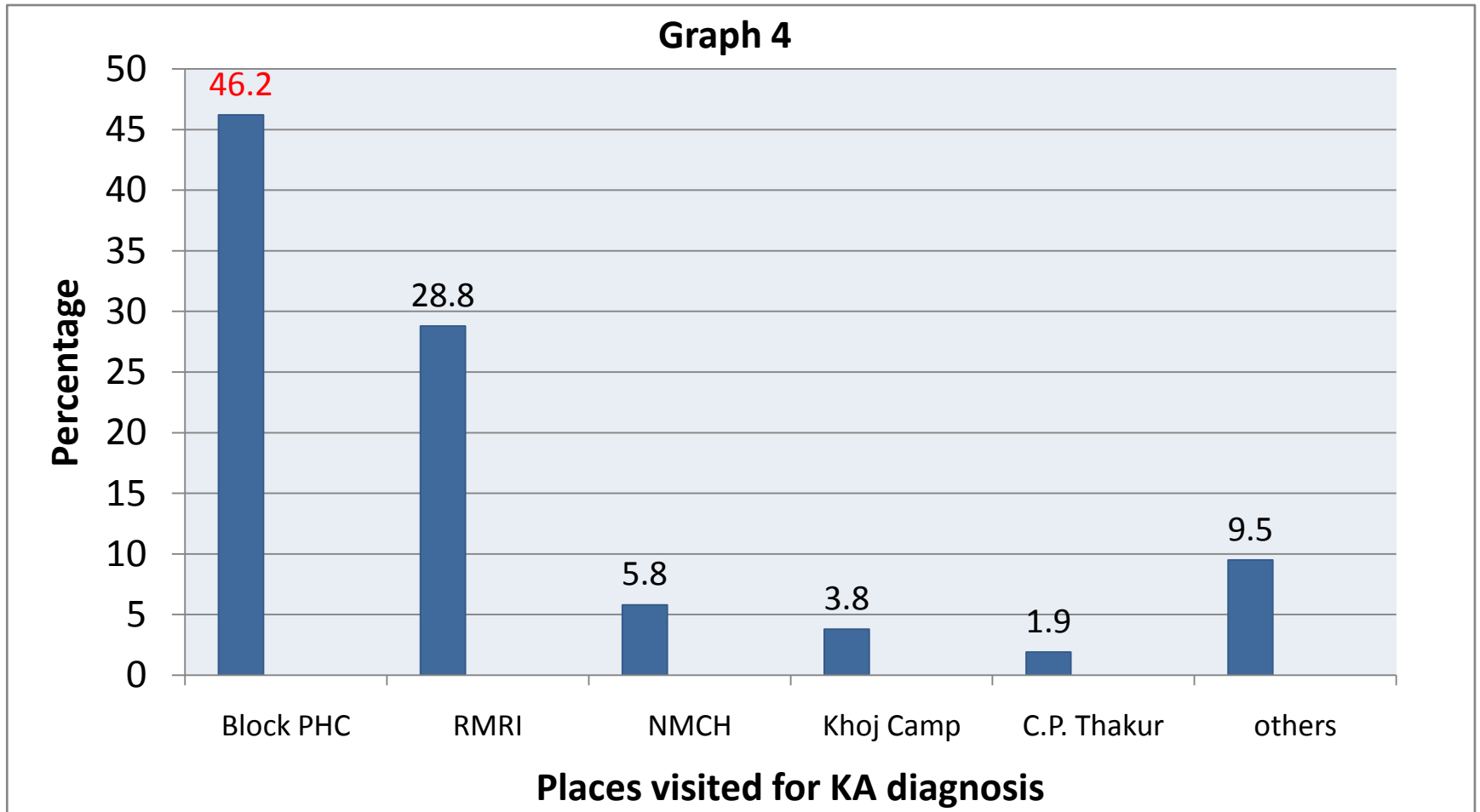


Type of facility/ providers Zone wise division	PHC	RMP	Private Practitioners	RMRI	Others	Total Number	P value
High endemic	20.6	23.5	26.5	23.5	5.9	34	0.002
Low endemic	0.0	80.0	6.7	0.0	13.3	15	
Total	7	20	10	8	4	49	

Reason for not preferring PHC as first health care

- Not being aware of availability of medicine at PHC.
- Don't inform ASHA about their illness.
- Directly go to PP or RMRI.

Places of diagnosis

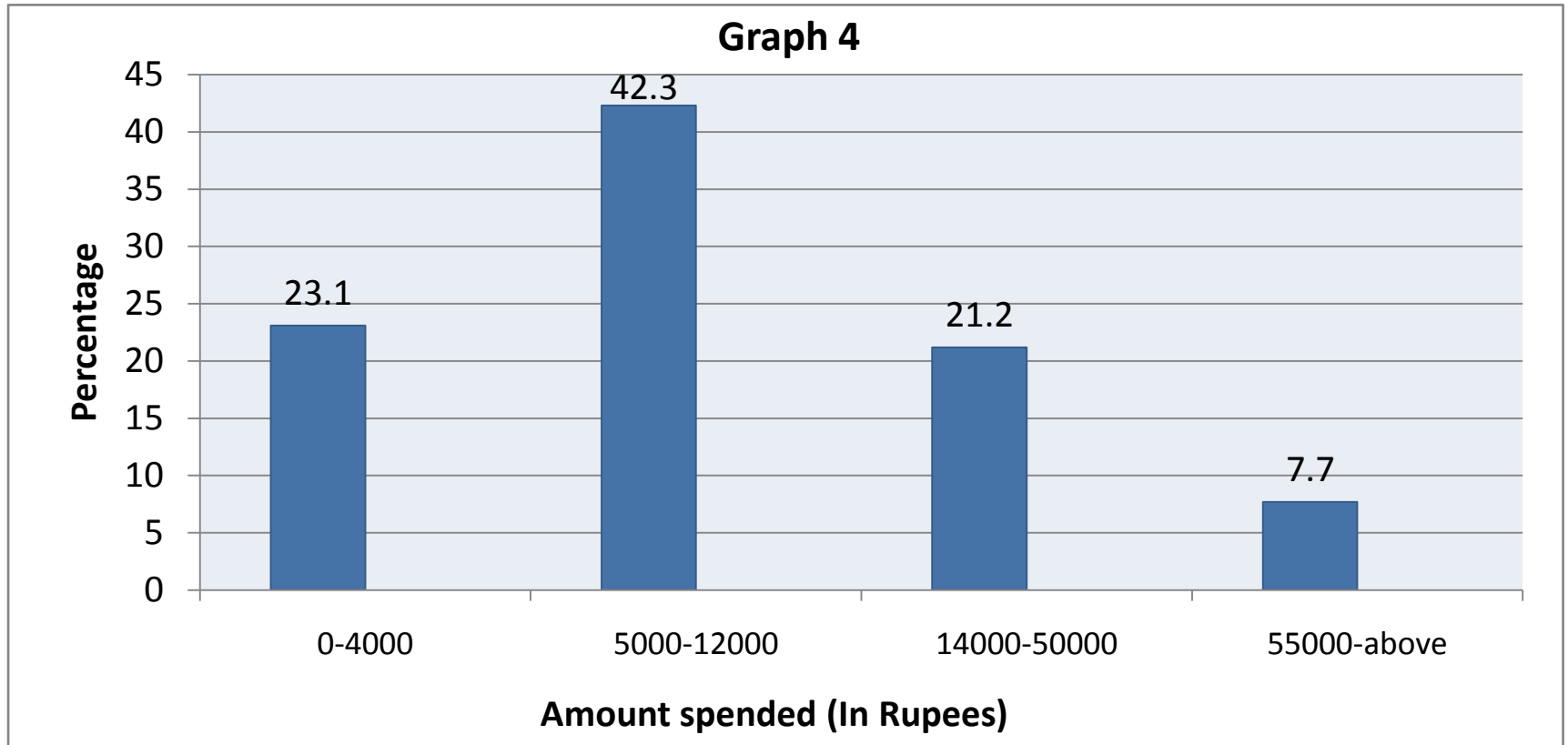


Reasons for diagnosis at PHC

- First has contact RMPs/Private practitioners, when these providers are unable to the patient(s) .
- If prolonged fever/left with no money for further treatment/ in debt .

As stated by one of the ASHA “ *they call as only after they have experienced failure in treatment from other facilities* ”

Out of pocket expenditure on treatment



The expense include transportation, fee for consultancy, medicines, on attendant.

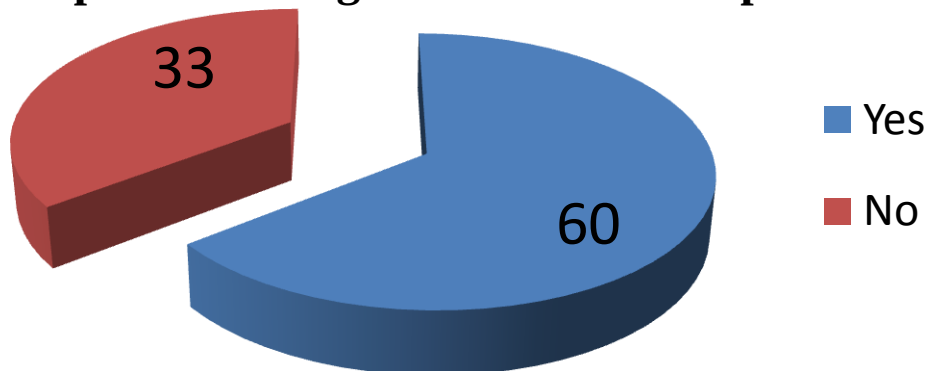
Rate of Defaulter and follow up services

	Total
Patient completed treatment	94%
Defaulters	6%

Reason for defaulter

1. Did not went to PHC for taking next dose.
2. Not got medicine from PHC.
3. Not getting well in spite of taking medicine, hence stopped the course in between.

Graph 5: percentage distribution of patients being called for follow up



Out of the 60% those who were called up for follow, none of them turned up

Community level control program (IRS)

- Only 81% of respondent had their house sprayed last round, where there are partial spray also.

As responded by ASHAs “ *The community does not allow spray to be done because of the bad smell and spots on the wall*”.

Asking about the same from respondents they said “*the mosquitoes number rather increase after spray.*”

- 24 % response came for IRS is done for Kala Azar
- 91% did not see or hear of any pre IRS information by any IEC man other than ASHA.

Conclusions

- ASHA and ANMs are having sound knowledge about diagnosis, but due to the incentives issue they are not putting the program in the priority.
- Diagnosis is mostly done at PHC, but its not the first point for seeking health care.
- There is association between type of endemic zone and first point of contact for health seeking.
- Less rate of defaulters.
- Out of expenditure, even after the provision of free diagnosis and treatment at PHC and RMRI.
- Partial and refusal cases need to be reduced for complete coverage and eradication.

A way forward.....

- Supply side:
 - From the point of service delivery stock maintenance of diagnostic kit and medicine must be available at PHC so that patients don't leave the treatment in between due to unavailability of medicines at PHC.
 - Timely incentives to ASHA for case diagnosis and treatment completion and for patients against the wage loss.
 - Re line listing can be done as many patients were found not register in line listing , this will reflect the real case load which can improve the programmatic approach.

- Involvement of MoIC in patients counselling or monitoring the IRS round.
- **Demand side:**
- Improving the knowledge of community by means it could be easily understood by them.
- Community program in all villages for awareness regarding the program components.

Limitation

- Due to season of crop cutting many of the respondents were not available during the time of interview. This reduces the sample size at time of interview.

References

1. Bora D. Epidemiology of visceral leishmaniasis in India, The National Journal of India 1999 Vol 12:62.3
2. Kumar Narendra, how do health care providers deal with Kala Azar in the Indian subcontinent, Indian J Med Res 134, Sep 2011.4
3. Sundar S, Mondal D, Rijal S, Bhattacharya S, Ghalib H, Kroeger A, *et al.* Implementation research to support the initiative on the elimination of Kala Azar from Bangladesh, India and Nepal - the challenges for diagnosis and treatment. *Trop Med Int Health* 2008; 13: 2-5.

The background of the slide is a dense, repeating pattern of small, light blue water droplets. Each droplet is rendered with a soft highlight and shadow, giving it a three-dimensional appearance. The droplets are scattered across the entire frame, creating a textured, refreshing visual effect.

Thank You