

TREATMENT SEEKING BEHAVIOUR AMONG THE CASES OF EYE DISEASE IN THE RURAL AREAS OF ALLAHABAD DISTRICT

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ABSTRACT:

Research question : *What various types of health facilities are present in the specified rural areas and treatment seeking behaviour of cases of eye diseases in that area.*

Objectives :

To access the effect of the treatment seeking behaviour of the cases and outcome of the treatment.

Study Design : *Cross sectional study design.*

Settings : *Households of the village of Allahabad district.*

Methods : *A total of eight villages were selected from the two blocks namely Jasra and Saidabad with the help of multistage random sampling technique.*

Result : *Out of total 931 cases of eye disease a maximum of 56.07% did not go anywhere for treatment. Amongst the remaining 20.84% cases went to PHCs/ CHCs/ district hospitals and 11.82% cases went to general practitioners for treatment. Out of total 409 cases who sought treatment, a maximum of 95.11% has taken Allopathic treatment followed by 1.96% cases who had taken Ayurvedic treatment. Various practices like jhad phoonk, kajal surma were followed by 1.47% cases, 1.22% cases sought Homeopathic treatment: while 0.24% went to Unani doctor.*

Key words : *Eys diseases, cataract surgery, treatment seeking behaviour.*

Introduction :

Indian has 8.9 million blind out of 45 million blind present in the world. But the economically blind according to the National health Surveys conducted in 1971-74 by Indian Council of Medical Research (ICMR) are 1.38% and according to **National Programme for Control of Blindness /WHO survey (NPCB/WHO 1986-89)** 1.49%. Major economically blinding conditions are cataract (80.1%), refractive errors (7.35%), corneal scar (4%), trachoma (0.39%), glaucoma (2%), Vitamin A deficiency (1%), and other rare causes (5%), Blindness due to smallpox, trachoma and Vitamin A deficiency have gone

down remarkably. With socioeconomic development and improvement of personal hygiene the incidence of infections has come down, although the prevalence of blindness has increased from 1.3% in 1971 to 1.49% in 1986. High prevalence has been observed in Andhra Pradesh, Bihar, Madhya Pradesh, Uttar Pradesh, Maharashtra and Tamil Nadu. These states contribute nearly two-third cases of blindness in India. The blindness due to cataract has increased from 55% (1971) to 81% (1986). It is observed that blindness is more common in rural than urban areas, more in females than in males, and more amongst the poor than rich. Incurable blindness is just 10% of the total.

Aims and objective :

The present study was conducted in the rural areas of Allahabad district with the following aims and objectives:-

1. To study the treatment seeking behaviour of community for eye care.
2. To access the outcome of the treatment sought by the cases.
3. To suggest some preventive measure for early diagnosis and treatment for proper eye care.

Material and methods :

The present study was conducted in the Department of Community Medicine, M. L.N. Medical College Allahabad district. Cross sectional study design was adopted in the present study. A multistage random sampling technique was adopted to select the study subjects. At the first stage a sample of two blocks out of total blocks of Allahabad district was drawn at random. A block was covered by Community Health Centre or Primary Health Centre in the district. Within each selected first stage unit that was the block a sample of two PHCs or new PHCs was drawn randomly as second stage units. From each selected second stage unit, one Sub Centre was selected in order to have a sample of four sub centres as third stage units. From each selected Sub Centre, a sample of two villages was drawn. In this way a sample of eight villages was available as fourth stage units. All members in the selected households were surveyed and comprised study unit in the present study. Optimal sample size was calculated on the basis of pilot survey results where in about 75% households has the cases of eye diseases. Based on this the sample size was obtained to be 750 households using the following formula ($n_{opt} = 4p(1-p)/L^2$)

Observations :

Table 1 shows distribution of eye diseases by socioeconomic status of the cases. The highest number of 399(42.86%) cases of eye diseases was observed in socioeconomic class V and successively followed by 244 (26.21%) cases of the class IV, 167 (17.94%) cases of the class III, 95 (10.20%) cases of Class II and the lowest 26(2.79) cases was of class I. A similar pattern was also observed for individual diseases of eyes. Out of total cases of cataract, 152 (38.97%) were belonging to class V and 9 (2.31%) to class I.

The treatment seeking behaviour of persons with eye problems in the present study observed maximum of 522 (56.07%) did not go any where for treatment. Amongst the remaining 194 (20.84%) cases went to PHCs / CHCs, / district hospitals and 110 (11.82%) cases went to general practitioners. Only 59 (6.34%) of persons went to specialized hospitals.

Regarding the treatment of eye diseases, out of total 409 cases, a maximum of 389 (95.11%) had taken allopathic treatment followed by 8(1.96%) cases who had taken Ayurvedic treatment. Various practices like jhad phoonk, kajal and surma were followed by 6(1.47%) cases, 5(1.22%) cases sought Homeopathic treatment while a single case (0.24) went to Unani doctor (Table 2).

Table 3 shows the outcome of the treatment among the cases who had taken any type of treatment. Out of total cases, 139(35.64%) had got only, symptomatic relief followed by 111(27.14%) cases who had recovered completely. there were 106 (25.92%) cases who told that there was no improvement from the treatment, while 53 (12.96%) cases told that they had got only partial relief by the treatment.

Table 1
DISTRIBUTION OF EYE DISEASES BY SOCIOECONOMIC STATUS

| Diseases of eye | Class I | Class II | Class III | Class IV | Class V | Total (%) |
|---------------------------|----------|-----------|------------|------------|------------|------------|
| | No.(%) | No. (%) | No.(%) | No.(%) | No. (%) | |
| Cataract/ Aphakia | 9(2.31) | 46(11.79) | 76(19.49) | 107(27.44) | 152(38.97) | 390(41.89) |
| Refractive errors | 6(2.99) | 24(11.94) | 48(23.88) | 61(30.35) | 62(30.85) | 201(21.59) |
| Glaucoma | 2(4.44) | 5(11.11) | 8(17.78) | 11(24.44) | 19(42.22) | 45(4.83) |
| Infective diseases of eye | 1(2.27) | 2(4.55) | 7(15.91) | 6(13.64) | 28(63.64) | 44(4.73) |
| Xerophthalmia | 0(0.00) | 4(4.21) | 7(7.37) | 16(16.84) | 68(71.58) | 95(10.20) |
| Uveitis | 0(0.00) | 2(6.67) | 2(6.67) | 5(16.67) | 21(70.00) | 30(3.22) |
| Corneal opacity | 4(9.52) | 4(9.52) | 7(16.67) | 10(23.81) | 17(40.48) | 42(4.51) |
| Others | 4(4.76) | 8(9.52) | 12(14.29) | 28(33.33) | 32(38.10) | 84(9.02) |
| Total | 26(2.79) | 95(10.20) | 167(17.94) | 244(26.21) | 399(42.86) | 931(100) |

Table 2
TYPES OF TREATMENT SOUGHT

| Types of treatment | No. of cases | Percentage |
|-----------------------------------|--------------|------------|
| Allopathic | 389 | 95.11 |
| Ayurvedic | 8 | 1.96 |
| Homeopathic | 5 | 1.22 |
| Unani | 1 | 0.24 |
| Others (Surma, Kajal Jhad phoonk) | 6 | 1.47 |
| Total | 409 | 100 |

Table 3
OUTCOME AFTER TREATMENT

| Outcome after treatment | No. of cases | Percentage |
|-------------------------|--------------|------------|
| Full recovery | 111 | 27.14 |
| Partial recovery | 53 | 12.96 |
| Only symptomatic relief | 139 | 35.64 |
| No improvement | 106 | 25.92 |
| Total | 409 | 100 |

$\chi^2=37.81662$ df-3 (>7.82 the tab. Value at 5% level of significance³), $p<0.0001$

Discussion :

The present study has shown a gradual rise in the prevalence of ocular morbidity from high socioeconomic class to low socioeconomic class e.g. 26(2.79%) cases among class I, 95 (10.20%) cases among class II, 167 (17.94%) cases among Class III, 244(26.21%) cases among Class IV, 399 (42.86%) cases among class V, and the similar trend has been seen for individual eye diseases i.e. cataract, refractive errors, Glaucoma, Infections, Xerophthalmia, Uveitis, Corneal Opacity and others.

Sharma et al have observed similar findings in year 1962. They have observed a close correlation between the prevalence, incidence of ocular problems and socio-economic status. It was seen that there was a gradual rise in the prevalence with the lowering of socio-economic status. The rates were 5.67% and 5.1% for class V and IV respectively as compared to 2.8%, 3.7%, and 4.3% for class I, II, III respectively.

Similarly in the study of O.P. Pandey (1983), the prevalence rate was highest amongst social class IV (70.9%) and lowest in social class III and I being 47.38% and 47.8%

respectively.

The treatment seeking behaviour of persons with eye problems in the present study observed maximum of 522 (56.07%) did not go anywhere for treatment. Amongst the remaining 194 (20.84%) cases went to PHCs/CHCs/ district hospitals and 110 (11.82%) cases went to general practitioners. Only 59 (6.34%) of persons went to specialized hospitals. Among those (409 cases) who have sought any treatment, a maximum of 389(95.11%) had taken Allopathic treatment followed by 8 (1.96%) cases who had taken Ayurvedic treatment. Various practices like jhad phoonk, kajal and surma were followed by 6(1.47%) cases, 5(1.22%) cases sought Homeopathic treatment while a single case (0.24) went to Unani doctor (Table 2).

Similarly Agarwal A.K. et al (1996), after reviewing 100 patients with advance stage glaucoma in the hospital setup, observed that majority of patients (70%) did not know that they were suffering from the eye disease as they never sought any ophthalmic consultation, only 30% patients knew their disease but had poor knowledge regarding course and severity of

their disease. Agarwal A.K. et al (1996), after reviewing 100 patients with advance stage glaucoma in the hospital setup, showed that 70% patients never sought any ophthalmic consultation the reasons for neglect were, 20% got treatment by quacks, 15% had some preserved vision in affected eye or other eye, 15% were inaccessible to hospitals, 10% negligence was due to poverty and 10% due to illiteracy. And only 30% patients sought ophthalmic consultation.

Conclusion and Recommendation :

The study area have well organized primary health care and health care delivery system nearby but due to unawareness of the locale it is not good enough for them to get all types of facility for their ocular health. On basis of the present study the following suggestions can be given to the local health personnel like Aganwari Workers to bring awareness in the community for proper cleanliness and hygiene i.e. the eyes should be washed with clean water and should be wiped with clean towel and should avoid exposure of eyes to household smoke and dust as much as possible. The local health personnel to suggest the parents of

children that for the safety of eyes, their children should be allowed to play only with blunt objects and avoid bows and arrows, gulli danda and such activities.

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