Assessment of Counseling Skill of DOT Providers with A View to Prepare A Counseling Teaching Plan

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ABSTRACT *Tuberculosis is a public health challenge around the world. Under RNTCP, the DOTS agent is trained in case management and counseling to motivate clients to complete treatment and be cured of TB. This study aims to assess the counseling skills of DOTS providers and to identify gaps in counseling skills.A descriptive study design was adopted and the counseling skills of fifty DOTS providers were assessed by a counseling skill observation checklist. The results showed that the counseling skill scores of the DOTS providers ranged from 6-17 (max score: 20) with a mean score of 10.76 + 3.01. None of the DOTS providers had excellent level of counseling skill scores and only few (6%) had good counseling skill scores.*

Introduction :

Tuberculosis is one of the six killer diseases in India. According to WHO report 2012, worldwide 8.6 million people were infected with TB and 1.3 million people died due to TB[1]. India accounts for nearly 1/5th of the global burden of tuberculosis with about 2.2 million new cases every year[2]. Tuberculosis is a chronic disease and has the potential to take on a 'life form of its' own'. The disease weakens the client and lowers their potential to work which adds on to the financial burden of the family. A sense of prior independence takes a toll on one's self-esteem, self-worth and self-image. As a result of increased dependency there are emotions around the loss of status, power and control that overwhelms a once healthy, capable and functioning individual. There can be stigma associated with the disease and compounding all of these is the blame imposed on the self for having contacted the disease. In addition to trying to manage the actual illness on a daily basis, the profound nature of these emotional consequences not surprisingly can lead to feelings of helplessness and hopelessness[3]. Learning ways to take charge of self and having a positive outlook to treatment and health care creates a sense of well-being. This transcends the grasp that the illness has had on the affected person, one's attitudes and approach to life. This in turns improves life quality.

Counseling is a key component in any health care intervention. Counseling informs the client of the seriousness of the disease, motivates the client of the necessity of health intervention and guides the client to make the right choices in treatment. In tuberculosis disease, counseling by the Directly Observed Treatment Short term (DOTS) provider plays a vital role as tuberculosis still remains a major public health challenge in the world. The Revised National tuberculosis control programme trains DOTS providers to be competent in handling every TB case so as to eliminate TB as a public health problem. This study thus focuses on the assessment of counseling skills of DOTS providers so as to identify gaps in training. This would aid in preparation of a counseling teaching plan for the DOTS providers. However tuberculosis is both preventable and curable.

Review of literature:

A case control study was conducted in Nepal to determine the association of professional –patient interaction in DOTS. Sample consisted of 50 cases (non-adherents) and 100 controls (adherents). The participation rate was 80% for 50 cases and 95% for 100 controls. All covariates with p-value ≤ 0.2 were included in a multivariate logistic regression model to identify the factors significantly associated with treatment non-adherence. The re-

sults revealed that poor-grade communication (OR = 11.2; CI 2.5–50.4) and fair-grade communication (OR = 2.7; CI 1.2–6.3) between patients and dispensers were significantly associated with non-adherence. The study suggested that better communication between health professionals, particularly dispensers, and patients are essential for improving treatment adherence in TB treatment, even under DOTS[4].

A study was conducted in Bangalore city to identify socio-demographic and treatment related risk factors predictive of default with DOT. A cohort of 264 new (CAT I) and 219 retreatment (CAT II) bacteriological positive patients treated under DOTS were selected. Data collection was through interviews at treatment initiation and at treatment outcome using pre-tested semi-structured interview schedules. Defaults were 25% and 45% in CAT I & CAT II respectively. The predictive factors associated with default identified through multivariate logistic regression were male (Adjusted Odds Ratio (AOR) =2.49(1.10-6.18)-CAT I, 2.78(1.15-6.7)-Cat II) and alcoholism (AOR=6.38 (3.25-12.5)-CAT I, 3.93 (2.1-7.5)-Cat II). Majority (CAT I =65.7%, CAT II =71%) of the patients defaulted in the Intensive Phase particularly after the 12th dose. Those returning for treatment after default and having poor knowledge of disease were additional risk factors among retreatment patients. The study concluded that DOTS providers should pay more attention to those at potential risk of default from the initiation of treatment with close supervision and repeated counseling. This would be a major input to minimize defaults and achieve desired goal of RNTCP[5].

A cross sectional survey was done to assess the knowledge, attitude, and practices of private health care providers in Kibera Slum, Nairobi to identify their training needs. The KAP of PHP's was assessed using an interview administered questionnaire. The results revealed that out of 75 primary health care practitioners interviewed, majority (96%) were paramedics, 51(77.1%) did not consider sputum smear microscopy in patients presenting with prolonged cough or when a chest X-ray was suggested of TB , of 29(38.7%) who indicated familiarity with the drugs used in TB treatment, 20(58.5%) would have chosen the NLTP-recommended regimen for the treatment of the various types of TB;16(21.3%)PHP's indicated that they treated TB , six (37.5%) of whom were not familiar with anti-tuberculosis drug regimen. All the PHP;s referred TB suspects to the public sector for diagnosis. Thus there reveals a significant gap in TB knowledge among the PHP;s in Kiberia slum. The study identified gaps in the implementation of DOTS and suggested that DOTS would be implemented better with adequate training to the health care provid-

ers[6].

Objectives:
1. To assess the counseling skills of DOTS providers on TB and its related QOL as measured by a counseling skill assessment checklist.
2. To find the association of mean counseling skill score of DOTS providers with selected baseline variables.

Methodology:
Setting:
The study was conducted in selected DOTS centers at Mangalore, South Karnataka.

Population:
DOTS providers posted at DOTS centers which includes DOTS clinics attached to hospitals, PHC's and anganwadi units.

Sample size:
50 DOTS providers

Sampling technique:
Purposive sampling.

Research Design:
Descriptive survey.

Tools:
Baseline Performa with 9 items

Counseling skill observation checklist with 20 items. This instrument was developed to cover the role of the counseller in the four phases of a regular counseling session i.e, orientation (5items) identification (9 items), exploitation (3 items) and termination (3 items).

The tools were validated by five experts. The tool was tested for its reliability. The coefficient of reliability (inter-rater) obtained was 0.8772 (calculated by using SPSS 11.5 Version).

Data collection Procedure: Permission for the study and ethical clearance was obtained before the start of the study. Data collection was done at the DOTS center by non participant observation with concealment. The investigator sat unobtrusively at a small distance and observed the counseling between the DOTS client and DOTS provider. The findings were marked in the observational checklist and were analyzed by SPSS 16.0 software.

Data Analysis:
The baseline performa of the DOTS provider was analysed in terms of frequency and percentages. This showed that majority (48%) of the DOT providers were in the age group of 38-40 years and only two percentage of the sample were between 51-60 years. Maximum number (48%) of the DOTS providers were females. An equal percentage (36%) of the DOT providers studied uptil SSLC/PUC. Majority (78%) of the DOT provider were married. Highest number (36%) had less than one year experience in DOTS and only 24% had more than five years of experience. Most (58%) of the DOT providers attended to less than 10 patients in the past one year.

Description of counseling skill scores of DOTS providers.
Findings revealed that counseling skill scores of the DOTS providers ranged from 6-17 (max score: 20) with a mean score of 10.76 ± 3.01. It was also evident that that none of the DOTS providers had excellent level of counseling skill scores and only few (6%) had good counseling skill scores. Majority (88%) of the DOTS providers had poor level of skill (<15).

Table 1: Distribution of the DOTS providers as per their level of skill in counseling.

N=50

Level of Skill	Range of scores	f	%
Excellent	18-20	-	-
Good	15-17	6	12
Poor	<15	44	88

Max score: 20

It was evident that DOT providers had better skill in the orientation phase of the counseling session (mean percentage 70%) and had lesser skill in the exploitation and termination phase of counseling sessions (33.33% each).

Table 2: Areawise Mean , SD and mean percentage of the counseling skill scores of DOTS providers.

N=50

Content	Max Score	Mean	SD	Mean %
Orientation phase	5	3.5	1.2	70.0
Identification phase	9	4.0	2.4	44.4
Exploitation phase	3	1.0	1.0	33.3
Termination phase	3	1.0	1.0	33.3

Max Score: 20

Association of mean counseling skill score of DOT provider with selected baseline variables (table 3) revealed that there was no significant association of DOT providers skill with baseline variables like age ($\chi2$=0.56), gender($\chi2$=0.76), religion ($\chi2$=0.61), educational status ($\chi2$=0.37), marital status ($\chi2$=0.46), years of experience ($\chi2$=0.40) and average number of clients attended to ($\chi2$=0.81) as the calculated value was lesser than the tabled value at 0.05 level of significance.

Discussion:
The present study revealed that majority (88%) of DOTS providers had poor counseling skill scores. Only six percent had good counseling skill scores. Contrasting findings were found in a study conducted in Malawi, Madhya Pradesh (2012) where it was found that 56.9% of health care provider had basic skills in counseling[7]. In this study, majority (98%) of DOT providers were females. This finding is similar to a study conducted in Patiala (2012), where 74% of the DOT providers were females[8]. There was no significant association of counseling skills score of DOT providers with baseline variables such age, gender, educational status, marital status, years of experience and average number of clients attended to. These findings were contrast to the findings of a study conducted in Ujjain where good knowledge was significantly associated with age, education and job experience[9].

Conclusion:
In general the study proves that the DOTS providers skills in counseling has to be improved.

Recommendations:
In service training to the DOTS providers on counseling and soft skill training would enhance the capacity of the DOTS providers to counsel clients with tuberculosis.

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