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Factors contributions to delay in diagnosis of pulm,onary tuberculosis patients after care seeking in the District of Anuaradhapura Sri Lanka
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Tuberculosis remains as a public health problem since ancient times. Delay in diagnosis of pulmonary tuberculosis can bring harmful consequences not only to the patients but also to the community. This study aims to identify the factors contributing to the delay in diagnosis since care seeking in the district of Anuradhapura. This is a descriptive study conducted at the main chest clinic and branch chest clinics located in Anurildhapura district. Study population composed of non-institutionalized pulmonary TB patients aged more than is years old. During the study period, it \\as possible to recruit 134 eligible subjects. An interviewer administered questionnaire \Vas used for data collection. The information obtained \\as cross checked \\ith available medical records. Mean age of the patients studied was 46-.4 years (SD = 1-.+ 0) ;lnd i.lhl)ut 60 percent of patients interviewed were in the economically active age group (ie 26 tel 55 years) Out of the patients studied 79 percent were males, 87 percent were Sinhalese, and 86 percent resided outside city limits. About 43 percent of patients had only primary education and 86 percent were unemployed or unskilled. Median health care provider delay for pulmonary TB patients studied was 36 days (mean 52 days). Out of the patients studied, 84 percent of patients (n ~c 112) experienced longer provider delay (10 days). Age (chi-squire =: 3.,14, df= 2, p 0.05), sex (chi-square = 1.19, df=: I, p 0.05 and OR =: 2.0, 95 percent CI: 0.7, 5.6), ethnicity (chi-square = 0.51, df = 1, p 0.05 and OR =: 0.6, 95 percent CI: 0.3, 1.8), occupation (chi-square =: 0.22, df = I, P 0.05), mode of referral (Chi-squ:ne =: 0.09 J, df =: 1, p 0.05), sputum negativity (Chi-square = 2.794, df =: I, P 00.5) '",,: smoking (Chi-square = 0.29, df = 2, r 005) and alcohol addiction (Chi-square =: 0.39, df =: 2, p 0.05) did not significantly associate with longer health care provider delay. There were also no statistically significant associations between provider delay and the type of symptoms present during first visit such as cough (Chi-square = 0.1 17, df = 1, p 0.05 and OR = 0.8), haemoptysis (Chi-square = 2.642. df= 1, p 005 and OR = 0.46) and fever (Chi-square = 0.704, df = I, p 0.05 and OR = 0.65). The main limitation of this study is the failure of recruiting adequate number of eligible subjects. I !however this was beyond control considering the number of patients registered in the study area over the years. Continuous medical education for health care providers. improvement of diagnostic facilities and establishment of a referral mechanism were S0rne of the strategies recommended to reduce the provider delay. Age (chi-squire =: 3.,14, df= 2, p 0.05), sex (chi-square = 1.19, df=: I, p 0.05 and OR =: 2.0, 95 percent CI: 0.7, 5.6), ethnicity (chi-square = 0.51, df = 1, p 0.05 and OR =: 0.6, 95 percent CI: 0.3, 1.8), occupation (chi-square =: 0.22, df = I, P 0.05), mode of referral (Chi-squ:ne =: 0.09 J, df =: 1, p 0.05), sputum negativity (Chi-square = 2.794, df =: I, P 00.5) '",,: smoking (Chi-square = 0.29, df = 2, r 005) and alcohol addiction (Chi-square =: 0.39, df =: 2, p 0.05) did not significantly associate with longer health care provider delay. There were also no statistically significant associations between provider delay and the type of symptoms present during first visit such

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