CHAPTER II

HEALTH SERVICES

a. Health Policy, Delivery of Health Services & Health Care

087

AU: Ukil AC
TI : Legislation and tuberculosis.
SO: All India Conference on Tuberculosis, 2nd, New Delhi, India, 20-23 Nov 1939 p. 216-223.
DT: CP
AB: This was a presentation made to the President and Chair of the TB Workers' Conference in British India, 1939. The presenter traced the history of the organized control of TB in many countries with reference to State legislation and, described the variations in laws passed and their impact on different aspects of the anti-TB efforts. The latter part of the presentation was focussed on legislation and TB in India. Defects in certain existing provincial laws were explained as also the negative impact of some of them on the patient and his/her family. It was considered premature to consider any comprehensive and useful TB legislation in India at the time before correcting existing provincial laws and recommendations were made to enforce laws concerning certain factors which promoted the spread of TB.
KEYWORDS: SOCIAL REFORMS; SOCIO-POLITICAL; SOCIAL ETHICS; INDIA.

088

AU: Banerji D
TI : Health problems and health practices in modern India: A historical interpretation.
SO: INDIAN PRACTITIONER 1964, 17, 137-143.
DT: Per
AB: In this paper an attempt is made to examine how the data from the history of medicine in India can help in formulating health programmes that deal with health problems as an integral part of the overall causation. India's 5000 years of history provides an enormous perspective of the nature of man's struggle against his environment starting from Indus Valley Civilization, the influence of Vedic Way of life of Buddhism, followed by frequent foreign invasions and general decline in the living standards of people. At the time of independence in 1947, India faced on one side, staggering problem of poverty, hunger, illiteracy, size in population and, on the other side, advantage of having ready made technological knowledge which could create effective weapons for dealing with these problems. An ecological analysis of the history of medicine in India shows an expansion of population due to availability of abundant resources, which meant an increase in prosperity and social development. Public health facilities of the city of Mohenjodaro were superior to all other communities of the ancient orient. Almost all households had bathrooms, latrines, often water closets and carefully built wells indicating the extent of health consciousness of ancient Indian people. During Ashokan period, there is existence of social medicine along the line of Buddhist ideology. Emperor Ashoka states that "all over his dominions and adjoining territories, medical

treatment is provided for men and animals". However, the radical changes that followed after the introduction of British rule dealt a fatal blow to the practice of the Indian System of Medicine. A shift to practical western medicine during Nineteenth and Twentieth centuries led to neglect of Indian medicine and further decline.

These historical data help in providing a better understanding of the genesis of the present situation and are also of immense importance for forecasting the pattern of health problems and health practices in the context of ecological changes that are expected to be brought about by other social development programmes, e.g., mechanisation of coal mining might influence the epidemiology of ankylostomiasis through better standard of living; conversely, effective ankylostomiasis programme may bring prosperity by increasing the productivity of the coal miners. This is known as Positive Circular cumulative causation phenomenon. Today, Indian society stands on the threshold of far reaching social, cultural and economic changes. Utilization of the scientific knowledge generated by Industrial Revolution for dealing with the health problem is essential for practicing modern medicine. A sound medical and public health programme must have a very sound infrastructure of overall social, cultural and economic development. In a natural process of social evolution, medical and public health services cannot grow without such an infrastructure. Even if it were hypothetically possible to create artificially (at an astronomical cost) efficient medical and public health services without correspondingly developing the infrastructure, the social benefits accruing from such services will be of doubtful significance. What benefits will a hypothetical 'disease free' state bring to a population that is otherwise ill fed, ill clad, and ill housed and illiterate?
KEYWORDS: HEALTH SERVICES; HEALTH CARE; INDIA.

089

AU: Banerji D
TI : India's National Tuberculosis Programme in relation to the proposed social and economic development plans.
SO: INDIAN J PUBLIC HEALTH 1965, 9, 103-106.
DT: Per
AB: It has been shown that most of the infectious TB cases in a rural community in south India are at least conscious of the symptoms of the disease; about three-fourths of them are worried about their sickness; and, about half of them actively seek treatment for their symptoms at rural medical institutions. The existing facilities deal with only a very small fraction of even these patients who are actively seeking treatment. India's NTP has been designed to mobilise the existing resources in order to offer suitable diagnostic and treatment services to those who already have a felt-need. India's health administrators have to initiate suitable administrative and organizational reorientation of existing services to satisfy these already existing felt needs. Simultaneous social and economic growth will help in developing the epidemiological strategy and the rise in living standard itself may have a significant impact in controlling TB.
KEYWORDS: SOCIO-POLITICAL; HEALTH CARE; INDIA.

090

AU: Rao KN

TI : Tuberculosis problem in India.

SO: INDIAN J TB 1966, 136, 85-93.

DT: Per

AB: The article provides a description of the health facilities including medical manpower available in India in the mid-60s. Given that the population was rising by 2.2% per annum, it was suggested that the social and sociological significance of the increase of TB morbidity be considered in relation to population growth. Since the Indian tubercle bacillus, while less virulent, varied from strain to strain considerably more than in the European countries, it was recommended that devising ways to combat TB be based on the specific needs of the country. Over Rs. 2,000 crores per annum was expected to be needed to combat TB in India. Therefore, it was more cost- effective to expend funds in the prevention and control of TB rather than used towards covering the cost of illness and premature death.

TB control was one of the priority items in the National Health Programmes incorporated in the successive Five-Year Plans covering 30 years. On reviewing the earlier history of TB Services in India, it was evident that, while the prevalence of TB was recognised in India from 2,500 B.C., the awareness of its existence as a major problem only occurred in the early part of this century. The establishment of the TAI in 1939 marked the first national voluntary effort and also when domiciliary treatment for TB patients was first offered. The break out of the Second World War and the aftermath of the partition of India in 1947 brought all nation-building efforts to a standstill. Subsequently, in 1948, the Indian Government set up a separate TB Section in the DGHS, encouraging rededication to providing TB services; at the same time antibiotics began to replace the use of pneumo-thorax treatment. By the mid-60s, the TB control programme in India covered wide-ranging activities such as Preventive Services, TB Clinics, Hospitals & Sanatoria, Rehabilitation, Research and Health Education. The emphasis was on providing preventive & clinical services and domiciliary, anti-microbial activity. A description of various other anti-TB measures taken by governmental, voluntary and international agencies completes the review.

KEYWORDS: SOCIAL PROBLEM; HEALTH CARE; INDIA.

091

AU: Banerji D

TI : Tuberculosis programme as an integral component of the general health services.

SO: J INDIAN MED ASSOC 1970, 54, 36-37.

DT: Per

AB: Sociological investigations have revealed that more than half of all infectious cases in rural areas seek relief at various health institutions and that as many as 95 percent of them are conscious of the symptoms of the disease. These findings lead to the formulation of a felt-need oriented TB programme as an integral part of the services that are offered at the rural health institutions. Specialised TB institutions at the higher levels lend support to them by offering referral facilities. For a population of a million and a half, there is a DTC to give them administrative support. Such an integrated programme

is not only very economical, but it also grows along with the GHS. Its orientation to felt need makes it more acceptable. It also has a potential for covering some 95 percent of the infectious cases in the community, thus indicating that it can have an impact on the incidence rates of the disease.
KEYWORDS: SOCIAL RELIEF; HEALTH SERVICES; SOCIAL WELFARE; HEALTH CARE; INDIA.

092

AU: Mechanic D
TI : Sociology and public health perspectives for application.
SO: AME J PUBLIC HEALTH 1972, 62, 146-150.
DT: Per
AB: Much of the content of sociology directly concerns man's adaptation to his changing environment and therefore, this field has important implications for public health practice. This paper reviews some major perspectives and some examples of research that illustrate how an appreciation of sociological variables can assist the public health practitioner.
KEYWORDS: HEALTH CARE; USA.

093

AU: Ruderman AP
TI : Health programmes and new directions in social and economic development.
SO: BULL IUAT 1974, 49, 50-56.
DT: Per
AB: The changes in the place of health programmes in the international development process, over time, has meant that the role of health has come full circle, today. The paper describes this changing role of health, from the classic imperative of the medical practitioner to heal the sick and comfort the afflicted through a period when the justification for spending money on health programmes had to be sought in their contribution to economic development to the current period, in the 70's, when once again, health programmes can be justified without recourse to economic arguments. To support this view, several figures, presenting data on the comparative savings from BCG and standard TB treatment in Burma (in the 60s) and the prevalence of TB in the Indian labour force (in the early 60s) are illustrated to show how they might convince development economists to provide money for the TB health programme.
KEYWORDS: HEALTH SERVICES; SOCIAL COST; HEALTH CARE; CANADA.

094

AU: Newell KW
TI : Development of health services.
SO: BULL IUAT 1974, 49, 57-61.
DT: Per
AB: TB is a good example around which a discussion of change can take place. The health technology of TB already exists and is widely understood. Economic and effective

methods of prevention and treatment have been evolved, widely tested, and made available world-wide. The question is how to get this to the right people in the right way.
KEYWORDS: HEALTH SERVICES; SWITZERLAND.

095

AU: Nagpaul DR
TI : A tuberculosis programme for big cities.
SO: INDIAN J TB 1975, 22, 96-103.
DT: Per
AB: A City TB Programme (CTP) has been suggested that meets with most of the existing conditions in our big cities and is in accord with the principles underlying DTP and NTP.
KEYWORDS: HEALTH CARE; HEALTH SERVICES; SOCIAL WELFARE; INDIA.

096

AU: Banerji D
TI : Public health perspectives in the formulation of the National Tuberculosis Programme of India.
SO: NTI NL 1981, 18, 50-56.
DT: Per
AB: Formulation of a nationally applicable, socially acceptable and epidemiologically effective NTP for India involved use of a wide range of principles of the discipline of community health. These principles can also be very profitably applied in the formulation of nationwide programmes to deal with other major community problems. Government commitment to strengthening rural health services in India by using multi-purpose health workers and by employing community health volunteers has further strengthened the case for adopting the approach developed for formulating the NTP on a much wider scale. This approach also gets further endorsement from the concept of primary health care contained in the Alma-Ata Declaration.
KEYWORDS: HEALTH CARE; HEALTH SERVICES; HEALTH SURVEY; INDIA.

097

AU: Nagpaul DR
TI : Problems and prospects of National Tuberculosis Programmes in developing countries.
SO: BULL IUAT 1983, 58, 186-190.
DT: Per
AB: The purpose of the paper is to spotlight some of the problems of NTPs in developing countries and what to expect in the future. The paper presents a review of NTPs' problems with respect to whether they have achieved community-wide coverage, rural people's socio-cultural expectations concerning the health centers, integration of NTPs with GHS and certain management aspects. The conclusion is that a majority of these problems are managerial and attitudinal in nature. For instance, the wide variability in the quality of TB services provided at the periphery because of insufficient knowledge or awareness of some GPs, the lack of equitable sharing between hospitals (urban or rural), with health centers (urban or rural), the reluctance of well-qualified staff to accept rural postings, irregular

supply of medicines and lack of staff supervision by senior officers have prevented NTPs from community-wide coverage. While all ingredients for physical integration with GHS are present, functional and attitudinal fusion, of the generalists with the specialists and of rural health centres with higher level institutions up to teaching medical colleges are still lacking. Managerial problems manifest in administration, operation and training are described and the need for political will or leadership is explained. Suggestions to overcome these problems include undertaking a number of operational studies to understand what has happened with regard to NTPs and why, improving training and/or supervision and making the GHS more quality-conscious and management-oriented.
KEYWORDS: SOCIO-CULTURAL; SOCIO-POLITICAL; HEALTH CARE; INDIA.

098

TI : Hospitalization for pulmonary tuberculosis: Editorial.
SO: INDIAN J TB 1988, 35, 1-2.
DT: Per
AB: The editorial describes briefly, the history of hospitalization for pulmonary TB, noting that this history, in the two succeeding centuries, had been chequered, as it was influenced by successive scientific advances. Currently, even the near revolution of modern chemotherapy has not made hospitalization obsolete. In the developing world, this may not happen for a long time, because admission criteria other than medical could have equal weight. Those who will not accept that hospitalization for TB may have become irrelevant were ignoring economic reality and sensible practicality. It is urged, therefore, that hospitalization for TB be confined to managing emergencies, as a part of general emergency services. In developing countries, all the beds thus released could be handed over to the GHS as contribution to newly emerging primary and secondary health services.
KEYWORDS: SOCIO-POLITICAL; SOCIAL MEDICINE; INDIA.

099

AU: Nagpaul DR
TI : India‘s National Tuberculosis Programme- an overview.
SO: INDIAN J TB 1989, 36, 205-212.
DT: Per
AB: The overview takes into consideration the historical, socio-economic, administrative and technical factors, which have played a prominent role in shaping India‘s NTP. It comprises an analysis of the current status, trend during the past ten years and discussion of some aspects that need further attention. Now, a majority of the constraints are administrative and not even operational, while the needed technical improvements are few. At the present stage of development, it would appear premature to say if the programme has succeeded or failed.
KEYWORDS: SOCIO-POLITICAL; HEALTH CARE; INDIA.

100

TI : Health services for Indian middle class: Editorial.

SO: INDIAN J TB 1989, 36, 1-2.

DT: Per

AB: Change is continuous and its ripples deep spreading in society far, wide and long, influenced as well as maintained by the factors that trigger the change. A society therefore needs sentinels to monitor the social changes and try influencing the socio-political thinking of those in power in order not to let events overtake people. Otherwise, the resulting adhocism is seldom capable of dealing with the national situations properly. The emergence of a large middle class in India is one such situation.

KEYWORDS: HEALTH SERVICES; SOCIO-POLITICAL; SOCIAL CHANGE; INDIA.

101

TI : A national task force for NTP: Editorial.

SO: INDIAN J TB 1990, 37, 173-174.

DT: Per

AB: The editorial comments refer to the 1989 Ranbaxy-Robert Koch Oration given by Dr. William Fox, titled "TB in India - Past, Present and Future". Dr. Fox highlighted most of the major aspects of TB in India, being familiar with the TB scene in India for over 35 years. Emphasis was placed on the need to improve research, training and evaluation aspects of NTP and on improving programme administration and management based on these findings. However, Fox's recommendation to establish a long term National TB Standing Committee with various powers is considered to reveal his unfamiliarity with various aspects of the Indian administrative and political climate and the social upsurges prevalent at the time. The editorial suggests an alternative way to manage the TB programme, while supporting Dr. Fox's views, in general.

KEYWORDS: SOCIO-POLITICAL; HEALTH POLICY; HEALTH SERVICES; INDIA.

102

AU: Desai VP & Khergaonkar KN

TI : Urban tuberculosis programme: The greater Bombay set up.

SO: INDIAN J TB 1991, 38, 235-238.

DT: Per

AB: The article provides a detailed description of the urban TB programme established in 1986 in Bombay and covering the city. The existing health infrastructure was inadequate to deal with an estimated 1,50,000 cases of TB, of which 40,000 were infectious to others. The organizational structure of the city TB programme is explained and the duties of the city TB officer are listed. A review found that since 1986, about 70,000 newly diagnosed patients were put on treatment every year, of which, only about 205 were able to complete the treatment. While there was good public awareness and an excellent transport service, poverty among a majority of the city dwellers and constant rural-to-urban migration were major problems in TB control. Future plans to improve the TB programme are listed.

KEYWORDS: HEALTH CARE; HEALTH SERVICES; HEALTH POLICY; INDIA.

103

AU: Chaudhuri K
TI : Tuberculosis programme: meeting the demand for its review.
SO: INDIAN J TB 1991, 38, 189-190.
DT: Per
AB: The article decries the concept of an episodic assessment of the NTP, done in an ad-hoc manner, with the definite potential of changing the very course of programme development, thereby, weakening rather than strengthening it. Instead, it is recommended that the NTP's existing in-built monitoring be revamped, reactivated and strengthened.
KEYWORDS: HEALTH CARE; HEALTH MONITORING; INDIA.

104

AU: Nagpaul DR
TI : Towards a rational national drug policy.
SO: INDIAN J TB 1992, 39, 65-66.
DT: Per
AB: The editorial offers some considerations that should go into the making of a rational, National Drug Policy (NDP). Primacy must be given to the National Health Policy in the formulation of the NDP and the task of producing adequate quantities of essential/life-saving drugs, of good quality and at reasonable prices, must be placed as a challenge before the pharmaceutical industry under market-friendly controls. The production of non-essential/fancy formulations could be left to the demand-supply mechanism, at the same time, stressing rational prescribing practices as part of NDP.
KEYWORDS: HEALTH POLICY; INDIA.

105

AU: Nagpaul DR
TI : Surajkund deliberations.
SO: INDIAN J TB 1992, 39, 1-2.
DT: Per
AB: This is an editorial on the Workshop organised by the DGHS, 11-12 September, 1991, to thoroughly review the NTP with respect to its overall achievements and shortfalls from expectations. Based on the deliberations, attended by representatives of various international agencies, several recommendations for action, to improve the NTP, were made. It was suggested that a Task Force be set up, with proper terms of reference and a suitable budget to oversee that the recommendations were implemented and that necessary corrective actions were taken, till the time of the next review.
KEYWORDS: HEALTH POLICY; HEALTH SERVICES; VOLUNTARY ORGANIZATION; INDIA.

106

AU: Stevens A, Bickler G, Jarrett L & Bateman N

TI : The public health management of tuberculosis among the single homeless; is mass miniature X-ray screening effective?

SO: J EPIDEMIOL COMMUNITY HEALTH 1992, 46, 141-143.

DT: Per

AB: The aim of the study was to test the assumption that mass miniature X-ray screening of the single, homeless (hostel residents) was a cost effective means of controlling pulmonary TB. The study was a prospective experimental screening exercise to identify new cases of active TB, completing treatment. The setting was eight hostels in South London. A mobile X-ray screening facility was set up outside the hostels. Subjects were 547 single, homeless residents in the hostels. They were encouraged to attend for chest X-ray and for active follow- up of abnormal X-rays. No new cases of active TB were found leading to the conclusion that mass, miniature X-ray was ineffective in controlling TB because of its unacceptability and increasing inaccessibility to this population.
KEYWORDS: HEALTH POLICY; UK.

107

AU: Uplekar MW

TI : Tuberculosis control in India: the urban viewpoint - Guest Editorial.

SO: INDIAN J TB 1993, 40, 59-60.

DT: Per

AB: The guest editorial considers that the NTP, while a well-designed one, has been deficient in implementation of the programme, that the blame for this deficiency should go to the general conditions under which the programme has to function and not the programme itself. Therefore, those who wish to improve the functioning of the NTP should direct their attention to improving the GHS. Regarding the TB control programme in urban areas of India, three trends that have emerged are described. Given these trends, it is considered that only a consensual approach based on mutual understanding towards achieving a common goal could bring about the desired change in the programme. A set of interventions to improve the programme are included.
KEYWORDS: HEALTH SERVICES; HEALTH SYSTEM; HEALTH CARE; INDIA.

108

AU: Nagpaul DR

TI : Tuberculosis programme in metropolitan cities.

SO: INDIAN J TB 1993, 40, 99-102.

DT: Per

AB: The paper explains why the predominantly rural average Indian district received greater attention under the NTP than large cities. Also, why the DTP, as the basic unit of NTP, has not performed upto expectations on account of management weaknesses and not technological shortcomings. It has been shown why it is not necessary to think in terms of separate rural and urban TB services. The manner in which the existing TB services in most big cities can and should be made a part of DTP/NTP has been discussed. In metropolitan cities, where the operational environment is different, the principles of NTP

can still be applied, after due operational and sociological studies, but it is preferable if such studies are made a part of overall health services systems research.
KEYWORDS: HEALTH SERVICES; INDIA.

109

AU: Left DR & Left AR

TI : Tuberculosis control policies in major metropolitan health departments in the United States V. Standard of practice in 1992.

SO: AME REV RESPIR DIS 1993, 148, 1530-1536.

DT: Per

AB: Since 1978, in the United States, 28 metropolitan health departments initially reporting greater than 250 cases of TB per year were surveyed to determine the standard of practice in the control of pulmonary TB and factors affecting treatment policy. In this survey, results were compared with data obtained in 1978, 1980, 1984 & 1988. As in the previous years, all departments completed the survey. The predominant treatment regimen was 6 months of chemotherapy (64 + or - 1.33% of patients) involving isoniazid (I), rifampin (R) and pyrazinamide (Z). Estimated duration of treatment, which had decreased from 20.2 + or - 2.1 months in 1980 to 7.58 + or -1.02 months in 1988, increased to 9.34 + or -2.32 months in 1992 ($p< 0.01$). This was attributed to an increased incidence of HIV infection during the previous 4 years. In 1984, HIV infection was estimated to coincide with TB in 2.54 percent of all patients, 7.72 percent in 1988 and 17.42 percent in 1992. Several other major departures from prior perceived practices were reported. In 1980, 32.1 percent of all patients were hospitalized initially for TB treatment, and this number decreased progressively to 17.8 percent in 1988; in 1992, 34.2 + or -1.32 percent of patients with TB were hospitalized for initial treatment. In 1988, no program reported regular use of alternative therapy to isoniazid for chemoprophylaxis; in 1992, 21 programs used alternative regimens (predominantly R-containing). In 1992, nine programs reported increased funds for treatment of TB (27.2+/- 1.97 percent inflation), whereas 16 reported a mean decrease of 14 percent after inflation. The conclusions were that TB treatment in the major metropolitan health departments consisted predominantly of SCC utilizing I, R and Z and that overall mortality was not greater because of initially drug-resistant organisms. However, HIV-associated disease now was a major etiologic factor in TB, and the number of hospitalizations had doubled in 4 years. The lack of increase in funds for treatment was expected to exacerbate the problems in TB control, in the future.
KEYWORDS: HEALTH POLICY; USA.

110

AU: Nardell EA

TI : Beyond four drugs. Public health policy and the treatment of the individual patient with tuberculosis.

SO: AME REV RESPIR DIS 1993, 148, 2-5.

DT: Per

AB: Two extremes of the TB propagation cycle taking place simultaneously in different areas of the United States are illustrated. One illustration represents hypothetical, ideal

epidemiological conditions wherein the applied TB control measures bring about the desired cure in the expected timeframe. Actual conditions prevalent in the US, over the past several decades until recently and still existent in many areas, have been similar to this scenario. The other, more complicated diagram illustrates some of the factors responsible for the current TB resurgence and for the emergence and transmission of multi-drug resistant organisms in the US. Under these conditions, lack of health insurance and other barriers to primary health care often delay the diagnosis of active TB, allowing longer-term transmission. After diagnosis, many potential barriers exist to successful therapy including homelessness, financial and cultural barriers. Patients, not on effective treatment, often transmit multi-drug resistant TB (MDR-TB) in a variety of settings including hospitals and clinics, homeless shelters, jails, chronic care facilities etc. Based on different studies, it was found that among patients with AIDS under treatment for TB, the time period between infection and active disease was so short as to preclude treatment. Studies using genetic finger-printing showed new drug-resistant disease could result from exogenous infection. Vastly different strategies and resources are suggested to achieve control in the two different TB scenarios.

The TB situation in Massachusetts and two features of the control efforts are described in detail. The article by Graves et al (1993) on drug-resistant TB in Puerto Rico is also elaborated. Based on these two sources, it is urged that four-drug (Isoniazid, Rifampicin, Ethambutol and Pyrazinamide) initial therapy and universal drug susceptibility testing be given for all patients. DOT is recommended for previously treated persons and those living outside Puerto Rico and the US mainland. A progressive, step-wise, case management approach to TB treatment, from least to most restrictive, is listed.
KEYWORDS: HEALTH POLICY; USA.

111

TI : Forum on Demand and supply of drugs (this title is constructed by the indexer for identifying the article as the information is without title).
SO: INDIAN J TB 1993, 40, 172-173.
DT: Per
AB: Keeping the list of drugs available in the market to the bare essentials, reducing practices (such as hosting of conferences, advertising, peddling of samples and literature, etc.) which add huge overheads to the cost of production of drugs, rational drug prescription policies and consumer awareness as well as education are the essential ingredients which can ensure availability of low priced drugs.
KEYWORDS: SOCIAL COST; HEALTH POLICY; INDIA.

112

AU: Norregaard J, Grode G & Viskum K
TI : Restrictive treatment policy for pulmonary tuberculosis in a low prevalence country.
SO: EUR RESPIR J 1993, 6, 23-26.
DT: Per
AB: In Denmark, treatment of TB is generally recommended only if the diagnosis is confirmed bacteriologically. This policy may cause a delay in treatment if the patients are smear

negative. The duration of the treatment delay, and whether the delay would cause any serious health problems for the individual or risk of contact infections, in a retrospective examination of 324 cases of pulmonary TB was investigated. The mean treatment delay was longer in the oldest age group. Concerning death due to delay, there was no risk for those patients who were not weakened by other disease or old age. Only 11 patients (3.6 percent) over the age 10 years were treated without bacteriological confirmation (1 percent for Danes). The infection risk from the smear- negative but culture-positive patients was minimal as only one subject was definitely infected from a smear-negative patient. However, a risk of transmission exists from patients who are initially culture-negative but later become smear-positive. In conclusion, the epidemiological and individual risks were sufficiently low to continue the rather restrictive treatment policy.
KEYWORDS: HEALTH POLICY; DENMARK.

113

AU: Madico G, Gilman RH, Checkley W, Cabrera L, Kohlstadt I, Kacena K, Diaz JF & Black R
TI : Community infection ratio as an indicator for tuberculosis control.
SO: LANCET 1995, 345, 416-419.
DT: Per
AB: The relative importance of within-household and community transmission of infection among children aged 6 months to 14 years living in a Peruvian Shanty-town, was investigated. The prevalence of mycobacterium TB exposure among 175 contact children (sharing a household with a person who had confirmed pulmonary TB) and 382 control children (living in nearby households free of active TB) was defined as the proportion of children with a positive purified protein derivative (PPD) skin test.
Ninety-seven (55 percent) contact children and 129 (34 percent) controls were PPD positive. Living in a contact household (odds ratio 1. 74, 95 percent CI 1.11-2.73) and age (1, 11, 1.06-1.18) were significant risk factors for PPD positivity. The community infection ratio (CIR) was calculated as the odds ratio of PPD positive controls to PPD-positive contacts:

$$CIR = \frac{\text{Prevalence in controls/ (1-prevalence in controls)}}{\text{(Prevalence in contacts/ (1- prevalence in contacts).}}$$

A low CIR therefore suggests mainly household spread of infection, whereas a high value suggests frequent transmission outside the household. The adjusted odds ratio (for age, sex, within -household correlation, and household size) was 0.40 (95 percent CI 0.26-0.64), compared with values of 0.18-0.37 in studies elsewhere. Currently recommended TB control strategies are suitable for areas with low CIR`s. Different strategies may be needed for areas such as the one studied here, with high values.
KEYWORDS: HEALTH MONITORING; SOUTH AFRICA

114

AU: Ete K & Khrime TC
TI : Utilization of changing health infrastructure by National Tuberculosis Programme
SO: NTI BULLETIN 1995, 31, 7-13
DT: Per
AB: Since NTP is integrated with GHS, any improvement in GHS is bound to improve NTP. Similarly, if GHS suffers from any inadequacy, it gets reflected in NTP. In other words,

NTP will sink or sail with GHS. Thus, to achieve the objective of Health for All by 2000 A.D. through primary health care, the existing infrastructure for GHS should be strengthened as per the recommendations and utilised effectively. This becomes all the more compelling in view of the AIDS epidemic which is knocking at the doors of India.
KEY WORDS: HEALTH SERVICES, HEALTH INFRASTRUCTURE; INDIA

115

AU: Diez E, Claveria J, Serra T, Cayla JA, Jansa JM, Pedro R & Villalbi JR
TI : Evaluation of a social health intervention among homeless tuberculosis patients
SO: TUBERCLE & LUNG DIS 1996, 77, 420-24
DT: Per
AB: The setting is Homeless and other fringe groups are a priority in the global strategies of TB prevention and control in big cities, as a consequence of their generally poor adherence to treatment and concurrent multiple social and health problems. The objective is to evaluate a social care and health follow-up programme targeting homeless TB patients in Ciutat Vella District, Barcelona, which covered 210 patients from 1987 to 1992. During directly observed treatment, primary health care and, if necessary, accommodation was provided. The design of the study is the differential TB incidence rate between Ciutat Vella and the other districts of Barcelona, the percentage of successfully completed treatments and the days of hospitalization saved by the programme were measured.

There was a significant decrease in the TB incidence rate among homeless patients in Ciutat Vella (from 32.4 per 10^5 inhabitants in 1987, to 19.8 per 10^5 in 1992, P=0.03), compared to an unchanged rate elsewhere (1.6 per 10^5 inhabitants in 1987, compared to 1.7 per 10^5 in

Interaction with TB patients

1992, P=0.34). A smaller than expected proportion, 19.6%, of patients failed to complete their treatment, and a decrease in the mean period of hospitalization for TB in the district hospital was recorded, falling from a mean 27.1 days in 1986 to a mean 15.7 days in 1992. The programme appears to be both effective and efficient, as it has enabled a large number of homeless patients to complete their treatment successfully, at the same time saving twice the amount of funds invested.
KEY WORDS: HEALTH POLICY; SOCIAL ASPECTS; HOMELESS TB PATIENTS; BARCELONA.

116

AU: Jagota P

TI : Sociological research conducted in the field of tuberculosis in India

SO: STC NEWSLETTER 1999, 9, 5-15

DT: Per

AB: The paper presents a comprehensive analysis of the sociological research on TB conducted in India between 1956-1998. Human suffering; health seeking behaviour, factors affecting and improving treatment compliance are the important sociological aspects of TB that have been investigated. The genesis of DOTS has been traced to the long-standing efforts to try different strategies to overcome the problems associated with treatment completion for e.g., development of supervised, intermittent and SCC regimens. Following are the salient conclusions given in this paper:

In the early 60s, the visionary approach of researchers to focus on the sociological and epidemiological aspects of TB ensured that the NTP, from its inception, was socially relevant and epidemiologically effective.
The level of knowledge of TB does not necessarily lead to patients seeking relief or taking treatment regularly. It is the physical suffering which is found to be associated with the action taking. Cough is found to be one of the most important chest symptoms of TB as it prompts patients to take action for relief.

Organizational and administrative factors such as insufficient facilities for management of TB, inadequate and irregular supply of anti-TB drugs, long distance to travel for seeking relief, drug intake or drug collection act as barriers and prevent patients to be adherent for treatment. Training of health providers is essential so that they give accurate advice to patients concerning treatment and manage the TB activities. Certain other actions to improve treatment adherence include decentralization of TB services while ensuring regular supervision of programme activities.

Increased research efforts in sociological aspects of TB are needed for successful implementation of DOTS programme. There is a need to explore the feasibility of including diverse groups such as private practitioners, social & leprosy workers and dais (birth attendants), as DOTS supervisor. We can also investigate the utilization of other agencies like STD booths and pan shops. The barriers to the expansion of DOTS programme should be removed.
KEY WORDS: SOCIAL RESEARCH; HEALTH SERVICES; INDIA

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AU: Weil DEC

TI : Advancing tuberculosis control within reforming health systems

SO: INT J TB & LUNG DIS 2000, 4, 597-605

DT: Per

AB: In developing nations, diverse health reform programs are affecting the design, financing and delivery of health care services as well as public health practice. This paper summarizes the characteristics of major reform strategies seeking to improve efficiency, equity and quality. Opportunities and risks for TB control are identified, as are responses in managing the reform transition. Recommendations are provided to advance TB control in this dynamic environment. These include participation in the planning process; demonstration of synergy between reform objectives and TB control; articulation of core functions to be protected; technical, managerial and leadership capacity-building; documentation of effects and best practices; and collaboration with those pursuing other public health priorities and reform analysis.

KEY WORDS: HEALTH REFORM, HEALTH SYSTEM; USA

No.of Records: 31