b) Socio-Cultural, Socio-Economic & Demographic Aspects

031

AU: Bloom S
TI : Some economic and emotional problems of the tuberculosis patient and his family.
SO: PUBLIC HEALTH REP 1948, 63, 448-455.
DT: Per
AB: The basic economic difficulties and some of the major problems of patients in the United States, created and intensified by TB, are discussed in this paper. Two major economic problems are listed. Provision for economic care ranges from little assistance in some communities to a minimum relief standard in others, with many intermediate variations. Concerning, emotional problems, those connected to the acceptance of diagnosis are of great significance. Several representative cases are described to illustrate the varying emotions patients experience. There is a growing interest to extend social services to address the above social problems and the social worker plays an important role in studying, evaluating and treating the social and economic problems of TB patients.
KEYWORDS: SOCIO-ECONOMICS; SOCIAL PSYCHOLOGY; USA.

032

AU: Hartz J
TI : Human relationships in tuberculosis.
SO: PUBLIC HEALTH REP 1950, 65, 1292-1301.
DT: Per
AB: This paper reviews some common attitudes towards TB, their sources and, offers suggestions for their management. It is suggested that the whole topic of human relationships needs to be studied and considered in relation to the problem of control of TB. Patients arrive at the sanatorium with some degree of emotional disturbance. Where morale is good and careful thought is given to the range of human personality reactions, most patients will adjust satisfactorily and respond as expected to treatment. However, a large majority can be expected to encounter serious difficulties during or after their hospitalisation, mainly because of emotional disturbances. These disturbances cannot always be avoided, but usually their occurrence can be foreseen and their seriousness modified if there has been an adequate personality investigation early in the patient's stay. Likewise, intelligent planning to cope with the social and rehabilitation problems of the patient will go forward much more realistically from such a base. Certainly, in terms of practical management, pulmonary TB can be as much a disease of the personality as it is of the lungs.
KEYWORDS: SOCIAL ATTITUDE; USA.

033

000
AU: Terris M & Monk MA
TI : The validity of socio-economic differentials in tuberculosis mortality.
SO: AME REV RESPIR DIS 1960, 81, 513-517.
DT: Per
AB: Deaths of resident white TB patients in Buffalo, New York, in 1949-1951 were found to be inversely correlated with socio-economic status as measured by economic quartile of

residence. Data on the previous residences of these 493 patients were obtained; 84% were traced to 1946 or earlier and, 66% were traced to 1935 or earlier. The socio-economic distribution at the earliest address found did not differ significantly from the distribution at the time of death; this held true even for those traced to 1925-1935. It is concluded, within the limitation of the study method that no positive evidence was obtained that the excess of TB mortality in low socio-economic areas is due to downward socio-economic "drift" by the persons afflicted with the disease.
KEYWORDS: SOCIO-ECONOMICS; USA.

034

AU: Andersen S & Banerji D

TI : Report on a study of migration in four taluks of Bangalore district.

SO: POPULATION REVIEW 1962, 7, 69-72.

DT: Per

AB: The purpose of the study was to establish the rate of emigration in a random selection of villages, with a view to forecast the likely loss of population in a follow-up study on BCG vaccination in the area. The study was carried out in the total population belonging to 35 villages of Channapatna, Devanahalli, Magadi and Nelamangala taluks of Bangalore district in April 1960. Demographic characteristics such as birth and death rates, immigration rates and proportion of persons temporarily absent, were also studied. The head of the household if absent, any other responsible adult was interviewed on a house-to-house basis, regarding the composition of the family, according to the NTI manual for census takers. Estimation of migration was to be based on the registered population of the current day, the population exactly one year ago and all relevant events during the intervening year.

The thirty five villages surveyed were found to have a population of 13,838 persons at the time of interview. This figure included: (A) 13138 persons in the household at the time of census taking also belonged to it one year ago. (B) 470 persons born during the past year. (C) 230 persons immigrated during the past year. (D) 200 persons dead during the past year. (E) 307 persons emigrated during the past year & (F) 770 persons temporarily absent. The net increase in the population from April 1959 to April 1960 was, 193 persons or 14 per thousand.

It was estimated that not more than 5% of the population would be lost by emigration over a period of two years. About 1/3rd of the emigration is within the same taluk. Only a small portion of the emigrants are above 30 years of age. It is also found that a good proportion of women's migration is due to marriage. The study findings revealed that the hypothesis that large number of people leave the village every year, making BCG coverage impossible could hardly be upheld.
KEYWORDS: SOCIAL DEMOGRAPHY; SOCIAL RESEARCH; INTERVIEWING; MIGRATION; INDIA.

035

AU: Banerji D

TI : Tuberculosis: A problem of social planning in developing countries.

SO: MED CARE 1965, 3, 151-159.

DT: Per

AB: The problem of TB in a developing country such as India must be considered in the overall social and economic context. Massive investment of money and resources to eradicate TB may interfere with other measures more important for the country`s progress. But a limited investment in a suitably oriented TB programme could hasten the decline of the disease. Social planners thus face a special challenge in such countries. The problems are almost overwhelming, while the resources available are extremely limited; scientists will have to formulate programmes which will ensure that these resources are utilised to give a maximal return from the investment. Thus, in considering TB as a problem of social planning in developing countries it will have to be dealt with at three different levels:

(a) Recognising the implications of factors other than a specific TB programme on the incidence of the disease; (b) developing methods that could offer the best possible returns from the available resources, both at any given point of time as well as at different time intervals; and (c) determining priority for allocating resources in a socially applicable TB programme. The NTI, Bangalore has used operational approach for formulating a nationally applicable and acceptable TB programme for India. The sequence of steps that led to the formulation of TB programme in India can as well be applied to develop a similar programme in any developing country.

KEYWORDS: SOCIAL PLANNING; SOCIO-ECONOMICS; SOCIAL PROBLEM; INDIA.

036

AU: Rao KN

TI : The socio-economic aspects of tuberculosis.

SO: INDIAN J TB 1965, 12, 115-117.

DT: Per

AB: The new approach to the role of socio-economic factors in TB control demands that social planning in respect of TB has to be in consonance with the overall development of the community. A rational allocation of existing resources in the context of this process of social change can be achieved only through a comprehensive and integrated approach. One of the important principles of social planning is the tailoring of a programme to the felt-need of the community. The intervention becomes more readily acceptable, less costly and allows the due share to the other felt-needs of the community. The overall development of the community and providing basic facilities leads to the better public participation in the TB control programme. Improved nutrition status of the people specially by feeding young, will help in preventing the breakdown of the disease. Since TB is equally prevalent in rural and urban areas, planning of the whole area by involving the existing facilities and development of effective rural TB services will bring the services within reach of every person. Regular and continuous training and supervision of the general staff to carry out TB activities is one of the prerequisite. A continuous anti-TB drug supply for treating about 4 million cases per year for a very long period of 20-30 years can be achieved with the help of international assistance.

Even if the programme is fairly effective, it is visualised that the control programme and social planning should be on long term basis for several decades.
KEYWORDS: SOCIO-ECONOMICS; SOCIAL PLANNING; INDIA.

037

AU: Williams EC

TI : Family problems of Tuberculosis patients.

SO: National Conference on Tuberculosis and Chest Diseases, 26th, Bangalore, India, 3-5 Jan 1971, p. 302-304.

DT: CP

AB: The study examined the socio-cultural consequences of acquiring TB on the patients and their families. A random sample of a hundred TB patients who received treatment at the Tuberculosis Chemotherapy Center, Madras, were chosen to determine the types of problems encountered in families stricken with pulmonary TB. The patients varied widely in marital status and by occupation. The problems encountered by the patients were broadly classified into three categories, sociological, financial and psychological. Of these, sociological problems such as disruption of family life, maladjustment, break-up of homes and loss of mental balance were the most commonly experienced problems and were more significant than occupational problems. It is suggested that unless the community and various Government and voluntary agencies act together to tackle the socio-cultural aspects impacting TB patients, along with the medical treatment, the patients will not achieve the desired benefits.
KEYWORDS: SOCIO-CULTURAL; SOCIAL APPROACH; INDIA

038

AU: Khan SU

TI : The railway and the social aspects of tuberculosis.

SO: National Conference on Tuberculosis and Chest Diseases, 26th, Bangalore, India, 3-5 Jan 1971 p. 312-316.

DT: CP

AB: The aim of the sample survey conducted in January-February 1968 in the railway colonies of West Bengal was to determine the "Sociological Tuberculogenic Factors" that were responsible for the development and spread of TB in the population. The sample studied was found to be representative of the general population. The trend and behaviour of disease was dependent on the relevant standard of living (separate colonies were built for officers, upper subordinates and other categories with wide difference in social conditions), working conditions, habits and social evils such as alcohol consumption and "ganja" (illicit drug) smoking. The incidence of disease was more rampant amongst the low-paid categories and was inversely related to the group's income. Based on the findings, some suggestions were made to check the progress and spread of TB.
KEYWORDS: SOCIAL ASPECTS; SOCIO-ECONOMICS; SOCIAL CONDITION; INDIA.

039

AU: Nayar DP

TI : Socio-cultural factors and health planning.

SO: SWASTH HIND 1973, 17, 7-9

DT: Per

AB: Effective strategies of health planning would begin by identifying and strengthening, through modern interpretation, the existing healthy habits, and practices of the community. After building an adequate rapport with the people through the sympathetic interpretation of their cultural heritage, the health planner should identify their deficiencies and tell them how to overcome them. Both the processes require considerable amount of education and persuasion. In this task, the local leadership and the local institutions can play an important role. Also, the Indian system of medicine and the system of nature cure should be fully encouraged and taken advantage of.

KEYWORDS: SOCIO-CULTURAL; HEALTH PLANNING; INDIA.

040

AU: Wiese HJC

TI : Tuberculosis in rural Haiti.

SO: SOC SCI MED 1974, 8, 359-362.

DT: Per

AB: A study was conducted in southern Haiti, from Sept. 1969 through to March 1971, to determine the socio-cultural factors associated with the utilization of a TB out-patient clinic by the indigenous population. In the entire region of some 2200 miles, there was one western health facility for the treatment of TB. Dossiers of 832 patients, newly diagnosed with pulmonary TB and admitted to treatment between 1967 and 1970, were reviewed to determine their treatment utilization pattern on the recommended 2-year chemotherapy regimen. The data from these records were then anlaysed to investigate possible correlations between rural variables involved in patient utilization of the facility: a) the age distribution of the TB patients, b) the geographic distribution of their residences, c) proximity of these residences to main roads, d) withdrawal from treatment over varying time spans. Preliminary analysis revealed that this clinic was largely ineffective in combating the disease. A vigorous examination of its organization mechanism and patient files revealed that the attrition rate among the TB patients was 75.12 percent within the first 6 months of treatment. An in-depth analysis of the total cultural situation indicated that the clinic`s lack of knowledge about the local culture (the term TB meant symptoms not serious enough to merit a visit to the clinic in the local people's minds, the Haitians' concept that any person able to discharge their normally expected social functions was healthy and the clinic's operating time schedule which did not fit with the local people's way of life and activities) and consequent failure to operate within it was a major source of the problem. Suggested changes include: a) Shifting the clinic schedule to correspond with the daily flow of people in the rural areas, b) undertaking health education measures to teach the early signs of TB, the importance of early detection and the need for prolonged treatment, c) changing the term used in advertising the clinic and, d) using the newer combination drugs to reduce the treatment cost and enable patient to remain on treatment longer.

KEYWORDS: SOCIO-CULTURAL, CENTRAL AMERICA

041

AU: Bailon SG

TI : Beliefs about tuberculosis and their implications to health education.

SO: ACTA MED PHILIPP 1978, 14(II), 8-19.

DT: Per

AB: There is some variation in certain beliefs about TB according to the types of barrio residence plain, coastal or upland). This could be due to a difference in the prevalence of the disease and in the amount of exposure to health information of people in these three types of locals.
KEYWORDS: SOCIAL TABOOS.

042

AU: Waaler HT

TI : Tuberculosis in the world.

SO: BULL IUAT 1982, 57, 202-205.

DT: Per

AB: The author presents a few selected topics for discussion expected to assist in the future formulation of strategies against the spread of TB. One such topic is demographic changes. In most developing countries, with constant age-specific rates, increasing population and a relative increase of the older age groups are expected to lead to an increase in the absolute number of TB cases, as illustrated with a simulation. The consequences of the fact that TB services are reflections of the health services which, in turn, reflect the general public services in the community and, that TB is closely related to the prevailing socio-economic conditions are discussed in detail. Also, it is suggested that the immediate and impressive successes of the reductionistic medicine led to an underestimation of the importance of the general living conditions in the generation of health.
KEYWORDS: SOCIO-ECONOMICS; SOCIO-DEMOGRAPHIC; GLOBAL.

043

AU: Collins JJ

TI : The contribution of medical measures to the decline of mortality from respiratory tuberculosis: An age period-Cohort model.

SO: DEMOGRAPHY 1982, 19, 409-427.

DT: Per

AB: The decline of mortality in the more developed nations has been related to two major influences, economic development and the introduction of medical measures. The contribution of medical measures has been a source of continuing controversy. Most previous studies employed either a birth cohort or calendar year arrangement of mortality data to address this controversy. The present study applies an age-period-cohort model to mortality from respiratory TB in England & Wales, Italy, and New Zealand, in an attempt to separate economic influences from that of medical measures. The results of the analysis indicate that while the overall contribution of medical measures is small, when examined by calendar year, specific birth cohorts both in Italy and England and Wales benefited substantially from these measures. The environmental conditions in New Zea-

land, however, were such that the introduction of medical measures barely affected declining mortality levels from respiratory TB.
KEYWORDS: SOCIAL CONDITION; SOCIO-ECONOMICS; HEALTH MONITORING; UK.

044

AU: Kashyap Mankodi
TI : Socio-cultural context of tuberculosis treatment: a case study of southern Gujarat.
SO: INDIAN J TB 1982, 29, 87-92.
DT: Per
AB: Existence of public medical facilities does not ensure their acceptance contrary to what was assumed by the NTP. Besides their limited research in the whole community, their case-holding is marred by defaulters. Defaulters are not necessarily the poor and the underprivileged, but are as likely to be those who indulge in medical consumerism out of consideration of status. To secure better case finding and case holding, involvement of private medical practitioners is suggested along with possible means of enlarging the "catchment area" of the DTC, like identifying special target referrals can be encouraged selectively, and emphasizing the superiority of routine diagnostic and curative activities of the DTC vis-a-vis private practitioners, so as to give a sociological "face lift" to the DTP, which will attract more of those patients who pay more, and get less, from private practitioners.
KEYWORDS: SOCIO-CULTURAL; PRIVATE PRACTITIONER; INDIA.

045

AU: Rajiv G, Bhagi RP & Menon MPS
TI : A clinical and socio-economic study of hospitalized patients of tuberculosis.
SO: Eastern region Conference of IUAT, 15th, Lahore, Pakistan, 10-13, Dec 1987; p. 396-402.
DT: CP
AB: The study examined the clinical profile of five hundred TB patients admitted to the Rajan Babu TB Hospital, Delhi and determined the clinical and socio-economic factors important in hospitalization, default and failure of therapy. An attempt was also made to judge the health awareness in these patients and from that the success or failure of the health education programme. It was found that the percentage of cases who had relapsed or who were drug failures was quite high in hospitalized patients. Socio-economic factors were solely or partially responsible for the patients seeking admission in almost 20% of the cases. These factors as well as lack of education and proper motivation were responsible for drug default and subsequent failure in a large number of cases. Health awareness was quite low even in patients who had stayed in the hospital for a prolonged period pointing towards a failure of health education.
KEYWORDS: SOCIO-ECONOMICS; SOCIAL AWARENESS; INDIA.

046

AU: Nagpaul DR

TI : Tuberculosis problem seen epidemiologically and sociologically simultaneously.

SO: Eastern Region Conference of IUAT, 15th, Lahore, Pakistan, 10-13 Dec 1987, p. 96-100.

DT: CP

AB: Selected data from the Philippines TB Survey (1981-1983) are presented to study the relationship between epidemiological and social aspects of TB, specifically, awareness of certain symptoms and prevalence of TB. Qualified sociological interrogators were drilled for several weeks prior to the survey in setting interview situations, non-suggestive questioning followed by a few leading questions, anatomy of the questionnaire and the standard way of handling it, testing for consistency both prior to use and during the survey. Individuals 20 years and above were asked if they had any suggestive symptoms, namely, cough, fever, chest and/ or back pain, or haemoptysis during 4 weeks prior to an interview. Of 9,090 such persons interviewed, 2,515 (28%) had one or more of the stated symptoms. Of those with symptoms, 3.6% had positive smear results compared with 0.5% among the asymptomatics. For culture positivity, the corresponding proportions were 4.2% and 0.9% and, for radiographic TB, 11.4% and 4.1% respectively. These differences were highly significant and applicable to all age groups. There appears to be a fairly close relationship between the epidemiological parameters and suffering awareness of symptoms produced by TB. This conclusion was supported by the finding that, when both symptomatics and asymptomatics were equally pressed to attend for the investigations, the presence of symptoms appeared to have increased the suspects' likelihood to attend for the investigations ($P<0.0001$).

Further, the data suggested that eliciting suggestive symptoms in a manner to reflect suffering awareness had a reasonably high degree of sensitivity and specificity; the highest level of sensitivity (74%) was reached with respect to smear-positive cases. Thus, using the symptom suffering as a useful sociological parameter is feasible. Concerning action-taking, on analysis, the pattern varied with age, gender, urban/rural habitat, nature and duration of symptoms, whether a symptom occurred alone or in combination, etiology of the symptom and social perception of what needs to be done for a particular kind of symptom and how an individual/ family should proceed if an action taken was unsuccessful. Nevertheless, the choice of action was related to the TB/ non-specific etiology of symptoms. Based on these findings, there appears to be a good case to develop an objective measurement of cough, of a selected duration and action taking as a sociological parameter of suffering to go along with the epidemiological measurement of TB in a community.

KEYWORDS: SOCIAL AWARENESS; SOCIAL ACTION; INDIA.

047

AU: Schoeman JH, Westaway MS & Neethling A

TI : The relationship between socio-economic factors and pulmonary tuberculosis.

SO: INTERNATIONAL J EPIDEMIOLOGY 1991, 20, 435-440.

DT: Per

AB: The role of socio-economic factors for the risk of developing TB is unclear. Differences and similarities between cases and controls on various socio-economic factors were determined. Some 84 black TB patients on ambulatory treatment and 84 disease free

controls living in the same urban area (South Africa) and matched for age and sex were studied. Variables measured were demographic details, general living conditions, household ownership of luxury items and, weekly consumption of four proteins (meat, fish, chicken & cheese). Three socio-economic indices were constructed from the above variables. No significant differences were found between cases and controls on most of the variables. Overall, significant differences were found on the pattern of language groups (chi-square; p= 0.031) employment groups (chi-square; p= 0.029) and meat (chi-square; p= 0.012) and chicken consumption (chi-square; p=0.034). A tendency was observed for more employed cases than controls to have a primary school education. However, no conclusive evidence was found on the association between socio-economic factors and risk of developing TB. The development of a more appropriate socio-economic measure for developing countries is a necessary step for further research.
KEYWORDS: SOCIO-ECONOMICS; SOUTH AFRICA.

048

AU: Rubel AJ & Garro LC

TI : Social and cultural factors in the successful control of Tuberculosis.

SO: PUBLIC HEALTH REP 1992, 107, 626-634.

DT: Per

AB: Early case identification and adherence to treatment regimens are two remaining barriers to successful TB control. In many nations, however, fewer than half of those with active disease receive a diagnosis and fewer than half of those beginning treatment, complete it. These twin problems derive from complex factors. People's confusion as to the implications of the TB symptoms, cost of transportation to clinic services, the social stigma that attaches to TB, the high cost of medication, organizational problems in providing adequate follow-up services and patients' perception of clinic facilities as inhospitable all contribute to the complexity. Socio-cultural factors such as the cultural understanding that people with symptoms apply to their disease, staff reluctance to adapt their work environments to patients' daily activities and the socio-political organisation of health delivery services have been emphasised. The importance of studies carried out on three specific subtopics: a) Perception and interpretation of chest symptoms, b) Influence of social stigma on help-seeking and adherence to therapy and, c) Adherence to treatment recommendations are discussed in detail.

A knowledge of the health culture of their patients must become a critical tool for health care providers if TB programmes are to be successful. Several anthropological procedures such as adopting focus group sessions are recommended to help uncover the health culture of TB patients. Thus, a comprehensive analysis of the health culture of groups at high risk for TB, as it interacts with the availability of effective chemotherapy will provide the needed groundwork to eliminate remaining barriers to successful, enduring TB control.
KEYWORDS: SOCIO-CULTURAL; SOCIAL STIGMA; USA.

Waiting room at District TB clinic in Netherlands

049

AU: Wilton P

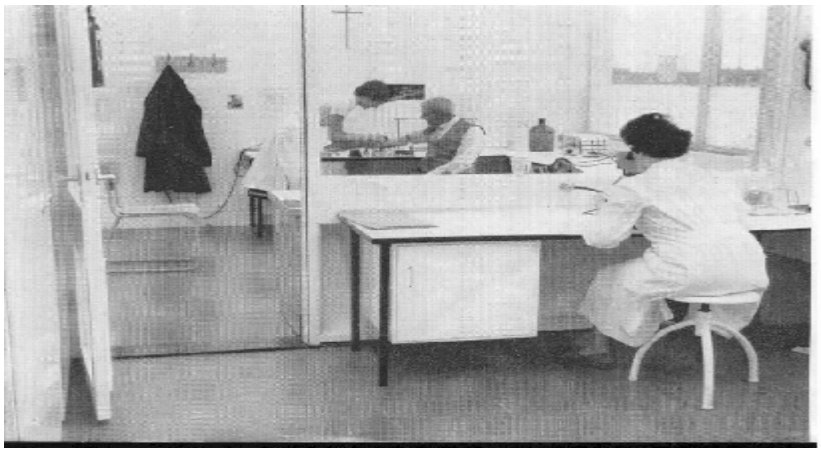
TI : "TB voyages" into High Arctic gave MD`s a look at a culture in transition.

SO: CAN MED ASSOC J 1993, 148, 1608-1609.

DT: Per

AB: Doctors aboard a Canadian Coast Guard ship travelled to and surveyed the Inuit communities residing in the most isolated areas in Canada, the Eastern High Arctic, for pulmonary TB in 1962. The ship's four doctors surveyed 2,510 people, thoroughly examining half the number. Seventy-nine cases of TB were found. These patients were transported south to a Sanatorium for treatment and several measures were taken to minimize the patients' shock in being separated from their natural environment. Medical facilities and treatment became more accessible to the Inuits in the late sixties and early seventies.

KEYWORDS: SOCIO-CULTURAL; CANADA.



Laboratory, at District TB Clinic in Netherlandss

050

AU: SAARC Tuberculosis Center

TI : Seminar on socio-cultural aspects of tuberculosis.

SO: STC NEWSLETTER 1994, 2, 1-2.

DT: Per

AB: The newsletter lists a series of recommendations following the SAARC Seminar held in Nepal, in 1993. Giving priority to support operational research studies on the above topic, stepping up the information, education, communication activities, encouraging community participation in early case detection, referral and follow-up examinations, including NGOs in future SAARC meetings are some recommendations to control the spread of TB.
KEYWORDS: SOCIO-CULTURAL; NEPAL.

051

AU: Tada CS

TI : Socio-economic factors influencing tuberculosis; A status report of findings at Sagalee, during mass sputum sample survey with effect from 12-3-84 to 31-3-84.

SO: SOUVENIR OF TB ASSOCN OF ARUNACHAL PRADESH 1994 p. 16-18.

DT: Sov

AB: A survey of the socio-economic status of nine villages in Sagalee Circle, Arunachal Pradesh, was carried out from 12-31 March, 1984, during a Mass Sputum Sample Survey, in order to determine the relationship between socio-economic status and TB. A total population of 1004 from 84 households was covered. The family structure in the ethnic group studied was that of a joint family and the custom of polygamy was practiced. Many areas surveyed were difficult to reach. The survey results revealed that the people were generally exposed to different types of common infections and diseases, preventable if the socio-economic status had been higher. However, the incidence of TB was less than the national level of 4%. Several recommendations are offered to assist future health planning and health promotion in the state.
KEYWORDS: SOCIO-ECONOMICS; INDIA.

052

AU: Kearney MT, Wanklyn PD, Goldman JM, Pearson SB & Teale C

TI : Urban deprivation and tuberculosis in the elderly.

SO: RESPIR MED 1994, 88, 703-704.

DT: Per

AB: The study examined the possible association between urban deprivation and TB in the elderly by comparing the TB notification rates in the Urban Priority Area (UPA, which includes the inner city and most of the poorer housing estates) and the rest of Leeds, UK, between 1986-1990. The results were analysed by chi-square test and revealed a greater than two-fold increase in notifications for TB in elderly subjects resident in areas of urban deprivation. The findings highlight concerns over continuing poverty and deprivation among Britain's elderly population.
KEYWORDS: SOCIO-ECONOMICS; UK.

053

AU: Nikhil, SN

TI : Socio-cultural dimensions of tuberculosis.

SO: HEALTH MILLIONS 1995, 43-46.

DT: Per

AB: Several case studies are presented in this paper to emphasize that the social and cultural dimensions of TB are of paramount importance from the management point of view. The conclusions drawn were: 1) The social stigma against TB was still dominant regardless of caste, social class, economic status, level of literacy and geographic location, 2) Maid servants appeared to be one of the most important transmitting agents of TB, 3) The perception of the patient towards his/her life and people (society) changed within moments of learning that they had contracted TB, 4) The physical recovery of the patient was faster than their psychological recovery. It is recommended that the NTCP take note of the behavioural dimensions of the TB patient from the management perspective.
KEYWORDS: SOCIO-CULTURAL; SOCIAL STIGMA; INDIA.

054

AU: Juvekar SK, Morankar SN, Dalal DB, Sheela Rangan, Khanvilkar SS, Vadair AS, Uplekar MW & Deshpande A

TI : Social and operational determinants of patient behaviour in lung tuberculosis.

SO: INDIAN J TB 1995, 42, 87-93.

DT: Per

AB: Two hundred and ninety nine patients registered for treatment with the public health services-103 with rural PHC`s and 196 with urban TB clinics in Pune district were interviewed in order to understand social and operational determinants that influence treatment behaviour in lung TB. Detailed quantitative as well as qualitative information was elicited. The study showed that despite weak, if not missing, health educational inputs, patients' understanding of TB was satisfactory. Their preference for private doctors over public health services for TB, their frequent change of health providers for diagnosis as well as treatment, their poor treatment adherence despite knowledge of its ill-effects and their related actions perceived clearly as deleterious to their own good were influenced more by social, economic, and operational factors than by their self-destructive attitude and behaviour. The study concluded that it was the availability, affordability and acceptability of health facilities for TB-factors related primarily to the provider behaviour- that deserved greater and priority attention. Attempts at rectifying provider behaviour were likely to be more productive than those at disciplining patients.
KEYWORDS: SOCIAL BEHAVIOUR, SOCIO-ECONOMICS, HEALTH PROVIDER; INDIA.

055

AU: Hudelson P

TI : Gender differentials in tuberculosis: the role of socio-economic and cultural factors

SO: TUBERCLE & LUNG DIS 1996, 77, 391-400

DT: Per

AB: This paper reviews current knowledge about the role that socio-economic and cultural factors play in determining gender differentials in TB and TB control. The studies

reviewed suggest that socio-economic and cultural factors may be important in two ways: first, they may play a role in determining overall gender differences in rates of infection and progression to disease, and second, they may lead to gender differentials in barriers to detection and successful treatment of TB. Both have implications for successful TB control programmes. The literature reviewed in this paper suggests the following:

Gender differentials in social and economic roles and activities may lead to differential exposure to TB bacilli;

The general health/nutritional status of TB-infected persons affects their rate of progression to disease. In areas where women's health is worse than men's (especially in terms of nutrition and human immunodeficiency virus status), women's risk of disease may be increased; A number of studies suggest that responses to illness differ in women and men, and that barriers to early detection and treatment of TB vary (and are probably greater) for women than for men. Gender differences also exist in rates of compliance with treatment. The fear and stigma associated with TB seems to have a greater impact on women than on men, often placing them in an economically or socially precarious position. Because the health and welfare of children is closely linked to that of their mothers, TB in women can have serious repercussions for families and households.

The review points to the many gaps that exist in our knowledge and understanding of gender differentials in TB and TB control, and argues for increased efforts to identify and address gender differentials in the control of TB.
KEY WORDS: SOCIO-ECONOMICS, SOCIO-CULTURAL, GENDER DIFFERENTIALS; UK.

056

AU: Davies RPO, Tocque K, Bellis A, Rimmington T & Daview PDO

TI : Historical declines in tuberculosis in England and Wales: improving social conditions or natural selection?

SO: INT J TB & LUNG DIS 1999, 3, 1051-1054

DT: Per

AB : Since there has been an association between TB, poverty and over-crowding, most observers assumed that during pre chemotherepeutic era, decline in mortality due to TB has been because of the improvement in social conditions alone. As per the records available from 1850, except during the world wars, mortality from TB has steadily declined. However, the possible effects of natural immunity acquired by successive generations in a process of natural selection and selective mortality of susceptible individuals or family are over looked in studies of historical TB rates. The aim of this study is to reinvestigate the association between changes in mortality from TB on the one hand and mortality from other poverty related diseases, socio-economic conditions and measures in Victorian England on the other. Mortality statistics for England and Wales from 1853 to 1910 (before world war) were obtained from the Registrar General Annual Reports. These publications included data on TB, cholera and dysentery. Infant mortality, total mortality rates, socio-economic measures, statistics on average real

earnings were also taken from the same source. Data on other diseases over the same period of time were not as complete, hence not included for the comparison.

The results showed total mortality rates declined by 0.80 per year where as TB mortality declined by 1.71. The average annual declining for TB was therefore twice that for all causes. The infant mortality a closer indicator of improvement in social deprivation declined even more slowly by 0.58 per year. Secondly, while TB deaths showed a steadily improving trend over the 60 years, infant mortality improved only from 1900. The study showed that TB mortality declined at a much faster rate than any indicator of social deprivation improved for the period 1853 to 1910. It is therefore unlikely that social improvements alone were responsible for the remarkable steady decline in TB mortality. Other diseases such as diphtheria and cholera thought to be poverty related showed no similar decline. The decline in TB mortality far exceeded improvements in social conditions and other disease markers of poverty. Some other factors are likely therefore do have been playing a part, of which the most important is probably the process of natural selection.
KEY WORDS: MORTALITY; SOCIAL CONDITION; HISTORICAL; ENGLAND.

057

AU: Rajeswari R, Balasubramanian R, Muniyandi M, Geetharamani S, Thresa X & Venkatesan P

TI : Socio-economic impact of tuberculosis on patients and family in India

SO: INT J TB & LUNG DIS 1999, 3, 869-877

DT: Per

AB : This study was undertaken to quantify the socio-economic impact of TB on patients and their families from the costs incurred by patients in rural and urban areas.

An interview schedule prepared from 17 focus group discussions was used to collect socio-economic demographic characteristics, employment, income particulars, expenditure on illness and effects on children from newly detected sputum-positive pulmonary TB patients. The direct and indirect costs included money spent on diagnosis, drugs, investigations, travel and loss of wages. Total costs were projected for the entire 6 months of treatment.

The results showed that the study population consisted of 304 patients (government health care 202, non governmental organization 77, private practitioner 25), 120 of whom were females. Mean direct cost was Rs.2052/-, indirect Rs.3934/-, and total cost was Rs.5986/- ($171 US). The mean number of work days lost was 83 and mean debts totaled Rs.2079/-. Both rural and urban female patients faced rejection by their families (15%). Eleven per cent of schoolchildren discontinued their studies; an additional 8% took up employment to support their family.

It was concluded that the total costs and particularly indirect costs due to TB, were relatively high. The average period of loss of wages was 3 months. Care giving activities of female patients decreased significantly, and a fifth of schoolchildren discontinued their studies.
KEY WORDS: SOCIO-ECONOMICS, SOCIAL COST; WOMEN; INDIA

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AU: San Sebastian M & Bothamley GH

TI : Tuberculosis preventive therapy: perspective from a multi-ethnic community

SO: RESPIRATORY MEDICINE 2000, 94, 648-653

DT: Per

AB: A study was undertaken to explore the knowledge, attitudes and perception of TB and their influence on the adherence to preventive therapy for TB. During 1997, 24 subjects were interviewed by using a semistructured questionnaire which included demographic details, background information on TB, knowledge and perception of TB and chemoprophylaxis. The persons were interviewed in the outpatient clinic in London at the start of the treatment and at monthly intervals thereafter. They were given INH daily for 6 months. The data was analysed descriptively and thematically. The outcome was assessed ≥ 6 months after the start of preventive treatment.

The sample was representative of age, ethnicity and previous BCG vaccination status. The study results revealed that 63% were aware of TB before starting chemoprophylaxis indicating a medium level of awareness. None mentioned health centre as the source of information. Knowledge of TB was gained outside the family. About 63% of them knew about transmission of the disease but few symptoms of active TB were recognized. Most (92%) were aware that TB was infectious. The perceived threat from TB was high (71% believed that TB was potentially fatal), although the estimated risk was low. Over half of the subjects (66.6%) suggested that TB was preventable. Knowledge of preventive therapy exceeded the general knowledge of TB, although the latter was associated with better adherence. Most denied knowledge of the risk of hepatitis from isoniazid. Defaulters failed to attend their first appointment, attributed more side effects to isoniazid and perceived a longer waiting time in clinic. The rate of non-attendance for appointment at the TB clinic was high.

The study has shown that there is an important lack of knowledge of the symptoms of TB. A better general knowledge of TB is more helpful than merely an understanding of the treatment regimen in promoting adherence. It recommends a single daily tablet, prior warning of dizziness and an open discussion of the problems of keeping to treatment for 6 months encouraging adherence to preventive treatment.

KEY WORDS: SOCIO-CULTURAL; SOCIAL AWARENESS; SOCIAL ATTITUDE; TB PREVENTION THERAPY; UK

No.of Records: 28