

Journey of Tuberculosis Control Programme : NTP to NTEP

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Coagulation Studies in Women with Intra-Uterine Contraceptive Device (I.U.C.D.)

SINGH, G., KAUR, S. AND SHARMA, S. D. (*J. Obstet. Gynaec. India*, 19: 593, 1969) from Department of Pathology, Dayanand Medical College, Ludhiana and Family Planning Centre, Sector-22, Chandigarh, write:

One hundred and thirty-three cases who came for I.U.C.D. insertions were investigated for coagulation mechanism status prior to insertion.

The only abnormality detected was the positive Hess test in 11 cases the results of the rest of the tests were all within normal range.

Out of 111 cases, who came for I.U.C.D. insertion, 19 showed markedly increased menstrual periods or menorrhagia. Out of these, 9 had positive Hess test even prior to loop insertion (47.4 per cent).

Use of Hess test as a screening procedure is suggested.

Genetics and Laws Prohibiting Marriage in the United States

FARROW, M. G. AND JUBERG, R. C. (*J. Amer. Med. Ass.*, 209: 534, 1969) from the Genetics Laboratory, Department of Paediatrics, West Virginia University, Morgantown, write:

Laws prohibiting marriage in the 50 states, the District of Columbia, and two territories have been classified as those inclusive for categories of lineal and collateral relatives, and those specific for lineal, collateral, and affinous relatives. A person may not marry a parent, grandparent, child, or grandchild except in Georgia, where a man is not prohibited from marrying his daughter or grandmother. While all political units prohibit marriage between a person and a sibling, an aunt, or an uncle, their prohibitions vary considerably for other degrees of collateral relationship. The uncle-niece marriage is not prohibited in Georgia and among Jews in Rhode Island. Generally, marriage between persons with a coefficient of relatedness equivalent to first cousins or closer has been prohibited. Fewer than one half of the political divisions have prohibitions regarding affinous relatives.

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Tuberculosis Programme as an Integral Component of the General Health Services

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TUBERCULOSIS AS A PROBLEM OF SUFFERING A SOCIOLOGICAL STUDY

A sociological study (Banerji and Anderson, 1963) of the problem of tuberculosis in a rural community in South

India revealed that, motivated by the suffering caused by the disease, more than half of all the infectious cases sought treatment at different health institutions—primary health centres, dispensaries, clinics and hospitals; about a quarter of them was found to be 'worried' by the suffering and most of the remaining cases were 'conscious' of the symptoms of the disease.

A survey of the rural health institutions in this community revealed that most of the patients who visited were not even diagnosed as cases of pulmonary tuberculosis; for the few who were diagnosed as a case, there were virtually no facilities to offer them the treatment.

A FELT NEED ORIENTED TUBERCULOSIS PROGRAMME AS AN INTEGRAL PART OF THE GENERAL HEALTH SERVICES

Basic postulates—The following findings led to the formulation of the two basic postulates of India's National Tuberculosis Programme: First, as already a very large number of patients are actively seeking treatment at various health institutions, top priority is to be given in the national programme to provide services to those who have a felt need, i.e., it should be a felt need oriented programme.

Secondly, as those who have felt need seek treatment at health institutions, tuberculosis services should be given as an integral part of the health services provided at different institutions. A series of operational research investigations were conducted to work out the details of such a felt need oriented programme as an integral part of the general health services (Banerji, 1965; Bordia, 1967; Baily *et al.*, 1967). Some of the major premises of the programme are: (a) Cases of tuberculosis can be diagnosed at rural health institutions by examining by microscopy sputum from those who come to health institutions with a complaint of chronic cough (Banerji, 1965). These findings, incidentally, confirmed the forecasts that were made on the basis of the sociological investigations: at least one out of every twenty-four persons reporting with chronic cough at health institutions in a sputum-positive case of pulmonary tuberculosis. (b) Domiciliary treatment of the diagnosed cases from rural health centres can give reasonably satisfactory results (Banerji, 1965). (c) Facilities for diagnosis and treatment of tuberculosis cases, including keeping of certain basic records, can be developed within rural health institutions by making marginal investment (Bordia, *loc. cit.*; Baily *et al.*, *loc. cit.*). (d) Services of specialised tuberculosis institutions at the higher levels (tuberculosis clinics, sanatoria, hospitals having chest surgery units, etc.) can be made available to the rural health institutions. This can enable them to refer the more complicated cases to them for getting additional facilities for diagnosis and treatment. (e) At the district level (covering a population of a million and a half), provision can be made to have a district tuberculosis centre. Besides providing referral facilities to the peripheral institutions within the district such a centre can be provided with trained staff (Bordia, *loc. cit.*) to carry out also the functions of planning, organisation, coordination, training and supervision of all tuberculosis work at various institutions within the district. The district tuberculosis centre can also maintain a tuberculosis case register for the entire population of the district. (f) As a step towards integration of the BCG campaign with the general health

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services, BCG teams can be attached to district tuberculosis centres so that, apart from doing inoculation work, these teams can also participate in other activities of the tuberculosis programme, for instance, retrieval of treatment defaulters. (g) There can also be a State tuberculosis centre, covering, on an average, population of about 30 million. Meeting the training requirements and evaluation of the tuberculosis programme in the State can be two of its special functions.

ADVANTAGES OF AN INTEGRATED TUBERCULOSIS PROGRAMME

ADMINISTRATIVE ADVANTAGES:

Cost of the services—In term of requirements of personnel, equipment and funds, cost of diagnosis and treatment of a case through an integrated programme is a small fraction of what it costs through specialised tuberculosis programmes in rural areas (Banerji, 1967).

Balanced growth with the general health services—One great advantage of an integrated tuberculosis programme is that even with very modestly developed health services, it is possible to build into it a tuberculosis programme. Later on, as more and more resources are funnelled in to strengthen the 'infrastructure' of the health services, it automatically strengthens the tuberculosis programme (Baily *et al.*, *loc. cit.*). Growth of the tuberculosis programme thus becomes a function of the growth of the general health services.

On the other hand, a specialised tuberculosis programme grows by depriving the general health services of the resources that are badly needed for its growth. This is particularly so in developing countries where there is an acute scarcity of resources. Also, as mentioned earlier, in terms of cost of diagnosis and treatment per case, it gives very poor returns from the investment.

Increased organisational effectiveness—Integration of a tuberculosis programme also increases the effectiveness of the health organisation (Baily *et al.*, *loc. cit.*) e.g., development of tuberculosis work leads to mobilisation of 'unutilised capacity' of the organisation. Use of the microscope for tuberculosis work may stimulate its use for diagnosis of other conditions, e.g., eosinophilia. Development of channels for referring of the causes who need specialised services at the district and State levels lead to more effective utilisation of these services.

SOCIOLOGICAL CONSEQUENCES:

Providing a sociological basis for allocation of efforts—Dealing with tuberculosis as a problem of suffering, side by side with the suffering caused by other health problems, ensures that investment of efforts for tuberculosis work broadly conforms to the importance attached to the disease by the community.

Better acceptability—Dealing with those who have felt need ensures better acceptance of the treatment.

Effect of meeting the felt need—Provision of reasonably efficacious services to those tuberculosis cases who have a felt need may, by itself, 'generate' felt need among those who are at present merely 'worried' or are 'conscious'. In this way a felt need oriented programme has a potential for including as many as 95 per cent of all infectious cases in the community (Banerji and Andersen, *loc. cit.*). Dealing

with the felt need of millions of cases through a nationwide network of thousands of health institutions can inspire confidence in the community and stimulate its active participation in other health and social development activities.

EPIDEMIOLOGICAL IMPLICATIONS:

In countries where the incidence of the disease has declined, factors other than a specific tuberculosis programme have played a dominant role (Dubos and Dubos, 1958; Grigg, 1958). Dubos and Dubos (*loc. cit.*) attributed it to a general rise in the standard of living in these countries; Grigg (*loc. cit.*) went a step further and claimed that mere exposure of a population to the tubercle bacillus over a period of time would lead to a decline in the incidence by a natural weeding out of the susceptible population. Some indirect evidence (Banerji, *loc. cit.*) of declining incidence of the disease due to such nonspecific factors is also available with regard to the epidemiology of the disease in India, e.g., similar rates of prevalence in rural and urban population, higher prevalence rates among the upper age-groups, comparatively lower virulence of the Indian strains of *M. tuberculosis*, etc.

Therefore, launching of an extensive tuberculosis programme on the presumption that this alone can reduce the 'pool of infection' appears to be untenable even on epidemiological grounds; at best, it can only reinforce the nonspecific factors that are bringing about a decline in the incidence. On the other hand, when such a programme grows as a function of the overall growth of the general health services, this growth of the programme is justified primarily by the pressure of the felt need for such services in the community; the contribution of such a programme (which is capable of covering some 95 per cent of the infectious cases) to the decline of the incidence of the disease can be regarded as an additional and a valuable by-product.

SUMMARY

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

Such an integrated programme is not only very economical, but it also grows along with the general health services. Its orientation to felt need makes it more acceptable. It also has a potential for covering some 95 per cent of the infectious cases in the community. This indicates that, as it grows, it can have an impact on the incidence rates of the disease.

REFERENCES

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