INTRODUCTION

Tuberculosis (TB) is uniformly distributed in urban and rural areas as per the ICMR survey conducted from 1955-58 and the prevalence of sputum positive pulmonary TB ranges from 2-8/1000\(^1\). However, relief seeking pattern depends upon various factors i.e., accessibility to health services, socio-economic and educational background.

District Bijnor of Uttar Pradesh having a population of 2.45 million is situated in the foothills of Shivalik range of mountains on the eastern banks of river Ganga, in the north-western part of Uttar Pradesh. It is surrounded by districts of Haridwar, Nainital and Moradabad in north, east and south respectively (Fig. I).

A study was conducted to find out certain characteristics of TB patients through the analysis of treatment cards of patients diagnosed at District TB Centre (DTC), Bijnor. This was essential to take corrective actions to implement effective control measures to the under represented groups of patients in the community.

MATERIAL AND METHODS

A total of 1415 treatment cards of patients belonging to district Bijnor, attending the DTC during the first fortnight of March 1999 were taken for analysis. Distribution was made according to age, sex, religion and place of residence (urban or rural). Statistical test for significance was employed using X\(^2\) test.

OBSERVATIONS

The patients were distributed age wise into four groups i.e., 11-20, 21-50, 51-60 and more than 60 years. It can be seen that 1415 (66.9\%) of patients were between 21 and 50 years which is the economically productive and sexually active age group. 56\% of patients were males and 44\% were females. This difference was found to be statistically significant. 48\% of the patients were Muslims and 51.9\% were Hindus. 29\% of the patients were from urban areas and the rest from rural areas (Table I).

DISCUSSION

The observation that about 66.9\% of patients were in the economically productive age group, in general, concurs with observations from the rest of the country.
This is of great relevance against the backdrop of increasing HIV sero-prevalence in the same age group. The finding confirms that the economic loss due to TB morbidity can be very significant. Regarding sex distribution, more male patients have been observed to attend the DTC. This can either mean that (1) more males are affected with TB; (2) male patients take action better than females; or (3) more male patients are able to travel to DTC in comparison with females for various reasons.

The percentage of Muslims in the district was 40.3% as against Hindus who constituted 57.8% of the population. Among the diseased, 48.1% were Muslims and 51.9% were Hindus. That higher proportion of Muslim TB patients have sought relief could indicate either a higher prevalence among them or higher action taking.

Eventhough DTC is located in the district headquarters and is more accessible to urban patients, as much as 71% of them are from rural areas. It can only indicate that more efforts should be taken to decentralise TB services to cater to local populations by implementing TB programme in the peripheral health facilities.

The observations further emphasise the importance of TB as a major socio-economic problem and also the need to offer services closer to the patients’ place of residence. We are hopeful that with the introduction of Directly Observed Treatment Shortcourse (DOTS), many of these problems could be effectively handled and solved.

REFERENCE

1. Indian Council of Medical Research: Tuberculosis in India - a sample survey 1955-58, ICMR, New Delhi 1959; Special report series No.34, p 55.