Int J Public Health 52 (2007) 199–201
1661-8556/07/040199-3
DOI 10.1007/s00038-007-0218-1

The socio-cultural challenge in public health interventions: the case of tuberculosis in India

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As per H. Graham, public health policies need to be reconfigured to improve population health and to address inequalities in the social distribution of health (Graham 2004). These reflections draw upon the fact that social determinants are central to programs and policies regarding prevention and control of diseases such as HIV/AIDS, malaria and tuberculosis (TB). While there is ample literature demonstrating that social factors promote and/or undermine the health of women, men, families and populations, there is limited knowledge about the social processes underlying the unequal distribution of health among specific populations, which in turn is at the root of persistent social disparities (Anderson 2000; Marmot 2000; Marmot 2005). The aim of these thoughts is to promote a better understanding, thereby a systematic account for how gender and other social processes operate in causing health inequalities in the case of TB management and control.

While epidemiological evidence indicates that in low or middle-income countries TB is more prevalent among men than women, studies show that this may be explained by gender differences in the social pattern of interactions (Eastwood & Hill 2004; Uplekar et al. 2001). In addition to differences in exposure and risk of infection, there is a difference in the progression from infection to disease as well as in the tuberculosis notification rates in men and women (Holmes et al. 1998). Approximately three million women worldwide contract TB annually and it is estimated that TB accounts for nearly 17 million Disability Adjusted Life Years (DALY) for women with about 750 000 dying of TB every year (Vlassoff et al. 2000; WHO 2002). Not only may women have higher rates of progression from infection to disease and a higher case fatality in their early reproductive ages, but consequences of the latter are felt at the household and community levels (Needham et al. 2001). As a disease of poverty, the social implications of TB are heightened among women living and working in resource poor areas, such as those found in urban slum settlements in Mumbai. Delays in seeking help that arise from gender disparities to access and entitlements to care have been demonstrated to play a significant role in Maharashtra (Vlassoff et al. 2000; Vissandjee et al. 2002). Research in Kerala suggests that stigma has adversely affected participation in programs such as DOTS (Directly Observed Treatment with Short course regimen), resulting in poorer treatment outcomes (Balasubramanian et al. 2004; McMurray 2007). Social discrimination on the basis of TB disease status may result from various factors, such as perceived danger and contagiousness, as well as adverse judgments which may attribute the condition to immoral behaviour and blame the victim for acquiring the disease. Social determinants of support and rejection influence the ways that people in the general population without TB interact with people who are symptomatic (Narayanan et al. 2003). In Western India, sex with prostitutes and menstruating women were perceived to be associated with the onset of TB, leading to increased stigma and cross-gender mistrust (Holmes et al. 1998; Uplekar et al. 2001; WHO 2006). Responses to TB unveil the moral basis of risk and vulnerability to this disease, suggesting a causal web of interactions linking ethnicity, culture and gender as social determinants of health and patterns of socialization (Narayanan et al. 2003). In this regard, findings of a multi-country study indicated critical links between the interests of TB control, gender studies, and the socio-cultural contexts of poverty, restricted access to needed resources, and interactions between illness and victimization (WHO 2006) .

Global partnership initiatives are needed to redress persistent gender inequities ingrained in TB control strategies. Such initiatives should address both the lack of resources and barriers (basic needs approach) as well as the opportunity to attain personal (including health) outcomes (capabilities approach) while designing participatory approaches, especially as it pertains to the urban slums such as those in Mumbai (Richardson & Allegrant 2002; Anderson 2000; Atre et al. 2004; Balasubramanian et al. 2004; Caburnay et al. 2001; Sen 2001; Sen et al. 2002; Uplekar et al. 2001; Vlassoff & Moreno 2002; Weiss 2001).

What constitutes best practices in one topic, or country for that matter, may not necessarily be relevant nor appropriate in another. Similarly, as population health mirrors the dynamism of human life, changing with emerging cultures, socio-economic circumstances and political realities, well-known authors in health promotion and public health refer to best processes rather than best practices in promoting health within a given population (Green & Frankish 2002; Green & Mercer 2001; MacQueen et al. 2001). The challenge remains in the extension of such best practices as identified in clinical practice (referring to TB clinical management) to the public health field and to selected groups of women and men identified as vulnerable.

Evidence derived in public health studies should demonstrate capacities to transpose to public health practices that encompass a population health perspective. As much as possible, public health interventions need to be embedded within socio-cultural dynamics and processes above and beyond practices so that they can be coherently tailored to those who are most at risk (Frohlich 2007; Green & Mercer 2001; MacQueen et al. 2001; Potvin et al. 2005).

One of the useful tools for carrying out an analysis of gender sensitivity and promoting effective and equitable outcomes is the framework proposed by the WHO and the International Centre for Research on Women in the context of the HIV/AIDS pandemic (McLaren 2000; WHO 2002).

By seeking best processes for the integration of gender-sensitivity in TB prevention and control strategies, the expectation is to contribute to more gender-equitable, community-based approaches in line with the MDG goals (3, 4 and 6) seeking to reduce prevalence and mortality of TB in countries such as India (Vlassoff & Moreno 2002; WHO 2006).

Acknowledgements

The authors would like to thank the following persons for their invaluable contribution to earlier versions of this paper: Dr. Lakshmi Lingham, Professor, The Centre for Women's Studies, The Tata Institute for Social Sciences, Mumbai, India; Ms Neha Madhiwalla, Program Director at the Centre for Studies in Ethics and Rights, Managing trustee of Chehak Trust, Mumbai, India; Ms Alisha Apale, University of Montreal.

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