SUMMARY AND CONCLUSIONS
BACKGROUND

Although tuberculosis has been a persistent problem for decades, over the past few years it has been receiving a lot of attention on both national and international front. This has been largely due to the apparent threat posed by the resurgence of the problem of tuberculosis in both developed and developing countries. India bears a disproportionate burden of the global problem of tuberculosis and therefore, holds the interest of a number of international organisations.

In spite of a well-formulated National Tuberculosis Programme in place for over three decades in India, Tuberculosis still tops as a major cause of morbidity and mortality in the country. In 1993, Government of India on technical advice from WHO, revised the tuberculosis control programme to achieve a high cure rate (85%) in patients diagnosed to have pulmonary tuberculosis. In order to achieve this, the strategy adopted was to implement the control programme through directly observed treatment, short-course (DOTS) in pilot projects in five cities of India, namely, Delhi, Mumbai, Calcutta, Gujarat and Bangalore covering a population of 2.35 million.

Indian cities and the urban slums in particular have a heterogeneous character in terms of both population and the health care infrastructure. Urban slums are comprised of fairly heterogeneous floating groups of
population, which are economically and socially deprived and face multifarious problems on health front. Various studies have shown that TB is a major health problem among the slum dwellers as the disease is commonly associated with poverty, overcrowding and malnutrition - features typically found in urban slums. Published literature and data available on the problem of tuberculosis in urban areas and exclusively on slums, are rather scanty. There is gross inadequacy of qualitative researches on the working of DOTS strategy and the people’s as well as the health provider’s reaction towards it. Further, gender differences in the perceptions and experiences of TB patients remain a largely unexplored field.

The present study makes a modest attempt towards bridging this gap. Broadly, it aims to understand sociologically the behaviour of patients and the attitude of the general slum population of Delhi towards tuberculosis and its control programmes, both National Tuberculosis Programme (NTP) and Revised National Tuberculosis Control Programme (RNTCP). The health behaviour of the study population has also been studied in terms of gender in order to highlight the feelings and experiences of women tuberculosis patients, particularly in slum environment, and the attitude of general population towards them. To attain the laid out objectives, the present study was conducted in a comparative manner in
two jhuggi-jhompri colonies of Delhi, one in which NTP was in operation at the time of data collection and another in which RNTCP had been implemented.

In Govindpuri slum, NTP was in operation during the period of data collection while Wazirpur J. J. colony is one of the few slums of Delhi where RNTCP has been implemented since October 1993. Govindpuri falls within the specified area of Nehru Nagar Chest Clinic (N.N.C.C.) and the TB centre responsible for treatment of patients of Govindpuri slum was located in the Chest clinic itself about 8-10 kilometers away from the slum. However, residents of Govindpuri slum had also access to the services provided by a voluntary organisation (CASP PLAN) TB centre (working under N.N.C.C.) which was located in the slum area itself and majority visited this centre for treatment of TB. Wazirpur J. J. colony falls within the earmarked area of Gulabi Bagh Chest Clinic (G.B.C.C.) and the TB centre catering to the population of Wazirpur J. J. colony was also located right in the middle of the slum area.

**METHODOLOGY ADOPTED**

As the research study was designed to be sociological in nature, a qualitative approach was employed to obtain in-depth information from the general slum population, the patients and the health personnel directly involved in delivery of tuberculosis treatment services to the slum dwellers.
For this purpose, different qualitative techniques were used, mainly being focus group discussion, (FGDs), in-depth interview and case study. Twelve focus group discussions were held (six in each slum area) with the non-patient population, each group comprising of six to eight individuals of similar age and sex.

All diagnosed pulmonary TB patients registered for treatment at the time of data collection in the Area TB Centres (ATC) of the two slums, a total of 89 patients in Govindpuri and 82 patients in Wazirpur, were interviewed with the help of semi-structured interview schedule. Information from doctors (one each) of the chest clinics, the health workers (two in Govindpuri and one in Wazirpur) of the ATCs and private medical doctors (two) were also obtained through in-depth interviews. Further, case studies (15 in each slum area) were conducted among the study patients to get in-depth information about the issues related to gender aspects of the disease.

The qualitative data, thus obtained, was subjected to content analysis and the data was thematically presented based on the objectives of the study. The major themes of the study related to the level of awareness of the study population about tuberculosis and its treatment, their experiences of interaction with the health providers, and the observed gender differences
in these aspects. The issues were studied in the background of the given physical and the socio-economic conditions of the slums.

The major findings and the broad conclusions of the present study are given in the following pages.

A PROFILE OF THE STUDY AREAS

A profile of the physical environment of Govindpuri and Wazirpur J.J. colony showed that the study areas exhibited features of a typical slum environment, without much significant difference in the nature and size of the population. Govindpuri slum (which includes Navjeevan Camp, Bhumieen Camp and Nehru Camp) comprised of around 11,865 jhuggis while Wazirpur J.J. colony had approximately 10,000 slum households. The population in both the slums was essentially composed of migrants in search of jobs from different states like U.P., Bihar, West Bengal, Rajasthan, Madhya Pradesh and Haryana. The study population (both patients and non-patients) was predominantly Hindu followed by Muslims and primarily migrants from U.P., Bihar and Rajasthan. In both the slums, majority were living in ‘semi’- pucca houses, some in kuchlu huts and a few in pucca houses.

Gross inadequacy of public utilities and services were observed in the study areas, a common feature of Indian slums. The slum population of Govindpuri and Wazirpur suffered particularly from congestion,
unhygienic living environment and lack of protected water supply and proper drainage/garbage disposal system. High levels of illiteracy, low occupational status and low levels of household income were the common characteristics of both the slums. Largely people lived in nuclear family structure and with number of family members ranging between four to seven. Slum dwellers were observed to adjust to the city life, urban poverty and the slum environment mainly because of the continuance of close links with their villages.

The slum population in the study areas was, therefore, essentially from the lower socio-economic strata of the society who were unable to untie the knot of poverty mainly due to the low levels of education and rampant unemployment. A major cause of many of the sufferings of the urban poor was their low and erratic income levels which itself was the product of low wages, limited skills, irregular work and lack of knowledge about their rights and the opportunities available in urban environment.

Although Govindpuri and Wazirpur slums were quite similar in terms of their physical and socio-economic environment, some differences were, observed in the two areas particularly with regard to their locations and the integration of the slum population into the city life. Govindpuri slum is located right in the middle of big market places of Kalkaji and Tughlakabad Extension area and is adjacent to posh residential colonies of
South Delhi and the Okhla Industrial area, which provide a source of livelihood to many. On the other hand, Wazirpur slum is situated away from big market places, industrial areas and posh residential colonies in North Delhi. Moreover, while some NGOs were involved in welfare activities for slum population of Govindpuri, there seemed to be a lack of such organisations in Wazirpur slum for the betterment of its population. As a consequence, the slum population of Govindpuri seemed to be relatively more informed, exposed and well integrated into the urban city life while the slum dwellers of Wazirpur were observed to be less 'urbanized' and still having strong links with their village homes in spite of the number of years of stay in the slum area.

**AWARENESS ABOUT TUBERCULOSIS**

On the basis of data collected in the present study, one could infer that the slum dwellers (the patient and the non-patient group) were well-aware of a number of aspects of tuberculosis. A person sick with persistent cough, fever, weakness, chest pain and particularly with blood in the sputum, was taken to be suffering from TB by the majority of the slum dwellers. These symptoms were also enumerated by the study patients as the early indications of their disease. In Govindpuri slum, significantly more reported blood in sputum as an 'early' symptom of TB. But since blood in sputum indicates a later stage of the disease, this implies that
patients of Govindpuri were delayed in recognizing and in diagnosis of their disease.

The study population largely were found to associate the occurrence of the disease with the existing physical (the unhygienic surroundings) and the socio-economic environment (the lack of nutritious foods, the general weak body of the urban poor, the addiction to smoking, alcohol etc.) of the slum. But while the patients seemed to be more sympathetic and also well-informed as they laid stress on germs/infection and the physical exertion of the slum dweller as the important causative factors, the non-patient group was observed to put the blame more on the acts of the patient itself by highlighting bad habits (addictions, indiscriminate sex) as the primary cause of TB. Regarding the other aspects of TB, the study population was found to believe in the infectious and contagious nature of the disease, its curability and the same by the allopathic method of treatment.

An interesting observation was made regarding the beliefs of patients about curability of TB. A section of patients in both the slums were found to be unable to decide whether TB was curable and, therefore, responded "don't know" to questions regarding curability of the disease. One could feel that these people were torn between traditional beliefs and the new urban values. On the one hand, they had learnt from elders of their village that TB was an incurable disease and had sometimes witnessed themselves
the social ostracism of families having TB patients. On the other hand, they had been informed by doctors/health workers that if medicines were taken regularly, full recovery was definite and had also found TB patients living close to the general population in the urban slum environment. This group of patients, therefore, depicted clearly the conflict that urban slum dwellers often face between a few rural and urban ways of thinking and the difficulty in breaking free from values and customs derived from the rural society.

Although similarities did exist in the perceptions of the study population, certain variations could also be observed between: non-patient group of the two slums, patients and non-patients and patients of the two slum areas. With particular regard to the curability, method, source and duration of TB treatment, the non-patient population of Wazirpur slum as compared to that of Govindpuri seemed to be less informed. The observed variations could possibly be related to the different locations of the slum areas, the working of welfare organisations in the slums and the extent of exposure of the slum population to urban city life (as has been mentioned earlier).

In comparing the patient and the non-patient population of the two areas, the latter fared little poorly in terms of their awareness about the various aspects of tuberculosis, mainly about its treatment process. This
seems obvious since the patients were currently undergoing treatment (at the time of data collection) for TB and therefore had better knowledge about the disease through personal experience and counselling done by the health workers of the ATCs. Further regarding tuberculosis treatment regimen, the patients of Wazirpur were found to be more aware than the patients of Govindpuri. This was observed to be largely due to the increased interaction of health providers and patients in Wazirpur and the effective delivery of TB treatment services in the area.

HELP-SEEKING BEHAVIOUR

In the present study, for more than half of the study patients in both the slums, the first source of help on developing chest symptoms was primarily the private doctor. Though TB is considered to be a major illness by the slum dwellers, the early symptoms of TB (cough, fever) are perceived as minor and the help-seeking patterns become, therefore, similar to the general trend of help-seeking for minor illnesses. Around one-fourth (more in case of Wazirpur) of the patients were, however, found to visit directly ATC on developing the initial symptoms of TB. This again clearly shows the adequate level of understanding about the disease among the patients of the study areas.

However, while in comparison to government health services, significantly more number of patients in the two slum sought private
medical help, majority were, nevertheless, diagnosed as TB patients by the government health sector. Thus, although the first source of contact for slum TB patients, is often a private medical practitioner, this by itself is not leading to early detection of TB cases. The general reluctance among people to accept the diagnosis of TB, the fear of losing a client, and the often heavy expense involved in the medical tests recommended by the private medical doctor may have led to less number of TB cases being diagnosed by the private health sector.

COMPLIANCE AND NON-COMPLIANCE BEHAVIOUR: THE ROLE OF THE HEALTH SERVICES SYSTEM

Significant difference between the slums could be observed in terms of status of treatment of patients. The number of patients who dropped out of TB treatment regimen were found to be significantly much more in case of Govindpuri as compared to the Wazirpur. Compliance/non-compliance behaviour of people is generally the result of the interplay of numerous factors. Majority in both the slums were found to have a fair knowledge about the importance of regularity and completion of TB treatment. Therefore, ignorance of slum patients could not be taken as a reason for non-compliance. However, the health providers of both the slum areas in the present study argued that ignorance or the low level of awareness about tuberculosis among the slum dwellers led them to default. It was observed
that they had a tendency to put the blame for default on the patient by highlighting the ‘floating nature’ of the slum population and health not being given priority among the urban poor. The stress laid by the doctors and health workers in the present study was on educating the masses to make them more compliant.

But, the problem of non-adherence or non-compliance particularly in Govindpuri (where it was much more in number than Wazirpur) seemed to originate in large part within the health system only - primarily due to the lack of commitment of the health workers and the inefficient functioning of the ATC. It was found that patients in Govindpuri defaulted or dropped out completely because of mainly adverse drug reactions, irregular supply of drugs and financial problems (as medicines were often required to be purchased from the market) together with the disappearance of the initial symptoms of the disease. The Govindpuri patients were found to be largely dissatisfied with the behaviour of the health staff and the working of the ATC.

In general, patients of Govindpuri were observed to be under confusion as they remained unsure of where diagnosis tests were to be done, when and where to go for medicines, the days and timings of the TB centre etc. As a consequence they lacked confidence and faith in the health service system. In such a situation, patients who felt temporarily cured or
held beliefs about incurability of the disease, were most likely to default. The health workers of ATC at Govindpuri were reported to hardly spent much time in interacting with the patients and informing them about the length of the TB treatment regimen (significantly more Wazirpur patients had better knowledge about it), the dosage of medicines, the possible initial adverse drug reactions etc.

Given the situation, where the health providers did not have the time or commitment, nor did they give importance to regularity in drug distribution, how could the patients of Govindpuri be blamed for not maintaining regularity in drug consumption? It was quite evident from the prevailing circumstances and from the responses of the patient that what they needed foremost was the assured availability of ‘regular’ treatment for TB more than ‘supervised’ treatment.

In Wazirpur, however, cultural beliefs of people (regarding incurability of TB) were mainly responsible for non-compliance while on the other hand, the health service system seems to have played largely a positive role in bringing about better compliance. It was observed that the TBHV of Wazirpur TB centre interacted closely with the patients and informed them particularly about the cause and the manner of spread of the disease, length of the treatment process, the exact dosage of the medicines, the possible adverse drug reactions and about the significance of the DOTS
strategy. This greatly helped the patients to enhance their level of awareness and also to remove any misconceptions about the disease, thereby, to have high hopes of full recovery. A positive attitude towards the disease is necessary for both the health staff and the patients which acts as a constant persuasive force for the patient in completing the TB treatment course in otherwise adverse circumstances of poverty and social stigma.

The most significant factor contributing to compliance in Wazirpur was, however, the assured availability of drug supplies at the ATC, which did not require slum patients to visit the centre repeatedly and also made them realise that the health service system was equally serious about their treatment and complete recovery. DOTS strategy may have also played a positive role in greater compliance by Wazirpur patients but one could observe and feel from patient’s perceptions and behaviour that it was the regularity and the efficient delivery of TB treatment services in the area which made the difference. Further, it was noted that the health workers under RNTCP generally registered those patients who were not likely to default. This was ascertained by the system where a patient was required to give a contact person or in other words one who will guarantee his completing the treatment. The patients were often observed for a certain period of time while on treatment to ascertain their chances of defaulting. Generally those patients were continued on TB treatment regimen where
the health worker was assured of regularity in treatment. This may an important factor contributing to the higher compliance rate found under the DOTS strategy. Such a system possibly implies the existence of a group of TB patients in a population who are in need of treatment but are denied as they are believed to be 'potential defaulters'.

**ATTITUDE TOWARDS DOTS**

DOTS (Directly Observed Treatment, Short-course) is a comprehensive strategy promoted by WHO, World Bank and other international development agencies to detect and cure TB patients. As part of this strategy, health workers counsel and observe their patients swallowing each dose of medicines and patient's progress is monitored till each is cured.

When Govindpuri TB patients were probed about the efficacy and need for DOTS, it was observed, they had difficulty in perceiving the system as such. This was so since at the time of data collection in the area, NTP was in operation. On being informed about the DOTS strategy and the RNTCP, these patients came up with their view points. Majority of patients in Govindpuri (87 per cent) suggested that the DOTS system would be unnecessary, resulting in a wastage of resources. They argued that they were quite capable of taking medicines on their own and it is too much to expect the doctor or the health worker to ensure that they consume
medicines daily. Most of them felt that it would be wastage of time for both the health providers and the patients.

DOTS system would also require patients to visit the ATC daily and as a result it did not gain much favour in Govindpuri. This has to be seen in the light of the fact that many patients of Govindpuri slum did not have good experience with the staff and working of the ATC. The rest however, were in favour of the DOTS system, as they perceived it, since they faced difficulty in understanding the dosage of medicines and remembering to take it.

When Wazirpur patients in the study were probed about the efficacy of the DOTS system, three-fourth voiced their preference for DOTS as a system of TB treatment. The argument put forward by these patients was that this system made them more disciplined as they would otherwise tend to "forget and be careless". This was a major reason given by WHO for adoption of DOTS strategy and it seems to have been well propagated in the population. Many of these patients felt that although they had to face many problems in coming daily to the centre for few months, it was after all for their own good. Some among the patients preferring the DOTS system, further, felt that this system helped them to share their anxieties and hopes of recovery with each other.
On the other hand, around one fourth of the TB patients in Wazirpur, felt that the DOTS system was an unnecessary burden on them. It was argued by them that going daily to the centre created number of problems for them namely they had to take leave from their work to reach the centre, daily visits to the centre attracted the attention of neighbours and friends and that they were unable to go to their village home etc.

The health providers (doctor and the health worker) highlighted a few advantages and problems of the RNTCP/DOTS strategy. They argued that severe shortage of staff at the chest clinic caused serious problems as DOTS required frequent and sustained interaction of patients with the health staff. This made it problematic to handle the large numbers of patients coming for diagnosis tests etc. Further, there was the problem of water scarcity. According to the DOTS strategy, patients were supposed to consume medicines in front of the health worker. This meant that it was the responsibility of the TB centres to provide water to the patients, and also make sitting arrangement as in the initial months patients remain quite weak. This became a problem because of general water scarcity and due to lack of chairs, stools etc. at the ATC, which forced weak patients to stand for long hours in queues in order to swallow one dosage of medicine.

However despite the problems faced due to the DOTS strategy, the health providers were optimistic about the DOTS strategy. They felt that by
this system patients could be made more compliant and ensure completion of the treatment. According to their viewpoints, “DOTS helped them to maintain control and authority over the patients”.

The findings of the present study thus show the successful working of the DOTS strategy in the Wazirpur area, under the G.B.C.C. Both the beneficiaries and the health providers were found to be satisfied with the DOTS system. The enthusiasm and commitment shown by the doctors and the health workers was highly noticeable. It could be observed however, that the DOTS by placing the responsibility of compliance on the health providers gave the latter much power to exercise control and authority over the patients, which in some situations may have got misused. Moreover, while DOTS may be an ideal method for controlling the spread of tuberculosis infection, one wonders how far such a system will be successful if applied to the varied and bigger population of the country. It is felt that for its widespread application as well as success in the country, the DOTS system will have to be tailor made to suit the needs and preference of specific population.

People’s participation or lack of it makes any health programme success or a failure. In this context, community participation can be included in the DOTS strategy to make it reach to a wider population. For example, the responsibility for ‘observed treatment’ could be entrusted to
small groups in villages or towns where a PHC or sub-centres may be located at a distance from the village. However, the most important component of the DOTS system is the assurance of dependable and regular supply of anti-TB drugs. Thus, what finally becomes essential for any health programme to succeed is the existence of necessary political commitment.

**GENDER DIMENSIONS**

Poverty and ill-health are among the important causes of urban poor’s sufferings but it is the presence of gender inequality in the household which places this burden disproportionately on the shoulders of slum women. The health behaviour and experiences of men and women, thus, differ even when they are in comparable clinical condition and undergoing the same type of treatment. Such gender differences in health behaviour of TB patients were observed in the present study too.

Significant difference in the educational status of male and female patients of the two slums were found, both at the highest (secondary education) and the lowest (illiteracy) levels. Financial constraints, lack of access to educational institutions and some cultural beliefs were the major impediments in the way of educational upliftment of slum girls. Lack of education meant that women had limited knowledge, skills and were less exposed to the outside world. Further, social restrictions on mobility of women contributed to their lack of awareness, confidence, decision-making
ability and power. All these determined the level of expectation of people from women and of women from themselves which together significantly influenced their health behaviour of men and women.

An important difference observed between male and female patients of the study areas in terms of their responses regarding both causes and spread of TB was about their expressed ignorance. Significantly more women than men in Govindpuri and Wazirpur confessed their lack of awareness particularly with respect to causes and the means of transmission of TB. This directly reflected the low levels of education, limited mobility and the general low status of women. These women had got used to living in ignorance and being away from the outside world. They failed to see any immediate benefit in increasing their knowledge and awareness about various issues. The women argued that their domain was the household which they managed quite competently even with their limited knowledge. Awareness about their own health problems were also felt unnecessary as there were doctors and health workers to provide treatment, in whom they had complete faith. Men, on the other hand, stated their views about the causes, manner of spread and other issues related to TB with much confidence, even if their response was totally incorrect.

Differences were also observed in the reporting of symptoms of TB by men and women patients. More men than women reported cough as the
early symptom of the disease while more women than men recalled blood in sputum as the ‘initial’ indication of TB. This was found to be true in case of both Govindpuri and Wazirpur. It is worth noting that while persistent cough and fever were the initial symptoms of the disease, throwing out blood while coughing could not be taken as an ‘early’ indication of TB. This confirms a well known fact that in the existing socio-economic reality women are often compelled to give relatively less priority to their health as compared to men and were therefore, ‘aware’ of their health problems only when it was at an advanced stage. It was observed from the case studies conducted that more than women themselves being careless about their health, their family members did not encourage their seeking of early medical treatment for their illness.

Further, when women did seek help it was generally from a government or a free of cost health centre. More women than men in both the slums contacted the nearby government hospital or the ATC on developing the early symptoms of TB. Men, on the other hand, preferred the private medical doctors as the first source of help as they could expect immediate relief from the medicines given. This was possible since men being the ‘breadwinners’ in the family could not only afford private health services in terms of money but also due to the fact that they were relatively less accountable to others about the way they spent their income. Women
resorted to the government health centres because of the limited financial resources and the lack of 'luxury' of spending it according to their own priorities. This implied that the scarce resources which the families in slums had were not essentially meant to be spent on the women. However, in case of TB this tendency proved beneficial to the women patients as they did not have to indulge much in 'shopping' for treatment and move from one provider to another.

An important finding of the present study, has been that women were more compliant than men in pursuing treatment for TB in each slum area. From the perspective of the health providers, men were more non-compliant mainly due to their addiction to alcohol, tobacco, drugs etc., their pressure of employment, their frequent visit to their native village and perhaps because of their relatively carefree nature. On the other hand, women being confined to the household and the slum area largely, were able to continue with the treatment for TB more than men. They were also found to be having lot of faith in directions given by the doctor/health worker and were more sincere in completing the treatment, once started.

As per the reasons offered by patients for non-compliance, it was found that women in the study defaulted primarily because of health service related problems (like adverse drug reactions, rude behaviour of health staff etc.) and not due to their careless nature (like on having the
feeling of recovery). It was observed that women earnestly wanted to get rid of the disease as they had to bear the burden of household work no matter how sick they felt. Further, it was also necessary for them to recover fast as otherwise they feared possible rejection by their family.

The existence of gender bias in acceptance of TB patients by family, kin groups and neighbours was quite evident and also openly admitted by the study population. The society seemed open in terms of acceptance where men were concerned. Although in case of male TB patients also, people preferred to avoid their company for fear of getting infected, but once treatment was taken (even if partially) they were accepted back much more readily than women patients. This was the result of the interplay of a number of factors like women being considered as a burden or a liability, their economic dependence, the lack of recognition of their work, low educational levels and lack of decision-making ability and power or in other words, the general low status of women.

However, an important factor was the misconceived notions held by people about the causes and spread of TB. The causative relation drawn by people between tuberculosis and certain socially unacceptable behaviour determined to a large extent the general attitude and behaviour of slum dwellers towards women TB patients. Thus a few believe that TB do not occur among women as they could not indulge in such acts (smoking,
drinking, indiscriminate sex) while many argued that only women of 'loose morals' could possibly suffer from the disease. This also helped people to 'justify' the ill-treatment meted out to women sufferers of TB and their often traumatic experiences. If a woman once suffered from TB, it became difficult to disassociate the disease from the person and people did not forget, though they may become indifferent to it with period of time.

Although total rejection of women TB patients by their families or open social ostracism were not so common in the slums, ill-treatment of women definitely took place irrespective of their age and marital status. Unmarried girls suffering from TB became a burden on the household which the family preferred to 'shift' somewhere else and the disease was found to cause hurdles in such endeavours. The problems of married women also seemed much as the entire burden of household work rested on their shoulders, with no one to help particularly given the predominance of the nuclear family structure in the slum environment, while women remained at the mercy of their husband and in-laws. Married women TB patients without children feared rejection and those with young children had to remain tied to the household no matter how badly they were treated by their husband and in-laws.

There definitely exists an urgent need for women's organisations in the urban slums who would work for the welfare of women, striving to
make them economically independent and more confident to deal with the 'outside' world and the ill-treatment meted out to them. Proper health counselling by the health workers may help in reducing the existing gender bias towards women TB patients.

The present study, therefore, suggests that while it is necessary for any health programme (such as the RNTCP) to suit the needs of the people, it is also essential to take into account the specific needs, priorities and problems of women in the population. Move should be made in the direction towards mitigating the sufferings of women TB patients and in increasing their social acceptability.