CHAPTER VI

ANNOTATED BIBLIOGRAPHY

1. **Drummond M.F et al, Method for the Economic Evaluation of Health Care Programmes, Oxford New York Toronto, Oxford University Press, 1997 (second edition).**

This book deals with the effort arising from our common concern to improve the quality of economic evaluation in the health care field. The contents of the book comprise of 10 chapters. In chapter 1 is the orientation for the reader how to use this book. In the chapter 2 discuss the kinds of question economic evaluations seek to answer, and the basic forms of evaluation. Then in the chapter 3 present a check-list of questions to ask about any economic evaluation published in the literature. As well as providing a method of systematically appraising the quality of existing evidence, this chapter sets out, in an organized manner, the main methodological issues that would need to be resolved by anyone undertaking an economic evaluation in the health care field. There are four main forms of economic evaluation, each dealing with costs but differing in the way that the consequences of health care programmes are measured and valued. The first form considered, cost analysis, is discussed in chapter 4 and deals only with costs. Chapter 5 examines cost-effectiveness analysis (CEA). In this form of economic evaluation the consequences of programmes are measured in the most appropriate natural effects or physical units, such as 'years of life gained' or 'cases correctly

diagnosed'. Cost-utility analysis (CUA) is discussed in the chapter 6. In this form of economic evaluation the consequences of the programmes are adjusted by health state preference scores or utility weights. Chapter 7 deals with cost-benefit analysis. In this form of economic evaluation attempts are made to value the consequences of programmes in money terms, so as to make them commensurate with the costs. Chapter 8 and 9 discuss practical aspects of undertaking and using economic evaluations. Chapter 8 discusses data collection and analysis. Chapter 9 discusses the presentation and use of economic evaluation results. Chapter 10 concludes this book with some thoughts on how to take matters further. It contains some hints on issue to clarify before undertaking an economic evaluation and some further sources on the more thorny methodological issues.

2. **World Health Organization, 2002. Strategic framework to decrease the burden of TB/HIV. WHO- Stop TB and HIV/AIDS, Geneva**

The unprecedented scale of the epidemic of HIV-related tuberculosis demands effective and urgent action. The strategic goal is to reduce tuberculosis transmission, morbidity and mortality (while minimising the risk of anti-tuberculosis drug resistance), as part of overall efforts to reduce HIV-related morbidity and mortality in high HIV prevalence populations. This evidence-based paper concentrates specifically on tuberculosis control in high HIV prevalence populations, while addressing those aspects of the HIV epidemic relevant to tuberculosis. It is complementary to the Global Health Sector Strategy against HIV/AIDS under development by WHO. It sets out a new WHO/UNAIDS strategic framework to decrease the burden of the intersecting epidemics of tuberculosis and HIV (TB/HIV). Instead of the previous "dual strategy for a dual epidemic", the new framework represents a strengthened unified health sector strategy to control HIV-related tuberculosis as an integral part of the strategy for HIV/AIDS. The interaction between tuberculosis and HIV has implications for the public health approach to tuberculosis control among HIV-infected people. Untreated HIV infection leads to progressive immunedeficiency and increased susceptibility to infections, including tuberculosis. Tuberculosis in high HIV prevalence populations is a leading cause of morbidity and mortality, and HIV is driving the tuberculosis epidemic in many countries (especially in sub-Saharan Africa).

3. **Centers for Disease Control and Prevention, National Center for HIV, STD, and TB Prevention, Division of Tuberculosis Elimination, Self-Study Modules on Tuberculosis Last Reviewed : March 20, 2002**

The Self- Study Modules on Tuberculosis are a series of educational modules designed to provide basic information about tuberculosis in a self- study format. The target audience for this course is entry level public health workers who have little or no background in tuberculosis, such as newly hired outreach workers in health department tuberculosis or sexually transmitted disease programs. This course is also appropriate for staff of correctional facilities, drug treatment centers, migrant clinics, nursing homes, homeless shelters, or other facilities serving persons with or at risk for tuberculosis. The self-study package includes five modules, an introduction and a glossary. Module 1 deals with transmission and pathogenesis of tuberculosis, Module 2 describes about epidemiology of tuberculosis, in the Module 3 deals with diagnosis of tuberculosis infection and disease, Module 4 emphasize on treatment of tuberculosis infection and disease and the last module describes with infectiousness and infection control.

4. **U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES, Centers for Disease Control and Prevention (CDC) Atlanta, GA 30333. Targeted Tuberculin Testing and Treatment of Latent Tuberculosis Infection**

This statement provides new recommendations for targeted tuberculin testing and treatment regimens for persons with latent tuberculosis infection (LTBI) . This statement is issued in recognition of the importance of these activities as an essential component of the TB Elimination Strategy promoted by the U.S. Public Health Service Advisory Council on the Elimination of Tuberculosis, and reports the deliberations of expert consultants convened by the American Thoracic Society (ATS) and Centers for Disease Control and Prevention (CDC). Isoniazid for 6–12 mo has been the mainstay of treatment for LTBI in the United States for more than 30 yr. However, the application of isoniazid for LTBI has been limited because of poor adherence, due to the relatively long duration of treatment required, and because of concerns about toxicity. Therefore, there has been interest in the development of shorter, rifampin-based regimens as alternatives to isoniazid for the treatment of LTBI. During the past decade, a series of studies of "short-course" treatment of LTBI in persons with human immunodeficiency virus (HIV) infection has been undertaken. The results of these trials have recently become available, and the in-depth analyses of these and prior studies of isoniazid form the scientific basis of the treatment guidelines presented in this report.

5. **Ngamvithayapong J., et al. Adherence to tuberculosis preventive therapy among HIV-infected person in Chiang Rai, Thailand. AIDS 1997,11:107-112**

The objectives of this journal is to determine the level of and reasons associated with adherence to tuberculosis preventive therapy among asymptomatic HIV-infected individuals in northern Thailand. A prospective cohort study with a 9-month follow up is used for study design. A total of 412 HIV-infected persons were enrolled in a tuberculosis preventive therapy programme in a hospital. A 9-month isoniazid regimen was prescribed. Adherence was determined by pill count. Participants who missed a scheduled appointment for more than a month were interviewed. Five focus group discussion sessions were held among those who successfully completed the therapy. The results revealed that out of 412 participants, 69.4% (286) completed the 9-month regimen. The adherence rate, defined as the proportion of those who took more than 80% of pills, was 67.5% (n=278). Sex, source of participants and history of physical symptoms were associated with adherence. A significant portion of defaults took place at the beginning of the therapy. Out-migration, denial of HIV status, and perceived side effects of isoniazid were frequently cited as reasons for non-adherence. The journal comes up with the conclusion that although an isoniazid preventive therapy programme was shown to be feasible, further adjustments on the selection of participants, enrolment process, and follow- up system on these finding are necessary to increase the adherence.