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NON-COMPLIANCE AMONGST T.B. PATIENTS

AT

MORETELETSI HOSPITAL

BY

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DEDICATION TO MY FAMILY

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SUMMARY

NON-COMPLIANCE AMONGST T.B. PATIENCE AT MORETELETSI HOSPITAL

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The aim of the study was to explore non-compliance with T.B. treatment amongst T.B. patients at Moretelelesi Hospital. Due to the nature of the data that was needed the phenomenological strategy as a research strategy / design was used.

Interviewing was used as a method of data collection and 20 T.B. patients at Moretelelesi Hospital were interviewed.

The medical aspects of T.B. were discussed with emphasis on: what T.B. is, how it is diagnosed, T.B. treatment as well as social work intervention with patients.

The patients indicated that members of the community are not supporting them. They further mentioned that western medicines have side effects on them and that the health centres are far from them.

It was established that it is difficult for many T.B. patients to understand the causes of T.B. as they are explained from the western medical orientation because they associate T.B. with witchcraft. There are several factors that cause patients not to comply with medical treatment with the dominant one being the strong belief in traditional medicine.

The community should be educated to emotionally support the patients. A holistic approach in the form of bio-psychosocial model can be of great benefit when used so that all the needs of the patients can be given attention.

The research report was concluded by the conclusions and recommendations.

KEY CONCEPTS

Client	-	Klient
Culture	-	Kultuur
Hypothesis	-	Hipotese
Interview	-	Onderhoud
Pilot study	-	Voorondersoek
Population	-	Populasie
Social work	-	Maatskaplike werk
Sample	-	Steekproef
Research design	-	Navorsingontwerp
Support	-	Ondersteuning

CHAPTER 1

NON-COMPLIANCE AMONG T.B. PATIENTS DISCHARGED FROM MORETELETSI HOSPITAL

1.1. INTRODUCTION

T.B. (Tuberculosis) is one of the serious health problems in South Africa. This is confirmed by Pela Mokgadi (2000:13) when he indicated that South Africa has one of the highest incidents of T.B. in the world. It is indicated in the annual report of the Department of Health in South Africa (1998) that 116 000 people were treated for Pulmonary Tuberculosis and 65, 700 were infected, which means that they were capable of spreading the infection to people around them.

This report further states that T.B. kills 1000 people a month, although it is almost 100% curable. Louw (2000:15) the medical advisor of T.B control for the Department of Health contends that in 1999 there was 16, 181 new pulmonary tuberculosis patients diagnosed in Gauteng and 1811 patients are known to have died. Ratsela (2000:30), SANTA's chief executive officer, indicated at a press briefing to mark world T.B. Day held in Johannesburg on the 24th of March 2000 that the government should collaborate more with non-profit making organization such as South African National Tuberculosis Association, in the fight against Tuberculosis.

According to the annual report of the Department of Health in South Africa (1996:6) (T.B.) is still a major problem. Department of Health has as a result of this declared T.B. a priority and introduced a more cost-effective programme known as Directly Observed Treatment Short course (DOTS) to reduce the prevalence of T.B. In T.B. advocacy publication (1998-1999) Dr N. Zuma pointed out that DOTS is the effective strategy for controlling T.B.

According to the Department of Health (1997:16) before DOTS was launched, T.B. action group was formed consisting of:

- Department of Health personnel
- SANTA employees and volunteers
- Traditional Healers Association
- Local authority personnel
- Local Industry representatives

According to the above information, the researcher found that it is necessary to formulate guidelines for social work intervention concerning non-compliance to T.B. treatment within the multi-disciplinary health team.

1.2. MOTIVATION FOR THE CHOICE OF THE SUBJECT

The researcher observed that higher percentages of T.B. patients are not complying with the treatment after few months of being discharged from Moretelelesi Hospital near Rustenburg. The treatment course takes six months. The patients are treated in the hospital during the first two months and treated for four months as out patients. This motivated her to investigate the reasons behind this situation. The result of this study will assist in formulating appropriate intervention for social workers within the health team. This is supported by the director of communicable disease control directorate of the Department of Health, Dr Cameron (1997:8), when he said that a good T.B. Control Programme would build a good health service.

According to the researcher, programmes of this nature are important and are more effective when implemented by health teams.

1.3. PROBLEM FORMULATION

The following statistics confirm the researcher's observation that there is higher occurrence of non-compliance amongst T.B. patients at Moretelelesi Hospital.

2001 = Total of 154 for the year
2002 = Total of 130 for the year
2003 = Total of 48 for the first quarter,
Total of 324 for the Two and one-quarter years

It could be concluded from the above statistics that T.B. is still a problem even though it is curable. Many patients still relapse because of non-compliance therefore is a need to investigate why there is this high incident of non-compliance of T.B. patients. This information is supported by Matsha (2000:10), advocacy officer of the national T.B. Control Programme, when she indicated that T.B. is a curable disease yet it kills more youths and adults than any infectious disease in South Africa today.

According to the annual reports of the Department of Health, the estimated T.B. cases per 100 000 people in 1996 were the following:

- Eastern Cape 504
- Western Cape 559
- Kwa-Zulu Natal 381
- Gauteng 375
- Northern Cape 340
- Mpumalanga 286
- North West 271
- Northern Province 266

The above-mentioned statistics from different provinces, confirms that T.B. is still the problem in South Africa.

1.4. AIM AND OBJECTIVES OF STUDY

AIM OF THE STUDY

To investigate the causes of high rate of non-compliance of T.B. patients after being discharged from Moretelelesi Hospital.

OBJECTIVES

- To investigate T.B. as phenomenon through literature review.
- To conduct an empirical investigation on the causes for high rate of non-compliance on T.B. patients.
- To provide recommendations for social work intervention concerning non-compliance of T.B. treatment within the multi-disciplinary health team.

The aim and objectives of this study were met through literature and empirical study

1.5. HYPOTHESIS OR ASSUMPTIONS FOR THE STUDY

A hypothesis could not be formulated because it is an exploratory study as little is known about the topic. Bailey (1992:41) asserts that a hypothesis is a testable proposition while Royse (1991:17) views it as a statement. Mckendrick (1992:255) adds that hypothesis is formulated as a statement containing the relationship between the independent and dependent variables.

The researcher has formulated assumptions as little is known about the topic. The assumptions formulated are as follows:

- Cultural beliefs have effects on non-compliance amongst T.B. patients.
- Side effects of medication, has an effect on non-compliance of T.B. patients
- Distance to health centres has an effect on medical treatment

1.6. RESEARCH APPROACH

According to Schrunik and Strydom (in De Vos 1998:15) a qualitative approach is the research approach in which the procedure is not strictly formalised while the scope is more likely to be undefined and a more philosophical mode of operation is adopted. The researcher used qualitative approach in the sense that she aimed at collecting information through interviewing. Qualitative approach was therefore found to be appropriate for this study. Qualitative approach was used because the researcher was interested in the rich data from the respondent.

1.7. TYPE OF RESEARCH

William, Tutty & Grinnel (1995:329) maintain that applied research is a search for practical results that can be utilized to solve problems or in practice applications. Bailey (1992:24) is of a different view that applied research is interested in whether or not the results of the study can be applied to limit certain problems. Applied research was used in this study, because the aim was to address the problem of non-compliance of T.B. patients at Moretelelesi Hospital.

1.8. RESEARCH DESIGN

Reid and Smith (in Mckendrick 1992:25) contend that the research design is the overall plan or strategy by which questions are answered or hypothesis tested.

According to De Vos & Fouchè (1998:80) phenomenology as a research strategy that enables the researcher to understand and interpret the meaning that subjects give to their everyday lives.

The researcher does not have enough knowledge why patients are not complying with treatment course, as a result she would like to explore the causes in order to render an appropriate service. Therefore, phenomenological strategy was used in this study.

1.9. RESEARCH PROCEDURE AND STRATEGY

The researcher used the interviews as a means of data collection. The permission was received from the respondents in order to record their information on tape. Greeff (2002:304) maintains that a tape recorder allows a much fuller record than notes taken during interviews. Greeff (2002:304) further indicated that by using tape recorder, the researcher could concentrate on how the interview is proceeding and where to go next. The above information indicates that tape recorder has an advantage and as a result, the researcher found it to be of great benefit to use it.

Data was analysed through extracting themes and categories, which were then interpreted.

1.10. PILOT STUDY

Pilot study is necessary in order to be more conversant with the topic to be researched, to get ideas from experts, to find out whether the topic is feasible for study and pilot testing the measuring instruments.

1.10.1. PILOT TEST THE MEASURING INSTRUMENTS

According to Strydom (2002:211) the pre-testing of a measuring instrument consists of “trying it out on a small number of people having characteristics similar to those of the target group of respondents.” Strydom (2002:211) further pointed out that a pilot study could be regarded as small-scale trial run of all the aspects planned for use in the main inquiry. Bless and Higson-Smith (2000:155) added that pilot study is a small study conducted prior to a larger piece of research to determine whether the methodology, sampling, instruments, and analysis are adequate and appropriate. Due to the fact that interviews were used as a data collection method no pilot test of measuring instruments was done in this study.

1.10.2. LITERATURE STUDY

Neuman (1997:89) asserts that literature review is based on the assumption that knowledge accumulates and that we learn from and build on what others have done. The researcher did the literature study by obtaining information at the following universities:

Pretoria Academic Hospital, University of Pretoria, Medical University of South Africa. Additional information was obtained from the library of the Department of Health in Pretoria and Library of Moreteletsi Hospital. Pamphlets on “Batho Pele” were obtained from Batho Pele Office in Pretoria. Information received from the above sources helped the researcher to have a clearer understanding of the topic. Detailed literature findings are presented in chapter 2 of this dissertation.

1.10.3. CONSULTATION WITH EXPERTS

De Vos & Fouchè (2002:337) advised that interviewing expert is important in qualitative research, for the purpose of identifying themes for further investigation. The researcher consulted experts who are directly working with T.B. patients in order to gain more knowledge.

Dr B Barua and Dr Hameed who were allocated to T.B. wards at Moreteletsi Hospital were consulted. More information concerning the conditions of the patients, concerning non-compliance with treatment was received from these doctors.

The following people were also consulted: they played a great role in assisting the researcher to identify respondents.

Ms Paula – Coordinator of T.B. at Mareteletsi Hospital

Mr Mabe – Staff Nurse working in T.B. wards at Moreteletsi Hospital

1.10.4. FEASIBILITY OF THE STUDY

This study was conducted at the researcher's place of employment therefore no extra time was needed for interviews as it was part of the daily activities. Permission was obtained from the clinical manager of Moreteletsi Hospital to conduct the research.

1.11. DESCRIPTION OF THE RESEARCH POPULATION, DELIMITATION, BOUNDARY OF SAMPLE AND SAMPLING.

1.11.1. POPULATION

Williams, Tutty & Grinnel (1995:337) view population as an entire set, or universe of people, objects, or events of concern to a research study from which a sample is selected. The population for this study consisted of all the T.B. patients at Moreteletsi Hospital who have not complied with the treatment course.

1.11.2. BOUNDARY OF SAMPLE AND SAMPLING METHODS

Mouton (1996:110) pointed out that during the process of selecting or sampling, the aim is to get a sample that is as representative as possible of the target population. The researcher has chosen probability sampling for this study. William et al (1995:223) and Strydom & Venter (2002:203) agree that probability sampling is based on randomisation. There are different types of probability sampling and type that was found suitable for this study was systematic sampling.

Twenty respondents were selected. The case register was used to select respondents. The respondents were selected according to a particular interval; each third name on the list was selected.

1.12 ETHICAL ASPECTS

Williams et al (1995:30) advise that for people engaged in social work research studies, the ethical issues are more pervasive and complex. Williams et al (1995:30) add that a fundamental principle of social work research is increased knowledge,

while much to be desired, must never be obtained at the expense of the human beings. The above information suggests that respondents must not be harmed in any way.

1.12.1. INFORMED CONSENT

Strydom (2002:74) highlights that it should be ascertained that the consent of participants is voluntary and informed, without any implied deprivation or penalty for refusal to participants` privacy and dignity. The respondents were well known to the researcher and as a result, they easily gave the researcher consent in order to participate in the research.

1.12. PROBLEMS AND LIMITATIONS OF THE STUDY

- The concept of non-compliance is broad, as a result the researcher had to limit it so that it could be manageable
- Some patients were the researcher`s clients and this might have affected their responses
- Greater percentage of patients who were not complying with T.B. treatment course were under the influence of traditional beliefs and literature on traditional beliefs was limited
- The study was costly, as the researcher did not have any sponsor.
- The researcher was using the tape recorder to collect data as a result the respondent might have given some positive answers in order to please the researcher.
- The working conditions of the researcher were not conducive and caused a prolonged period to conduct this study.

1.13. DIVISIONS OF THE RESEARCH REPORT

Chapter 1	General introduction
Chapter 2	The medical aspects of Tuberculosis
Chapter 3	Social works intervention with T.B. patients

Chapter 4 Empirical Findings

Chapter 5 Summary, conclusions, and recommendations

The following chapter focuses on T.B. as a phenomenon

CHAPTER 2

THE MEDICAL ASPECTS OF TUBERCULOSIS

2.1. INTRODUCTION

Tuberculosis is classified as an infectious disease and can affect any part of the body although it mainly attacks the lungs. This is indicated by the Department of Health (1991:1) when it pointed out that “T.B is a disease that mainly affect the lungs, but it can be found in any other body organ. WHO, (1993: 21) agrees with Department of Health (1991: 1) that T.B. is a chronic disease. WHO, (1993: 22) further indicates that T.B. can affect any part of the body but most commonly infected are the spine, the brain (T.B. meningitis) the lymphatic system and the gastro intestinal system.

According to the Department of Health (2000: 12), T.B. remains the number one infectious disease in S.A., with its terrible twin AIDS, it is changing society by attacking the weak, the poor and the uninformed. It continues its devastation despite the powerful anti-T.B. drug and the BCG vaccination, which emerged in the mid 20th century as the supposed saviour of T.B. patients.

The above-mentioned information is supported by the practical incidents where the researcher is working, at Moretelelesi Hospital because most patients are suffering from T.B. of the lungs. It has also been observed that most patients are from low socio-economic status. This puts the patient at risk of not attending the available treatment, due to lack of money for travelling to the health facilities.

This chapter will deal with following aspects: Definition of medical concept, incidence of T.B., T.B. as an illness, Prevention of T.B., T.B. and HIV/AIDS.

2.2. DEFINATION CONCEPTS

The following concepts are defined to facilitate understanding of this chapter: -

-AIDS –(Acquired Immune Deficiency Syndrome) a life threatening, slowly progressing disease in which the human immune deficiency virus (HIV) infects the body through contact with blood or tissues that line the vagina, eyes and mouth or through breaks in the skin (Barker: 114).

-Ambulatory Treatment-Treatment pertaining to working (Collins 1992:28).

-Antigen - Any substance, organism or foreign material recognized by the immune system of the body by being “non-self” which will provoke the production of a specific antibody (Young son 1992:42)

-Antibody- Protein substance called an immunoglobulin, produced by the B group of lymphocytes in response to the presence of an antigen (Youngson1992: 42)

-Antibiotic Drug- An extensive range of drugs able to kill or prevent reproduction of bacteria in the body without killing the patient (Youngson1992: 42)

-Airborne-It refers to the transmission of infection from one person to another by means of moisture that contains the causative organism (Blacwell1994: 16).

-Bacteria –A one celled organism without a true nucleus cell organelles belonging to the kingdom procaryotae (Venes, & Davis; 2001:213)

-Bacillus-A genus of bacteria of the bacillae. All species are red shaped sometimes occurring in chains (Venes & Davis 2001: 211)

-Culture- The development of micro-organism on artificial media under ideal conditions of growth (Blackwell: 1994:179).

- **Chemoprophylaxis** - The oral, intramuscular or intravenous administration of specific chemical agent to arrest the progress or eradicate, a specific pathological condition in the body without causing irreversible injury to healthy tissue, widely used in treatment of cancer (Blackwell1994: 136)
- **Discharge** - To release someone from custody (Robinson 1996: 380)
- **DOTS** - Is the name (Directly Observed Treatment Course) for a comprehensive strategy, which primary health services around the world are using to detect and cure T.B. patients (Department of Health (1998:63)
- **Epidemic** - An infectious disease or condition that attacks many people at the same time and the same geographical area (Venes & Davis, (2001:719)
- **Epidemiology** - The study of the frequency and distribution of a specified phenomenon such as a disease, that occurs in popular group in a given period (Barker 2003: 145).
- **HIV** - The Acquired Immune Deficiency Syndrome (AIDS) virus, which attacks the body's immune system, and thereby leaves the HIV –infected person eventually vulnerable to the deliberately or fatal opportunistic infection, cancer or neurological condition (Barker2003: 203)
- **Inoculation** - Immunisation or vaccination (Youngson1992: 586)
- **Lethargy** - An abnormal state of apathy, sleepiness, drowsiness or lack of energy (Younson1992: 355).
- **Macrophage** - It is an important cell in the immune system especially in the liver, lymph nodes, spleen and bone marrow. (Youngson 1992:373)
- **Malignant** - Growing worse or resisting treatment (Venes & Davis; (1997:1287)

- **Non-compliance** - It is the failure or refusal of a patient to cooperate by carrying out that portion of the medical care plan under his or her control (Venes & Davis 2001:1402).
- **Pathogenesis** – The origin and development of diseases (Blackwell 1994:500)
- **Pathology** – The branch of medical science dealing with bodily disease processes, their cause, and their effects on body structure and function (Blackwell 1994: 500).
- **Primary Health Care** – Refers to either or both two kinds of care (1) care the person receives at his first point of contact with the health care worker by the same individual or team. It stresses holistic care and includes identification, management and or referral of health problems (Blackwell 1994:529).
- **Sputum** – Mucous often mixed with pus or blood, which is secreted by the goblet cells in the mucous membrane lining of the respiratory tubes (Blackwell 1994: 44).
- **Streptomycin** – The first antibiotic found to be effective against T.B. (Blackwell 1994: 44).
- **T-cell** – One of the two broad categories of lymphocytes, the other being the B cell group (Youngson 1992: 581).
- **Therapy** – One of disease or of conditions supposed to be disease (Geddes & Grosset 2002:226)
- **Tuberculosis** - Tuberculosis is an infectious disease caused by the bacillus mycobacterium tuberculosis is characterised by the tubercles especially the lungs (Hawkin 1991: 1550).

2.3. INCIDENCE OF T.B.

Tuberculosis is one of the leading infectious diseases in South Africa. This is emphasised by Modisane (2000:2) when she pointed out that T.B is the major infectious disease in Africa. Modisane (2000:2) further indicated that according to WHO there are 200 million T.B. sufferers in Africa, and that one person dies of TB, every 40 minutes and also that 160, 000 new cases of the disease are reported annually.

Department of Health (1997:119) indicated that the interaction between HIV and T.B. has enabled the HIV epidemic to contribute to a further increase in T.B. incidence and that other factors contributing to the increase of T.B. incidence, is the development of multi- drug resistant T.B which is difficult and expensive to treat.

The above-mentioned information indicates that TB is the main infection diseases in South Africa. It also shows that the development of multi-drug resistant T.B. and the interaction between HIV and T.B. increase T.B. incidence.

2.4. T.B. AS AN ILLNESS

According to the Department of Health, (2000:14) T.B. is an airborne disease and when a person with T.B., coughs, sneezes, or spits carelessly, these germs spread into the air and then be breathed into the lungs. Thus, the spread of T.B. happens without a person's awareness because it is silent. If untreated it is deadly but if the T.B. infected person could receive treatment, within two weeks of starting the treatment, he/she is no longer infectious.

Department of Health (2000:14) further pointed out that 60 percent of South Africa's population carries the T.B. germ in their bodies and if the germ has not become active, it is called a dormant germ. The researcher has observed in her work situation that people sneeze and split carelessly, which increase the spread. This challenges every body to spread the information to reduce infection. The researcher could as well play an important role here by actively being involved in educating the community about T.B.

2.4.1. HISTORICAL BACKGROUND OF T.B.

According to Bignall (1982: 4) Tuberculosis has been killing for a long time. It afflicted the Incas of Peru long before Europeans sailed to South America. It attacked Egyptians during days when Pharaohs ruled in splendour from the 18 century to the 20 century. T.B. was the leading cause of death in the Western world. Eventually in 1981, German doctor Robert Koch officially announced his discovery of the bacillus responsible for disease. Bignall (1982: 4) further indicated that, thirteen years later, Wilhelm Rontgen discovered X-Rays, making it possible to scan the lungs of living persons for signs of Tuberculosis lesions. Bignall (1982: 4) also stated that in 1921, French dentists created a vaccine against T.B. named after the scientist who discovered it. B.C.G (Bacillus Calmette Guerin) vaccine remains the only available vaccine against the disease.

Patients suffering from T.B. were sometimes sent to sanatoriums for intensive treatment. These hospitals were frequently located in the mountains where patients could rest.

It is evident that T.B. has long existed, attacking people in different countries and being the leading cause of death more than any other disease.

2.4.2. PATHOGENESIS OF TUBERCULOSIS

World Health Organization (1996:20) argues that pathogenesis of tuberculosis is as follow: -

- **Primary infection**

Primary infection occurs on first exposure to tubercle bacilli, inhaled droplet nuclei are so small that they avoid the muco-ciliary defences of the bronchi and lodge terminal alveoli of the lungs. Infection begins with multiplication of tubercle bacillus in the lungs.

- **Post-Primary TB.**

World Health Organization (1996:20) further indicated that post primary TB occurs after a latent period of months or years after primary infection. It may occur either by reactivation or by re-infection. Re-activation means that dormant bacilli persisting in tissues for months or year after primary infection starts to multiply.

2.4.2.1 MODE OF TRANSMISSION

- **Inhalation**

-Droplets: When a sufferer coughs, droplets inception is inhaled into the lungs of uninfected person

-Dust: The infected dust may be inhaled if disturbed by sweeping, wind or children playing on the ground (Glatthaar 1994:14).

- **Ingestion**

-Drinking unpasturised milk from an infected animal.

-Swallowing infected dust or particles.

-Sucking infected milk (Glatthaar1994: 14)

- **Inoculation**

Accidental inoculation through the skin may occur during post mortem examination (Glatthaar1994: 140)

2.4.2.2 COMMUNICABILITY

Glatthaar (1994:15) argues that communicability of TB. varies tremendously from patient to patient and the excretion of tubercle bacilli depends on the therapy.

Glatthaar (1994:16) further argues that a patient receiving regular therapy may excrete viable bacilli for approximately one month; the patient is for all practical purposes non-infectious within twenty-four hours of the onset of treatment for the following reasons.

- The invading tubercle bacilli are unable to induce active disease.
- Therapy reduces coughing and the patient is taught not to cough without covering his mouth.
- At the time of diagnosis, the patient has already infected his contacts and little is gained by isolating the patient at this stage however, the patient with infectious T.B. should be kept away from small children for about one month.

It is evident that the patient is non-infectious within twenty-four hours of the onset of treatment because the invading tubercle bacilli are to induce active disease, which is very positive in the sense that patients need not to be isolated for long period.

2.4.2.3 SUSCEPTIBILITY

According to Glatthaar (1991: 15) T.B recognised no difference between colour, race, creed or social status and anyone may become infected or develop active T.B. The possibility of developing active disease is greatly influenced by socio-economic and other physical and emotional stress factors.

This information is supported by Modisane (2000:3) when she indicated that Archbishop Desmond Tutu got T.B as an adolescent, T.V. presenter Gerry Rantseli was diagnosed with it in 2001 and former South African president, Nelson Mandela contracted the disease at Pollsmoor Prison.

The researcher concludes that any person can be susceptible to T.B. irrespective of race, colour or creed, and this can be greatly influenced by different factors like socio-economic status and stress. Although the fact that the majority of the T.B patients are living in poverty cannot be ignored.

2.4.2.4 PATHOLOGY

Schlossberg (1994:42) views pathology as consisting of three broad types of tuberculosis. Firstly, there are exudative lesions, consisting of an influx of all elements of the leukocytic series including polymorphonucleurs, monocytes, and lymphocytes with vasodilatation, edema and a fibrinous exudate. There are proliferative lesions consisting of aggregations of macrophages, epithelioid cells, and lymphocytes, third there are composite with characteristic of both exudative and proliferative lesions.

Glattharr (1991: 16) is of view that recent research findings suggest that contrary to present belief, humoral immunity plays a far more significant role in the resistance mechanism in T.B. Further, according to Glatthaar (1991: 16) specific antigen known as protective antigen are being identified that stimulate macrophages. They have ability to evoke specific T-Cell response in man.

Glatthaar (1991: 16) pointed out that in a non-immune host the invading bacillus is able to multiply before the development of cellular immunity.

The following factors are adversely affecting cellular immunity: malnutrition, stress, age, diabetes, long-term corticosteroid therapy, immune suppressive therapy, lingering malignancies, viral infections, silicosis and alcoholism, (Glatthaar 1991:9).

It would seem the person's immunity plays important role in the resistance towards T.B. This means that people need to be careful regarding things that might weaken their immunity and avoid them as much as possible.

The above information shows that T.B. is a broad concept, which needs to be appropriately attended.

2.4.3. CLINICAL TYPES OF T.B.

PULMONARY TUBERCULOSIS

The following clinical types of T.B. will be briefly discussed, because they are the most prevalent types.

Schlossberg (1994:95-96) asserts that pulmonary tuberculosis frequently develop without any striking clinical evidence of disease.

Schlossberg (1994:47) further mentioned that although on x-ray pulmonary tuberculosis is usually manifested as a local pneumonia or as a cavity lesion in the upper portion of the lungs, it does occasionally occur in the lower portions. The above information suggests that pulmonary tuberculosis may develop without any clinical evidence of illness.

Many forms, according to the Department of Health (2002:21) originate from lymphatic or haematogenous spread of mycobacterium from a primary focus in the lungs. Schlossberg (1994:47) differs from the Department of Health (2002:21) by mentioning that most extra pulmonary tuberculosis is due to haematogenous dissemination. Schlossberg (1994:47) adds “however tuberculosis laryngitis is due to a direct spread of tubercle bacilli from the lungs through the bronchi and trachea to the larynx and gastrointestinal tuberculosis usually due to bacilli in bronchi secretions that are swallowed.

It would seem that unlike other forms of tuberculosis, in extra-pulmonary tuberculosis, the disease process occurs outside the lungs.

Department of Health (2000:21) adds that the following are the most common types of extra pulmonary tuberculosis, T.B. meningitis, T.B. lymphadenitis, miliary tuberculosis, tuberculosis serous effusions, tuberculosis empyema, tuberculosis pericardial effusion, ascites, and T.B. of the bones.

It is evident that the type of extra pulmonary T.B. depends on the organ that has been infected which call for carefully investigation by medical team, to ensure that appropriate treatment is provided.

2.4.4. CAUSES OF TUBERCULOSIS

Glatthaar (1991:4) and Porter & Perry (1993:399) argue that there are different causes of tuberculosis although they mentioned two types being mycobacterium tuberculosis and bovis mycobacteria. Several sources namely Department of Health (2002:51), Noback & Carolla (1995:788) Schaat, Cotton de Villiers and Donald (2000:33) agree that tuberculosis is a chronic disease caused by a specific bacillus mycobacterium of which its severity varies from patient to patient, depending on variety of factors.

2.4.4.1.PREDISPOSING FACTORS FOR TUBERCULOSIS

According to Kobe, (1996: 19) tuberculosis is influenced by poor socio-economic conditions. The researcher from her caseload has observed this, as most of the patients suffering from T.B. have poor socio-economic background. The numbers of patients who are suffering from T.B. are also living in poor socio-economic conditions.

Glatthaar (1991: 16), Kobe (1996: 26), and the Department of Health (1997: 87) agree on the following as predisposing factors for tuberculosis: Poor housing, emotional or physical stress, malnutrition, and ill health.

- **Poor Housing**

The researcher works within the community, which is 80 percent rural. Many houses are poorly built due to lack of funds, which is caused by the high rate of unemployment. The researcher had one case, from her caseload where an extended family consisting of nine people in one small house, one family member was infected by T.B. but unfortunately within few months' time, five of the members were already infected with T.B.

This is supported by Kobe (1996; 27) who pointed out that people who are in close contact with an infected person are at risk. The problem of poor housing contributes towards poor control of the spread of T.B.

- **Emotional and physical stress**

There are different factors that can cause the person to have stress. According to Glatthaar (1991: 17) for example, the rural black man coming to the city to work, is under tremendous stress in spite of better food and housing.

Kobe (1996: 26) argues that on the other hand “Man is designed to cope with stress, but when it comes too great, his natural resistance to disease breaks up.

The researcher had one case from her caseload at Moretelelesi Hospital, a man who was working in Bleskop Mines in the district of Rustenburg whose home was in Sheshibitswe Village in Madikwe which is 120 KM to the mine, but the man had to travel home every day due to ill health of his wife who was suffering from T.B. This situation was affecting this man emotionally as he had to cope with wife’s ill health and travelling long distance from home on daily basis. This man contracted T.B. within a short period of time.

- **Malnutrition**

There are different factors that cause malnutrition. In the community where the researcher is working, most people are unemployed; as a result, women and older women make and sell African beer in order to generate income. Those women sometimes make bad African beer because they mix bad ingredients. This beer becomes entertainment for most old and younger people and they do not have time for food, and take beer into empty stomachs. Most of these people’s immune systems are weakened as a result they become subject to T.B. as they live in an area where it is prevalent. This is supported by Kobe (1996: 28) when she pointed out that T.B. is an infectious disease, opportunistic disease where poor socio-economics conditions exist. Kobe (1996: 27) also pointed out that T.B. is prevalent in rural areas where there is

poor nutrition, illiteracy, and high incident of disease. Kobe (1996: 27) further indicates that alcoholism also leads to malnourishment and this lowers the ability of the body to fight off disease.

It is evident that there are different contributory factors that predispose a person to T.B. It is therefore necessary for health teams to educate the community on these aspects so that they can take necessary precautions for prevention.

- **Ill health**

Kobe (1996:27), and Department of Health (1997:5) agree that the person may suffer from ill health due to different disease like AIDS and renal failure. Once the person's immune system is lowered due to these diseases, T.B. takes an advantage of the person.

It would seem there are different predisposing factors for tuberculosis as a result it will be of great importance for the health team to educate people in order to take the necessary precaution.

2.4.5. SIGNS AND SYMPTOMS

T.B. may manifest in the following manner.

2.4.5.1 RESPIRATORY SYMPTOMS

Glatthaar (1991: 25) and Thompson et al (1993: 108) agree on the following respiratory symptoms.

- **Cough**

Much of this is due to respiratory infections and this lasts only a week or two. It can be a dry cough and later it can be productive. A cough is not specific to pulmonary

T.B. It is common in smokers and patients with upper and lower respiratory tract infection.

- **Chest pain**

It can be a dull ache sometimes worse in breathing due to pleurisy. It can also be due to muscle strain caused by coughing and sometimes the cough has been so severe that patient has cracked a rib.

- **Haemoptysis**

This is a late sign and usually indicates advanced disease. The haemoptysis may be profuse or there may be staining only, i.e. specks of blood in the sputum.

- **Dyspnoea**

This is shortness of breath. Shortness of breath is usually a late sign caused by one or more of the following: lung destruction, pneumothorax, pleural effusion or broncho-pleural fistula.

- **Wheezing**

Occasionally the patient has a localized wheeze. This is due to local tuberculosis bronchitis or pressure of a lymph node on a bronchus.

2.4.5.2 SYSTEMATICS SYMPTOMS

There are different respiratory symptoms which appear before the person is attacked by T.B. as result it is necessary for a person to give them urgent attention before the condition become worse.

The following are the systematic symptoms indicated by Glatthaar (1991:25) and Thompson et al (1993:108)

- **Fever**

This fever can be of any type. There may be only slight rise of temperature in the evening. This temperature may be high or irregular.

- **Loss of weight**

The patient may be very ill and loose weight. The patient may be very thin with obvious loss of weight.

- **Lethargy**

The person in this condition is always tired and does not feel like doing anything.

- **Night sweats**

The patient usually has sweats at night mainly due to toxæmia (not due to pyrexia). The sweat is usually cold and clammy.

- **Loss of appetite**

Loss of appetite starts early in the disease and becomes worse as the disease progresses.

- **Hoarse voice**

This usually develops during the late stage being combined with one or more of the other symptoms.

It would be beneficial if the community members could be educated on these signs and symptoms, to ensure that action is taken immediately when they appear. The researcher can play a pivotal role in this regard at the prevention level of intervention.

2.4.6 T.B. TREATMENT

Frankel (1991:251), and Department of Health (1994:7) agree that T.B. is treatable and curable when found early enough and if the course of treatment is completed. T.B. can sometimes not be easily cured due to the person's cultural belief for example in the community where the researcher, is working, most community members believe in traditional healers and faith healers more than medical doctors.

It is common practice that T.B. patients abandon treatment immediately when they feel better. The researcher discovered through discussion with the patients that they have the following reasons for abandoning the treatment: -

- Prefer consulting their traditional healers and faith healers.
- The clinic and hospital are far
- They do not believe in both

The following treatment modes will be discussed briefly:

2.4.6.1.DIRECTLY OBSERVED TREATMENT COURSE

According to Kotze (1997:124) DOTS is a patient centred approach, which provide support to T.B. patients by observing them as they swallow their T.B. drugs and ensuring that they complete their treatment.

According to Mhlophe (2002:17) the benefits of DOTS are many as they include cure rates up to 95% in even the poorest countries as well as well as the prevention of new infections by curing infectious patients, thus breaking the chain of transmission. It also helps to prevent multi drug resistance – T.B. by ensuring the full course of treatment is followed. Mhlope (2002:17) further pointed out that DOTS was implemented in South Africa in 1997 and that it needs to be implemented more rigorously along with a campaign to increase public awareness of the need for early treatment.

The following are the key to be successfully DOTS strategy.

- **Manage T.B. service**

Managers must be put into place to be overseer all the components of the strategy.

- **Ensure the cure with direct observation**

Observation is crucial for successful T.B treatment. Therefore trained supporters who will observe patients while they swallow each dose of their medication, which is especially important during the first two months of treatment, are necessary.

- **Training the staff**

All the staff involved with T.B. control must be trained in the correct diagnosis, treatment and monitoring of T.B. patients.

- **Use of microscope to detect T.B. bacteria**

The patient must be diagnosed in the least expensive and most reliable way and infectious patients must be identified.

The researcher concluded that it is necessary to probe further through research into the issue of abandoning T.B. treatment by patient to find out what may be the real cause. The findings would assist in establishing the service that will be relevant to patients needs.

2.4.6.2.MULTI-DRUG RESISTANCE (MDR)

According to the Department of Health, (1996:6) curing T.B. is an arduous, which takes at least six months of drug treatment. Multi-drug resistance T.B. can develop when patients do not finish their full course of medication. Sometimes they stop

because they feel better, after the first few months or they move to a new location, or their health worker fails to supervise them closely.

However, if someone stops treatment so soon he will most likely get sick with T.B. again since the T.B. bacteria in the person's body has already been exposed to T.B. drugs. The bacteria may well have developed resistance, meaning that repeat treatment with those same drugs will be ineffective. Often it will be impossible to save this person's life.

According to Mvusi (2000:17) ignorance is a factor in increasing cases of Multi-drug resistance T.B. (MDR-TB). Mvusi added that the term is used when the germ develops resistance to anti-T.B. drugs. This can happen from incorrect or incomplete treatment or unreliable drug supply. Mhlope (2000:17), a World Health Organization (WHO) training advisor for improved T.B. Management in South Africa, mentioned that MDR – T.B. is more difficult and lengthy to treat and also costly.

The Department of Health (1996:10) further contends that out of 2000 South Africans found with multi-drug resistant T.B. in 1995, most will die of this disease. The threat of drug resistance T.B. also stretches much further. People who develop multi – resistance T.B. can spread it to others as easily as regular T.B.

The above information is supported by the manager of the national AIDS control Programme of Malawi: Poni (2000:18) when he stated that although only patients have been diagnosed with multi – drug T.B. in the past six years in Malawi, health officials are worried about the disease because it is not easy to treated. He further affirms that this new type of T.B. comes as a result of people buying combination treatment for T.B. with the hope that they will cure HIV/AIDS. Further, according to Poni (2000:18) “as a result, T.B. is mutating and developing a resistance to normal treatment”. Poni (2000:18) stated that the above mentioned six patients with multi – drug resistance T.B. will infect their community.

It is evident that patient should complete their full course of T.B. medication in order to avoid multi – drug resistance T.B. more especially that is more difficult to treat.

2.4.6.3 SIDE EFFECTS OF T.B MEDICATION

Department of Health (1996:14) and Tuberculosis Practical Guidance (1993:13) agree on the following side effects of tuberculosis medication.

- **Minor sides effects**

- Gastro intestinal discomfort
- Joint pains
- Flue-like symptoms

These minor side effects are not very much irritating during the first months of development and this can become the reason for non-compliance. It is therefore necessary for problems of the patients to be taken serious. The researcher had among her cases, the patient who complained of side effects after taking medication and he ended up not coming for follow-up treatment. A visit was paid where he stays because he explained that it was because of side effects that he had abandoned the treatment. He was motivated by the researcher to come to the hospital so that the matter could be discussed. This clearly shows the negative impact of the side effects on the T.B. treatment process.

- **Serious side effects**

The Department of Health (1996:29) further mentioned the following serious side effects:

- Jaundice
 - Rash and fever related to drug use
 - Bleeding tendency, shock, and renal failure.
 - Visual acuity colour perception become impaired
 - The patients hear some ringing in the ears and they also experience deafness
- In all these side effects the patients should be advised to stop drugs immediately and the doctor should be consulted.

It is not always that all these side effects are affecting the person; sometimes one or two may appear. Some of the patients at the hospital where the researcher is working, at Moretelelesi Hospital pointed out that they get side effects after using traditional (or herbal) medicine, in combination with western medicine, blaming a mixture of prescription and herbal medicine for huge rise in deaths caused by adverse reactions to drugs.

It becomes very important for the medical team to provide the patients with all the information, so as to prepare them for the side effect that might occur during the treatment process.

2.4.6.4. NON-COMPLIANCE

Patients are not complying to the treatment because it take a long time to complete the course which is usually six months, in order that the infection could be cleared. This is confirmed by Wynberge Noback, and Corolla (1995:78) who contend that part of the problem with patients to comply with the T.B treatment is that it takes six months of intensive treatment to clear up the infection. Such a rigorous treatment is difficult for patients to sustain especially if they are homeless or drug addicted.

Smetherman (2000:2) pointed out that people are not complying with the treatment because tables are taken for a long time. He further mentioned that simpler doses, for shorter period could solve the problem. Several authors agree on different factors, which disturb compliance to T.B. treatment. Shyrock (1987:631) and WHO (1993:19) agree on the following factors, which disturb compliance to T.B.

- Mental retardation
- Casual employment
- Lack of fixed address
- Lack of comprehension of the purpose of the treatment
- Discouragement by the family
- Lack of time between referral and appointment
- Frequency of medication used and their effects
- Effectiveness of the patient / provider interaction
- Being a teenager (peer group pressure)

- Sanctity
- Physical disability
- Previous history of poor compliance
- Psychological and/or social gains perceived by patient.
- Distance from nearest health centre
- Alcohol abuse
- Economic constraints
- Poverty

Kobe (1996:32) differs from the above authors in the sense that she pointed out that most patients are not complying with T.B. treatment course due to cultural beliefs. They do consult traditional healers who inform them that this is poison and they make them vomit.

It is therefore necessary for researcher to work together with the traditional healers in educating the community because according to Department of Health (1997) traditional healers have been providing treatment within the community for a long time, and their patients, who always comply with the treatment, respect them.

2.4.6.5. CULTURAL BELIEF IN THE TREATMENT OF T.B.

The Department of Health (1994:7) pointed out that traditional healers could work in conjunction with western medical professionals to prevent non-compliance. They are resourceful and can complement health services. The method they use fit in with the local beliefs and customs.

According to Van Dyk, (2001:126) no T.B. prevention programme can succeed in Africa without the help of traditional healers services. Traditional healers and spiritual healers are effective agents of change because they have authority in their communities. They function as psychologists, marriage, and family counsellors, physicians, priests, tribal historians and legal and political advisers. They are the guardians of traditional code of morality and values, they are legitimate interpreters of customary rules of conduct, and they have the authority to change or invent new rules and to influence their people in matters relating to T.B. Traditional healers have

greater credibility in their communities than village health workers, especially with regard to traditional and spiritual matters.

Van Dyk (2001:126) further asserts that about 80% of people in Africa rely on traditional medicines for many of their health care needs. Traditional healers are well known in the communities where they work for their expertise in treating T.B. Health programmes involving traditional healers are under way in many African countries, and all indications are that traditional healers can effectively be involved in HIV/STD prevention programmes.

Van Dyk (2001:127) also pointed out that the South African government recently hired a traditional healer who has many years of experience to train fellow healers. She immediately suggested that traditional healers need to be involved in a participatory approach to training and that they need to be shown the utmost respect. Her advice was: “Let them burn incense in training.” This means that if their customers are respected, the training will be successful. She also emphasised the importance of using fellow-healers to train others because healers are far more receptive to hearing new things from their peers. It is further argued by Van Dyk (2001:127) that health care professionals who work in Africa should resist the temptation to stigmatise all traditional African beliefs and practice as ridiculous, superstitions and harmful. They should further focus on those beliefs that can promote T.B. education and prevention. Airhihenbuwa (in Van Dyk 2001:27) proposed a strategy or model (the PEN model), in terms of which traditional cultural health beliefs and behaviour can be categorized as positive (P), exotic (E) or negative (N) thereby providing a basis of western health care professionals to understand and cope with traditional cultural health beliefs and behaviour.

It would seem traditional healers and spiritual healers have more influence in communities than western health care professionals, as a result it would be beneficial if they can be included in the teamwork, to focus on those beliefs that can facilitate T.B. treatment.

2.5. PREVENTION OF T.B.

Mhlope (2001:2) pointed out that it is necessary to prevent, rather than to treat it, because its treatment process is more expensive than its prevention. It can even develop into multi-drug resistant T.B. (MDR-T.B.), which is more difficult and expensive to treat. This is further emphasised by Mhlophe (2002:02) when she pointed out MDR-T.B. is more difficult and length to treat. She also pointed out that it is even more costly.

According to Smetherman (2002:2) the new vaccine called the super BCG Vaccine has shown to prevent T.B. in guinea pigs and expected to work in humans. The vaccine works by secreting a protein of the tuberculosis virus, which stimulate the immune system.

Smetherman (2002:2) added that the BCG Vaccine is currently the only vaccine available. He further pointed out that South African prevents some children not all from getting T.B. meningitis and miliary (blood-born), it provides little protection against T.B. in the lungs.

According to the Department of Health (1993:3) T.B. can be prevented by adopting “Stop” policy which indicate that

- Smear positive patients
- Treat for six months
- Observed treatment
- Patient centeredness

Eating balance diet for example, meat, eggs, beans, milk, brown bread, maize meal, vegetables, and fruits. This statement is supported by Modisane (2002:2) when she pointed out that it is essential that T.B. patients should be on a proper diet while being treated because T.B. in particular thrives on low immune system. Alcohol should be avoided because it lowers resistance. Smoking also should be avoided because it causes further damage to the lungs and apart from that it causes heart disease and lung cancer.

It is necessary to stay in a clean environment to prevent T.B.

The above information suggest that BCG is currently the only available vaccine in South Africa for T.B. and it does not prevent T.B. for all the children and also has little protection against T.B. in the lungs and as a result it is necessary to eat balanced diet while being treated and avoid alcohol and smoking.

It becomes very important to have communities educated on how T.B. is contracted in an effort to prevent its spread and protect those who are not yet infected.

2.6. TB AND HIV/AIDS

Schaarer & McAdam (1998:8) pointed out that in 1983 the relationship was found between AIDS and tuberculosis. They further pointed out that group of Italian immigrants in South Florida in whom AIDS developed were more likely to develop tuberculosis than other populations. Schaarer & MacAdams (1998:8) also mentioned that cities with the greatest AIDS and HIV disease problems were also among the first area of the country to show an increase in tuberculosis. Still others noted that active tuberculosis seemed to develop as manifestation of AIDS or HIV infection in those populations traditionally at great risk for tuberculosis infection.

The Department of Health (1996:16) maintains that HIV, the virus that causes AIDS, is simultaneously devastating populations and fast tracking the T.B. epidemic. Smetherman (2002:2) adds that T.B. and HIV are called terrible twins as the two diseases exacerbate one another. He further pointed that it has been estimated that over 50% of people with T.B. are HIV positive. Smart (2000:14) explained that HIV positive people are extremely vulnerable to infections and are more likely to be at risk with T.B. than people who are HIV negative.

According to the South African Tuberculosis Programme (1996:15) children with HIV/AIDS are more susceptible to infection with T.B and the clinical picture is often unusual.

The above information suggests that people who are HIV positive and who suffer from AIDS are vulnerable to opportunistic infection of which T.B. is not an exception.

As a result it becomes very important to make sure that prevention of both HIV and T.B. is emphasised at all times. The researcher as a member of the multi-disciplinary health team has a very crucial role to play in this regard.

2.7. CONCLUSION

T.B. is one of the major infectious diseases in South Africa and it can attack any part of the body. It can attack any person irrespective of socio-economic status.

T.B. is one of the leading causes of death in South Africa that is why in 1993; it was declared a global emergency. Its mode of transmission is through inhalation, ingestion, and inoculation, and there are different types of T.B. like pulmonary and extra pulmonary tuberculosis.

T.B. treatment is usually difficult, because people are usually not complying due to different reasons. This in most cases turn into multi-drug resistance T.B. that is usually difficult to be treated. DOTS, is however introduced in order to help patients to comply with treatment of T.B.

The following chapter highlights social work intervention with T.B. patients.

CHAPTER 3

SOCIAL WORK INTERVENTION WITH T.B. PATIENTS

3.1 INTRODUCTION

Department of Health (1991:15) pointed out that social work is aimed at people with the intention of establishing effective social function as well as preventing and rectifying malfunctioning. The researcher is in agreement with the above information because the role of a social worker is to deal with psychosocial implications of illness on patients and their families.

Many patients admitted at Moretelelesi Hospital, where the researcher is working, are not complying with medical treatment; as a result social work intervention is necessary.

Dhooper (1997:44) pointed out that the central focus of the social work is on the person in his or her life situation, which demands simultaneous attention to the individuals and the environment. Dhooper (1997:44) further pointed out that social workers are trained to look at the total picture, to consider the relevant larger societal forces –malignant as well as benevolent – while dealing with the private problems of individuals, and to keep in mind the suffering of the individual while dealing with the public issues.

The above information suggest that social work intervention will be of great benefit if the patient is holistically treated, that is, attending the patient's social problems by taking his social environment into consideration.

This chapter deals with the following aspects: social work in health care, team work, social work intervention with individuals, social work intervention with the groups, social work intervention with communities, home-based care and community-based care.

3.2 SOCIAL WORK IN HEALTH CARE

Cowles (2000:12) pointed out that social workers in health care settings are concerned with the interaction of physical, psychological, and social conditions of the client, both as causes and effects. Social situation of life change event (such as marital dysfunction, social isolation, loss of jobs or death of loved ones) can produce emotional distress that can lead to changes in physical health functioning that increase one's vulnerability to disease, Cowles, (2000:12) further pointed that a physical health problem can erode self-confidence or interfere with the ability to perform customary activities which can affect marriage or other social roles and relationship and, in turn, lead to emotional distress.

The above information suggest that it is necessary to take the patient's social environment into consideration in order to understand the causes of the patient's problems and the effects of these problems on him

Dhooper (1997:3) is of the opinion that in all health care settings, social works have provided a holistic perspective on problems and situations, highlighting the social antecedents and consequences of illness and the need to deal with the larger picture along with immediate concern. Dhooper (1997:3) further pointed out that at the level of the individual s' acute or chronic illness, a social worker's focus is on the patient's physical, psychosocial, and environmental health needs. The above-mentioned information suggest that the social worker's intervention is of great important in dealing with problems of patients but they need to be attended to with immediate concern. According to Dhooper (1997:45) social work in health care has an impressive, proud, and rich past because in the 19th century, social workers were in the forefront for the movement for reform in labour. They participated in the prevention, case findings, treatment on tuberculosis and maternal and child care problems. Social worker have in different ways contributed their skills to different health care settings, which benefits the patients and facilities their recovery process.

3.3. TEAM WORK

According to Rehr and Rosenberg (1991:20) the patient can no longer be fragmented in the delivery of services, he/she is best served if he/she is kept whole; in fact her care is comprehensive and coordinated. To achieve those goals group of people need to work together for health education. Rehr and Rosenberg (1991:21) further pointed out that health team should be involved in the following way concerning education of the patients:

The team members should be aware of the patient's reaction to be informed of the diagnosis of T.B, as this will affect the patient's readiness to information of TB.

- The patient's level of comprehension must be known so that the level of information on TB can be adjusted accordingly;
- Information on TB should be provided to the patient preferably in the language with which the patient is familiar.

Cowles (2002:10) pointed out the importance of the team as follows:

- Shared assessment of patient problems and needs;
- Exchange of relevant information;
- Team teaching of clients/ patients;
- Ethical decision making;
- Development of intervention plans;
- Delegation of tasks and responsibilities;
- Modification of plans as needed;
- Evaluation of outcome.

The researcher is of the opinion that the patient is best served when the whole health team attends him holistically, as this will ensure a comprehensive service.

3.4. SOCIAL WORK INTERVENTION WITH INDIVIDUAL

Kobe (1996:77-80) contend that it is necessary that the social workers should intervene in the following way in respect of the TB patient.

-Inform the TB patient of his diagnosis and about the nature, symptoms, complications, and treatment of tuberculosis. She/he must reassure and encourage the patient in order to allay fears and get his cooperation in therapy. The patient is more likely to cooperate if he understands what is happening to him and what is expected of him in therapy.

-Inform the family and patient's employer to get their cooperation. The employer is enlightened as to the nature of T.B. management and persuaded to keep the patient in employment and play an active part.

-Assess the patient and his environment in consultation with the patient to choose a suitable therapy regimen with which the patient is likely to comply. Patient compliance is more likely to be obtained if there is consultation about the following: -

Home conditions and special problems, for example the problem of dependants when contemplating sending a mother or a breadwinner to hospital; the wishes of the patient; the patient's ability to work; as influenced by his physical state and his keenness to continue employment and facilities for supervised and ambulatory treatment at work or at the clinic and difficulties to reach the clinic due to distance.

Kobe (1996:77-80) further pointed out that the patient is likely to comply if he/she is informed about his/her diagnosis.

The researcher has observed that in order for patients to comply with treatment, it is necessary to discuss suitable treatment plan with them.

If they are involved in the treatment process they own it and this increases compliance, which is always crucial in TB treatment.

Kobe, (1996:20) asserts that psychosocial factors have a bearing on the TB patient's self image. The T.B. patient will have a direct bearing on how he views himself, his capabilities, and his functioning in society.

This usually affects his compliance. The researcher has seen some of the patients at Moretelelesi Hospital suffering from stigma of being labelled as TB patients not even being called by their own names. Psychosocial aspects on individuals should be taken into consideration when rendering services to them.

The researcher is of the opinion that the TB patient should be treated like any other person in the community to avoid disturbing their self-image

3.5. INTERVENTION WITH GROUPS OF TB PATIENTS

Toseland and Rivas (1998:12) pointed out that group work is goal-directed activity with small groups of people aimed at meeting socio-emotional needs and accomplishing tasks. According to Toseland and Rivas (1998:12) this activity is directed to individual members of a group and to the group as a whole within a system of service delivery.

The importance of treatment group was stressed by Toseland and Rivas (1998:74) when they pointed out that the primary purpose of treatment groups is to meet members' socio-emotional needs, including those for education in order to comply with TB treatment.

Mckedrick (1992: 80) mentioned the following advantages in working with groups, which are beneficial to TB:

- They are provided with the opportunity of both identifying and testing out new skills in interaction with others.
- They are relieved from isolation as they notice the similarities between themselves and other group members
- There are more appropriate solutions to problems as T.B. patients share their experiences

Mackendrick (1992:100) argues that leader must be non-directive and focus on providing support to T.B. patients, facilitate, their communication and encourage the transfer of skills they achieved in the group to life outside the hospital when they are discharged.

The above-mentioned information confirms the benefits that group members have by belonging to a group. It is evident that group work with T.B. patients is beneficial in empowering them to cope outside the hospital.

3.6. SOCIAL WORK INTERVENTION WITH COMMUNITIES

According to Mckendrick (1992:106-112) community work is an umbrella term used to refer to various intervention approaches by professional practitioner to help community irrespective of the approach used, it is concerned with bringing about change in the environment and social institutions for example, the community will be educated to support and accept the T.B. patient. T.B. resources can be developed in the community like health centres so that the patients can comply with treatment.

Mckendrick (1992:106-112) further pointed out that involved in the process are relationship goals, which have their objective as developing organizational and interpersonal relationship among group members to facilitate change effort among them.

Department of Health (2001: 17-22) further pointed out that the social worker are equipped to help T.B. patients in the following ways:

- To enlarge their competence and to increase their problem solving ability.
- Help them to obtain resources like disability grant.
- Make organisations responsive to patient needs for example, building health centres near to patient's homes.
- Facilitate interaction between T.B. patients and other in their environment so that the T.B. patients cannot feel lonely, isolated or rejected.

It is evident that the social worker can improve the quality of life of patients by exposing them to different resources from which they benefit and by increasing their problem solving capacity in order to comply with T.B. treatment.

The above information indicates that it is better if different professionals come with their different expertise for the welfare of the T.B. patients to ensure an appropriate service, which promote compliance.

3.7. HOME-BASED CARE

Although this is frequently spearheaded by members of the health sector, in order for home-based and community-based care programmes to be truly successful, the support of members of the welfare of other sectors like education, social development, local government, traditional leaders, traditional healers, faith-based organizations, non governmental organizations and community organizations are all vitally necessary. The support of other members of the team is necessary to T.B. patients so that appropriate treatment can be provided.

WHO, (2001:1) defines home-based care as the provision of health services by formal and informal caregivers in the home in order to promote, restore and maintain T.B. patients' maximum level of comfort, function and health including care towards a dignified death. Home-based care services can be classified into preventive,

promotive, therapeutic, rehabilitative, long-term maintenance and palliative categories.

Home-based care is an integral part of community-based care. Community based care is the care that the consumer can access nearest to home, which encourage participation by people, responds to the needs of the people and encourages traditional communities life and creates responsibilities. (WHO 2001:1)

WHO (2001:1) and the Department of Health (2001:25) maintain that home based care calls upon the resource skills, time, energy and funds of community and governments. It is implicit that “health” is the outcome of the overall social and economical development of the community. Therefore, no single entity is able to meet the total requirements and challenges of home-based care. A collaborative effort is fundamental to success. Care in the community must become care by the community.

Department of Health (2001:25) further indicated that the reasons for the erection of home-based care are as follows: -

- Shortage of hospital beds
- Inadequate number of medical, nursing and allied health professionals in the public sector
- Lack of resource for treatment and drugs
- Increasing demands of curable conditions on existing institutional care.
- Hospitals, which are crowded and over stretched, are often unsuitable for managing patients with terminal or long-term diseases
- Cost of institutional care.

WHO (2001:4) and Department of Health (2001:25) agrees on the following principles, for home-based care:

- Person centred, sensitive to culture, religion and value systems, to respect privacy and dignity (community-driven, and customer centred).
- Ensure access to comprehensive support services.

- Promote and ensure quality of care, safety, commitment, cooperation, and collaboration.

- When addressing problems of the T.B. the following aspects need to be taken into consideration by the researcher for necessary intervention that is physical, social, emotional, economical, and spiritual aspects.

- The researcher during intervention should be sensitive to the patient's culture, religion, and value system in order to respect privacy and dignity of her clients.

- The researcher must be involved in multi sector involvement to render effective intervention to T.B. patients. This include preventive, promotive, therapeutic, rehabilitative and palliative.

- The researcher should empower and allow capacity building to promote the autonomy and functional independence of the individual and the family or care givers.

- Access to comprehensive support services should be ensured by the social worker.

- The researcher should promote and ensure quality of care, safety, commitment, co-operation and collaboration

- The reasons for including community-based and home-based care into RHC strategy in assisting T.B. patients are the following (Department of Health 2001:25):

- The researcher should allow the patients to take part in deciding about appropriate care in their environment

- The intervention will be beneficial if patients are involved in taking part in decision concerning their health care.

3.7.1. IMPORTANCE OF HOME BASED CARE AND COMMUNITY BASED CARE IN RESPECT TO T.B. PATIENTS.

According to WHO (2001:1) home-based care and community-based care are important to the welfare of the community and their importance are indicated as follows:

- Allow people to spend their days in familiar surrounding and reduced isolation.
- Enable family members to gain access to support services.
- Promote a holistic approach to care and ensure that health needs are met
- Create awareness of health in the community.
- Bring care providers in touch with potential beneficiaries.
- Intervention is pro-active rather than reactive
- Beneficial to family and friends as it allows direct time with clients and involvement in care giving.
- Avoid unnecessary referrals to and from higher levels.
- Ensure that caregivers and all key role players are well-informed (knowledgeable), - received adequate skills training and utilize other partners in care.
- Caregivers are fully involved and informed about the individual care plans

According to WHO (2001:4) the purposes for including community based care and home based care into primary health care strategy in the service to T.B. patients are the following:

- The researcher will reduce pressure on hospital beds and other resources at different levels of service.
- The researcher will involve these patients in group work in order to avoid isolation.
- The awareness campaign will be conducted to make patients aware of importance of health families in the community.
- The researcher will advocate for clients with care providers to be in touch with them.
- The researcher will link and complement existing health services in order to assist clients with necessary intervention.
- Ensure continuity and consistency in services, quality assurance, and management.
- It is evident that home-based care and community-based care in dealing with T.B. has a major gap to fulfil to the benefit of the patients and their families and clients.

3.8. T.B. AND PRIMARY HEALTH CARE WITH REFERENCE TO SOCIAL WORK RESEARCH

According to the Department of National Health and Population Development (1991:1) at Alma Ata in 1997, the World Health organization issued a declaration appealing to health for all patients. This can only be achieved through the implementation of primary health care form of health of promotion

The Department of National Health and Population Development (1991:37) and Kotze (1997) agree that primary health care is “essential health care based on practical scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain in the spirit of self reliance and self determination”

The researcher is of the opinion that the health status of T.B. patients can be improved through primary health care and implementation of the principle of “Batho Pele” of access by making the following accessible to patients:

- Making information available to people; and
- The provision of food and correct nutrition;

This will bring a remarkable improvement in the quality of patients suffering from T.B.

The Department of Health (1991:2) pointed the following aspects to be accessible to patients: -

- The provision of an adequate supply of safe water and basic sanitation;
- The rendering of mother and child health services, and family planning;
- Ensuring immunization against the major infectious diseases;
- Controlling and preventing endermic diseases;
- Providing suitable treatment of general diseases and injuries; and
- The provision of essential medication.

These principles will be briefly discussed as their implementation can improve the quality of life of T.B. patients.

- **The provision of an adequate supply of safe water and basic sanitation**

Department of Health (1991: 5) highlights the importance of water and basic sanitation the social workers usually work in rural areas where there is shortage of water it is their duty to make recommendation to the government to supply people with safe water more especially so that life T.B. patient can be prolonged due to safe water, Department of Health (1996:31) indicated that the social worker usually do assessment and thereafter marks recommendation to the relevant people like water supply authority, Department of Health (1991:31) added that in rural areas where sanitation service are not of technological standard the pit toilet system is usually encouraged to be used, but the people must be encouraged to observe high standard of hygiene

- **To ensure the provision of and child health services and family planning.**

Dennil & Swanepoel (1999:37) stressed that the provision of maternal and child health service must be make ensured the social worker must usually do the necessary assessment during home visits to make sure that the mother is health together with children the will help for the prevention of many diseases including T.B. the mother should also be encourage for proper spacing of children in order to give other children enough time for health growth without T.B

- **Ensuring immunization against the major infectious diseases.**

Dennil and Swanepoel (1999:38) advise that immunization of children is one of the most cost effective means of improving child survival.

- **Controlling and preventing endemic diseases**

The department of health (1991:8-19) maintains that these services contains the following: -

- The combating of tuberculosis and other diseases.
- The tracing and treatment of contacts carriers of the above diseases

The social worker has an advantage of doing the home visit and when people are infected by T.B. she can form multidisciplinary team in order to provide health guidance programme to T.B. patients This could help in ensuring that the spread of T.B. is controlled and those who are infected are identified and then provided with treatment as early as possible.

- **Providing suitable treatment for general diseases and injuries.**

The Department of Health (1991:9) asserts that this involves treatment of common illness and injuries and is determined by medical protocol, which is a list of certain conditions, such as tuberculosis, and which is compiled by the Department of National Health and Population Development in conjunction with the health authorities, The social worker can play the major role by supervising whether the T.B. patients are taking treatment on regular basis, Department of Health (1996:34) is of the opinion that social workers can be mostly involved in providing mental health guidance and providing support services to the patients and their families.

- **The provision of essential medication**

Department of Health (1996:34) contends that this service entails listing and making the drugs available that are in accordance with the medical protocol, Department of Health (1996:34) adds that having looked into the various fields of primary health care, one is able to fit in the social worker. The social worker through her role of home visits can help patients who are not complying to treatment to take these drugs on regular basis.

- **Health Education.**

Education to individuals should be implemented in an effort to reduce the spread of T.B health education is the best tool to empower people to fight against T.B education regarding T.B. provides a good opportunity to expose patient to more information about T.B. day. This is in line with the principle of “Batho Pele”(which means putting people first), which indicates that people should be given full, accurate information about the service they are entitled to. According to the Department of Health (1997:125), every year on March 24, the world focuses its attention on T.B.

Department of Health (1997:125) further pointed out that March 24 was the day in 1882 when Dr.Robert Koch announced his discovery of the bacillus that causes T.B. and that world T.B. day should be used as an opportunity to inform the general public about DOTS and to reduce the stigma attached to T.B.

The importance of education in as far as T.B. is concerned cannot be overemphasized. It is the only way that could ensure that communities are equipped with knowledge to combat T.B. It is also important to make sure that T.B. patients are encouraged to cooperate with the volunteers who are willing to support them with regard to DOTS.

- **Promotion of provision of food and correct nutrition.**

The Department of Health (1991:4) and annual report of the Department of Health (2003/2004: 56) agree that providing education on all facets of correct nutrition with special attention to T.B. patient is of great importance

President Thabo Mbeki at his state of the Nation Address on 8 February 2002 pointed out that people must take care of their lives by protecting and enhancing their immune system and as a result nutrition is an important matter. The researcher is therefore of the opinion that people can improve nutrition by engaging in vegetable gardens. The researcher has therefore decided to involve her patients, who are not very ill at Moretelelesi Hospital, in vegetable gardens in order to get good nutrition and income by selling rather than relying in outside resources like migratory labour and social security This will at the end improve their health. This is done based on the goal of

social work which is to enhance social functioning in people's lives by linking them with resources.

3.9. CONCLUSION.

Social work intervention is implemented to alleviate the social or emotional impact of physical illness and to promote conditions essential to assure maximum benefits from short and long-term health service.

There are three methods of social work intervention i.e. intervention with individuals, groups, and with communities work

It is necessary that the patient should be informed about their diagnosis, symptoms, complications and treatment of tuberculosis. The patient must also be encouraged in order to allay fears and get his cooperation

Group work is of great benefit to the patients so that they can derive support from other T.B. patients and to establish support system. There are however, many things that can be achieved in a group that cannot be achieved with individual one-to-one basis. The social workers have special skills, which they use in order to coordinate resource to help the T.B patients.

Primary health care within the hospital is concerned with the protection and promotion of the health of all T.B. patients. Health education as part of primary health care has been emphasised when dealing with T.B. patients. The social worker has the necessary skills, methods and strategies to help patients to help themselves in order to avoid non-compliance to T.B. treatment.

The social workers must ensure that there are available services that are acceptable and affordable at all times

The following chapter deals with the empirical findings

CHAPTER 4

THE EMPIRICAL FINDINGS REGARDING NON- COMPLIANCE AMONGST T B PATIENTS AT MORELETSI HOSPITAL

4.1. INTRODUCTION

The researcher found it necessary to describe research methodology and research findings below. To facilitate understanding of research findings, themes were extracted from what the respondents experienced.

4.2 RESEARCH METHODOLOGY

The researcher used applied research which according to Williams et al (1995:69) is practical and useful knowledge that can directly help in improving certain condition while Bailey (1992:24) asserts that applied research is interested in whether or not the results of the study can be applied to limit certain problems. Applied research was used in this regard with an aim to address the problem of non-compliance amongst T.B patients at Moreletelesi Hospital. Phenomenological strategy was used. According to Williams et al (1995:243) research design is a logical strategy for planning research procedures and providing evidence for the development of knowledge.

A total of 20 interviews were conducted. These were T.B patients who were not complying with the T.B treatment at Moreletelesi Hospital between November 2003 and March 2004.

The interviews were conducted by the researcher and capturing data done by the tape recorder with the permission of the respondents. The researcher made detailed introduction and purpose of the study clear to the respondents before the interview process could take place. Privacy was ensured through informed consent.

The interviews were based on the following central themes.

- Tell me how did you feel after being informed that you are suffering from TB.
- Tell me about your cultural belief concerning the treatment of T.B illness
- Tell me about support from family, friends and community.

4.3 RESEARCH FINDINGS

Themes of non-compliances amongst T.B patients were highlighted after data was collected and qualitatively analysed. Some of the statements that indicate non-compliance among T.B patients at Moretelelesi Hospital are quoted verbally from interviews in order to highlight their experiences.

4.3.1 CENTRAL THEMES

Following are themes extracted from the collected data:

- **Cultural beliefs**

The majority of respondents indicated that they have belief in traditional healing than in western medical treatment. They pointed out that according to their cultural belief they should first consult traditional healers before they can consult medical doctors. The following statements indicated this:

“I went to my traditional healer to see whether ways {things} are right before I went to the hospital”

“My traditional healer treated me with the medicines which helped the hospital x-ray to indicate my illness”

“Traditional medicine helps me more than hospital medicine”

“I did not use hospital medicines but used traditional medicine when I used traditional medicine when I was discharged from the hospital for the first time”

It is indicated by Van Dyk (2001:127) that about 80% of the people in Africa rely on the traditional medicine for many of their health care needs. He further asserted that traditional healers are well known in the communities where they work, for their expertise in treating diseases. Kobe (1996:89) also supports the above information when she indicated that “when illness attacks, the decision that the patient makes regarding the action to take is influenced by the traditional background”. African National Congress (1994:55) indicated that people have the right to access the traditional practitioners as part of the cultural heritage and belief system.

- **Rejection**

Patients suffering from TB indicated that some friends and some members of the community always reject them. This is supported by the following statements from the patients

“They tell their children not to play with my children”

“When I go to where people are gathering to avoid loneliness, they immediately move away from me and they leave me alone”

“My neighbours tell their children not to play with my children because they would get TB”

- **Loss**

Most TB patients feel that they have lost many things e.g. physical ability, financial stability due to loss of employment. According to Van Dyk (2001:256), “the most commonly experienced loss, is the loss of confidence and self worth occasioned by the rejection of people who are important to them, who were once friends but now reject them because of the physical impact of TB

It is clear that the loss of physical ability due to TB makes people to feel worthless.

- **Low self esteem**

The patients suffering from TB mentioned that they feel less important because friends and some of community do not consider them in many things. The following statements confirm this: -

“I feel worthless because they do not consider me in many things like being invited at social gathering”.

“When I am coughing and people are looking at me I think they are talking about me”

Mathekga (2001:68) pointed out that these people usually feel let down as they realise that they are no longer being recognised as before.

It is therefore clear that the self-esteem of TB patients is lowered by the above-mentioned factors.

- **Denial**

The researcher noticed that many patients go through the stage of denial especially when they have not yet accepted that they have T.B. This feeling of denial gives them strength. The feeling of denial is indicated by the following statements from the patients: -

“It is Ok even if I am suffering from T.B. because it is not dangerous like AIDS”

“T.B is an illness like other illnesses”

“I do not care even if I suffer from T.B.”

“Even if I suffer from T.B. I am the person like other people”

Evian (2000:278) pointed out that people with T.B. have great difficulty believing or accepting that they have a serious condition.

The researcher is of the opinion that denial of T.B. patients is important because it reduces stress, the researcher should however not allow it if it causes abnormal behaviour.

- **Depression**

T.B. patients always feel worthless because they feel they can no longer do many things in life.

This is indicated by the following statements from respondents.

“I feel useless”

“I feel powerless”

“I feel hopeless”

“I feel guilt “

“I feel lonely”

“The world has changed for me, it does not look like before”. According to Syme (1997:183) these people feel let down because of T.B. illness.

The researcher is of the opinion that it can be of greater benefit if the community and next of kin can support the T.B. patient so that they can not be depressed

- **Wish**

The respondents that were interviewed by the researcher wished they could be healthy like other people. These are some of their expressions: -

“I wish I could be healthy and work for myself”

“I wish I could be like other healthy people”

“My family wishes that I could be better”

Jeffery et al (1989: 87) confirm the above-mentioned information when he stated that good health is necessary for every man's life.

- **Acceptance**

Many respondents accepted that they are suffering from T. B. and this is indicated by the fact that they have been seeking help from different places like at traditional healers and faith healers. They even went to the hospital to seek assistance.

This was confirmed by the following responses: -

“I accept that I am suffering from T.B.”

“My traditional healer informed me that I suffer from T.B.”

“The hospital diagnosed me for T.B.”

Hunt and Monarch (1997:186) agreed that the acceptance of one's own situation could take time to occur.

It's clear that most respondents accepted the condition of their illness. This is indicated by their efforts to seek medical attention at either traditional healers or western medical treatment.

- **Side effects**

Many patients complained that they have side effects from medication, that is why they were not complying with medical treatment, and resorted to traditional treatment. These are some of the statements to confirm the above information.

“I suffer from nausea”

“I suffer from diarrhoea”

“I am vomiting”

“I suffer from dizziness”

“I suffer from abdominal pains”

“I suffer from joint pains”

“I suffer from skin itching”

The above information indicates that patients are not complying with medical treatment because the medication is causing side effects to them. To ensure that patients do not abandon treatment because of side effects, it is important for the medical team to educate them on these side effects, before they start treatment.

- **Spiritual concerns**

Most people suffering from T.B have the perception that their illness is punishment from God and they tend to ask many religious questions with the aim to get religious support.

These are some of their responses: -

“Is this illness punishment from God”?

“I want to ask forgiveness from those I sinned against so that God can forgive me”

“Will God help me cure this illness when I pray” “why did God cause T.B.”

“Why does God cause suffering to take place on earth”?

This statement is supported by Van Dyk (2007:311) when he indicated, “would it not have been advisable for God to have excluded all suffering such as illness from this earth?”

The importance of dealing with the spiritual need of T.B patients can be of great benefit to them, only if they believe that.

- **Fear**

The person suffering from T.B has many fears. These are expressed by the following statements: -

“My friends are isolating me. They are no longer near me like before I became ill”

“I am not sure of how long am I going to live”

“I feel I have lost my power”

The above information suggests that education can equip the patients to deal with reality in as far as T.B. is concerned.

- **Anger**

T.B. patients always express feeling of anger due to T.B illness. This was confirmed by the following responses: -

“I am angry with my husband because he talks too much about T.B. even when it is not necessary”

“I am not happy about myself because I am not becoming better from T.B.”

“I easily become angry since I suffer from T.B.”

Van Dyk (2001:257) agrees with the above-mentioned point when he indicated that T.B patients are very angry with themselves and others and this is sometimes directed at the people who are closest to them. The researcher is of the opinion that people are angry because they are not sure what may happen about their state of health.

- **Anxiety**

The respondents indicated to be anxious, as they doubted their future state of health. They expressed this in the following statements:

“I am worried about condition of my health”

“I am worried because my friends and relatives are rejecting me”

“I am worried because my family will cope with my condition when it deteriorates’.

Van Dyk (2001) pointed out that “uncertainty associated with the progress of T.B. aggravates feelings of anxiety”. It is clear that the respondents are worried about their state of health and whether they will enjoy support from their significant others.

- **Suicidal behaviour**

Respondents reported that they had a tendency to have suicidal ideation, which was confirmed by the following statements: -

“I feel like dying”

“The pain that I am feeling make me feel useless to live”

“Why am I living”?

The above information indicates that T.B. affects the emotional feeling of patients to an extent that they find life worthless.

- **Social support**

The researcher noticed that the respondents do not have support from the community but only from their family members and traditional healers.

These were expressed by the following statements: -

“Community members do not support me and call me by different names”

“Only members of my family supports me”

“I feel lonely”

This calls for the serious health education in an effort to equip the community regarding T. B to reduce the stigma and enhance acceptance of people suffering from T. B.

- **Non compliance**

The patients mentioned that they are not complying with medical treatment due to the fact that they are always getting side effects from the medication. The other reason cited is the fact that the treatment takes a long period of time. The respondents further indicated that due to the poverty that they find themselves faced with, they are unable to afford the travelling costs to reach the health centres, especially that these centres are far from their homes. This is a challenge to make sure that the services are accessible to the patients.

4.5 SUMMARY

The findings of the empirical study revealed the following information.

The respondents have more belief in traditional medicine than western medicine and this has an aggravating factor for non-compliance of patients with medical treatment. The patients pointed out that they have to consult traditional healers before deciding on medical treatment whenever there is need to use that.

They mentioned that western medicine have side effects on them and also that the treatment take long time and they end up being tired to continue with the said treatment. They also mentioned that some health centres are far from them

The patients indicated that members of the community are not supporting them in their illness but only members of their families.

The patients suffer from feelings of loss, as they are no more engaged in employment. They as a result suffer from low self-esteem, as they feel worthless more especially as they are no more considered in many things.

Most patients have accepted that they are suffering from T. B and that they have hope that they would be better. This is shown by their efforts of consulting medical doctors and traditional healers. Some are still denying the fact that they are ill and that they suffer from depression.

It is necessary for the medical social worker to respect the traditional belief of the patient in order to render the necessary interventions.

Most patients did not comply with medical treatment due to travelling distance to the clinics and hospitals. It is therefore important that health facilities are established near to where people are living, to increase compliance.

Some patients have complained that they were suffering from financial problems therefore it can be of great benefit if they can be considered for a disability grant.

CHAPTER 5

SUMMARY, CONCLUSIONS, RECOMMENDATIONS, AND CONCLUDING REMARKS

1.5 INTRODUCTION

Non-compliance amongst T. B. patients at Moretelelesi Hospital and Social Work intervention was discussed in the study. The information from the literature and empirical data will be explained.

5.2 SUMMARY

The aim of this research was to explore non-compliance amongst T.B. patients at Moretelelesi hospital. The objectives of this study were met through the literature and empirical study. The researcher had the following as objectives of the study:

- To investigate TB as a phenomenon through literature review.
- To conduct an empirical investigation on the causes for high rate of non-compliance on T.B. Patients.
- To provide recommendations for social work intervention concerning non-compliance of TB. Treatment within the multi disciplinary health team.

This essay is composed of five chapters and is divided as follows: -

CHAPTER 1

Comprises of a broad introduction of the study, motivation for the subject, problem formulation, aim and objectives of the study, hypothesis or assumption of the study, research approach, research procedure and strategy, pilot test of the measuring instruments, description of the research population definition of concepts and division of the research report as well as the problems and limitations of the study.

CHAPTER 2

It comprises incidence of TB. As an illness, clinical types of TB, Causes of TB, signs and symptoms, treatment, and prevention of TB /HIV-AIDS.

CHAPTER 3

Focused on social work intervention with TB. Patients i.e. social work in health care, teamwork, social work intervention with individuals, groups and communities, importance of home-based care and community-based care in respect of T.B Patients and primary health care.

CHAPTER 4

Focused on the empirical findings

CHAPTER 5

Focused on summary, conclusions and recommendations.

5.3. CONCLUSION

The following conclusions were made

- Patients have more belief in traditional medicine than western medicine, as a result this interfere with compliance to their medical treatment
- There are still members of the community who are stigmatising T.B. patients.
- Patients are more emotionally supported by traditional healers than by members of the community.
- Most of the patients suffering from T.B. are also. HIV positive.
- There are still members of the community who are stigmatising T.B. patients.
- T.B is a serious problem that affects most people in the world irrespective of colour or race.
- In most families' more than one member are affected by TB.

- Many families are unemployed as a result; they are unable to provide themselves with healthy diet.
- Patients who are unemployed have no money to travel to distant health centres
- Most patients complained that western medicine have more side effects on them than traditional medicine.
- Most patients complained that the period of taking treatment is too long as a result they become tired during the process and end up abandoning the treatment before they could complete the course.
- Most patients prefer to use both types of medicine, that is traditional medicine and western medicine rather than stopping using western medicine.
- Many patients are experiencing different emotions that calls for social work intervention.
- It can be of great benefit for the social workers to render a service within the framework of the multi disciplinary team to make the team aware of the psychosocial aspects affecting the patients that might lead to non-compliance.

5.4. RECOMMENDATIONS

- The community should be educated to support the patient and not to reject them.
- The social worker should consider cultural belief in order to render services that are responsive to the needs of the patients.
- The social worker should be equipped with different cultural knowledge regarding the community she/he is providing a service to, so that he/she can be sensitive to the diversities.
- A holistic approach should be used in order to attend to all the needs of the patient.
- Disability grant should be granted to T.B. patients who are having a chronic condition, because they are unable to be employed again.
- The social worker should be well informed on the nature, background, and treatment of T.B so that she could provide the patients with a service that will be responsive to their needs as she/he will be able to understand them.
- The patients should be educated on the importance of treatment and compliance.

- The social worker should render the service as a member of the multi-disciplinary team in order to equip them with psychosocial implication of patients' illness.
- It should be seen that carers of patients properly implements the DOTS system
- T.B. has psychosocial implication, as a result there must be a social worker placed permanently at the T.B. clinic to attend to psychosocial aspects of the patients.
- Volunteers should be trained to help in supervising the patients. They could form a valuable support system.
- Government should be encouraged to build health centres or clinics near to all villages so that services can be near to people.

5.5. CONCLUDING REMARK

The study indicated that non-compliance to medical treatment by patients is influenced mainly by cultural belief system, side effects of medical treatment, travelling distance to health centres and long time to take medical treatment. It could be better if the patients could be allowed to use medical treatment and traditional treatment. There has to be proper supervision to ensure compliance to the treatment.

The social worker should be a member of the multi disciplinary team since she is mostly dealing with psychosocial aspects of the patients and as a result in a position to make members of the team aware about cultural influence in treatments of diseases for the patients.

When the patients are allowed to communicate freely with the multi disciplinary team, the members of the team will know appropriate steps to take to prevent non-compliance.

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