

THE ROLE OF THE SOUTH AFRICAN NATIONAL TUBERCULOSIS ASSOCIATION (SANTA), FAMILY PRACTITIONERS AND OTHERS IN THE FIGHT AGAINST TUBERCULOSIS

By TFB Collins MBBCh, DPH

One of the principles of family medicine is that the general practitioner is a 'manager of resources'. Sometimes these resources offering services to the community are neither well known nor obvious. Many of them are non-governmental or non-profit organisations.

In this series we invite contributions which describe these organisations, what they do and how they perceive their relationship to general practitioners.

FORMED IN 1947, SANTA IS THE UMBRELLA BODY for a number of anti-tuberculosis associations in South Africa (some of which date back to the latter half of the 19th century), which has as its main objective the providing of care and support for victims of the disease and their families, including health education and information.

Soon after the amalgamation the Association was requested to establish treatment centres for convalescing patients. The Union Health Department matched pound for pound the money raised in a national fund-raising campaign for construction costs. Today there are 22 SANTA Centres around the country. Very soon after the first centres began operating it became obvious that they would have to receive newly diagnosed patients in the face of a rising epidemic. A daily bed tariff based on actual running costs was negotiated with the government.

According to official notifications the epidemic reached a peak in the middle of the

century, followed by a slow decline until around 1980, when the trend was reversed. At the same time the disastrous effect of co-infection with the AIDS virus on persons harbouring dormant tuberculous infections was discovered. This phenomenon occurred worldwide, affecting even prosperous industrialised countries. In South Africa today the number of victims of TB is again increasing steadily, aggravated by unemployment and other negative social factors.

Early in the 20th century, the introduction of isoniazid (INH) as a potent anti-TB drug, together with the already available streptomycin and para-amino salicylic acid (PAS), meant that for the first time in the history of this disease effective chemotherapy became available. Over the following years other effective drugs, including rifampicin and pyrazinamide (PZA), were added to the armamentarium, and health authorities were confident that many patients could be treated on an ambulatory basis, sometimes after a short period of hospitalisation. Short-course (six

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months) treatment instead of the 18 months or two years previously regarded as standard became possible.

THE PROBLEM

THE TRAGIC MISTAKE MADE BY HEALTH AUTHORITIES was their assumption that simply handing a periodic supply of effective drugs to a patient would result in cure after six months. The reality is that patients are notoriously unreliable when required to take medication regularly over long periods of time. It soon became apparent that in every large population of TB bacilli such as those in the lungs of sick patients there exist a few that are resistant mutants to one or another of these drugs. If treatment is irregular or inadequate in dosage or combination, these resistant organisms will flourish as the susceptible bacilli are killed. Under such circumstances, when the bacterial population is resistant to the most powerful drugs (INH and rifampicin), the illness may become virtually untreatable. Even more seriously, such patients can infect others with their 'super bugs'. This condition is known as multi-drug resistant TB (MDR-TB), and it carries a mortality rate of up to 80%, despite lengthy, costly and toxic treatment (when other standard drugs are also ineffective).

Other factors which contribute to the problem are lack of sufficient personnel and transport to ensure that treatment is taken regularly, and failure to appreciate the seriousness of the situation. As the World Health Organisation has stated, we are faced with a global emergency which, if drastic action is not taken now, will take us back to the days when diagnosis of the disease would amount to a virtual death sentence. Another factor is the frequent delay in diagnosis resulting from the lack of awareness that we are *all* at risk, including the affluent section of our population. Inadequate diagnostic facilities also aggravate the situation, as does the shortage of medical and nursing personnel trained and experienced in controlling this common disease.

THE SOLUTION

DIRECTLY OBSERVED TREATMENT, SHORT-COURSE (DOTS), is essential for success. This literally means that *every dose of tablets must be seen to be taken* by some responsible person. Although SANTA has succeeded in obtaining volunteers to undertake this task to a limited extent, unpaid workers, however well motivated, cannot be expected to walk long distances in all kinds of

weather to perform this task; and so it is limited largely to reasonably close neighbours and family members.

Family practitioners able to offer this service free of charge to patients in their areas, using drugs supplied from the nearest clinic, could contribute to the DOTS strategy, as long as each visit is recorded and liaison maintained with the clinic for immediate reporting of patients who fail to attend as required. Prompt referral for investigation of new patients with signs and symptoms suggestive of TB would facilitate early diagnosis. Willing pharmacists, too, could expand the DOTS network of what would essentially become satellite clinics for TB patients.

SANTA, in addition to using its treatment centres for the same service where practical, will supply information and advice through its many branches throughout the country, or direct from its National Office in Johannesburg. The telephone number is (011) 336-9636, and the postal address is SANTA, PO Box 10501, Johannesburg 2000.

Like cancer, TB *can* be cured, but only if the DOTS strategy is applied on a national basis to the vast majority of patients whose organisms are susceptible to standard treatment regimens. Those suffering from MDR-TB should be identified as soon as possible and isolated for as long as they are capable of infecting others. There is still time to avert a formidable epidemic of untreatable TB.

In his book *Let Not My Country Die* Credo Mutwa refers to the similarity of the double-barred Cross of Lorraine to a triple-barred symbol of death, and he alleges that it turns people away from TB clinics and hospitals. (*See Talking Point on page 550.*)

Use of the Cross of Lorraine was carefully considered by SANTA some years ago when objections from the above author were received. It is a centuries old symbol of mercy recognised internationally, adopted by the International Union Against Tuberculosis (IUAT) and all voluntary bodies dealing with the disease worldwide. Discussions were held at the time with various African people, including health educators, and it was concluded that there was no valid reason for the South African organisation, which is affiliated to the IUAT, to break with this tradition.

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TRADITIONAL HEALERS HELP IMPLEMENT DOTS STRATEGY

How it all started

DURING ONE OF OUR SANTA BRANCH MEETINGS IN 1989, we were considering the reasons why TB patients default and why those not yet diagnosed are not coming forward, even if they have been referred for X-ray.

It became apparent in the discussions that most TB sufferers have a belief that they have been poisoned and that only traditional healers can help them. We decided to approach the traditional healers and offered to inform them about this disease. We discovered that they had a local association and that Mr Michael Ntsele was the chairman in KwaThema.

I initially approached him with this proposal. A week later he replied that the members were interested and that a meeting could be arranged. This meeting was scheduled for a Tuesday afternoon in my home. About 20 traditional healers attended, and we explained what TB is all about. We appealed for their assistance and stressed that they would not lose patients. The only thing we asked them was not to make the patients vomit.

We proposed that when they were satisfied with what the patient told them and that the signs they saw were suspicious of TB, they would refer the patient to the clinic – or even bring the patient to the clinic themselves. Once a diagnosis of TB was confirmed it would be the traditional healer's responsibility to monitor the patient's therapy and ensure that the patient continued to attend

follow-up appointments at the clinic.

Some healers initially felt that we were taking their patients from them. However, after a year it became apparent that the healers could be involved in other fields of primary care such as family planning, AIDS education and STDs.

A primary health course for traditional healers and other health workers was started at the Brakpan Tsakane Clinic in 1992. The following subjects were included:

- tuberculosis
- immunisation
- diarrhoea and oral hydration
- family planning
- breastfeeding and maternal care
- nutrition and food gardens
- mental health
- STDs
- AIDS
- infertility
- cancer

The traditional healers visit clinics in their own areas and professional nurses answer their questions and provide further information about the way we do things as nurses.

In KwaThema, the traditional healers have formed a TB care group. They undertake home and hospital visits. The purpose of the home visit is to ensure that after patients have left hospital they attend the clinic to obtain their treatment until they are discharged.

Zodwa Mokoena RN

From a traditional healer's point of view

IWORK HAND IN HAND WITH THE CLINICS. I WAS educated about primary care in 1989, 1990, 1991 and 1992. I then started to know about TB, STDs, HIV/AIDS and what chronic diseases are. I learnt what I can do to make communities aware of these diseases. I tell people that SANTA can cure tuberculosis within six months if the patients take treatment as they are told to.

My job is to care for these people. The symptoms and signs can talk to me before the patient tells me. My aim is also to reduce infections and the pool of tuberculosis sufferers,

and those who carry a lifelong risk of developing tuberculosis. I promote community awareness and active participation in the control of TB. I also ensure that all the traditional healers are appropriately trained not to delay the treatment of the TB patient. This includes never making the patient vomit and referring the patient to the clinic or hospital before they themselves treat them.

I also attend meetings which are concerned with health. As I am a member of the SANTA care group, I also do home visits to those who are still sick. It is my duty to remind mothers to

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breastfeed their children and to take them to the clinic to be immunised. Immunisation can reduce morbidity and mortality from preventable childhood diseases. These include mumps, rubella, measles, tetanus, tuberculosis, polio, pertussis, diphtheria and Hepatitis B.

I also educate people about STDs, HIV and AIDS. I counsel people who are already HIV positive. I was also working at the 'House of Concern' donated by the people of Parkland Clinic for AIDS patients. I worked daily from 10am to 5pm, answering more than 10 calls, distributing up to 500 condoms and counselling three to four people a day.

Even doctors referred patients to this house. Some patients came from the clinics with different diseases. I would refer patients with STDs and TB to the clinics for treatment.

I have been doing this as a volunteer and have not been earning an income from this work. I sometimes ask a friend to come and help me. Unfortunately the house was closed. I am now working on the street and visiting people with TB and HIV/AIDS in their homes.

Michael Ntsele,
Traditional healer

LETTERS TO THE EDITOR

*Letters should be addressed to:
The Editor, SA Family Practice, PO Box 2731, Rivonia 2128*

(The following slightly modified letter was originally published in SA Family Practice in May 1996 – Editor)

Sir,
THIS LETTER IS IN RESPONSE TO YOUR FEBRUARY CME section on TB by Dr Chris Ellis. It is a plea for family practitioners (FPs) to become more intimately involved in TB management. For 15 years, while in state rural practice, I gained experience especially in the practical management of TB patients. For the last three years I have been in private practice in rural areas, first in the Western Cape and now in the Eastern Cape. In both places I was involved in TB care (part-time appointment with the Regional Services Council).

My latter experience is that the private FP is often involved only in reading X-rays for diagnostic purposes or for follow-up, and does not actually see the patient. When FPs suspect TB in a patient they often merely refer him or her to the nearest clinic for investigations and treatment and have no further contact with them. In some

instances I have known clinic sisters to send X-rays to TB officers far away for reading, resulting in long delays (while a local family practitioner was available). This, as well as the long delay in getting sputum results in rural areas, often means that patients are put on TB treatment with insufficient evidence and are kept on treatment for too long. Compliance, though, and not diagnosis, remains the greatest challenge in TB management. All too often patients are given a packet of TB tablets for a month with no direct supervision of treatment. It is here that I think the family practitioner's holistic approach is desperately needed, even more so with the increasing incidence of MDR-TB and AIDS.

The FP looks at the patient not just from a clinical point of view but takes into account his fears and expectations, as well as his family and his environment.

The question arises: why are FPs not more involved in TB management at present? Is it because we are perceived by other health professionals as uninterested in, or ignorant of TB, maybe with reason? Is it because the nursing