

Traditional attitudes towards TB

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The purpose of this paper is to investigate the extent to which individuals in the study know about TB, and their decision to follow the prescribed treatment; whether or not compliance is related to the following criteria: age, sex, religion, occupation, education, and also general attitudes towards TB and the medical profession.

Special attention has been paid to attitudes from both categories of compliance and non-compliance.

We all know that any set of beliefs and attitudes in the health-disease area will be integrated with other important belief and practice systems, such as kinships, relationships, religion, beliefs, methods of political and social control and interest in esthetic pursuits.

There will also be variation from group to group in the way that illness is perceived and handled.

The list of questions drafted for this investigation were framed to elicit information on: *How the participants define TB? What TB means to them? What are their notions of prevention and etiology?*

I Methodology

The data consists of the responses given to the first enquiry administered in the period February — March, 1982. The sample comprised: 50 hospitalized TB patients at Ga-Rankuwa Hospital and 50 outpatients TB sufferers receiving treatment at Boekenhout Clinic. The former were a readymade group, interviewed in the ward. The latter were followed up at their respective homes scattered over Mabopane A

and B and Winterveldt.

Great use was made of hospital/clinic records, to obtain the required demographic data and clinical diagnosis:

- The analysis controlled for sex, occupation, education and religion.
- In all of these, attitudinal variables were involved. Of these, some are related to the future expectations of the respondents for being cured with treatment, others are concerned with family life, others deal with societal attitudes, and others have to do with health and the medical institutions/profession.

II Sample description

The 100 respondents were classified into three broad categories for investigation:

Category 1 New Cases: all patients who were attending the TB Clinic or hospitalized for TB for the first time.

Category II Defaulters: those patients who never completed, or were irregular in taking their treatment for various reasons.

Category III Reactivators: known cured or completed treatment, but had a relapse.

NEW CASES		DEFAULTERS		REACTIVATORS		TOTAL
	%		%		%	%
Hospital	Male	13	15	5		50
	Female	10	04	3		
Boekenhout Clinic	Male	14	10	1		50
	Female	15	8	2		
				TOTAL		100

AGE DISTRIBUTION	MALE	FEMALE	TOTAL
	%	%	%
10 — 20	6	2	8
21 — 30	11	10	21
31 — 40	14	13	27
41 — 50	15	10	25
50 — over	12	7	19
TOTAL	58	42	100

EDUCATIONAL STANDARD	MALE	FEMALE	TOTAL
Sub A — Std 6	28	10	38
Std 7 — over	16	20	36
Illiterate	14	12	26
TOTAL	58	42	100

	Dutch Reformed	Anglican	Roman Catholic	Lutheran	Apostolic	None	Total
	%	%	%	%	%	%	%
Male	9	7	6	5	19	12	58
Female	6	4	4	9	15	4	42
TOTAL	15	11	10	14	34	16	100

Both sexes included	PERCENTAGE
Students	18
Labourers	82
Professionals	Nil
TOTAL	100

Mabopane A and B
Winterveldt
Ga-Rankuwa
Soshanguve
Makgabelwane

III Results

Respondents symptoms that motivated people to seek medical care

% Frequency

- Persistent cough 90
- Chest pain and vomiting 90
- Loss of weight 90
- Coughing and vomiting 80
- Aching joints 69
- Abdominal pain and vomiting 58

IV Knowledge of the causes of TB

Use was made of the two-sample non-parametric test to check on differences between hospitalized versus clinic patients.

There were no real differences in attitudes, level of knowledge about TB between our two major samples. No real differences between the responses of males and females

came through from both samples. They all had very limited medical knowledge concerning TB, and were very skeptical about medical treatment. However, the males were more skeptical about medical treatment than the females, and complained more of female nursing staff and their attitudes.

Ethnic, educational differences and differences in socio-economic status as measured by occupation, were not taken into account when interpreting a number of these differences.

V Respondents' conception of the causes of TB (verbatim accounts)

Behavioural approach

% Frequency

- Excessive drinking of beverages containing yeast, eg home-made beer 80
- Heavy cigarette smoking, fills the chest with smoke 80
- Smoking dagga 50
- Inhalation of benzine which fumes burn up the lungs 20
- Not eating enough good food 60
- Adultery/infidelity of one spouse cause "Thibamo" lung blockage ... 5

Socio-political approach

% Frequency

- TB is an outbreak just like

cholera; does not belong to this country; probably brought in from Europe by visitors to South Africa 50

- Witchcraft which casts an evil spell known as NDERE, on its victims 65
- Poisoning by enemies via food 60
- Sores on lungs caused by mysterious worms eating up these organs 30
- Overcrowded housing 70
- Too many hospitals, doctors and nurses all looking for work, therefore they cause TB 40

General

% Frequency

- Some of the respondents claimed they had no idea what causes TB 20
- TB is inherited from parents. It runs in the family through blood links 20
- TB is caused by germs in the air. A few of the respondents knew about the TB from listening to Radio Bophuthatswana broadcasts on TB. To them it sounded like a new invention, like Cholera — broadcasts ran concurrently they claim. 25
- Some claim TB is not infectious — you are born with it and can only pass it on to those children earmarked by fate to have it in one's family (like albinism) 25
- The rest of the respondents say TB is infectious and if victims are careless, they can infect the whole world 20

VI Ideas on prevention and cure of TB in order of numbers and responses

% Frequency

- Separate eating utensils. ... 20
- Do not spit saliva all over the place. 20
- Modify wrong habits — ie. quit smoking, drink less alcohol. 75
- Eat good food, eg. give small children honey in their porridge every day, they will not suffer from TB 60

- Drink lots of milk and eat wild fresh fruit, like our forefathers did. 65
- Visit clinic/hospital 60
- Visit traditional healer to protect or cure one. 65
- Some respondents were nonchalant about prevention/cure of TB because they claim
 - Nothing can be done about unavoidable inherited disorders 20
 - One can never live without enemies who can bewitch one to suffer from TB 65

VII Medical care preferences

Choice, treatment, place

Some patients would prefer to be treated by health professionals in the hospital, clinic or at home.

	HOSPITAL	CLINIC	AT HOME	NO CHOICE
	%	%	%	%
No. of respondents	10	20	65	5

Reasons for disliking hospital treatment

% Frequency

- Hospital staff very harsh, too much in a hurry 63
- Hospital is too rigid a place, one gets more infected in a hospital 51

Clinic

- Not as well equipped as the hospital 25
- Everybody sees you receiving TB treatment and they gossip . . 67

Home

- A lot of privacy
- Relatives there to nurse one . 75
- All can be treated together
- Category really doesn't matter 25

VIII Contact for treatment

20 percent of the respondents admit they had tried alternative treat-

Preference of drug prescription

INJECTIONS

Very effective, go direct into blood stream to fight off the poison/disease

TABLETS

Too many given simultaneously, cumbersome to take, they can choke one. Everyone will know one suffers from TB

LIQUID MEDICINE

Very effective, but sometimes diluted. Does not work as fast as injection, but no one will know it is a TB mixture

ment agents before visiting the hospital or clinic. When initial symptoms showed to be persistent, they visited their traditional healers, 55 percent attempted self-medication — bought cough mixture from chemist, brewed some homemade cough mixture — mint leaves and honey, others used aloe (Mokalakane).

25 percent had relatives who advised them to go straight to a GP clinic or hospital.

which we are all heir and which we may be tempted to use in situations that are high in ambiguity and fraught with great threat. Although used in disguised form, clothed in up-to-date language, this belief still exists.

The findings of our investigations corroborates the theory postulated by anthropologists many centuries ago about disease being caused, within the framework of magic, by a number of different factors — three of which come up strongly from the responses: *Sorcery* — casting a spell on someone (60%), *Breach of Taboo* — wrong style of life, eg excessive smoking and drinking (80%); *Disease object intrusion* — eg worms invading lungs (80%).

IX Concluding remarks

Beliefs and attitudes towards any disease in any group will be held with tenacity and assurance that they are quite adequate to explain and handle illness. These beliefs cannot be dismissed as mere superstition.

To the people themselves they are real and sensible, and interpretations of any case are valid to the person making it, the one who is ill and probably to the significant people in his environment as well. It is imperative, therefore, for health professionals engaged in TB eradication, to understand how patients perceive their situation.

We note from the data gathered in this study, that somewhat bizarre notions, and unsophisticated systems of beliefs and attitudes about TB, are still frequently found today, even in societies that are apparently dominated by the scientific method.

Witchcraft and magic are not as far away as we might like to think. These serve as a background to

Recommendations

Our investigation shows that the message of what TB is all about has not reached everybody, and if it has, it has been grossly misinterpreted.

I recommend, therefore, that there should be:-

- Further country-wide surveys of attitudes towards TB.
- Improve patient compliance through massive education programmes on TB which is more effective than personal education of patients, because it involved the whole community, eg. at schools, in churches, clubs, etc.
- Improvement of nurse-patient relationships, which will serve as a basis for effective community communications. Doctor's don't have the time, but the nurse lives with the people and speaks their language.
- Improve the socio-economic standard of all peoples through better wages, thus improving nutrition.
- Provide adequate living quarters for families throughout the land.