Understand TB related stigma and discrimination in community

Background

Stigma and consequent discrimination that patients suffer from, once being identified as having TB, have a double impact on TB control; firstly when seeking care and secondly when continuing with care hindering access to service on daily basis. Delay in seeking care and interrupted treatment practice leads to disease severity and increased risk of transmission. The impact on sufferers is considerable, yet there is a gap in understanding the precise nature of the causes which underlie stigma and discrimination of TB patient in the community. Therefore further research is needed in order to pin down these causes and to explore the existing copping mechanism taken by patient whilst also identifying the appropriate way to deal with TB related stigma and discrimination in community.

Objective

The study aims to understand the underlying causes of the prevalent stigma and discrimination associated with TB, explore copping mechanism adopted by TB patients and the appropriate ways to deal with TB.

Methods

The study was conducted in urban and rural settings of Lalitpur district, Nepal. It involved qualitative method and applied grounded theory approaches. Series of in-depth interviews and focus group discussions were carried out among TB patients, their family members, health workers, TB volunteers and community members.

Results

TB was recognized in various different local terms And conceptualized with varying causal explanations and communicability. Because of its infectious nature, TB was highly feared and as a result patients experienced discrimination from their family, their work place and in their community. Concerns about treatment and curability, fear of social rejection, along with perceived long term impacts and reduced marriage prospects (especially for girls) all induced the underlying stigma. To many patients it was unclear whether or not TB was curable and even when known to be curable, patients were worried about the lengthy treatment; the need to attend health facilities regularly, finding a person to accompany them, and additional expenses such as travel. Self-abasement in relation to smoking and alcoholism was most often found during relapse. Moreover disease concealment was highly noticed; however it wasn't always possible for patients to make excuses to cover up for their daily visit to the health facility. In addition protective precautions either taken by patients themselves or imposed on by others were also found to be associated with TB related stigma, and sometimes made the patient feel as an imposition and hatred while it might not always be the case.

Increased interactions with others, having fun with friends, keeping busy and entertained, all provided distraction to TB patients, which helped them to cope emotionally. Similarly, concern and support from family and friends encouraged patients to access and continue with their treatment and care. Besides, not taking notice of other people' reactions towards them, rationalization and acknowledgment of their separation from family and friends, done in order to protect other, and reduced social contact were also practiced by TB patients to reduce potential discrimination.

A clear message that TB is curable and reassurance by the health workers together with support from family/friends could decrease the worry and increase self-confidence of the patients. Similarly one of the best ways to deal with stigma was found to be through education, adequate information and sharing of experience through the former TB patients and their family members.

Conclusion

TB was highly stigmatized regarding its transmissibility, treatment and curability. It is urgently needed to take action and develop stigma reduction strategy with defined concrete activities that focus to convey the appropriate messages and promoting disclosure helping TB patients to gain emotional and social support.