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FACTORS ACCOUNTING FOR TUBERCULOSIS STIGMA AND DISCRIMINATION AMONG HEALTH WORKERS. A STUDY IN KORLE-BU TEACHING HOSPITAL.

BY

AMALBA DAVID AYINNE

THIS DISSERTATION IS SUBMITTED TO THE SCHOOL OF PUBLIC HEALTH, UNIVERSITY OF GHANA, LEGON IN PARTIAL FULFILLMENT OF THE REQUIREMENT FOR THE AWARD OF MASTER OF PUBLIC HEALTH DEGREE.

SEPTEMBER, 2004

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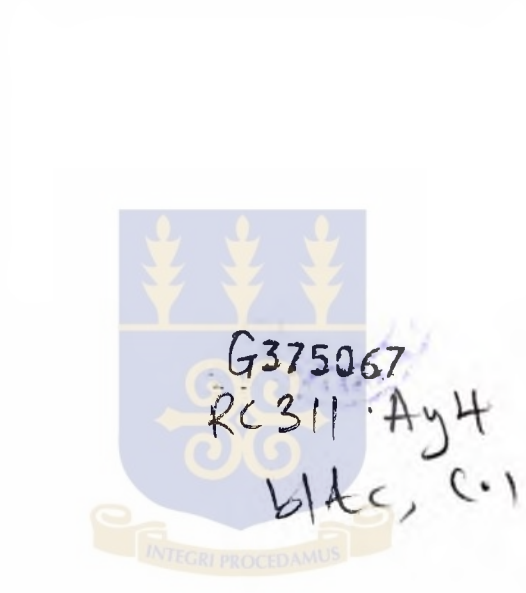

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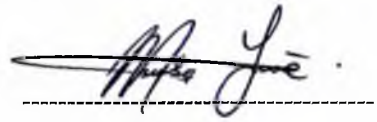

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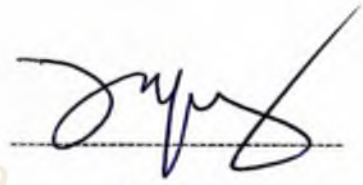

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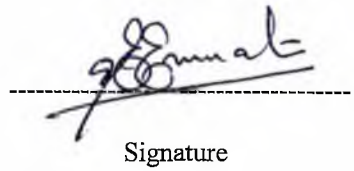

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DEDICATION

This piece of work is dedicated to all my children; Christiana , Felicia, Donatus and Janet for missing my company for one year.

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I wish to thank my academic and field Supervisor Dr John Gyapong for all support, advice and direction given me during this study. Without him this study would not have been what it is.

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LIST OF ABBRVIATIONS

AIDS	ACQUIRED IMMUNE DEFICIENCY SYNDROME
CTU	CARDIO-THORACIC UNIT
DOTS	DIRECT OBSERVED TREAMENT SHORT COURSE
ENT	EAR, NOSE AND THROAT
HIV	HUMAN IMMUNO-DEFICIENCY VIRUS
KAP	KNOWLEDGE, ATTITUDE AND PRACTICE
KII	KEY INFORMANT INTERVIEW
NTP	NATIONAL TUBERCULOSIS PROGRAMME
TB	TUBERCULOSIS
PEP	POST EXPOSURE PROPHYLAXIS
WHO	WORLD HEALTH ORGANIZATION
WHO/AFRO	WORLD HEALTH ORGANIZATION AFRICA REGIONAL OFFICE

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ABSTRACT

Tuberculosis is one of the communicable diseases that infect people across the world. Various drugs are available for the effective management of the disease but most patients default treatment. Defaulting treatment is often attributed to the long duration of treatment and the stigma associated with the disease. Like other stigmatized diseases such as mental illness and HIV/AIDS, patients are discriminated by the family and community members. They are isolated and refused socialization with the family or community members.

The stigma and discrimination is extended to health workers in the Tuberculosis unit in health facilities. Health workers in the unit are discriminated against in terms of personal development, distribution of goods, socialization, recognition and respect.

This study sets out to investigate the factors accounting for the stigma and discrimination against workers of the TB unit/department by health workers with the aim of making recommendations that will help health facility managers to reduce/minimise the practice of stigmatization and discrimination at workplace.

The study was carried out in Korle-Bu Teaching hospital in June 2004, using a mix of qualitative and quantitative data collection methods.

The study yielded a number of findings:

First, there was general awareness of TB and its management strategy- Direct Observed Treatment Short Course (DOTS) by most of the health workers in the hospital. Majority (68.5%) of the professional groups such as doctors, nurses, laboratory and radiography staff have had refresher training on TB and DOTS within the last eight (8) years. Only the non – professional groups like Ward Aides, Orderlies and Labourers never had any pre-service training or refresher training on TB. Despite this awareness and refresher trainings, the discrimination against the workers of the TB unit was prevalent among all the groups.

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A second critical finding was the perception of the health workers about the workers of the TB unit/department. The TB department workers are perceived as having TB or are carriers of TB bacilli. For this reason, other workers do not want to socialise with the workers. This was partly due to inadequate knowledge, and largely to the influence of traditional belief and public perception of the disease.

Another interesting finding of the study was the discrimination against the workers of the unit by fellow health workers. There was a general belief across the category of workers in the unit that they were being discriminated against by the workers in other units of the hospital. Some workers in the other units of the hospital confirmed the practice of discrimination. The major reasons assigned for the discrimination are fear of contracting TB disease if they socialize with the workers who are believed to have TB and the stigma associated with the disease. Based on these findings certain recommendations are made to reduce or eliminate the stigma and discrimination.

First, the management of the hospital should develop a structured In-Service training plan for all categories of workers of the hospital on Tuberculosis with emphasis on effects of stigma and discrimination on TB patients and especially on workers rendering healthcare to the patients.

Secondly, the hospital management should set up a committee to campaign against TB stigma in the workplace. Funds should be provided for the production of learning materials for all categories of workers in the hospital. Periodic social mix should be organised in the TB unit environment for all workers in the hospital. These measures may help reduce the stigma and discrimination against TB and the workers in the unit.

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CHAPTER ONE

1.0 INTRODUCTION

1.1 BACKGROUND

Tuberculosis(TB) is an infectious disease caused by a bacterium called *Mycobacterium tuberculosis*. Three main types of tubercle bacilli are recognized: *Mycobacterium tuberculosis, Mycobacterium bovis and Mycobacterium avium*. The principal reservoirs of these types are man, cattle and birds respectively. Types of tubercle bacteria differ in characteristics and pathogenicity. The disease most commonly affects the lungs (pulmonary tuberculosis) and causes a persistent cough (sometimes with bloody sputum), chest pain, exhaustion, night sweats, fever, and shortness of breath. The infection can also disseminate and infect other organs, including the reproductive tract and central nervous system. The bacteria can be transmitted through airborne droplets when the affected person coughs, sneezes, or speaks. Active pulmonary tuberculosis is thus the only form of the disease that is infectious. Pulmonary tuberculosis is infection of the lungs by mycobacterium tuberculosis. The transmission of the disease is facilitated in several ways. For example, demographic forces such as urbanization, increased travel, and migration of persons from high-incidence areas are contributing to the spread of tuberculosis worldwide. The increasing incidence of HIV is a major factor in the tuberculosis epidemic in many regions, particularly Asia and Africa.

Movement of people is a major factor contributing to the spread of the disease. Generally, TB spreads quickly in crowded camps and shelters and, globally, displaced people and refugees are increasing daily. Moreover, the Human Immuno-deficiency Virus (HIV) /Acquired Immune Deficiency Syndrome (AIDS) pandemic is worsening the situation. It is known that

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HIV and TB form a lethal combination, each spreading the other's progress. Since HIV weakens the immune system, some one who is HIV-positive and infected with TB is many times more likely to become sick with TB than someone infected with TB who is HIV-negative.

Patients with stigmatized diseases like TB are often discriminated against (Sumartojo, 1993). Historically, TB had no cure in the olden days and therefore patients became weak and emaciated and finally die. This created fear for the disease and a tendency to discriminate against the TB patients because of the fear of contracting a disease that had no cure. When a cure was later found, the patients had to be on the treatment for several months to be cured. The stigma and discrimination of the TB patients' results in ostracization, shunning, abandonment by husbands/wives, divorce and loss of social support.

1.2 BURDEN OF TUBERCULOSIS

1.2.1 Global Burden

Approximately one-third of the world's population – about 1.9 billion people - is infected with Mycobacterium tuberculosis (WHO, 1998). Globally, TB kills approximately two million people each year while one percent (1%) of the world's population is newly infected with the disease annually. Two million TB cases per year occur in sub-Saharan Africa (WHO, 1998). This number is rising rapidly as a result of the HIV/AIDS epidemic. Furthermore, breakdown in health services, the continued spread of HIV/AIDS and the emergence of multi drug-resistant TB are further contributing to the worsening impact of the disease.

In 1997, there were an estimated eight (8) million new tuberculosis cases and almost two (2) million deaths from tuberculosis (see Table 1.1). The global case fatality rate was 23 percent, but exceeded 50 percent in some African countries with high human immunodeficiency virus

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(HIV) rates such as Botswana, South Africa, Uganda etc. The World Health Organization (WHO), however, estimates that between 2002 and 2020, approximately 1000 million people will be newly infected with TB, 150 million people will get sick and 36 million will die of TB if efforts at fighting the disease are not further strengthened (WHO,1998).

Table 1.1: Tuberculosis Burden by Region, 1997

Region	New Cases (Rate†)	Deaths (Rate†)	HIV-Positive Cases
Africa	1,586,000 (259)	540,000 (88)	515,000
The Americas	411,000 (52)	66,000 (8)	25,000
E. Mediterranean	615,000 (129)	141,000 (30)	16,000
Europe	440,000 (51)	64,000 (7)	10,000
Southeast Asia	2,948,000 (202)	705,000 (48)	64,000
Western Pacific	1,962,000 (120)	355,000 (22)	9,000
Total	**7,962,000 (136)**	**1,871,000 (32)**	**640,000**

† Per 100,000.

Source: Dye C, et al, 1999.

On average, over 95 percent of new tuberculosis cases and deaths occur in developing countries (see Table 1.1). The highest incidence and number of deaths occur in Asia and sub-Saharan Africa. Asia is the disease's epicenter, containing nearly two-thirds of the world's tuberculosis-infected population (WHO, 1998). Tuberculosis outbreaks are also occurring in Eastern Europe and the Republics of the former Soviet Union, due in part to a reduced effectiveness of many health services. In this area, the number of notified tuberculosis cases rose by as much as 25 percent from 1994 to 1996 (WHO,1998).

In Africa, HIV is the single most important factor that has increased the incidence of TB in the past 10 years. According to a report issued by the World Health Organization's Regional Office for Africa, TB infects 1.6 million people and kills 600,000 others in Africa every year,

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making the disease one of the most common preventable causes of death from a single infectious agent in the Region. Similarly, the WHO/AFRO Tuberculosis Surveillance Report published in 2001 indicates that the "TB burden is an enormous challenge for the African Region. Even though Africa's population is only 10.1% of the world's population, the African region contributed at least 23.8% of infectious forms of lung TB." The report attributes the "huge upsurge" in the incidence of TB cases and deaths over the past several years largely to the impact of the HIV/AIDS pandemic currently affecting many countries in the southern and eastern epidemiological blocs of the Region.

1.1.2 National Burden

National Tuberculosis Programme (NTP) Manager-Dr Frank Bonsu – stated that globally, Ghana ranked 32nd and 13th in Africa in TB prevalence in 2002. TB-related mortality rate in Ghana is estimated at 50-100/100,000. Overall, about 30,000 new cases are registered every year in the country and with the increasing growth in population, overcrowding, and rising poverty, the problem of TB is getting worse (PANA, March, 2000). The regional distribution of cases indicate that Greater Accra Region alone recorded more than 2,000 cases in the year 2000, with 63 per cent being males and 37 per cent females. The disease was also prevalent in highly populated areas like the Central, Western, Eastern and Ashanti Regions. In Korle-Bu hospital alone, 365 new cases of TB were reported in 2003 (Table 2). About 16% of TB patients die annually at this hospital (Korle-Bu TB Unit Admissions and discharges Records).

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Table1.2: KORLE-BU TUBERCULOSIS REPORT ON NEW CASES AND RELAPSES FOR 2003

QUARTER	NEW CASES	RELAPSED CASES	TOTAL
First	134	9	143
Second	9	6	15
Third	64	5	69
Fourth	78	6	84
Total	365	26	311

SOURCE: Korle-Bu TB Unit Records Dept.

The distribution by age indicates that 60% of all TB cases in Ghana occur to young women and men of reproductive age (15-45 years). This implies that wives, mothers and wage earners are being cut down in their prime. In terms of sex, even though fewer numbers of women are infected they die rapidly because of the stigma and late reporting to the hospital (Bonsu, 2002). In fact, among women of reproductive age, tuberculosis is a leading cause of death, surpassing all causes of maternal mortality.

The National Tuberculosis Programme (NTP) implementing the Direct Observed Treatment, Short Course (DOTS) strategy is to detect and cure TB. It is to increase case detection to 70% and increase the cure rate to 85%. However the incidence rate of the disease continue to increase. This is partly because people still hide the disease because of the stigma. The stigma is not only with the patients but the health workers who are working in the TB units could also be stigmatized by their fellow health workers.

TB patients require a dependable and supportive environment where separation and isolation are kept to a minimum. However, stigma of the disease is denying them this support. The

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stigma has obvious consequences for health care providers. In addition to complicating adherence to diagnosis and treatment plan, it makes household contact tracing a sensitive issue. In a close-knit community where two-thirds of families may live under one roof, people are as reluctant to share information about their TB status, as they would be about their HIV status.

Stigma is impeding progress in diagnosis and treatment despite decades of public health efforts. Taboos surrounding TB remain strong and relief programs have failed to produce significant behavior change. TB is spreading fast because sufferers are too scared to come forward and report it, as it is often viewed as shameful and unclean. (Barer, 2002). Stigma thus fuels the spread of TB. Immediately a person is diagnosed with TB, his family moves him into another room outside the house. He/she becomes completely isolated because nobody visits him in the room. He/She has his/her own plates, spoon etc. He/she is forbidden to sit with either family members or the community members.

1.3 STATEMENT OF THE PROBLEM

Stigma is an attribute that is deeply discrediting (Goffman, 1963). It involves elements of labeling, status loss, separation of "them" and "us", discrimination. Stigmatization is a process for ensuring group membership or social exclusion (Reidpath, 2004). Stigma is a Public health problem because:

1. It contributes to disease burden
2. It influences the course and outcome of a disease in terms of delays in help seeking and poor quality of care.
3. It is also the cause of disease as it influences the quality of life significantly (Jacoby, 2004).

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Patients with stigmatized diseases like TB, HIV/AIDS and mental illness are often discriminated against (Sumartojo, 1993). They are sometimes ostracized, shunned, abandoned by husbands/wives, divorced and generally lose social support.

A study revealed that workers worry more about HIV/AIDS stigma from co-workers than racial discrimination (Horizon report, June 2003). Health workers in TB units are also stigmatized and discriminated against by their colleagues. Stigma perpetuates negative practices among health care providers, such as secrecy, neglect and poor treatment of TB patients (Ginny, 2003). The attitude of health service providers towards their colleagues working in TB clinics may be affecting service delivery in the TB units. Health workers posted to TB units accept the postings reluctantly. Those who go there do not work with happiness because of the stigma and discrimination their colleagues have against them (Views of a staff of TB unit in Korle-Bu, 2004). This is reflected in their negative attitude and behavior towards the patients. According to Ginny (2003), health care workers in TB hospitals, clinics and wards have intense daily exposure to TB patients and suspects (Ginny, 2003). Thus, the fear of contracting the disease de-motivates them from rendering quality care to the TB patients. The stigma perpetuates negative practices among health care providers, such as secrecy, neglect and poor treatment of TB patients (Ginny, 2003). Despite special incentive packages given to health care providers in TB clinics, fear of isolation and ridicule from co-workers and community members discourage them from working in these clinics (Views from Staff in TB Unit in Korle-BU, 2004). Those who accept to work in these units often vent their frustration on the patients. No health worker will willingly like to work in a TB unit (Personal opinion of Head of TB unit in Korle-Bu, 2004).

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Although research work has been done on Tuberculosis stigma at the family and community levels in Ghana, to the best of my knowledge no research or study has been conducted on TB stigma among health workers.

Health facilities are supposed to have an environment free from stigma and discrimination. Anecdotal evidence suggests that health workers in TB, HIV/AIDS and Mental clinics are all stigmatized and discriminated against. For instance a nurse was refused admission into Midwifery Training College because she was working in a TB clinic. However the intervention of the Korle-Bu hospital authorities made the school to rescind its decision (Personal information from some TB clinic staff a Korle-Bu). In another related incident, a Medical Doctor was refused entry into his bungalow by the wife until he had removed all that he was wearing outside. What is more interesting in this case is that the wife of this Doctor is also a Medical officer who is knowledgeable in the epidemiology of the disease (Personal information from the affected Medical Officer). Also heads of the nursing division in some hospitals post nurses who are alcoholics and drug addicts to the TB units. Others are posted there on disciplinary grounds (Opinion of some nurses in TB unit in Korle-Bu). Informal discussion with some of the health workers in the TB units revealed that TB units are considered "HELL" where undisciplined health workers are posted as punishment. These are undocumented but practical problems that have happened. As a result of this stigma, those who are posted to the units consider it as hatred on the part of the Officer making the postings. This clearly raises questions on whether efforts at the community level to reduce TB stigma will succeed if health workers themselves are stigmatized and discriminated against just because they are working in the unit. As a result of the important position health care professionals hold in society, these individuals must be tapped as sources of positive education in the fight against TB stigma. To accomplish this goal, we must begin to face the

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hesitation and fear that exists among all types of health service providers – doctors, nurses, home care providers, and traditional healers alike (Bharat, 2001).

Stigma perpetuated by the health care establishment is especially damaging to the well being of people living with TB for two principal reasons. First, because of the special status that society accords to health care workers, societies tend to hold the actions of health care workers to be model behaviours in dealing with the sick. Second, health care workers of all types play important roles in the lives of the ill. An example of this importance is that a doctor or nurse may provide a single critical link between a person newly diagnosed with TB and the health care system. If that health care professional treats the newly diagnosed patient in a disrespectful manner, the patient may be lost to the system permanently. He or she may be traumatized by the experience at the hands of the health care provider, and subsequently fear further contact with health care workers. Should the patient flee the system entirely, his or her health is likely to decline rapidly.

The question is: Why do health care workers promote TB-related stigma? If we can discover the sources of health workers' concerns, we will understand the basis upon which interventions can be built to lessen the stigma.

RATIONALE

This study tries to identify factors accounting for the stigma among health workers. The findings may go a long way to help identify solutions to de-stigmatize and encourage health workers to willingly accept postings to TB units. De-stigmatization among health workers will also improve the quality of care to the patients and willingness of workers to accept posting to the TB units. Any observed positive attitudinal change in health care providers towards each other may indirectly affect communities' perception of the disease, which would

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in turn help to reduce morbidity and mortality in TB. The results of the study will also guide employers to create stigma-free work environments for their workers since it is the stigma that is forcing people to hide the disease. There is no evidence of any previous attempt to study stigma among health workers. This does not mean stigma does not exist among health workers. This study, therefore, attempts to answer the following research questions.

1.4 RESEARCH QUESTIONS

1. Why are health workers in TB units stigmatized and discriminated against by their fellow health workers despite their bio-medical knowledge of the disease?
2. How do health workers perceive the disease that is, TB unit and non-TB unit?

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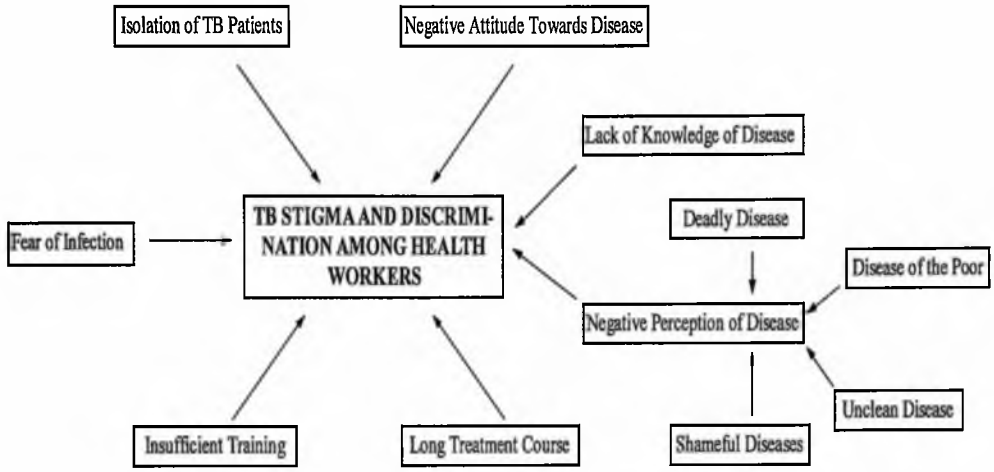
FIGURE 1.1: PROBLEM ANALYSIS DIAGRAM

CONCEPTUAL FRAMEWORK



Stigma and discrimination is often associated with diseases such as Mental Illness, TB, Leprosy and HIV/AIDS. Health workers in these areas such as TB units are believed to be stigmatised with the disease and discriminated against. The reasons/factors for the stigma and discrimination are as follows:

1. Fear of infection from the workers who are believed to be infected with the disease.

2. Inadequate knowledge of the disease

3. Negative perception of disease, such as considering TB as shameful and deadly disease.

4. Fear of social isolation.

This study will investigate whether these factors apply to my study.

(See Figure 1.1 above shows the problem Analysis)

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1.5 RESEARCH OBJECTIVES

MAIN OBJECTIVES

The main objective of the study is to investigate the factors that contribute to stigma and discrimination among health workers against health workers in TB unit.

SPECIFIC OBJECTIVES:

1. Describe health workers knowledge, attitudes and perceptions about Tuberculosis/the TB workers.
2. Determine the factors that contribute to TB stigma among health workers.
3. Document experiences of health workers working in TB clinic/ward in a health facility.
4. Make recommendations on how to reduce the social stigma among health workers in order to improve quality of care.

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CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 SOCIO-ECONOMIC BURDEN OF TUBERCULOSIS

Tuberculosis is much more than a health concern. It is a complex socio-economic problem that impedes human development and traps the world's poorest and most marginalized in a vicious circle of disease and poverty (AFRO/WHO Website, 2003). TB is primarily a disease of the poor but it can affect everyone. It affects the most productive and economically active segment of the population and this has serious implications for the society in general and the individual in particular. The costs to households include lost household production, adverse impacts on the health and education of family members (withdrawal of children from school), and sub-optimal land use. In addition to these economic costs, TB causes psychological and social costs.(AFRO/WHO Website, 2003). Confronting TB thus requires action across the health sector and coordination of efforts with the relevant sectors of the economy (AFRO/WHO WEBSITE, 2003).

Globally TB kills approximately 2 million people every year. (Dye , et al, 1999). About 7-8 million around the world become sick with TB each year and ninety-five percent (95%) of these occur in developing countries. It is estimated that about one-third of the world's population is already infected with TB. TB causes twenty-six percent (26%) avoidable deaths in the developing world. The comparative incidence rate in South-East Asia is approximately 3 million cases per year, while that for Eastern Europe is over a quarter of a million a year (Dye, et al 1999).

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2.2 STIGMA AND ACCESS TO HEALTH FACILITIES

Poverty is much more than a lack of income; it is a lack of information and access to health and other services. In the case of TB, it is access to important information and relevant services which can enable the proper diagnosis and treatment of TB and to prevent the further spread of the disease. It is also freedom from stigma and discrimination due to TB. It is the opportunity to work or go to school even if a person or one of their family members contracts the disease. When these options are denied, overall development is compromised and not sustainable. (WHO Report, 1998). Fear of TB-related stigmatization by health care providers, including doctors, counselors, nurses, home-based carers and traditional healers, combined with fear of stigma from society means that many people living with TB do not feel able to access care and support services. Why do health care providers stigmatize – is it because of fear of infection or is it because of judgmental attitudes (WHO Report, 1998)? Health care providers may stigmatize themselves for working with TB positive people or that they may be experiencing stigma of their own because they are TB positive.

Throughout history, tuberculosis has been the deadliest scourge of mankind; in Europe, it reached its greatest severity in the mid-nineteenth century as a consequence of the dramatic socio-economic changes caused by the industrial revolution. Following the Second World War, there was a rapid decline in incidence and mortality throughout Europe, except in Scotland and Portugal, where the situation continued to worsen. Tuberculosis cast a deep shadow across the land, not only because of its high mortality, but also because of the serious stigma attached to it. Individuals and families were loathe to talk about it or even admit to having had the disease. It was thus a harrowing experience to have to tell a young person that the diagnosis was tuberculosis. Even more painful was having to tell the parents of a child that their offspring had tuberculous meningitis, which was inevitably fatal, usually within a matter of days or weeks (Williamson , 1958).

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2.3 STIGMA AND TUBERCULOSIS

Stigma experts believe that stigma affects all patients to varying degrees. Research into the impact of stigma with respect to individual medical conditions has been going on for a long time. Studies have found, for instance, that fear of stigma from a cancer diagnosis means people are less likely to look out for signs of the disease (Victoria, 2001).

Fewer doctors are interested in specializing in most stigmatized conditions, For some conditions, patients hesitate before breaking the subject to their physicians, if they go in at all, and are less likely to comply with treatment regimens. In AIDS and tuberculosis, stigma is considered one of the major factors contributing to the raging worldwide epidemic (United Nations Report, 1997).

There are varying reasons for delays in diagnosis and treatment other than stigma, including income, insurance status and education. Experts believe that stigma plays a significant role both by itself and as a complicating factor to other barriers. A solution to this problem is emerging as an important prize. Experts are hoping to learn something from the ever-lessening stigma associated with HIV/AIDS and epilepsy but most expect that reducing stigma will take a combination of education, increasing contact between people who do have stigmatized illnesses and those who do not, and legislation.

The stigma of tuberculosis can be especially severe for women. Marriage chances may also be affected if women are known to have TB. The same can be said of a woman who has a family member with TB, since the stigma associated with the disease may affect all household members. Women with TB thus have particular difficulty finding a marriage partner, and some families go to great lengths to deny or hide an unmarried daughter's illness. In-depth interviews with TB patients in Bombay indicated that married women were concerned about rejection by husbands and harassment by in-laws while unmarried women worried about their

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reduced chances of marriage and being dismissed from work (Liefooghe, 1998). Unmarried women with tuberculosis often encounter difficulties finding a partner, and married women can be at risk of abandonment. In Pakistan, for example, women who develop tuberculosis are more likely to be divorced or separated, or to be married to a man who takes a second wife, than women who do not have tuberculosis (Liefooghe, et al, 1995).

In India, women are more exposed to tuberculosis than their men folk because of their particular duties and tasks. Besides these physical considerations the shame and stigma of the disease affect women more – to the point where women commonly keep their diseased state a secret and unmarried girls fear that it will affect their marriage chances. Some researchers consider that there is often interplay between biological and social factors that might be influencing women all through their lives and most especially in their reproductive years (Jackson, 2001).

People with tuberculosis face discrimination and rejection in almost all cultures and regions. As a result, many people with tuberculosis, particularly women, deny their diagnosis and delay seeking treatment until the disease has progressed, which increases their risk of death as well as transmission of the disease to others. For example, in the Philippines, some tuberculosis patients choose to say that they have cancer because it is more socially acceptable than tuberculosis (Liefooghe, et al 1995). Stigma is an essential aspect of illness experience for many chronic disorders, especially mental illness, leprosy, and tuberculosis. The study examined the magnitude and qualitative nature of self-perceived stigma among patients and social stigmatization in the community, providing an approach to validate culturally appropriate stigma scales that are sensitive to locally distinctive formulations of stigma.

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In one survey, three quarters of recently arrived Vietnamese immigrants to New York said that community members would fear and avoid someone known to have TB (Carey et al, 1997). The adverse social impact of tuberculosis has also been noted in Honduran and Hispanic communities (Sumatra, 1993).

Stigma is a barrier presenting a serious obstacle to successful TB control. Health seeking behavior includes a balancing of costs and benefits to the patient. The benefits of getting well may out-weigh the costs of social and family rejection and loss of employment or accommodation. A direct approach to addressing stigma involves understanding the beliefs and attitudes of the communities towards the disease through qualitative research and addressing the problem through awareness campaigns. An indirect approach to reducing stigma is to create more socially accessible services, by associating the stigmatized disease treatment. This was done in Pakistan when Family Planning services were integrated into the Primary Health Care system, resulting in improved social accessibility for women (Liefooghe et al, 1995). By integrating TB treatment with regular health service and by increasing community involvement, stigma associated with TB should fall.

Recognizing the immensity of the global tuberculosis epidemic and the impact of social and cultural factors on efforts to control it, scientists have been engaged in research in India and the Philippines. It is the leading cause of female deaths from infectious disease, killing one million women every year. Ethnographic methods have also been employed by social scientists directly in the community (e.g., focus groups, in-depth interviews, participant observation, and other participatory methods) and through interviews with lay health workers who have followed the treatment of people with TB in their community. Patients, family members, non-affected laypersons, and health care providers in selected villages of Pune District have been studied with appropriately adapted interviews. Many women (28%) identified sadness, anxiety, and worries as troubling features of their disease. Narrative

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accounts showed they worried about their husbands' sexual behavior and the possibility of marrying another woman. Because of that they wanted to complete treatment as quickly as possible and return home with a certificate-confirming cure. Married women staying with their in-laws were most concerned about the stigmatization of their condition. They typically tried to avoid disclosure of their condition in the joint family, in some cases attributing respiratory symptoms to asthma (Liefooghe, et al 1995).

A study in South Africa shows that using health education campaign decreased the stigma of TB in workplace environment (Maher, et al 1999). Traditionally TB is viewed as a deadly disease of the poor and the strong social stigma it provokes makes it more difficult for people with TB to seek diagnosis and treatment. This can be countered by greater knowledge and understanding. The patients colleagues understanding of the disease can change their attitude and they became part of a peer educational team in their families and communities. The study concluded that workplace is an important venue for promoting behavior change with regards to silence and stigma surrounding TB and can play a major role in promoting public health acceptance and non-judgmental responses.

According to WHO guidelines for workplace TB control activities (2003), the myths and shame surrounding TB should be dispelled, workers rights promoted and confidentiality respected. This is essential to successful prevention and cure.

For the Sidama people of Ethiopia, the word for tuberculosis is used as an insult. (Vecchiato, 1997). In some cultures the stigma of tuberculosis remains as powerful as that of HIV. A recent Seattle Somali community focus group discussion helped shed some light on why the diagnosis of tuberculosis is so powerful in their culture. From childhood Somalis learn that tuberculosis is a horrible disease that leads to social isolation. In many East African cultures, family and friends share food and eating utensils. One drinking cup may be used for

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a group of several people who are eating together. A family eats with their hands from a single plate of food. When a person becomes symptomatic from tuberculosis, he or she may fear that others will refuse to share food and drink. This fear of social isolation may lead the person to deny the true nature of the disease to himself or others.

Furthermore, because anti-tuberculosis medicines were not available until recently (and even today remain expensive and difficult to obtain especially in rural areas) some may not realize that the disease is curable. Thus persons with chronic coughing may refuse to see health care providers for diagnosis and treatment, because if they are diagnosed with tuberculosis they may be forced to use their own cups and utensils, publicly signifying their illness. This stigmatization has obvious consequences for health care providers. In addition to complicating adherence to diagnostic and therapeutic plans, it makes household contact tracing a sensitive issue. In a close-knit community where two or three families may live under one roof, people are as reluctant to share information about their diagnosis of TB as they would be about HIV.

Health care workers' fear of infection is often founded. Dr. Shalini Bharat (Health Dev. Network, 2001) noted that AIDS/TB-related stigma was more pronounced among health workers in countries with weak health infrastructure. In such settings, health care workers have inadequate access to universal precautions, such as gloves, post-exposure prophylaxis (PEP) and safe blood collection kits. Because of inadequate protective measures, health care workers' fears of contagion are fueled by "unsafe" contact with positive patients. (Health Dev. Network, 2001).

In Ghana, the Programme Manager of the National Tuberculosis programme, Dr F. Bonsu has urged the public not to shun TB patients by asking them to use different plates, cups, spoons

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and even rooms adding "the stigma even helps in killing them very fast"(Bonsu, 2004, Unpublished Presentation). He also appealed to the public to report to the nearest hospital whenever they detected symptoms like persistent cough for more than two weeks, progressive loss of weight, feeling breathless, sweating excessively at night and having chest pains.

Everybody is at risk of getting TB infection if the one is exposed to an infected person and according to the Programme Manager, stigma is a research priority both because it may account for delayed help seeking and because it contributes substantially to the social burden of the illness. The author went further to show that despite the social marketing interventions, stigma remains a more significant issue than anticipated (Bonsu, January 2004, Unpublished Presentation). Also Dr Sampson Aboagye-head of the chest clinic in Korle-Bu Teaching Hospital, says husbands reject TB infected wives. According to him some husbands approach him or other Doctors to give them notes of certification of disease to enable hem to divorce their wives because they have contracted TB (Spectator, July 3, 2004).

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CHAPTER THREE

3.0 METHODOLOGY

3.1 STUDY AREA

The study area is the Korle-Bu Teaching hospital, which is situated in Accra. Accra is the national capital of Ghana with a population of three (3) million people (Ghana Housing and Population Census-2000). It is located in the southeastern part of Ghana, on the Gulf of Guinea. The Korle-Bu Teaching Hospital is the premier and leading national referral hospital in Ghana. It serves as the teaching hospital for the College of Health Sciences of the University of Ghana, Legon. Built in 1923, the hospital has a bed capacity of 1,600 and a work force of 3000. The average daily out-patient attendance is 1,000 and an average of 120 people are admitted daily. The hospital has now developed into seventeen (17) clinical and diagnostic departments and centres. These are the Obstetrics and Gynaecology, Surgery, Child Health, Polyclinic, Oral Maxillofacial Surgery, Medicine (TB unit is under Medical Dept), Radiotherapy as well as the Ear, Nose and Throat (ENT) departments. The rest are Haematology, Microbiology, Eye Clinic, Reconstructive Plastic Surgery and Burns Centre, Cardio-thoracic Unit (CTU) and Pathology/Mortuary, Chemical Pathology departments. The hospital also plays an active role in the training of health professionals. It conducts research and carries out outreach services in Ghana and other West African countries. Korle-Bu is not only a teaching hospital for the College of Health Sciences but also serves as a platform for training students of other health institutions located within the hospital's premises. The schools include the School of Public Health, School of Allied Health Sciences and the Nurses and Midwifery Training Colleges.

Korle-Bu is the national referral centre for Tuberculosis and other chest diseases. The head quarters of the National Tuberculosis Programme (NTP) is located here. They practice the Directly Observed Treatment Short course (DOTS) programme and admit an average of four hundred (400) patients a year (Admission register –2003).

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3.2 STUDY METHODS AND PROCEDURES

3.2.1 Study Type:

This is a descriptive exploratory study to determine the factors accounting for tuberculosis stigma among health workers. It is a qualitative and quantitative research, which involves Key Informant Interview (KII) and Structured questionnaires.

3.2.2 Study Population

The study population is health workers in Korle-Bu teaching hospital who are working in the TB unit and other units in the hospital. These health workers were grouped into eight (8) categories. These were: Medical Doctors, Nurses, Laboratory Technicians, Radiology staff, Dispensary staff, Laborers, Orderlies/Ward Aides, Biostatistics/Records. The heads of these groups were targeted for Key Informant Interview and the rest were given self-administered questionnaires to complete. Staffs on night duty were interviewed in the night when they report for duty. The names of staff that were on leave were deleted before the random sampling.

3.2.3 Sample Size

Epi Info Statcal (Kish, et al, 1965) was used to calculate the sample size. With a population of 3000 health workers in the Korle-Bu Teaching hospital and expected frequency of stigmatization of about 10% and 5% worst acceptable results at 95% confidence level, the sample size was estimated to be 132. The heads of the groups were interviewed separately and that brought the total sample size to 140.

3.2.4 Sampling Procedure

The study was conducted at the Korle-Bu Teaching hospital. The health workers were grouped into eight (8) categories. To have a fair representation of each category/group of staff, the sample

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size was distributed in a proportionate manner according to the population/total number of each category/group (Refer to appendix for distribution according to population of category of workers). A simple random method was then used to select the respondents from the list of names of each of the eight groups members to form the study sample. In the event of a respondent on "leave" another sampling was done to replace him/her.

Two sets of questionnaires were used for data collection. One set was for health workers working in the TB unit whilst the other set was for the rest of the health workers working in other units in the hospital. The population of the TB unit was fifty-seven (57), which form 2% of the total population. Calculating 2% of 132 will give you 3, which is not representative enough for this study. I therefore over sampled by 25% to have a fair representation of the TB unit workers in the study. The findings/results from this study can be generalized to the whole TB unit. One-quarter (1\4) of the sample size was therefore purposely allocated to the health workers working in the TB unit and three-quarters (3\4) for the rest of the heath workers. The breakdown is as follows:

1. Sample size for health workers in TB Unit =30 (Refer to Appendix)
2. Sample size for health workers outside TB Unit =102 (Refer to Appendix)

3.2.5 Data Collection tools and Techniques

Data were collected using both qualitative and quantitative methods. The qualitative segment of the study used Key Informant Interview for heads of the eight categories of health workers.

The quantitative part of the study involved conducting interviews with health workers both working in the TB unit and those working in other units.

3.2.6 Pre-Test

The pre-test was carried out at the Achimota hospital, which is another health facility in the Accra Metropolis. This was to test the data collection tools/instruments to determine their appropriateness. The results from the pre-test were incorporated into a modification and finalisation of the data collection instruments.

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3.2.7 Training of Fieldworkers

The Research Assistants who assisted in collecting the data using the semi-structured questionnaire were given a two-day training in interview techniques. The two Research Assistants were second year undergraduate nursing and sociology students. Training consisted of introductory talks on the rationale for the study, discussions of suitability of terminology in the questionnaire, interview techniques, role-play and Peer group assessment of interviewing techniques.

3.2.8 Supervision and Quality Control of Data Collection:

To ensure that the data collected were of good quality, the Principal Investigator conducted spot checks of the fieldworkers. Questionnaires were re-administered to 10% of the study units to ensure that the field workers were conducting the interviews well. All completed questionnaires were checked for completeness, accuracy and internal validity.

Steps were taken to ensure that the data collected as well as the data collection tools were well kept. Special plastic files were provided for safe keeping of the tools. Completed questionnaires were numbered and coded. Forms were given unique identifiers and arranged in order.

3.2.9 Plan For Data Processing and Analysis:

The data were entered and analysed using Epi.Info.6 (EPI6) program. The main method of data analysis was simple frequency and cross tabulations. The qualitative data was analysed manually.

3.2.10 Ethical Issues

A written permission was first obtained from the management of the hospital before proceeding to collect the data. To ensure that the rights of individuals were not violated, the purpose of the study was explained to the respondent to seek his or her oral consent before the interview.

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Participants were told that participation was purely voluntary and that they would not suffer any consequences if they refused to participate. They were also assured of confidentiality of any information they provided and that their personal identity would be kept secret. There was no inducement to get participants to participate.

3.3.1 VARIABLES

The variables for this study include:

1. Age
2. Rank
3. Family relation
4. knowledge of disease
5. Perception of disease
6. Attitude toward TB workers
7. Fear of infection
8. Quality of service
9. Community relation with H/workers in Tb unit
10. Career Dvelopment

Table 3.1 shows the Variables.

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Table 3.1: VARIABLES

The table below contains the Variables of the study, how each variable will be measured and the method of data collection for each variable and the objective each variable is covered.

VARIABLE	DEFINITION	MEASUREMENT	METHOD OF DATA COLLECTION	OBJECTIVE COVERED
Knowledge of disease	facts or information about TB	ORDINAL eg good/poor	Structured Questionnaire	KAP
Perception of disease/TB workers	belief about the disease	ORDINAL eg good/bad	KII and Structured Questionnaire	KAP
Attitude towards TB workers	behaviour towards patients	ORDINAL eg Good/Bad	KII and structured Questionnaire	KAP
Fear of infection	scared of contracting TB	ORDINAL eg True/False/Don't know.	Structured Questionnaire	KAP and factors contributing to stigma
Refresher training of health workers	undergo In-Service course on TB & DOTS	CONTINUOUS eg percentage discrete	KII and Structured questionnaire	factors contributing to stigma
Lucrative unit	extra benefits from working in a unit	ORDINAL eg True/False	KII and Structured questionnaire	same as above
Quality of service	output from work done	ORDINAL eg good/bad	Structured questionnaire	experience of H/W in TB unit
Career dev't	personal growth	ORDINAL eg	Structured	same as above

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	from courses and training	True/False	questionnaire	
Communiy relation with H/workers in TB unit	socialization and acceptance by community	ORDINAL eg good/bad	KII and Structured questionnaire.	Same
Family relation	socialisation and acceptance by family	ORDINAL eg good/bad	Structured questionnaire	Same
Age	age at last birthday	CONTINUOUS eg in months	Structured questionnaire	Demographic characteristics
Rank	last promotion	ORDINAL eg senior/ junior	KII and Structured questionnaire	social characteristics

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CHAPTER FOUR

4.0 STUDY FINDINGS

Data were collected using the Structured Questionnaire and Key Informant Interview Guide. The Quantitative data were collected from two categories of health workers: Workers of TB unit and Workers outside the TB unit through interviews. The heads of the categories of health workers were interviewed using a Key Informant Interview guide. This chapter presents the findings in the following order:

4.1 BACKGROUND OF RESPONDENTS

For the quantitative segment of the study, a total of one hundred and thirty-two (132) hospital workers were interviewed. Table 4.1 provides information on the total sample of categories of staff interviewed.

Of the total number of 132 respondents interviewed, 16(12.1%) were Doctors, 62(46.9%) were Nurses, 22(16.9%) were in the Technical grade (Dispensary, Laboratory and Biostatistics), and 32 (24.2%) were Ward Aides/Orderlies/Labourers. Out of the 132 respondents, only 30 were workers in the TB unit, the rest were workers in different department/units of the hospital. Apart from the Labourers, all the respondents had formal education at least up to Middle School/Junior Secondary School. Majority of the respondents were professionals like Doctors, Nurses and Laboratory/Radiography/Dispensary Technicians.

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TABLE 4.1: CATEGORY OF HEALTH WORKERS INTERVIEWED

CATEGORY	TB Dept		Outside TB Dept		TOTAL	
	FREQUENCY	%	FREQ	%	FREQ	%
MEDICAL DOCTORS	5	16.7	11	10.8	16	12
NURSES	13	43.3	49	48.0	62	46.9
TECHNICAL GRADE e.g. Lab./ Dispensary/X-Ray	7	23.3	15	14.7	22	16.9
ORDERLIES/WARD AIDES	5	16.7	27	26.5	32	24.2
TOTAL	30	100	102	100	132	100

Out of the total number of 132 respondents, 102 respondents work in other units in the hospital. Of this 11 (10.8%) were Medical Doctors, 49 (48,0%) were Nurses, 15 (14.7%) Technical grade workers (TO-Dispensary, Laboratory and Biostatistics) and 27 (26.5%) were Orderlies.

Thirty (30) of the respondents are currently working in the TB unit. Of this number 5 (16.7%) were Medical Doctors, 13 (43.3%) were Nurses, 7 (23.3%) were in the Technical grade and 5 (16.7%) were Orderlies/Ward Aides.

The age of the respondents range between 20 and 65 years. The mean and the median age was 42 and 44 respectively.

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4.2 FINDINGS FROM HEALTH WORKERS WORKING OUTSIDE TB UNIT

4.2.1 Awareness Of DOTS And Refresher Training On TB For Workers Outside the TB Unit of the Hospital

The majority (66.7%) of respondents were aware of the Direct Observed Treatment Short Course (DOTS) and have had refresher training on TB. With the exception of the Orderlies, Ward Aides and Labourers who have not had Refresher training in TB and are not aware of the Direct Observed Treatment Short Course (DOTS) treatment plan and most of whom have never worked in a TB unit, there was generally a high level of awareness of the National Tuberculosis Programme (NTP) and Direct Observed Treatment Short Course (DOTS) among majority of Health workers, who have also had refresher training in TB.

About 89.2% (n=91) have heard of the National Tuberculosis Programme(NTP) and 66.7% have heard of the DOTS treatment plan and 68.5% have had refresher training in Tuberculosis in the last eight years. Although there was a high level of awareness of DOTS and refresher training among the health workers, only 52.9% (n=54) would willingly like to work in the TB unit. Also 54.9% (n=56) of the respondents have ever worked in the TB units and 45.1% (n=46) have never worked in the unit. The interest and pride to work in the TB unit was absent among most of the health workers. When asked for reasons for unwillingness to work in the TB unit, different reasons were cited such as risk of infection, negative perception about the unit, stigma of the disease. Another group of respondents said they just don't like the unit and would resign if forced to work there. A selection of responses from the open-ended questions of the structured questionnaire from two respondents are cited below:

"I just don't like the unit." - A Nurse.

'I am scared of the disease." - A Nurse

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4.2.2 Working In TB Unit

Reaction to posting to the TB unit varied among the respondents. The reaction of the respondents included accepting posting with happiness, reluctantly accepting posting and shock and disturbed if posted to the TB unit. A good number of the respondents, about 48% (n=49) indicated they would accept posting to the TB unit reluctantly because they have no choice and only 34.3% (n=35) said they would be happy if posted to the TB unit. Surprisingly, 17.7% (n=16) indicated they would be shocked and disturbed if posted to the unit. The results indicate that about 65% of the respondents would not happily accept posting to the TB unit. This should not be the case as health workers who are supposed to provide services to all types of patients irrespective of the disease, colour or race. Table 4.2 presents reactions of respondents to posting to the TB unit.

TABLE 4 :2: DISTRIBUTION OF RESPONDENTS (WORKERS OUTSIDE TB UNIT) BY THEIR REACTION TO POSTING TO TB UNIT

REACTION	FREQUENCY	**PERCENTAGE**
ACCEPT RELUCTANTLY	49	48.0%
HAPPY	35	34.3%
SHOCK AND DISBELIEF	16	8.8%
TOTAL	102	100%

Though health workers are trained to work in any facility and handle any disease and patients without discrimination, some health workers believe that working in some units is a punishment. This is evidenced by the responses. Majority of respondents (96.1%) indicated posting to the TB unit was not to punish the worker, however, 3.9% consider such posting as a punishment to the individual who was rude or disagreed with authority. Such respondents

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went further to cite a number of such cases where such posting has been done as punishment. (The number of such cases ranges from 1-3.) Though the percentage of individuals who felt posting to the unit is a punishment is small, the fact that health workers outside the TB unit consider working at the TB unit as a punishment and cited cases to buttress their point is something to worry about.

4.2.3 Perception About Workers In TB Unit.

The majority(52%) of health workers outside the TB unit expressed negative perceptions about those working in the unit whilst about 48.0% had no such negative perception. One group of respondents consider those working in the unit as TB patients, whilst others think the workers have acquired some immunity and are well protected to work there and believe that not everybody can work in the unit. This belief is so entrenched in some workers outside the TB unit that they are ready to forgo their promotion if such promotion is tied to working in the unit. A total of 14.7% are ready to sacrifice their promotion if it is conditional to their working in the TB unit. Though this is a small percentage, the fact that some health workers can forgo their promotion if they are to work in the TB unit indicates the serious negative perception health staff have about the disease and for that matter those working there. When asked further for their reaction if posted to the unit one respondent stated in the open-ended question of the questionnaire that:

" I will resign "- A Nurse.

A respondent in the Key Informant Interview who is a Deputy Director of Nursing Services (DDNS) said:

" *Other health workers feel they are very brave and dedicated whilst others think they are also TB patients" -A DDNS.*

Other perceptions expressed in the open-ended segment of the questionnaire include the following:

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"They have high risk of being infected with TB"- A Resident Medical Doctor

" In my opinion, other health workers feel that those working in TB units are not safe"- A Dispensary Technical Officer.

"A deadly unit" –A dispensary Technical Officer.

Table 4.3 presents data on what health workers would do if they were promoted on condition that they work in the TB unit.

TABLE 4.3: DISTRIBUTION OF RESPONDENTS BY WHAT THEY WOULD DO IF POSTED TO TB UNIT

PROMOTION	FREQUENCY	PERCENTAGE
ACCEPT PROMOTION AND POSTING	87	85.3%
REJECT PROMOTION AND POSTING	15	14.7%
TOTAL	102	100%

4.2.4 Discrimination And Stigma

The ethics of health workers include non-discrimination against patients irrespective of race, colour and disease. This is even more serious if health workers in some units are discriminated against, especially for working in stigmatized disease units. Out of 102 health workers interviewed working in other units in the hospital, 20.6% (n=21) said there is discrimination against those workers in the TB unit. About 45.4% (n=44) said there is no discrimination, whilst 33%(n=32) refused to comment on it. Table 4.4 below shows that 26.5% (n=27) respondents indicated that health workers in the TB unit are stigmatized with the disease, whilst 73.5% (n=75) said workers in the TB unit are not stigmatized. Though the number of respondents who believe

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that there is discrimination and stigmatization against TB workers is small, the mere fact that some health workers believe there is stigma and discrimination among health workers is of great concern. Also it is possible that most of the respondents could be denying the reality on the ground. The table also shows that the number of respondents from the professional groups such as Doctors, Nurses and the Technical staff who believe there is stigma are more than the non-professional groups such as Orderlies. This may be due to their direct contact with the TB patients. Table 4.4 presents opinion of other health workers regarding workers in TB unit being stigmatized with the disease.

TABLE 4.4: DISTRIBUTION OF RESPONDENTS OPINION BY CATEGORY ON STIGMATISATION.

CATEGORY OF STAFF	STIGMA PRESENT		STIGMA ABSENT		TOTAL	
	FREQ.	%	FREQ.	%	FREQ.	%
MEDICAL DOCTORS	4	36.4%	7	63.6%	11	100%
NURSES	10	20.4%	39	79.6%	49	100%
TECHNICAL STAFF eg Lab., Radiography, Dispensary	8	53.3%	7	46.7%	15	100%
ORDERLIES\WARD AIDS	5	18.5%	22	81.5%	27	100%
TOTAL	27	26.5%	75	73.5%	102	100%

4.2.5 Reasons For Discrimination And Stigma

Several reasons were assigned for the discrimination against those working in the TB unit. The reasons given by most respondents include:

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1. Respondents believe that the fear of contracting TB contributes to the discrimination against Tb workers.

2. The negative public perception of the disease is a contributory factor to the discrimination.

3. Other workers believe that TB workers are carriers of the TB bacilli hence the discrimination.

4. Others also think the workers in the TB unit are TB patients themselves and therefore the stigma and discrimination against them.

A small number gave other reasons like the environment of the unit gives them a negative perception of the unit.

Of the 102 respondents, 53.9% (n=55) cited fear of infection as the cause of the discrimination, whilst, 46.0% (n=47) cited other reasons as presented in Table 4.5.

TABLE 4.5: FACTORS/REASONS FOR DISCRIMINATION

RESPONDENT	FREQUENCY	PERCENTAGE
FEAR OF INFECTION	55	53.9%
OTHER REASONS such as Negative public perception of the disease and unattractive environment.	40	39.2%
NON-RESPONDENTS	7	6.9%
TOTAL	102	100%

In the open-ended questions of the structured questionnaire are some statements made by the respondents to buttress the existence of stigma and discrimination.

An Orderly for example, stated that among the health workers in the TB unit one cannot distinguish between those infected with the disease and those not, hence the discrimination.

" You cannot distinguish between those infected with the bacteria and those who are not"- An Orderly.

A Surgical Specialist also attributes the discrimination to fear of infection in the following words:

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" May be due to increased risk of contracting the TB".
"It is another field in healthcare as in any other department, but the cordial respect as a healthcare personnel is usually lacking."-A Surgical Specialist.

A Nurse believes that the discrimination exists because those working in the unit are close to the TB patients and could be infected and pass the disease to their colleague health workers.

" People think that because they are close to the patients, they could easily infect themselves and pass it on to them"-A Nurse.

As regards stigmatization of the workers in the TB unit, the reasons assigned by respondents are as follows: 64.7% (n=66) respondents attributed inadequate knowledge of the disease among health workers as one reason, whilst 22.5% (n=23) of the respondents attributed the stigmatization of workers in the TB unit to negative public opinion of the disease and 8.8% (n=9) assigned traditional belief of the disease and 3.9% (n=4) did not give any reason. Table 4.6 presents the REASONS assigned to stigmatizing by health workers in TB unit.

TABLE 4.6: REASONS FOR STIGMATISING WORKERS IN TB UNIT

REASONS	FREQUENCY	PERCENTAGE
Inadequate knowledge of TB among health workers	66	64.7%
Negative public opinion of the disease	23	22.5%
Traditional belief of the disease	9	8.8%
OTHERS	4	3.9%
TOTAL	102	100%

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The stigmatization is so serious that 31.4% (n=32) of respondents indicated they would not like to share a cup and plate with a worker from the TB unit during lunch break. The majority of respondents 68.6% (n=70) however indicated their willingness to share their cup or plate with a worker from the TB unit. Though 31.4% respondents is a small number, the fact that some health workers will refuse to share a plate with their fellow workers in the TB unit indicate the bad perception and practice of discrimination among some health workers which can have a negative consequence on the quality of service in the TB unit.

4.3 FINDINGS FROM WORKERS IN TB UNIT

4.3.1 Duration Of Work And How Posted

A total of 30 respondents from the TB unit were interviewed in the TB unit. The duration of working in the TB unit by the respondents range from1 month to 360 months. Majority of them, 63.3% (n=19) were posted to the unit on normal routine changes, whilst 16.7% (n=5) were posted to the unit by special request by the TB unit head and 6.6% (n=2) indicated that they were forcefully sent to the unit.

Majority of the workers are posted to the unit either by routine changes or special request from the unit head. A total of twenty-one (70%) of the respondents said their fellow health workers were either sad for them or made mockery of them when they were posted to the TB unit.

4.3.2 WORK EXPERIENCES OF WORKERS IN TB UNIT

The experiences of the staff of the TB unit were mixed. Whilst majority of the respondents said their fellow health workers in other units relate well with them, others indicated that their colleagues do not relate well with them because they work in the TB unit, which they consider a "No Go" area. The workers are often shunned and isolated by other workers. They are discriminated against for the false perception that they are TB patients or TB carriers. They are stigmatized with the disease. Other workers mock at them and the pride as health workers is lost.

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Gifts (food) from TB unit are rejected by other workers. Management discriminates against even repairs and replacement of equipment in the unit.

Majority of the workers in the TB unit believe that discrimination and stigma against those working in the TB unit exist and is practised. Of the 30 respondents interviewed, 73.3% (n=22) strongly believe workers in the TB unit are stigmatized with the disease and therefore discriminated against by their fellow health workers in other units. Only 26.7% (n=8) have a different opinion and think there is no discrimination. All the professional groups working in the unit hold the belief in the practice of stigmatization and discrimination. Table 4.7 presents the opinions of the various groups on stigmatization and discrimination.

TABLE 4.7: DISTRIBUTION OF RESPONDENTS BY CATEGORY OF HEALTH WORKER AND BY OPINION ON PRESENCE/ABSENCE OF DISCRIMINATION AND STIGMATISATION

CATEGORY	DISCRIMINATION AND STIGMATIZATION PRACTISED	DISCRIMINATION AND STIGMATIZATION NOT PRACTISED	TOTAL
Medical Doctors	4 (80%)	1 (20%)	5 (100%)
NURSES	11(84.6%)	2 (16.4%)	13 (100%)
Orderlies/Ward Aides	3 (60%)	2 (40%)	5 (100%)
Technical grade	4 (57.1%)	3 (42.9%)	7 (100%)
TOTAL	22 (73.3%)	8 (26.7%)	30 (100%)

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From the table above, the majority of workers who believe there is discrimination and stigmatization of TB among health workers are the medical doctors and nurses. This is because these two categories are directly involved in the care and handling of TB patients in the clinic. Thus they tend to feel the pain of the stigma and discrimination more than the other categories of workers in the TB unit. The lowest experiences of discrimination are the technical workers such as the radiographers and laboratory staff whose contact with the patients is very minimal.

4.3.3 Reasons For Discrimination And Stigma

Those working in the TB unit gave the following reasons/factors which fuel discrimination and stigma against them:

1. Other workers believe that they are carriers of the TB bacilli hence the discrimination.
2. The workers in other units fear of contracting the disease when they socialize with workers in TB unit so the tend to avoid or shun them.
3. Other workers believe the workers in TB unit are infected with TB hence the stigma and discrimination.
4. The other workers believe the TB bacilli is everywhere in the TB unit and can easily infect them and hence the dislike for the unit.
5. Ignorance or inadequate knowledge on TB by other workers outside the TB unit is contributing to the discrimination.

To illustrate the points some of the responses are cited in the box below from the open-ended questions of the questionnaire.

" *Workers at the TB unit are also TB patients*"- *A Senior Enrolled Nurse.*
"They believe all workers in TB unit have got TB"- A Nurse
"We are TB patients and the bacteria follows us everywhere"- A Community Health Nurse.

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When asked to give examples of the discrimination they experience, some respondents said:

" Other staff refusing to accept gift (food) from the TB unit"- A Medical Officer

Shun you when you enter any office". -An Orderly

Even the supply and replacement of equipment in the unit is believed to be associated with discrimination. A Principal Technical Assistant in the X-Ray department of the TB unit illustrated this when he said:

"*We still use manual processor instead of automatic because management think as TB unit we do not need a modern machine".*

A Senior Medical Officer in the TB unit summed up the extent of the discrimination, using her experience when she was reassigned to Children's Block from the TB unit to take care of children who report with TB to the children's consulting room. She perceived this as discrimination since she felt her colleague Doctors in the Children's block could equally handle the TB cases.

Majority of the respondents stated that the discrimination and stigma against them is affecting their work output. A total of 43.3% of respondents believe their work output is affected by the discrimination, whilst 56.7% indicated they are not disturbed by the discrimination. When asked for ways in which the discrimination affects their work the following were obtained:

"*Sometimes if a TB patient is having another problem and has been refer to another department they discriminate against the patient and this frustrate you." –A Superintendent Enrolled Nurse*

The discrimination according to some of the workers is so serious that something needs to be done to minimize these negative attitudes of their colleagues towards them.

When asked for suggestions to minimize the discrimination, the following were made:

1. Health workers should be encouraged to work by regular visit to the unit by management and other heads of departments.

2. Every health worker should be made to work in the unit for at least six months to one year. This may change their perception about the unit and the workers in general.

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3. There should be refresher courses for all health workers on TB. This may also influence their way of thinking.

On rating perceptions other staff have about those working in the TB unit, the rating range from Very Good, Good, Very Bad and Bad. Majority of respondents felt workers in other units of the hospital had bad perception about them. About 36.7% (n=11) thought workers in other units had Bad perception about them, 13.3% (n=4) thought others had Very bad perception and 50% (n=15) had either very good or good perception about them.

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When asked for suggestions on how to minimize these negative perceptions, some respondents made the following suggestions:

1. Refresher courses for all category of staff both senior and junior members on TB.

2. Visits to the TB unit by other staff should be encouraged.

A respondent seems to have given up hope of changing the perception of other staff and said:

" Negative perceptions are challenges, so workers in TB unit should have confidence and faith to overcome them. "- A Dispensary Assistant

nother said *" Regular rotation of all health workers to work in the unit"-A Senior Medical Officer*

According to a third of those working in the TB unit, they do not feel proud working in the TB unit despite the incentive package given them. As a result of the perception people have about them. Fortunately, the majority of those interviewed (66.7%) said they are proud working in the unit.

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CHAPTER FIVE

5.0 DISCUSSION OF FINDINGS

5.1 ATTITUDES AND PERCEPTIONS

There were negative attitudes and perceptions from health workers in other units of the hospital against those working in the TB unit. The results show that about 52% of the respondents outside the TB unit have varied negative perceptions about the workers in TB unit and 50% of respondents in TB unit rate the negative perceptions from other workers to be either very bad or bad. However this is not linked to inadequate knowledge. Apart from the non-professional groups such as the Orderlies/Ward Aides and Labourers, majority of the professional staff have had refresher training in TB and are aware of the new treatment regimen-DOTS. The findings show that 68 (66.7%) and 70 (68.5%) out of 102 respondents working in other units of the hospital have heard of DOTS and have had refresher training in TB respectively. Though the refresher courses have increased their knowledge on TB, it is not making any impact on changing the attitude and perceptions of the health workers about the disease and those working in the TB unit.

A good number of the staff still have negative perception of the disease and even those working in the TB unit. For example, some health workers stated that they just don't like the unit and scared of the disease. This indicates that the pre-service and in-service training they received on TB did not change their perception of the disease. This goes contrary to the study by Maher, et al (1999), which indicates that health workers understanding of the disease is supposed to change their attitude and perception so that they can become part of the educational team in the families and communities. According to Maher, et al, the workplace is an important venue for promoting behavior change with regards to silence and stigma surrounding TB and can play a major role in promoting public health acceptance and non-judgmental responses of TB. The negative attitude and perception by health workers of the hospital may be attributed to other factors other than inadequate knowledge such as deep-rooted traditional belief which view TB as a deadly disease and disease of the poor and so nobody wants to be associated with it. In some traditions, TB is considered a horrible disease. Vecchiato, 1997 study of the Somali people perception about TB confirms this as he reveals

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that from childhood Somali's learn that tuberculosis is a horrible disease that leads to social isolation. Also society generally gives recognition and respect to workers in other specialized fields such as Surgery, Obstetrics and Gynaecology or Physicians in other medical conditions, but demonstrate demean for stigmatized conditions such as TB, HIV/AIDS and Mental illness workers or specialist. This is confirmed by United Nations report, 1997, which said fewer Doctors are interested in specializing in stigmatized conditions such as TB, AIDS and Mental conditions. The stigmatized diseases reduces the dignity and respect of health professional working in these areas as confirmed by one respondent who is a Surgical Specialist in the hospital that " the cordial respect as a health care personnel is lacking in these areas".

The attitude of some facility managers in the hospital leaves much to be desired. Though the Unit heads that were interviewed did not agree that they post some staff to the TB unit as a punishment. However some respondents believe that this criterion of posting staff to TB unit is practiced and cited the number of workers affected by this criterion. The findings show that about 3.9% of the respondents outside the TB unit and 6.6% of respondents in the TB unit agreed that some workers are posted to the TB unit as a punishment. Respondents cited a total of 8 workers affected by this criterion. The possible reason for the negative attitude by the heads is to expose indisciplined workers to TB infection when working in the unit. However, TB can be contracted anywhere since it is airborne. The second probable reason is that if a worker is stigmatized with TB for working in the unit, it serves as a punishment and ridicule, as the Sidama people of Ethiopia use the word TB as an insult and ridicule. The WHO report, (1998) also confirms these findings where it reports that fear of TB related-stigmatization by health workers including Doctors and nurses combined with fear of stigma from society makes care and support services for TB patients difficult.

Health workers need to have positive perception of the disease and the staff, who work there, to be able to make a positive impact on the promotion of behavior change of the public on stigma and discrimination of TB. If health workers who are supposed to be more knowledgeable in TB have some negative perception of the disease and the staff who work with TB patients, they would be portraying a negative signal to the less knowledgeable public about the TB patients.

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5.2 STIGMA AND DISCRIMINATION

Why do health care providers stigmatize – is it because of fear of infection or is it because of judgmental attitudes? Stigma and discrimination among health workers in the health facility is real. The results of the study show that 21.6% of workers outside the TB unit agree that there is stigma and discrimination among health workers whilst 73.3% of workers in the TB unit confirm the discrimination and stigma against them. All categories of workers in the TB unit even Medical Doctors felt they are being stigmatized and discriminated against. This finding supports the AFRO/WHO findings (1998), which states "health care providers may stigmatize themselves for working with TB positive people". The study also found that for those workers who are posted on normal routine changes, 48% would accept the postings reluctantly and 17.7% would be disturbed and shocked by such posting. This is as a result of the stigma, which discourages workers in the hospital to willingly accept postings to the unit. This finding confirms the United Nations report, 1997 that fewer health workers would like to specialize in stigmatized diseases such as TB, mental illness and HIV/AIDS.

The study also found evidence of discrimination by some managers refusing gifts (food) from TB unit. To quote a Medical Officer in the TB unit, "Other staff refuses to accept gift (food) from the unit." The study found that other workers go to the extent of refusing to share a plate of food or drinking cup with TB unit workers. About 31.4% of workers in other units of the hospital would not like to share a cup or plate of food with other workers in the TB unit. Also some workers in the hospital shun the company of some of the workers in the TB unit. The workers in the TB unit cannot mingle with other workers during gatherings such as workers durbars. These findings confirm the findings of the study in East Africa by Vecchiato(1997), where people isolate patients and refuse to eat and drink from the same bowl and cup. However, this discriminatory behaviour by some of the hospital workers is contrary to what the National TB Programme Manager's advice e to the public not to shun TB patients by

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asking them to use different plates, cups, spoons and even rooms adding "the stigma even helps in killing them very fast." The social isolation has serious implications for the worker. Psychologically, the worker becomes depressed and would not render any quality care to the patient. The study found that 43.3% of workers believe their work output is affected by the discrimination and stigmatization. The effect of this "in House" stigma and discrimination affect the number of health workers who would want to specialize in the disease or work in the unit. About 30% of the workers in the TB unit interviewed wanted a change of unit in the hospital despite the incentive package from the Global Fund against Tuberculosis, Malaria etc, due to the stigma and discrimination against them by their colleagues in other units. This is buttressed by the United Nations report 1997, which states "fewer doctors are interested in specializing in most stigmatized conditions" such as TB, HIV/AIDS and mental illness. Some of the reasons for the stigma and discrimination could be attributed to the traditional belief of the disease, which we have grown and developed with and it is difficult to get rid from our mind. It could also be attributed to the weak health infrastructure in which access to items the universal precautions against infections such as gloves; sputum collection kits and post exposure prophylaxis are inadequate. The Health Development Network report (2001) supports this fact, which states "because of inadequate protective measures, health care workers' fear of contagion are fueled".

5.3 EXPERIENCES OF WORKERS IN TB UNIT

The workers in the TB unit experience stigma and discrimination, mockery, social isolation, frustrations and shame. Over 70% of the respondents unit agreed that they are stigmatized and discriminated against. This belief cuts across all the categories of workers in the TB unit. The stigma results in sadness, anxiety and worries as troubling features of the workers in the unit. The findings show that workers in other units of the hospital made mockery of the workers that were posted to the TB unit. The reasons given by the workers for this behaviour

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include: inadequate education on the disease among the workers in the hospital, negative public opinion of the disease and traditional belief about the disease. However, other possible reasons that could be attributed to the stigmatization of health workers in the TB unit may include: low self-esteem of those working in the TB unit, as well as lack of recognition and respect for workers of the unit.

Another experience of the TB unit workers is shunning and social isolation when with colleagues or when they enter any office in the hospital. This is due to the bad perception workers have about the unit and staff who work there. This is evidenced by 50% of the respondents in the TB unit who rated other health workers perception about them to be either very bad or bad. The fear of social isolation may influence the workers to deny working in the unit. The workers do not feel proud working in the unit because they would be isolated. This experience confirms Vecchiato's(1997) study of TB in Ethiopia, which identified fear of social isolation, influencing persons with the TB to deny the true nature of the illness to others. Also Liefooghe's(1998) study showed that married women in Bombay were concerned about rejection by husbands and harassment by in-laws whilst unmarried women worried about reduced chances of marriage.

The isolation and rejection experienced by the workers may be causing worry and anxiety to them. The married women workers may view their marriages threatened and the unmarried young workers may see their chances of marrying reduced. This may also account for why some workers vowed never to work in the unit. They would rather resign from the hospital than to work in the TB unit, whilst others would be ready to forgo their promotion if the promotion is tied to posting to the TB unit. However, there is the need to dispel myths and shame surrounding TB in workplaces, especially the hospitals in order to promote workers rights and also for the prevention and cure of the disease.

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CHAPTER SIX

6.0 CONCLUSIONS AND RECOMMENDATIONS

6.1 CONCLUSIONS

6.1.1 Workers Awareness Of Tuberculosis

Generally the majority of the hospital workers are aware of TB and have had in-service training on Tuberculosis in the last eight years with the introduction of the Direct Observed Treatment Short Course (DOTS) treatment plan. About 68.5% of the respondents have had in-service training on the disease and awareness of the disease is above average. However, the in-service training is limited to Medical Doctors, Nurses, Laboratory and Radiology workers of the hospital. The Ward Aides, Labourers and the Orderlies never received any refresher training on the disease. This group of workers therefore relies on traditional belief and the public perception about the disease, which have negative influence on their attitudes, and perceptions of the disease and the unit.

6.1.2 Attitude And Perception Of Workers About TB And The TB Unit.

The workers outside the TB unit generally have negative attitudes and perceptions about the workers in the unit. There is the perception that workers in the unit have acquired immunity to work there and so not everybody can work in the unit. Also, there is the belief that workers in the unit are infected with the TB bacilli. For these perceived ideas, the attitude towards the workers in the unit by other workers in the hospital is either very bad or bad. They isolate them, shun their company and discriminate against them. Some even make mockery of

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workers posted to the unit. Also, some workers will not even want to share food or water in the same plate or cup with the workers of TB unit and refuse gifts from the unit.

6.1.3 Factors/Reasons For Discrimination Against Workers Of TB Unit

Stigma and discrimination exist among health workers in the hospital and the factors/reasons for stigma and discrimination given by both groups of workers in the TB unit and outside the TB unit include:

1. Fear of contracting TB: Workers in other units of the hospital discriminate against workers of TB unit because if they socialize with them they may contract the disease, which they believe the TB workers are carriers. The workers in the TB unit also share the same believe that discrimination against them by other workers is due to fear of contracting the disease if they socialize with them. This fear is compounded by the weak health infrastructure where there are inadequate protective materials for the workers such as gloves, safe sputum kits, gowns etc. The report of the Health Development Network, 2001 confirms this assertion that because of inadequate protective measures health care providers fear of contagion is fueled.

2. Workers in TB unit are infected with TB bacilli: There is a psychological belief among health workers of the hospital that those working in the TB unit are infected with the TB bacilli. For this reason no worker wants to mingle with them or accept anything from them or share food with them during break hours.

3. Perception that workers in the TB unit are TB patients themselves: Other workers have the perception that workers of the TB units are TB patients and therefore the discrimination given to TB patients is extended to them. Health workers who are supposed to promote education to reduce stigma and discrimination are practising it and it is therefore not surprising that TB patients are discriminated against in the communities.

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4. Reduced respect and recognition as a health worker: Workers of other units in the hospital believe that workers of TB units are not part of the hospital staff. They are not given the same recognition as other workers. For example a Medical Doctor in the TB unit is not accorded the same respect and recognition as a colleague Doctor in the Medical or Surgical units. As stated by a Surgical Specialist *"the cordial respect as a health care personnel is lacking".*

5. Other workers believe the TB bacilli is everywhere in the TB unit and can easily infect them if they visit the unit. Workers believe that the whole TB unit is infected and every item or person that gets there is infected with TB bacilli. With this in mind no worker wants to accept posting to work in the unit or pay visit to the unit or accept gifts from the unit.

6. The other workers are influenced by the negative public perception of the disease: The public view TB as a horrible and shameful disease. Others think of it as a disease of the poor and people with the disease should be isolated from the family. The communities therefore isolate TB patients and some women are divorced when it is known that they have the disease. The hospital workers are therefore influenced by this public perception and for the fear of being isolated by the public, workers do not want to be associated with the TB unit or the workers.

6.1.4 Experiences of TB Unit Workers

The stigmatization of the health workers in the TB unit has negative consequences on the image and reputation of the workers. First, their pride as health workers is low/lost. There is low self-esteem and low respect and recognition for the workers in the unit. Secondly, their morale is low working in the unit and this has negative effect on their output. This is due to the social isolation they experience from their colleagues. They are worried and unhappy because of the label against them as TB patients by colleagues. Also their fellow workers

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discriminate against them and this worsens their frustration. They experience sadness, anxiety and worries and these are troubling features for the workers in the unit.

6.2 RECOMMENDATIONS

Based on the findings of the study, the following recommendations are made:

1.The study has revealed that majority of the staff of the hospital have not had refresher training on TB and the DOTS treatment strategy especially among the Orderlies, Ward Aids and Labourers and some professionals. It is therefore recommended that a well planned and well-packaged refresher training should be organized for all categories of health workers in the hospital. However, the Ward Aids, Orderlies and Labourers should be given priority. Emphasis of the training should be on source of acquiring the disease, the DOTS treatment regimen and effects of stigma and discrimination on patients and workers of the unit. The following should be emphasized:

Sharing of plate and cups with TB patients or workers in the unit do not lead to acquiring infection. The disease is airborne and it is not acquired through ingestion of food contaminated with TB bacilli.

Social isolation of patients delays recovery and health seeking. The same is applicable to workers in the unit, if they are socially marginalized it leads to depression, unhappiness and de-motivating and therefore quality of care to the patient will be compromised.

Availability of universal precautions such as gloves, and other logistics to protect workers. If hese precautionary measures are in place, it will reduce the fear of infection.

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2. The study also revealed that majority of the workers in other departments of the hospital have negative perceptions about the disease and the workers of the unit. This should be tackled to reduce/eliminate these perceptions especially among health workers:

First, all workers of the hospital should be encouraged to accept posting to the TB unit by reminding them of their professional "oath and ethics" which tells them not to discriminate against patients irrespective of race, colour or disease.

Secondly, departmental heads should also avoid posting workers to the TB unit as a punishment for disobedience or disrespect. Postings should be done strictly by routine changes. Workers sent to the TB unit should not serve too long or forever in the unit. This will dispel the notion that workers in the TB unit have acquired immunity for working there.

Thirdly, management should pay regular visit to the unit. It will dispel the negative perception that the unit is a "No Go" area and a sanatorium. It will also serve as a prove that one does not need to acquire immunity before visiting or working in the TB unit. Distribution and replacement of equipment should be fair in order not to create the impression that the unit is less important or being discriminated against.

Fourthly, management should treat all workers equally so that some people should not be made to remain in the TB unit whilst other refuse posting to the unit and no action is taken against them.

3. The findings of the study show that majority of the TB workers believe that they are being stigmatized with the disease and discriminated against. This was supported by some of the respondents from other units who indicated stigma and discrimination against the TB workers. To reduce this stigma and discrimination, the hospital management in consultation with the National Tuberculosis Programme (NTP) should make funds available for the

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production of learning materials such as TB flyers, pamphlets, manuals etc for all workers irrespective of the unit one is working. The hospital management should set up a committee to carry out an awareness campaign on TB for all workers in the hospital. The members of the committee should have representations from the various categories of workers in the hospital. This will help to reduce the stigma of the disease and discrimination of the workers of the workers. It will also improve willingness of workers to work in the TB unit and increase work output and quality of service.

4. The findings of the study show that TB workers have bad experiences of social isolation and discrimination. This may be due to the isolation of the patients from other units. The management of TB patients should be integrated into the medical wards of the hospital. The sanatorium system of isolating TB patients in a different unit should be abolished and integrated into the Medical block so that patients can be management in any medical ward. Patients should be put in cubicles and stay for a maximum period of two weeks in the ward. Patients can continue treatment as outpatients in any health facility near the patients' residence. The DOTS principle encourages this plan and with the global fund available, transportation cost of the patient to the health facility for treatment is refunded to the patient. The integration of TB management with other medical patients will increase the number of workers who will handle TB patients. This will reduce the stigma among health workers and unwillingness of workers to manage TB patients. Also, it will reduce the fear of contracting the disease by workers and may influence their perceptions of the disease and the workers of the unit. The morale and output of the workers may improve since they are not managing only TB patients.

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APPENDIX 1

INTERVIEW GUIDE: - FOR HEADS OF GROUPS

I would like to talk to you about some of the difficulties you face in the efficient management of TB cases. Our discussion would cover some of attitudes and perceptions some health workers have about the TB unit and stigma associated with it.

A: ATTITUDES

1. What criteria do you use to post health workers to the TB unit?
2. Apart from the formal criteria, what factors influence you to post a staff to the unit?
3. Are health workers willing to accept posting to the unit? if no, Why?
4. Describe how health workers outside the unit behave towards those working in the TB unit.
5. In your opinion, what factors influence these behaviours? *Probe!*
6. What is the attitude of health workers to TB patients? What are the reasons for these attitude?
7. Are health workers trained in TB? How? When? How often?

B: PERCEPTIONS

1. What is your personal view about those working in TB unit?

In your opinion, how do other health workers think about those working in TB unit? Why? *Probe.*

2. In your opinion, is working in the TB unit comparable to other units? (*Probe*; are there any poor perception of TB unit work?)
3. Do you think there are any dangers to health workers that are unique to the TB unit?
4. : Do you/other health workers think it is a pride/shame to work in the TB unit?
5. What is the influence of this feeling/thinking of other workers on the quality of care?
6. In your opinion, what are the contributing factors to these perceptions about the disease and those working in the unit?
7. What do you think are some of the measures to minimize/eliminate these perceptions?

C: STIGMA AND DISCRIMINATION

1. If you had a choice between being posted to the TB unit or other, what would be your choice? Why/Why not?
2. How, in your opinion, will your colleagues react if you are posted to the TB unit?
3. Why do health workers not want to work in TB unit?
4. Which unit will you want to work if you had a choice? Why?
5. In the work culture of health workers, especially nurses do you think there is any problem working in the TB unit?
6. How serious would you say is this problem?

Thank you for sharing all of this information with me. Are there any questions that you have for me?

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APPENDIX 2

SCHOOL OF PUBLIC HEALTH

UNIVERSITY OF GHANA

LEGON

STRUCTURED QUESTIONNAIRE

(FOR HEALTH WORKERS OUTSIDE TB UNIT)

I am carrying out a study on TB stigma among health workers. I would like you to answer the following questions, which will help me in my study. Whatever information you give will be used for this study only and confidentiality of your information is assured. Please write the number (Either 1, 2, 3, OR 4) of your answers in the boxes.

Questionnaire Number ------- DATE:……..

RANK/POSITION:…….. AGE:……

1. Have you worked in the TB unit before?

1. YES
2. NO ANS[ ]

2. Have you heard of National tuberculosis Programme?

1. YES
2. NO ANS[ ]

3. Have you heard of Direct Observed Treatment, Short Course (DOTS) for TB?

1.Yes
2. No ANS[ ]

4. Have you had any refresher training on TB within the last 8 years?

1.YES
2. NO ANS[ ]

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5. If you were given the option, would you like to work in TB unit?

1.YES

2. No ANS

6(a) If YES, state two (2) reasons why you would willingly like to work in TB unit?

6(b) If NO state two (2) reasons why you would NOT willingly like to work in the TB unit?---

---

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7. What would be your reaction if you were posted to the TB unit?

1. Shock
2. Happy
3. Disbelief ANS
4. Accept reluctantly
5. Other (Specify)----------

8. What is the criterion used to post some staff to TB unit?

1. Disciplinary grounds
2. Routine change of staff
3. Personal request ANS
4. Other (Specify)----------

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9. In your opinion, do you think some health workers are posted to TB unit as PUNISHMENT?

1. YES
2. NO ANS [ ]

9(b). If YES, give the NUMBER of such cases you are aware?

---

10. If your next promotion is tied to your posting to the TB unit, will you accept the promotion?

1. YES
2. NO ANS [ ]

11. State three (3) factors/reasons health workers in TB unit are discriminated by their fellow health workers.

1.----------

2. ----------

3.----------

12.In your opinion, what perceptions do other health workers have about those working in the TB unit?

.....

.....

.....

13.Health workers consider TB as a SHAMEFUL/DISGRACEFUL disease and do not want to be associated with the TB unit?

1. TRUE
2. FALSE ANS [ ]

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14.How will you best describe TB to your fellow health worker?

1. Disgraceful disease

2. Disease of the poor

3. Unclean disease ANS

4. Other (Specify)----------

15. Health workers discriminate against colleagues working in the TB unit because the disease is not acceptable in the community.

1. TRUE

2. FALSE ANS

16. Health workers in TB unit are stigmatized with the disease?

1. TRUE

2. FALSE ANS

17. Health workers discriminate against their colleagues working in TB unit because of the stigma attached to the disease?

1. TRUE ANS

2. FALSE

18. Which of the following will you assign for TB stigma by health workers.

1. Inadequate knowledge of TB

2. Traditional belief of the disease ANS

3. Negative Public opinion of the disease

4. Other (Specify).....

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19. Would you like to share the same cup and plate with your colleague working in the TB unit during lunch break?

1. YES
2. NO

ANS [ ]

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APPENDIX 3

SCHOOL OF PUBLC HEALTH

UNIVERSITY OF GHANA

LEGON

STRUCTURED QUESTIONNAIRE

(FOR HEALTH WORKERS IN TB UNIT)

I am carrying out a study on TB stigma among health workers. I would be grateful if you could take some time off your schedule to answer the questionnaire. Your confidentiality is assured. The information will be used only for this study. Please, write the Number Either(1, 2, 3, OR 4,) of your answers in the boxes.

Questionnaire Number…… DATE……

RANK/POSITION:…….. AGE:……..

1. How long have you been working in the TB unit? (State in months)

ANS

2. How were you posted to the unit?

1. Normal unit changes
2. Request by unit head
3. Self-request
4. Other (Specify)……

ANS

3. Will you want a change of unit **NOW?**

1. Yes
2. No

ANS

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If NO, skip to question 5

4. Why would you need a change?

1. Fear of contracting the disease
2. Avoid shame and isolation
3. Regain morale
4. Other (Specify)----------

ANS

5. What was your immediate reaction when you were informed of your posting to the TB unit

1. Sad
2. Happy
3. Indifferent
4. Afraid
5. Other (Specify)----------

ANS

6. What was the reaction of your fellow health workers towards you on hearing of the posting?

1. Sad for me
2. Mockery of me
3. Happy
4. Other (Specify).....

ANS

7. How do your fellow health workers relate with you now?

1. Very good
2. Good
3. Very bad
4. Bad

ANS

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8. In your opinion, are health workers in the TB unit discriminated against by their fellow workers.

1. YES

2. NO ANS [ ]

If NO, skip to question 10.

8(b). What factors/reasons can you give for the discrimination?

---

9. Does this discrimination affect your work output?

1. YES

2. NO ANS [ ]

If NO, skip to question 10.

9(b). State two ways in which the discrimination affect your work out put?

.....

.....

.....

10. Suggest ways to minimize any negative attitude of health workers towards you.....

.....

.....

.....

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11.How would you rate the perception of other health workers about those of you working in the TB unit?

1. Very good
2. Good
3. Very poor
4. Poor

ANS

12. What suggestions can you make to minimize/eliminate these perceptions among health workers about the TB unit?

---

13. Has working in the TB unit, had any effect on your career development?

1. YES
2. NO

ANS

13 (b). If YES, list 2 effects on your career?

14.How do the community members relate with you realizing you are now working in TB unit?

1. Normal
2. Poor
3. Shunning company
4. Other (Specify)----------

ANS

15 Has working in the TB unit, affected your relationship with your family members?

1. YES
2. NO

ANS

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16. In your opinion, are health workers posted to the TB unit as a "punishment"?

1. YES

2. NO ANS

17. Have you or any health worker in the TB unit ever being discriminated against in benefits/promotion/career development etc because you/the health worker concerned is working with the TB unit?

1. YES

2. NO ANS

If NO, skip to question 19

17(b). If YES, give two (2) examples of this discrimination by fellow health workers against you/colleagues.

.....

.....

.....

18. Do you feel equally proud working in the TB unit as you were working in other units?

1. YES

2. NO ANS

19. Do your fellow health workers outside the TB unit willingly share the same cup and plate with you during lunch break?

1. YES

2. NO ANS

20. When friends from other units visit you in the ward, do they willingly shake hands with you?

1. YES

2. NO ANS

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21. Which of the following reasons will you assign for TB stigma by health workers.

1. Inadequate knowledge of TB
2. Traditional belief of the disease ANS
3. Negative Public opinion of the disease
4. Other (Specify).....

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APPENDIX 4

DISTRIBUTION OF SAMPLE AMONG CATEGORY OF WORKERS OUTSIDE TB UNIT

CATEGORY	POPULATION	WEIGHT	SAMPLE
DOCTORS	433	14.6	15
NURSES	1382	46.8	47
RADIOLOGY UNIT	89	3	3
LABORATORY	86	2.8	3
DISPENSARY	147	4.8	5
BIOSTAT./RECORDS	143	4.7	5
LABOURERS	83	2.7	3
WARD AIDES	617	20.6	21
TOTAL	2,943	100	102

The total population is 2,943 because 57 of the TB health workers is deducted from 3000 work force in the hospital.

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Appendix 5

DISTRIBUTION OF SAMPLE AMONG TB HEALTH WORKERS BY CATEGORY

CATEGORY	POPULATION	WEIGHT	SAMPLE
DOCTOR	7	12	4
NURSES	25	45	13
DISPENSARY	4	7	2
LABORATORY	5	9	2
RADIOLOGY	3	5	2
ORDERLIES	9	15	5
BIOST/RECORDS	4	7	2
TOTAL	57	100	30