STGIMA AS SOCIAL BARRIER TO EFFECTIVE CONTROL OF TUBERCULOSIS IN THE TAMALE METROPOLITAN AREA OF GHANA

Abdul Yahayha

ABSTRACT

This document used a qualitative search approach to explore the reasons, symptoms and consequences of tuberculosis (TB) stigma in Tamale. It observes causes why TB is stigmatised and clarify how TB stigma manifests inside the community surroundings and the healthcare organization. It also sees the sights, feelings and experiences of TB patients, to emphasize how the dread of stigmatisation may influence case finding and treatment devotion.

Eight focal points (6 with the community associates, 1 with health employees, 1 with TB enduring. 40 individual meetings (20) community associates, 10 with patients and 10 with physical condition staff) were mannered. Data was examined, using Grounded Theory techniques and measures.

Eleven reasons of TB stigma were recognized: fear of illness; physical infirmity of TB patients; involvement of TB with HIV/AIDS; apparent causes and extend of TB; outdated societal live out about TB; public health perform and discussion; attitudes of healthcare staffs towards TB patients; health staff’s own terror of TB; self-stigmatisation by TB patients; decision, blaming and embarrassing TB patients; and precedent experiences with TB. Fundamentals of physical and ethical threats were recognized in all these sources of TB stigma. The hazard the disease poses to group of people led to the obligation of socio-physical detachment, participatory limitations and rules for unforeseen interactions on those anguish from TB in society. Within the healthcare organization, the threat of TB exaggerated the approaches and behaviors of healthcare employees in the direction of TB patients and TB labor. Health executive also mentioned TB units/divisions in isolated fraction of the hospital, and failed to make available adequate tools and equipment, hold up and supervision to facilitate the provision of excellence in TB services. The horror of stigmatisation completed the patients deny the clear symptoms of the ailment, and report to the infirmary only after protracted phase of self-medication in the society.

Keywords: Social Barrier, Tuberculosis, Grounded Theory

BACKGROUND

Ghana introduced a National Tuberculosis Control Program (NTP) in 1994, based on the Directly Observed Treatment, short-course (DOTS) strategy. To date, the plan has been put into practice throughout the state with reporting of over 80.6% (WHO, 2005). However, a decade after implementation of the strategy, the incidence of TB is still high and increasing alarmingly (NTP-Ghana, 2004). One major setback to the successes of the strategy globally, particularly for case finding and treatment adherence, is the stigma attached to TB in most societies, including Ghana. Consequently, present has been an augmented interest in considerable TB stigma to facilitate the expansion of suitable interventions to minimize the impact of stigma.

Although the concept of stigma has been defined in many ways, there are clear indicators of its social origins as well as the factors that perpetuate it (Smith, 2002). The process of constructing stigma involves the recognition of a difference based on some distinguishing characteristics values placed on varying social identity, and subsequent devaluation of the person who possesses them. Thus, any conversation of communally substandard attributes to be obliged to take into consideration a classification of what is the communal norm, given that stigma is normally linked with those substandard attributes which are usually regarded as average infractions.

For TB, it has been documented that the attached stigma can be a reflection of the way society understands the disease. It is therefore important to explore the community’s understanding of, attitudes...
and behaviors towards the disease, as this may help explain how TB stigma is constructed as well as the way it operates within the community setting to affect the ability of patients to seek help and comply with treatment. This proposal reports on the attitudes and behaviors of society members in the direction of TB in an urban district in Ghana. The proposal reports on the attitudes and behaviors of society members in the direction of TB in an urban district in Ghana.3.

RESEARCH PROBLEM

There is limited independent data from institutions and health care facilities explaining the social barriers to the control of TB in the Tamale Metropolis. This paper is therefore aimed at assessing (Determining) the social barriers to the TB control program.

Although Ghana is not single of the 22 TB high-burden states, the ailment remains a major public healthiness problem in the country. The WHO estimates that Ghana should be reporting at least 45,000 TB cases on an annual basis, but only one-third of that number are detected. This means that many more undiagnosed TB cases are continuously transmitting the disease to susceptible people (TB CAP, Report 2010).

The ailment easily in overloaded, poorly ventilated places. It’s more among populous with malnutrition. The population of Tamale name be noted by UNICEF to be the fastest growing in sub-Saharan Africa since poverty and malnutrition is more contributory factors to the disease, people of Tamale in most vulnerable on at greatest to the WHO declared TB a global emergency (2005) and has called for urgent, extra-ordinary action.

TB has infected a third of the world’s population 8.8 million new cases were recorded in 2005, with highest being in poor countries. Each TB patient will infect 15 people over year (WHO 2010).

The mutual burden and outcome of TB, malnutrition and HIV/AIDS co-infection as massive. The global burden of TB is increasing largely due to malnutrition and HIV pandemic. Without intervention, 30% of the HIV population dies within a year.

The WHO estimation about impure adults misplaces an average of 3 – 4 months of employment. Getting better from TB disease and regular years of economic movement is misplaced from each adult TB death.

On the 4th of October 2012, as recorded in the journal of Medical and Biomedical Sciences. Retrospective study on the prevalence of smear positive tuberculosis. From 2004 to 2012, the result recorded that, out of 5,720 registered cases, 4,762 were positive.

RESEARCH QUESTION

What are the barriers to the control and eradication of TB in the Tamale Metropolitan Area?

OBJECTIVES

To explore the communities within the Tamale metropolis for the insight and perceptions of tuberculosis and TB patients.

To study the attitudes and behaviors of health workers and community members that discourages TB patients from going to the hospital for early treatment or compliance.

To determine the barriers preventing effective control of tuberculosis in the TMA.

To study the challenges of DOTS at the TMA, and to inform the National Tuberculosis Program as to the best methods and techniques to effectively control TB in Ghana.

To improve the detection rate beyond the national goal of 85% by increasing sensitization and minimizing stigma.

LITERATURE REVIEW

TB is transmitted from person to person by droplet infection through sneezing and coughing. The infection is transmitted when the other person breathes in these droplets containing TB bacilli. Once infected with M. tuberculosis, a person stays infected for life but this does not necessarily mean that the person is ill. Most people have strong immune system to overcome the infection. However, some people may develop symptoms of TB disease at any time. Among infected persons without HIV infection, only 1 in 10 (10%) will develop TB disease; most (90%) will remain healthy. The most important trigger for TB disease is weakening of the immune system. Patients with weakened immune systems, such as those with HIV infection, diabetes and malnutrition, are at greater risk of developing TB.
Stigmatization is a social determinant of health. Stigma takes place since of community and institutional norms concerning unwanted or disvalued behaviors or uniqueness. When ailment is stigmatized, the dread of the communal and fiscal consequences following analysis can make individuals unwilling to seek and complete medicinal care. The arrangement of a community's viewpoints and norms regarding a disease and the ensuing stigma can, consequently, substantially bang health. In this piece of writing, we methodically reviewed the prose on TB stigma, as well as studies that characterized and deliberate TB stigma; charged its collision on TB analysis and treatment; and explored interference to decrease TB stigma, 3, 4 and 5.

Tuberculosis (TB) contentious to cause a large burden of disease in the world, killing just about 2 million citizens a year. It is estimated that 95% of all TB cases and 98% of all TB death occur in Africa. Fueled by poverty, poor public health systems, and increasing HIV/AIDS prevalence, TB contentious to be a persistent challenge for global health and development.8

TB direct programs at present highlight the DOTS small course (DOTS) strategy, endorsed by the WHO and the International Union against Tuberculosis and Lung Disease. The present goals are to attain 85% treatment victory and 70% case discovery. Amid others, TB global control at this time face up to two challenges to convene those goals: diagnosis delay and MDR-TB.10 and 11

The TB community has recognized and addressed system components in which behavior is a key issue. Both diagnosis holdup and non-completion of action are two middle behavioral confronts. Patients are predictable to look for care and absolute treatment. Health care contributor are probable to execute successfully a number of actions, including offering sputum smear assessment to patients, conducting test adequately, and monitoring medicine intake. Achievement in TB discovery and treatment entails specific performance of patients and health care contributor within circumstances that make possible those practices.5, 6 and 7

Dodor, (2009)in his publication in a journal; psychology health and medicine entitled; health professionals as stigmatisers of tuberculosis: Imminent from society associates and patients with TB in an town district in Ghana.

In that article, they mentioned that “Health professionals are in a power category within any social setting” so when they identify and label diseases with negative attributes, it can be recognized by society with discrimination, consequences for individuals affected in the community.

In that article, they also reported how activities of health professionals as perceived and consumed by community members can be can be a basis of stigmatization of patients with tuberculosis (TB) in the society.

One hundred human being consultation and 22 focus assembly were detained with community affiliates and patients with TB. The produced data was examined by means of the grounded theory methods and procedures.

Through examination of the words and statements of the participants, five unified habits by which behaviors of health experts may depiction patients with TB to stigmatization in the public were identified.5, 6 and 7

METHODOLOGY

Study design:

1. Qualitative and quantitative approach was used.

Focus group discussion and face to face discussion with patients:

Study area:
Tamale (marked is a municipality formally called Tamale Metropolitan District. Tamale has 537,986 populations according to the 2012 polls. It's the best ever growing metropolis in West Africa. The town is positioned 600 km north of Accra. Tamale inhabitants are modest group of Islam as reproduced by the massive amount of mosques in Tamale, most particularly the Central Mosque. The Sunnites and the Ahmadiyyans also contain their own middle mosques, north of the town centre all along Bologatanga Road.

Tamale is to be found in Northern Ghana. Tamale rose from an accumulation of towns wherever one might come across an architectural merge of traditional sludge houses and extra modern construction.

Due to its central site, Tamale dish up as a center for all managerial and marketable behaviors in Northern region, repetition as the biased, monetary and fiscal capital of Northern Ghana. The hub of Tamale hosts limited branches of monetary institutions and a substantial number of worldwide non-governmental organizations.

**Ethical clearance**

The study had ethical clearance from the University for Development Studies (UDS) ethical review committee. At the beginning of every data collection session, the purpose of the study was explained and verbal consent obtained from every participant to tape record the discussions. For patients in particular, it was made clear to them that participation in the study was voluntary and refusal to take part will not affect their access to services offered by the hospitals. To assist, keep the individuality of the patients and put off questioning by group of people, equally the focus set and entity interviews for enduring were detained within the infirmary premises. No form of inducement to entice the participants to partake in the study was done.

However, refreshment was provided after the group focus session. Patients with TB who traveled to the regional hospital to participate in the focus groups were also reimbursed for the cost of travelling. No identifiable records, such as, name and hospital number was kept on the tapes or written on the transcripts.

Community participants were identified with the help of community leaders in the nine communities (the sub-district capital and other communities with a high number of patients with TB in each of the five sub-districts within Tamale Metropolitan Area).

The institutional TB register in four government health institutions providing TB service in the district purposively selected the patients with TB for the study.

**Selection of participants:**

From the 2008 surveillance report, the Tamale Metropolitan Health Directorate have documented 8 sectors of Tamale city as the 8 most prevalent communities for TB; Namely, Sabonjida, Tishigu, Changli, Moshi zongo, Milene, Aboabu, Nyoahani Kalipohini, These 8 sectors was used for random sampling, out of which 5 sectors was selected. The houses were numbered 1, 2 and 3. Those houses with number 3 were used for the study.

**Data collection:**

Combination of quantitative and qualitative shall be used.

A skilful employ of a grouping of dissimilar procedures can decrease the possibility of bias, and will provide a further comprehensive consideration of the subject under study.
Qualitative research techniques involve the identification and exploration of a number of often mutually related variables that give insight in human behavior (Motivation, Opinions, Attitude), in the nature and causes of certain problems and in the consequences of the problems for those affected. ‘Why’, ‘What’, and ‘How’ are important questions.

Prearranged surveys that facilitate the investigator to enumerate pre- or post-categorized responds to query are an instance of quantitative explore techniques. The answers to questions can be counted and expressed numerically.

**ANALYSIS OF RESPONSE FROM COMMUNITY MEMBERS WHO PARTICIPATED IN THE RESEARCH.**

Table 1: Factors on which Posting of Health Workers to TB Units were Based

<table>
<thead>
<tr>
<th>Response</th>
<th>Frequency</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any staff can be posted</td>
<td>28</td>
<td>20</td>
</tr>
<tr>
<td>Experienced health Workers</td>
<td>61</td>
<td>43.6</td>
</tr>
<tr>
<td>No Idea</td>
<td>51</td>
<td>36.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>140</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>


Table 1 shows that 28 people out of 140 people said any stuff can be posted to the chest unit this represented 20% of the participants in the community. 61 out of 140 participants answered that experience health workers could be sent to TB units this represented 43.6% of the participants. 51 out of 140 answered that they had no idea this represents 36.4%.

Table 2: Reason for Health workers Refusal to be posted to TB Units

<table>
<thead>
<tr>
<th>Response</th>
<th>Frequency</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk of being infected</td>
<td>115</td>
<td>82.1</td>
</tr>
<tr>
<td>Stigmatization</td>
<td>25</td>
<td>17.9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>140</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Table 2 shows that 115 out of 140 people said the reason why health stuff refuse to work at TB units is the risk of being infected which represented 82.1% of the community whilst 25 people out of 140 people representing 17.9% said stigmatization is the reason.

DEMOGRAPHIC ANALYSIS OF PARTICIPANTS

<table>
<thead>
<tr>
<th>Response</th>
<th>Frequency</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>98</td>
<td>70</td>
</tr>
<tr>
<td>No</td>
<td>40</td>
<td>28.6</td>
</tr>
<tr>
<td>No Idea</td>
<td>1</td>
<td>0.7</td>
</tr>
<tr>
<td>No Response</td>
<td>1</td>
<td>0.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>140</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

As shown in the table 98 of 140 people representing 70% said yes they have seen a suspected TB patient before whilst 40 of the 140 representing 28.6% said no. 1 of the 140 representing 0.7% said they had no idea. 1 of the 140 people representing 0.7% said no response.

AGE OF RESPONDENTS

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Frequency</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-29</td>
<td>86</td>
<td>61.4</td>
</tr>
<tr>
<td>30-39</td>
<td>16</td>
<td>11.4</td>
</tr>
<tr>
<td>40-49</td>
<td>23</td>
<td>16.4</td>
</tr>
<tr>
<td>50-59</td>
<td>15</td>
<td>10.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>140</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>
As shown in the table above, 86 of the 140 representing 61.4% are within the ages of 20-29.16 of 140 representing 11.4% are within the ages of 30 and 39.23 of the 140 representing 16.4% represent the ages of 40 and 49.15 of the 140 representing 10.7% are within the ages of 50 and 59.64 of the 140 representing 45.7% are married whilst 76 of the 140 representing 54.3% are single.

**DISCUSSION:**

The hub characteristic of stigma is the control of attribute(s) that express diminish communal individuality, which is extensively common and well known in the middle of members of the society, and turn out to be a basis for not including or avoiding such person(s). As Ervin Goffman argues, “when an individual who might have been established with no trouble in ordinary communal intercourse possesses a mannerism that be able to draw the attention of others and turn those he meets away from him … such an individual possesses stigma, an undesired differentness from what we had anticipated”. To part of this Ghanaian civilization, TB patients were distinguished to have attribute(s) that intimidate the continued existence of the civilization.

**A conceptual framework of TB stigma**

Based on the category and extent of stigma portray, it is obvious that TB provokes much stigmatising retort from citizens since the enduring possess attributes that pose physical and moral threats to this Ghanaian society. The evidence here has shown that the infectious nature of the disease makes it a physical health threat to others.

This threat is heightened and/or endorsed by activities and practices of health professionals. The health threat the disease poses is also tinted by the noticeable homicide seen in the middle of the patients and fuelled by the fallacy and mythology, nearby the cause and spread of the disease. The ethical danger is owed to communal attitudes that TB is obtained by appealing in socially intolerable lifestyles, such as, smoking and drinking alcohol. Both the bodily and ethical threats are additional augmented by the association between TB and HIV/AIDS. A conceptual framework of TB stigma developed from the data and used to organise the discussion.

**Threat as a basis of stigma**

Threat as a basis of stigmatisation has been documented in the stigma literature. Jones and his colleagues recognized the importance of threat, which they term as “peril”, that is, the extent to which the stigmatising characteristic pretense a risk to others, seeing that a significant determinant of stigma. They pointed out so as to risk credited to stigmatising attribute(s) is finely tuned in catching diseases since the fear of infection upsets communal groups.

Stangor and Crandall (2000) also pointed out that the recognition of a potential threat and devising means to avoid it is a recognised basic survival strategy of all organisms, including human beings. They hypothesise that “stigma build up out of an initial, generally detained motivation to avoid danger”. They emphasised that a characteristic becomes stigmatising when it is perceived, either at individual or social level, to pose a threat to the survival of the individual or the culture.
The vision that intimidating characteristics play a primary role in the expansion of stigma is also hold up by researchers who take on the evolutionary standpoint of stigma, which argues that there is commonality across culture in what attributes are stigmatised. Such writers point out that each communal contact pretense a latent strength charge to the individuals concerned. They indicate that people are naturally equipped with the ability to identify those that may pose a danger to them. Once a threat is detected, usually based on attributes of the individual, the result is stigma-based exclusion of such persons from the interactions.

Members in this Ghanaian society recognised that TB patients are a risk to civilization so they used stigmatisation to keep out the enduring from their midst.

**Tuberculosis as a physical threat**

In this section, the attributes of TB that made it a physical threat and the factors that enhance the threat are examined.

**Fear of infection**

As obvious from the conclusion, equally health employees and society members established a physically powerful longing to keep away from TB patients because they are conscious that association with them could result in infection. They described TB as a highly infectious disease and said that it could be transmitted through casual contacts, including touching items used by the patients. Because of the deep fear of disease, the preponderance of them affirmed that once they turn out to be conscious that an entity has TB, they will not find close to interrelate with the being. Even social contacts and interactions such as eating from a common bowl, playing draughts games and meeting at funeral grounds are avoided.

Other writers have also experiential dread of disease as a cause underlyng stigmatisation of those suffering from TB. Indeed, in a Congolese community, TB killed many members, disturbing the society to such an unbearable amount that its associates protected themselves by observance the patients at a distance and judging them as not being normal. Similarly, in the minds of people in this urban district in Ghana,

TB is a ‘death sentence’ so the whole thing probable have to be done to keep away from contact with those with the ailment foremost to stigmatising attitudes and behaviors in the direction of them.

**Activities and attitudes of health professional**

The fear of TB is often heightened by TB control strategies used by public health authorities, such as, putting TB patients in isolation wards, sometimes on different compounds. The evidence has also shown that when health professionals wear a mask and gloves while attending to patients already on treatment it signifies fear of infection. Indeed, the majority of the wellbeing employees supposed that they were frightened of the patients, and therefore used up less time interrelates with them. These live out and behaviors, unluckily, send out mail to the society that TB is someway different, ensuing in a negative representation about the ailment in society. Such exclusionary practices can lead to stigmatisation of the disease and those who suffer from it. Many people in the community hold this view and said that they wanted those with TB to be treated away from the community.

The unsuitable physical condition learning messages by a number of healths specialized also adds to the stigmatisation of TB patients in civilization. As have been discussed in other studies, health workers in this Ghanaian humanity recommend the patients to employ separate tableware and serving dishes when eating. In most African societies, sharing household activities, such as, cooking and eating from a common bowl is the norm. Because health professionals are supposed to have a better understanding of diseases and advised against such practices, it was accepted by the community members. Consequently, they avoided eating with the patients and separated items the patients used from that of the household. The prohibition of such cultural norms and practices because of a disease can result in further isolation of the patients in society. This may have devastating consequences which can worsen the illness experience of those affected by the disease in society. Furthermore, although not practiced in recent times, the community members pointed out that, in the past, when people died from TB, health workers did not allow family members to get the corpse dwelling for the owing burial ceremony. The society Tamale, burial rites are used by members of the community, who knew the deceased person, to pay their last respects. The denial of such a socially important custom to any member of the community because of the disease he/she died from is indeed shameful. Thus, the past practices
attached with the ongoing fear-based response of health professionals in the direction of folks with TB portray stigmatising behaviours.3.

The significance of a tag allot to any particular body becomes chiefly important if it is functional by persons who hold places of power. As pointed out by Goffman, by desirable quality of the supposed information health specialized have about ailment, they are considered the 'wise' (Goffman, 1963). Since stigma is dependent on social, financial, and supporting power to be effectual, (Link and Phelan, 2001) when health employees are observed to be treating TB with fear, it augments the fear of the ailment, and debatably re-enforces the stigma attached to the disease in society (Liefooghe et al., 1995, Macq et al., 2005). It also reinforces similar stigmatising attitudes and behaviors of society associates in the direction of those miseries from the disease, as is evidenced in the statements of the community members.

Thus, the overstated fence nurture experienced by health specialized portrays dread of disease and serve up as a backing of comparable attitudes and live out by community associates.

Misconceptions and myths

When the cause of a disease is not well understood and it is treated as mystery, it tends to elicit fear from others (Sontag. 2001). Indeed, societal knowledge, understanding and beliefs about TB have been shown to be a cause of TB stigma (Bennstam et al., 2004, Rajeswari et al., 2005). As evidenced from the data, both health professionals and community members showed inadequate knowledge of TB, particularly, the cause of the disease and how it spreads. They also hold many beliefs on how those who suffered from the disease in the past were treated.

Furthermore, the faith that TB is extend when one ladder with nude feet on the sputum or shares eating tableware with the enduring can lead to avoid such individuals to keep away from contact with their sputum.

Consequently, the community members stated that they expected the TB patients to follow certain ‘codes of conduct’. Nearly all of them said that TB patients be supposed to not mingle with others, should wrap the lips when coughing, and place the sputum into a pot with a cover. When any of these ‘rules’ are out of order, TB patients were professed as having the purpose to contaminate others and this deteriorate the already anxious association existing flanked by the patients and the public members.

The misconceptions and myths about the disease are often aggravated by the incorrect health education messages from health workers, which most often do not explain to the community members how TB is not spread. When there is doubt concerning how a ailment is put on the air, the manifold interpretations of the source and extend that ensue have the tendency to fuel stigmatisation of folks anguish from the disease (Ogden and Nyblade, 2005).

Is fear of infection justified?

It is very important to position out that there is a genuine risk of virus with TB when one spends protracted era with patients, particularly, the spread positive ones. The danger of disease is above all recognized in the middle of health workers in urbanized countries (Menzies et al., 1998, Meredith et al., 1996, Kilinc et al., 2002, Schwartzman et al., 1996, Seidler et al., 2005, Curran and Ahmed, 2000). Although the problem is poorly characterized in the developing world, the obtainable literature point out that physical condition specialized in resource-poor countries are also at a advanced risk to get hold of TB in the route of their work (Harries et al., 1999b, Do et al., 1999, Alonso- Echanove et al., 2001, Harries et al., 2002, Pennelly and Iseman, 1999, Kayanja et al., 2005, Naidee and Jinabhai, 2006). In Malawi, for example, it was stated that, compared to the all-purpose population, the next of kin jeopardy of developing TB in the middle of health employees was 11.9 (Harries et al., 1999b).

Furthermore, the advent of HIV/AIDS in sub-Saharan Africa has made the problem of nosocomial transmission of TB to health workers very crucial, since this region has the highest incidence of HIV infection, a known factor responsible for the increased number of TB cases in the region (Fennelly, 1998, Harries et al., 2005, Harries et al., 1997).

Close contacts of TB patients, particularly, smear positive ones, are also at a higher risk of infection with TB, as well as the development of clinical disease. The rates of TB infection and clinical disease among close contacts have been found to vary between 37% and 51%, and 2% and 7% respectively (Dhingra et al., 2004, Vidal et al., 1997, Teixeira et al., 2001, Morrison et al., 2008, Jackson-Sillah et al.,
2007, Wang and Lin, 2000, Guwatudde et al., 2003, Kumar et al., 1984). Furthermore, in TB widespread society, a considerable broadcast of disease takes place within the group of people, more often than not during social connections, such as, drinking together (Classen et al., 1999, Lockman et al., 2001, Verver et al., 2004).

Furthermore, compared to adults and HIV-negative individuals, children less than five years and HIV-infected individuals are at considerably increased risk of developing TB when exposed to a source of the disease (Verver et al., 2004, Guwatudde et al., 2003).

Nevertheless, it is significant to create a difference amid legitimate safety measures to prevent the extend of TB to others and stigmatizing approach and behaviors. Such a work out needs to deem the slight balance flanked by public health risks and restrictive or exclusionary strategies of TB patients pedestal on convincing medical and epidemiological information (Weiss and Ramakrishna, 2001). Indeed, there is sufficient proof that the spread of TB to family contacts usually occurs before the diagnosis is made (Kamat et al., 1966, Ramakrishnan et al., 1961, Andrews et al., 1960). Furthermore, with effective treatment, TB patients are no longer infectious approximately two weeks after initiation of treatment (WHO, 2003, Harries et al., 1997).

When populace originally distinguish that their living is threatened, they overstate the perceptions and go halves them with each other awaiting there is a communal accord that they are in jeopardy (Stangor and Crandall, 2000). Similarly, the evidence presented here demonstrates that this genuine fear of infection is often exaggerated. Some health professionals were accounted to yell at patients by now receiving actions to wrap their mouth when coughing and others situate at a distance at what time talking to TB patients. Family and community members avoided contact with the patients, with some really presenting a violent posture alongside the continuing presence of TB patients in the community. That the fear-based reactions and practices may persist even after completion of treatment, points to stigmatisation of the disease, rather than safety measures to avoid infection

**Tuberculosis as a moral threat:**

In this section, the attributes of TB that made it a moral threat to the society and factors that enhance this threat are discussed.

**Deviant behaviors:**

Stigma has at all times had an ethical measurement, as obvious in the sense of the word ‘stigma’, which according to Goffman, is to “expose something unusual and bad about the moral status of the bearer” (Goffman, 1963 p.11). Consequently, individuals who are perceived to be a threat to societal principles will be stigmatized (Stangor and Crandall, 2000). The conviction in this civilization that assuming convinced ‘socially unacceptable lifestyles’, such as smoking of cigarette and cannabis, drinking alcohol and having multiple sexual partners could cause TB has been reported in other settings (Macq et al., 2005, Long et al., 1999, Sengupta et al., 2006, Ngamvithayapong et al., 2000, Edginton et al., 2002). Such moral positions can make people think that individuals who develop TB have themselves to blame because they undermined social morals. This can lead to societal attitude of condemnation towards those with the disease. By using ethical ideologies, the TB patient is observed as breaking communal norms and therefore moderately praiseworthy of stigmatisation. Thus, in the ‘mind’ of the non-stigmatised individuals, the expansion of the ailment is a ‘result of’ or ‘punishment for’ appealing in such ‘social vices’ and this eventually takes away any reaction of understanding for the patients.

**Mistrust and judgment:**

The perceptions of a discrediting attribute in an individual often make others think that the bearer possesses other negative traits as well (Katz, 1979).

During interaction between TB patients and members of the society, stereotypic conceptions of TB patients as “wicked”, with intention to infect others, was activated, and this affected their behaviour towards the patients. The information demonstrates that equally health employees and community associates do not belief TB patients and are extremely doubtful of them. They affirmed that convinced behaviors exposed by the patients, such as, keeping the analysis clandestine and giving their available food to public, especially children are premeditated attempts to contaminate others. There were also various unsubstantiated stories about successful infection of health workers by patients previously on treatment, using very ‘wicked’ means, such as, cough up in food items eaten by the employees and coughing onto handset at the hospitals. The distrust of TB patients by others, mainly, health employees have been accounted in another place (Macq et al., 2005). By
attribute to the patients other unenthusiastic attributes, it assist the non-stigmatised folks to allocate responsibility and hold the patients accountable for their quandary. By shifting the blame to the patients they tend to have less sympathy for them.

**Consequences of TB stigma**

**Delayed health seeking**

Since stigma is socially constructed, the attributes that are stigmatising are well known and shared in a culture (Goffman, 1963, Jones et al., 1984, Major and O’Brien, 2005, Dovidio et al., 2000, Link and Phelan, 2001, Crocker et al., 1998). This means that the community members may be aware of their stigmatising approach and behaviors in the direction of TB patients.

Moreover, when members of a society become aware that existing stereotypes about certain attributes can be applied to them, such a consciousness is often threatening (Stangor and Crandall, 2000, Steele and Aronson, 1995). For example, in an Ecuadorian group of people, when patients with indication evocative of TB were inquired to suffer laboratory examination for TB, just the consideration of undergoing such a check was enough to remark feelings of despair, loneliness and stigmatisation among them (Armijos et al., 2008). It is consequently probable that for terror of life form stigmatised, society members with symptoms evocative of TB may be unsuccessful to account to the hospital.

Also, the majority of the patients talked about that they knew extra close contacts, associates, and community affiliates who had TB long-ago, and power have been stigmatised. Consequently, when they build up symptoms evocative of TB, this was worrying adequate to deserve concealment or refutation. Undeniably, it has been recognized that because of the stigma close to TB, patients frequently decline to be familiar with the signs and symptoms of the ailment, and give details as owing to non-stigmatising circumstances, such as, ordinary cold or malaria, just to diminish the disdain of others (Cambanis et al., 2005, Liefoghe et al., 1997, Long et al., 1999, Eastwood and Hill, 2004, Dick et al., 1996, Liam et al., 1999, Johansson et al., 1999, Weiss and Ramakrishna, 2001, Macq et al., 2005). Similarly, the confirmation presented here has established that most of the enduring credited their symptoms to other ailment, and this made them use up comprehensive periods in the group of people self-medicating. It was merely when such explores did not give up any result that they accounted to the hospital. This may give details to four months holdup in diagnosing TB (Lawn et al., 1998) and the very low down case discovery rate of 38% in Ghana (NTP-Ghana, 2004). The exclusionary live out of public health authorities can moreover influence on health seeking behaviors of the society associates. When TB patients were cut off and treated in sanatoria in the urbanized world, unenthusiastic effects on TB treatment looking for behavior were observed. Among the

Natives in British Columbia, for example, TB case verdict and treatment were allegedly very tricky in the 1970s since people were frightened that if they urbanized TB, they would be propelled to die, gone from family and associates, in a sanatorium (Jenkins, 1977). Such historical practices and experiences were evident in the discourse of immigrants and Aboriginal communities in Canada, and still influenced their perceptions and thoughts about modern management of the disease (Gibson et al., 2005). Similarly, in this Ghanaian society, there were a lot of historic accounts of how, in the history, those who undergo from TB were hurl to isolated parts of the society, sometimes in the woodland, till moreover they died or were cured.

Such historical accounts may elicit fear among the community members, and may delay help seeking behavior.

**Adherence to treatment:**

The attitudes of others, particularly health professionals, towards individuals with TB may affect adherence to TB treatment. As Goffman emphasised, before health workers (‘the wise’), the stigmatised does not need to feel embarrassed, because in malice of the deteriorating, he/she will be seen as a usual person (Goffman, 1963). However, the confirmation here has established that health specialized frequently show prejudiced attitudes and behaviors in the direction of TB patients. This may put the patients in a difficult position since the support expected from the health professionals may not be available. Such unenthusiastic attitudes exaggerated the inspiration of the patients to stick on to treatment. Certainly, some of the patients point out that they could not endure the stigmatising attitudes and behaviours of some of the health professionals and had to move to another
health institution to be able to continue with the treatment. Although no information was available on how TB patients are managed at the hospitals they moved to, a study conducted at the Effia-Nkwanta Regional hospital in the SAEM district showed that one factor that motivated patients to complete TB treatment was the encouragement they received from health professionals (Dodor and Afenyadu, 2005). Thus, when health professionals show stigmatizing attitudes and behaviours towards TB patients, this can affect their motivation to adhere to the long duration of TB treatment.

Furthermore, persons with stigma study and slot in the stand-point of non-stigmatised folks in civilization and recognize the general conviction of being stigmatised persons (Goffman, 1963). As documented in other studies (Khan et al., 2000, Baral et al., 2007, Macq et al., 2005, Bennstam et al., 2004, Long et al., 2001, Lieföoghe et al., 1997, Atre et al., 2004, Hansel et al., 2004, R jeswari et al., 2005, Zhang et al., 2007, Somma et al., 2008, Armijos et al., 2008), TB patients in this Ghanaian humanity established the consciousness of the disgrace associated with having TB.

Nearly every one of them spoken terror of stigma when they were told of the analysis for the first time. Some originate the diagnosis tricky to acknowledge or rejected it, at the same time as others asked that the verdict be kept secret or hid it from others. Some of the patients mentioned that they had wanted to commit suicide when they were informed about the diagnosis.

Consequently, most of the patients cut off themselves and stay away from dealings with others. Some of them used diverse names when they came to the sanatorium or did not want anybody to see them impends into contact with the TB health center (Dodor and Afenyadu, 2005). Others described living secluded lives just to avoid being stigmatised.

This established their sympatheitic of the usually held sight about TB in society, and this clearly constituted a main source of torment to them. In other words, the patients demonstrated the shame of possessing the stigmatizing attribute (felt stigma) through their reactions and responses to the disease.

However, there is also adequate confirmation in the data to point out definite experience of discrimination because of possessing the negative attribute in question-enacted stigma (Scambler, 1984).

The patients also affirmed that they had to belief on communal support, such as, monetary help, provision of foodstuff and prayers from family unit and contacts as means of handling with the disease. Others had to make use of money to be talented to deal with the economic lumber. However, the greater part said that, for dread of infection, people did not get slam to offer any prop up. The data showed that the community members continued to avoid the patients even after completion of treatment, and often failed to provide any form of social support. In most African society, the accessibility of social hold up conveys communal identity and emotion of belongingness. Therefore, the absence of this may lead to a variety of stressors which may have negative consequences for the psychological health of the TB patients. Since non-adherence to treatment could be used as a strategy to relieve patients from the pain of stigmatisation (Meulemans et al., 2002), such societal attitudes and behaviours can lead to default from treatment (Ngamvithayapong et al., 2000, Dodor and Afenyadu, 2005, Long et al., 2001, Johansson et al., 1999, Jakubowiak et al., 2007).

Poor prognosis:

Humanity from TB is a solution for pointer and is also probable to be a important factor affecting the trustworthiness of the TB direct programme in the society. Since the majority of the patients pointed toward, they reported to the sanatorium very late, characteristically in a very awful state, the late beginning of treatment is less probable to get better the forecast of the disease. Such delays in reporting to the hospital and the subsequent late initiation of treatment may account for the high mortality documented among TB patients in some African countries (Dodor, 2004, Barker and Millard, 1998, Olle-Goig, 1999). The increased humanity from TB may habitually intensify the dread of the disease, and result in stigmatisation of the patients in society.

Limitations of this study:

The limitations of this study are discussed under two broad areas: effects of the researchers on the research process, language barriers, accessibility in to the communities and methodological issues.

Most of TB patients and community members were illiterates; translation of the medical terminology in to the local language was a problem to the research assistant.
Conclusion and Recommendation
This study used individual interview and focus group with TB patients, healthcare workers and community members to explore the causes, manifestations and consequences of the stigma attached to TB in an urban district in Ghana. The findings showed that TB poses physical and moral threats to members in this Ghanaian society. This stereotypic conception of the disease as a threat conveys a devalued social identity about the patients, and underlies the beliefs, thoughts, and actions of the whole society when interacting with the patients. It also links and fuels societal attitudes and behaviours and also explains how the whole society responds to TB patients. The risk of TB builds the patients to be diminished, rejected, and answerable and barred from social contribution (Weiss et al., 2006). The fear of stigmatisation makes individuals with very clear signs and symptoms to characteristic it to non-stigmatised diseases or conceal the diagnosis from others. Those put on treatment may end up defaulting from treatment because of lack of support. For an infectious disease such as TB, prompt diagnosis and initiation of treatment is the best way to minimise the spread of the disease (WHO, 2003). The TB control programme should therefore put in place interventions to reduce the stigma attached to TB in society.

Information, Education & Communication campaign
The inadequate knowledge of TB demonstrated by both health workers and community members can be improved through intensification of health education on the disease. The campaign needs be three-pronged: targeted at the patients, community members and health workers.

When TB patients are educated on the disease, the derived knowledge may be of help in the course of treatment. It can assist them to recognize their situation, make available them with the self-assurance needed to stand-up to stigmatizing behaviors from others and reduce self-stigmatisation (Rafferty, 2005). Education of patients would also help to improve early recognition of symptoms and subsequent reporting to the hospital for early diagnosis and initiation of treatment, which invariably would improve the prognosis of the disease.

The community campaign should be custom-made to suit the community’s needs and understanding of the disease, taking into account local culture and belief systems (Rafferty, 2005). Individual members of the community with deeper understanding of local beliefs and issues should be trained to spear-head the exercise (Rafferty, 2005). When community volunteers are trained to understand what TB is, and to communicate it to the community in their own words, this may assist lessen the fable and fallacy nearby TB and hence reduce the stigma attached to the disease (Rafferty, 2005). It is also important to target community leaders during the health education exercises. This is because such individuals have much power within the community setting and their attitudes and behaviours towards the disease may affect the experience of stigma among the general population (Weiss and Ramakrishna, 2001).

Health employees should also be “re-educated” to bring up to date their information of the ailment. Such a work out should aim those working at element of the sanatorium where TB patients are nearly all probable to be present at to, for example, out-patient department staff. Regular re-fresher courses, workshops and seminars should also be organised for the general health workers to help update and improve their understanding of the disease. The NTP should also ensure that information on TB services is widely circulated, not just to those working within the TB control programme. Information should be made obtainable to employees functioning in all units of the infirmary since such strategies and documents serve up as significant steer when they are commerce with TB suspects and enduring.

During the IE&C campaign, progress and successes of tuberculosis control programme should be highlighted. This has the potential of altering the perception of risk ascribed to the disease. For example, the fact that with successful drugs treatment in use of accurate doses, patients are no longer infectious a few days after starting treatment should be emphasised.

Meanwhile, group of people deliberations on TB should be confident since such open argue about the ailment will give confidence to those suffering from symptoms evocative of TB to distinguish it and account to the sanatorium. It may also lead to lessening in the stigma emotionally involved to TB in the society, since TB patients may not be seen as conflicting from any communal norms that may lone them gone for stigmatisation.

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