

Why do tuberculosis patients default in Tashkent City, Uzbekistan? A qualitative study

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SUMMARY

BACKGROUND: Tuberculosis (TB) control in Tashkent City, Uzbekistan, is organised in accordance with the DOTS strategy. Intensive phase treatment is provided in hospital, while the continuation phase is given on an ambulatory basis. In 2005, the defaulter rate was 21%. An earlier quantitative study explored when patients default and identified some of the risk factors associated with default, but did not answer the question: 'Why do patients default?'

OBJECTIVE: To investigate reasons for defaulting and to identify possible solutions.

METHODS: We conducted a qualitative follow-up study consisting of 32 in-depth interviews with defaulters, patients who had completed treatment and health care providers.

RESULTS: Communication between patients and health care staff is poor. Patients lack proper information on TB and its treatment. There is a widespread belief that TB is not curable. Hospitalisation is problematic due to poor general conditions in TB hospitals, costs incurred by patients during hospitalisation and because TB patients need to earn a living or take care of their families.

CONCLUSION: Poor communication between health care staff and TB patients is a key issue underlying several of the causes of default identified, and needs to be addressed. Reducing the period of hospitalisation may also improve adherence to TB treatment.

KEY WORDS: medication adherence; patient adherence; tuberculosis

WHEN PATIENTS are required to undergo lengthy treatment, such as is the case for tuberculosis (TB), poor adherence is a common problem.¹ This has also been observed in Tashkent City, the capital of the Republic of Uzbekistan. Following independence in 1991, the country inherited the Soviet TB control system, which had a strong focus on disease control and was characterised by active case finding and individualised in-patient treatment. Like many other former Soviet countries, Uzbekistan witnessed a steep increase in TB case notification rates from the early 1990s onwards.² To counter this trend, Uzbekistan embarked upon phased implementation of the internationally recommended DOTS strategy, and achieved full DOTS coverage in 2005. Case finding is now mainly passive and decentralised to general health facilities. In-patient treatment is limited to the intensive phase, i.e., the first 2–3 months, after which ambulatory treatment continues for another 4–5 months. Out-patient treatment is provided three times weekly under direct supervision of a health worker in especially desig-

nated rooms (DOTS corners) in general polyclinics. Treatment regimens have been standardised: new patients are treated for 6 months and patients with a history of previous treatment are treated for 8 months. Many elements of the former system are still in place, however, such as annual chest X-ray screening of the population and mandatory hospitalisation during the first 2–3 months of treatment. The practice of keeping patients on register after treatment completion and prescribing additional anti-tuberculosis treatment courses in spring and autumn^{3,4} have also been continued.

The TB situation in Uzbekistan has improved since DOTS implementation. The annual TB mortality rate decreased from 12.5 per 100 000 population in 2002 to 8.5 in 2006. Case finding reached its peak in 2005, and there are indications of a moderate decline in incidence. In 2005, a treatment completion rate of 80.5% was reported nationwide, with a default rate of 6.8%.⁵

In Tashkent City, treatment completion rates are

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substantially lower than in the rest of the country, mainly as a result of high default rates. In the present study, we define 'default' as the interruption of treatment for ≥ 2 months, in accordance with the World Health Organization definition.⁶ Of 1087 pulmonary TB patients started on treatment in 2005, 228 (21%) defaulted. An earlier quantitative study showed that most of these patients (61%) defaulted during the intensive phase while they were hospitalised. Another substantial proportion (26%) completed the intensive phase but did not initiate the continuation phase; they were lost during referral from in-patient treatment in a TB hospital to out-patient treatment at a TB dispensary. The most common reasons for default listed were 'refusal of further treatment' (27%) and 'violation of hospital rules' (18%). Unemployment, being retired and alcohol abuse were statistically significant risk factors.⁷

As treatment behaviour is a complex matter that cannot be explained solely by demographic and socio-economic factors, quantitative research may not be the most appropriate method for investigating it.⁸ Disease perception, health beliefs and subjective experience of illness may also play a role. We therefore conducted a qualitative study to identify and understand the reasons for default and to find ways of addressing the problem.

To structure our findings, we used a framework described by Munro et al. in a review of qualitative studies on adherence to TB treatment.⁹ Although the terms 'default' and 'non-adherence' cannot be used interchangeably, we considered default a form of non-adherence. The study framework distinguishes structural, personal and health service factors, with personal factors being influenced by the social context. The relation between personal factors and health service factors is assumed to be bi-directional, with health service interventions directed at patients likely to influence patient adherence behaviour through the filter of personal factors, and patients' interactions with the health services likely to be influenced by their knowledge, attitudes and beliefs about treatment as well as their interpretations of illness and wellness (Figure).

METHODOLOGY

We conducted 32 in-depth interviews with TB patients who defaulted from treatment ($n = 15$), patients who successfully completed treatment ($n = 8$) and health workers ($n = 9$). The interviews were conducted in January–February 2007 by researchers of the National TB Programme of Uzbekistan (Republican DOTS Centre) and the international non-governmental Project HOPE. All interviewers involved had a good background understanding of the social context and of how TB control is organised in Uzbekistan. They underwent one week of training in qualitative re-

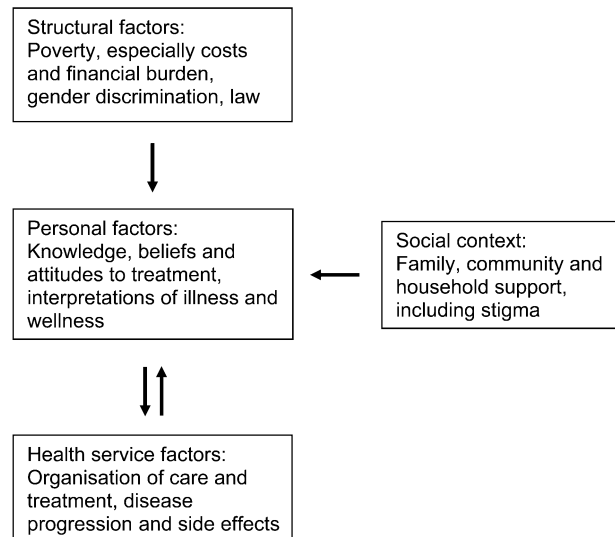


Figure Model of factors affecting adherence. (Source: Munro et al.⁹)

search and were supported throughout the study by a Tashkent-based research agency (Expert Fikri). Although some of the interviewers were staff members of the Republican DOTS Centre, none was directly involved in patient management. The role of the Republican DOTS Centre is mainly policy development and programme management. Interviews were conducted in Uzbek or Russian, depending on the language preferred by the participant.

We used a stratified purposeful sample taking into account the characteristics of particular subgroups of interest.¹⁰ Patients were selected from the TB patient registers of the Tashkent City TB services for the year 2006, aiming at equal representation in terms of sex, age groups (below and above 30 years) and defaulters and non-defaulters. Health workers were selected among doctors and nurses from TB facilities and from general health care facilities in Tashkent City, with the aim of representing the diversity of personnel involved in TB control.

Open-ended question guides were developed and field tested. The question guides were structured according to the flow of TB patients through the health care system. For TB patients, the following topics were covered: health care seeking behaviour from the start of illness, information provided about the disease, treatment sites and methods, reasons for interrupting and/or stopping treatment (only for defaulters), and elements perceived as facilitating adherence to treatment. For the health care staff, the guide focused on reactions to TB diagnosis, information provided to TB patients, and perceived barriers to and enablers of treatment completion.

Interviews were recorded and transcribed verbatim. Analysis was performed manually by two Russian-speaking researchers (EH, MK) using a grounded theory approach, allowing relevant themes to emerge

from the raw data during successive readings of the transcripts.¹¹ Preliminary results were further discussed, refined and triangulated through three meetings of the whole research team. The results were presented to and discussed with a sociologist not directly involved in conducting the study (PL).

The study was approved by the ethics committee of the Ministry of Health of Uzbekistan. All interviewees participated voluntarily. Informed consent was obtained and confidentiality was protected.

RESULTS

Patients interviewed were equally distributed by sex and age group (above and below 30 years); there were 19 pulmonary TB cases and four extra-pulmonary TB cases. Among the 15 defaulters, three defaulted during the intensive phase of TB treatment, while hospitalised; nine completed the intensive phase but either did not start the (ambulatory) continuation phase (4/15) or defaulted 1–2 months later (5/15). Two patients never initiated treatment and one patient classified as a defaulter had actually completed a full course of treatment. All patients interviewed had contacted the health care services at their own initiative.

The nine health workers interviewed included two TB specialists, two general practitioners, two nurses from TB services and three nurses from general health care facilities.

Detailed results are presented in accordance with the conceptual framework described earlier.

Personal factors

Personal factors encompass knowledge, beliefs and attitudes to treatment and interpretations of illness and wellness; as such, these are important determinants of health care seeking behaviour and perception of disease.

Nearly all patients interviewed first presented at a general health care facility (polyclinic), usually after having been seriously ill for quite some time.

It all started in 2004, I lost weight till I weighed only 43 kg, I was very weak and I was coughing.
(Woman, defaulter, 29 years old)

Upon being diagnosed with TB, the initial reaction of most of the patients was either fear or denial. Most thought that they were going to die.

I was frightened . . . better I go on hunger strike and die right away. A neighbour of mine seriously suffered from TB. I know what kind of disease it is.
(Man, defaulter, 76 years old)

TB was often perceived as being incurable based on previous negative experiences with relatives or acquaintances who had died from TB.

I think it's not curable, it can only be suppressed.
(Man, defaulter, 24 years old)

I think TB is not curable . . . But if it was possible, first of all I would have wanted to cure my father . . . My father took treatment at home, he took all his medicines correctly, he did not take plantain* like me, he did not believe in it . . . a friend was treated in hospital, but it had no effect either . . . I think TB is not curable, very unlikely.
(Man, defaulter, 19 years old)

Findings from interviews of health workers to a large extent confirmed the findings from the patient interviews. Patients consider TB to be incurable and want to conceal the fact that they have TB from people around them. General health care staff avoid talking to patients about TB.

. . . because these patients often refuse to accept that they have TB. There are some who even start shouting at us, they say that doctors do not know anything, that they cannot have such a disease.
(Doctor in polyclinic)

Whereas defaulters generally persisted in their initial belief that TB is not curable, most of those who had completed treatment had become convinced that TB was curable. This was usually the result of experiencing the effectiveness of treatment and of information provided by health workers.

I thought it was like cancer, that patients will die anyhow. We did not know anything about this disease, only that others despise TB patients. And when I was treated in the hospital, every day very ill patients died, mostly alcoholics. Later I was transferred to a normal ward, there nobody died, many were cured, then I started to believe that I would not die.'
(Woman, completed treatment, 22 years old)

Even among those treated successfully, some believed that without further treatment their disease would come back.

I don't know whether or not it is possible to be cured. When I was in the hospital I saw that some recovered but I'm not sure. I now have chest pains and I'm afraid to go to work. Last week I was in the TB dispensary and asked to be admitted to the TB hospital but they told me I first needed to have an X-ray done before they would refer me.
(Man, completed treatment, 35 years old)

Health service-related factors

Health service-related factors include organisation of care and treatment, disease progress and side effects of drugs/treatment. Each of these themes emerged during the interviews. Side effects of anti-tuberculosis drugs were very often mentioned as the reason for interrupting treatment, although in many cases these appeared to be perceived rather than actual side effects. Problems with the liver were frequently mentioned;

* A type of banana, generally used in cooking.

doctors prescribed specific treatment to protect the liver.

Many patients complained that these tablets have a bad effect on the liver, some affect the eyes, some the ears and some cause impotence. And I'm still a young man, of course I refused. (Man, defaulter, 45 years old)

But I did not take these tablets. I only took them for 2 months because they began to affect my liver. (Man, completed treatment, 30 years old)

For the liver, I was put on a drip. (Woman, defaulter, 29 years old)

They do not like DOTS treatment, they say they cannot tolerate these tablets, they show skin rashes or complain of stomach and liver problems. (Nurse in TB dispensary)

Unwillingness to be hospitalised was another recurrent reason. Patients were reluctant to be admitted because of perceived poor hygiene and general conditions in TB hospitals.

I did not like the hospital. I did not like it there at all. It's full of criminals. All the walls are filthy, it's despicable. You cannot even sit on the toilets. (Man, defaulter, 25 years old)

But it is such a dirty hospital, I used to wash myself with soap all the time. Fortunately, I had a room of my own. (Woman, defaulter, 35 years old)

But I did not agree to be admitted there because most of the patients are former convicts, it's a filthy hospital and it's far from home. (Man, defaulter, 47 years old).

The attitudes of health workers were mentioned as an important issue both by patients and by health workers themselves. For some patients, the poor attitude of health workers was a reason for interrupting treatment; on the other hand, there were also patients with very positive experiences. Negative attitudes towards TB patients among health workers appear to be related to the fact that health workers often associated TB with an anti-social lifestyle, i.e., alcoholism, drug abuse, delinquency. Staff from the general health facilities expressed reservations about treating TB patients because of perceived infectiousness.

In general, doctors and nurses in the TB hospital were so kind and interested, we were really surprised. (Man, completed treatment, 22 years old)

I did not want to go to the polyclinic because there the attitude of doctors towards patients is bad. I felt hostility towards myself, even though after the operation I was cured, still there was some sense of hostility. (Woman, defaulter, 24 years old)

I think most cases of TB occur among former prisoners. But for continuation phase treatment we also get decent people, I was surprised, how did they get TB? Could it be because they smoke? (Nurse in polyclinic)

And the nurses in the polyclinics themselves tell us that they don't like to see this kind of patients. I understand them very well. You see in the corridors of such polyclinics, there are also newborns. This mixing of patients is not right. (Doctor in TB dispensary)

Most patients, including those who completed treatment, did not know the correct duration of treatment. Although the treatment duration for new TB patients has been standardised at 6 months, only three of the patients who completed treatment were aware of this. By and large, health workers knew the correct duration of treatment, but their messages to the patients were often not very clear. Most did mention the two stages of treatment (in-patient and out-patient). However, some included the follow-up period after treatment, whereas those working in hospitals tended to focus on the duration of treatment in their facility. Treatment durations mentioned thus ranged from 2–3 months to several years.

They did not tell me how long I should take the tablets, they just said: 'Until we remove you from the register.' (Woman, defaulter, 29 years old)

To new patients I say that they will be treated by us for 2 months. After checking whether there are no more bacilli, we will discharge you and afterwards at the dispensary they will decide how long you should still be treated, how long you will remain on the register. (Nurse in TB hospital)

New patients are treated for about 1 year. They are checked quarterly. The TB specialists advise us and write referral letters. If it is a patient with an advanced form, then of course treatment is longer. (Doctor in polyclinic)

Even after patients have been cured, they are kept on register and are prescribed further treatment.

Yesterday I also went to the dispensary and they did the investigations; they gave me white tablets and told me to come back in 1 week. Until February, they will keep me on register, and then they will remove me from the register. (Woman, completed treatment, 20 years old)

After this (treatment) they advised me to take isoniazid tablets 3 times a week in spring and autumn. (Man, completed treatment, 50 years old)

Information provided by health workers on other aspects of TB treatment was also often incomplete or incorrect. A theme frequently mentioned was the infectiousness of TB, which was related to the need for hygiene; patients were told to maintain good personal hygiene and to use separate cutlery and crockery in order not to infect those around them.

We explain to them the rules about hygiene, that they should have separate cutlery and crockery. . . . Also they should think not about themselves in the first place but about us, and about the children, about their relatives; that they should not

spread the infection to their relatives. (Nurse in TB hospital)

Defaulters did often continue treatment for a while with anti-tuberculosis drugs bought from private pharmacies. Such treatments were usually prescribed by a TB doctor, but were taken irregularly and without supervision.

After they discharged me from hospital I continued taking tablets but I bought them myself. I did not want to travel up and down; I live with my family in Yunusabad but was treated in Lysunova because that's where I'm officially registered. (Man, defaulter, 24 years old)

Structural factors

Among structural factors, both direct costs and opportunity costs emerged as important obstacles to completion of treatment. Although TB drugs are provided free of charge, patients do have to buy other drugs. As most patients were employed on an informal basis, absence from work meant loss of income and the risk of losing one's job.

It's lack of money. Well everywhere they write that TB treatment is free of charge. And where is it free of charge? Only tablets they give for free. Everything else we have to buy – injections, drips . . . and then, who will feed my children? I don't have a job, I do not receive a pension. I live from what I can earn on the side. (Woman, defaulter, 42 years old)

I have to feed my wife and two children; my work is very important to me, I work in building construction, I'm not employed by the government so I have no hope of paid sick leave. (Man, defaulter, 24 years old)

The problem is that many patients are sole bread winners, they don't complete treatment as they're in a hurry to get back to work. (Nurse in TB hospital)

The social context

The social context, which includes the family, community and household support, including stigma, also emerged as an important determinant. Most patients decided not to disclose the fact that they were suffering from TB except to their closest relatives. Contrary to the expectations of the patients themselves, relatives were usually very supportive. Nevertheless, patients feared being ostracised and also there was the fear of infecting others.

I wasn't just afraid for myself, I thought that if the neighbours knew they would start fearing and avoiding me. (Man, defaulter, 76 years old).

Some patients were reluctant to go to the polyclinic for TB treatment because they were afraid of being recognised by neighbours; this was also mentioned by health workers.

My mother brought the tablets from the polyclinic. I myself was hesitant to go to the polyclinic in case someone should see me. (Woman, completed treatment, 22 years old)

The same polyclinics are visited by their neighbours, and the probability of meeting someone you know is 80%. All patients are afraid to meet their neighbours. (Doctor in TB dispensary)

A doctor in one of the TB hospitals observed that women with young children were often under pressure from their husbands to return home and take care of the children.

Especially among women—married women default because of family circumstances. Their husbands come and start shouting, 'How much longer does my wife have to be treated?' You see, the children are on their own. (Doctor in TB hospital)

DISCUSSION

In their comprehensive review of three decades of research into patient adherence, Vermeire et al. state that although many studies have investigated causal relationships between patient factors, doctor factors and adherence, no consistent story has yet emerged.¹² Their conclusion is that adherence is not determined by the nature of the disease, the referral process, the clinical setting or the treatment regimen, and that demographic and social factors are also poor indicators of adherence. The most salient influences on adherence in their view are patient beliefs about medication and medicines in general, as well as those of family members and friends. They emphasise the importance of the doctor-patient relationship, in which the patient's autonomy and right to self-determination should be respected. The role of the doctor should be that of an expert advisor, but it is ultimately the patient who decides what is in his/her own best interests. Communication between doctor and patient is thus of key importance.

Results from our study confirm the importance of the doctor-patient relationship, but we also identified a few other factors that appear to be important in the particular setting of a post-Soviet country. Our findings fit very well into the general framework described by Munro et al., which is an indication of its relevance.⁹ The most prominent personal factor to emerge is lack of knowledge about the disease and its treatment, which confirms the importance of individual patient beliefs described by Vermeire et al. Many do not really believe that TB is curable and therefore do not see the need for prolonged and regular treatment. In addition, most patients do not know how long they are supposed to be treated. Our results also clearly indicate that these personal factors are very often being reinforced by factors related to the health services. This strong association seems related to the particularities of the setting. The former Soviet

Union is a very specific setting, and earlier studies also identified structural factors and factors related to the health services as important determinants of non-adherence.^{13–16}

Considering the long period patients spent in TB hospitals, their lack of knowledge could be considered a health service-related factor, as there had been ample time for health workers to educate them. Poor communication between health care staff and patients is not unique to the TB system in Tashkent but has also been observed in other former Soviet Union settings.^{17,18} Moreover, the information patients received was partially incorrect or inappropriate.

Even among health workers, there is no clarity about the duration of TB treatment. A possible explanation may be in the conflicting guidelines. Treatment regimens in Uzbekistan have been standardised in accordance with the DOTS strategy but, as mentioned in the introduction, the old guidelines are also still in place.¹⁹ These prescribe a follow-up of at least 2 years after cure, including biannual courses of chemotherapy in spring and autumn.

Intolerance to anti-tuberculosis drugs is another area where health service and personal factors interact. Many defaulters mentioned intolerance to anti-tuberculosis drugs as an important reason for stopping them; there was a particular concern about damage to the liver. Although hepatotoxicity is a known side effect of some anti-tuberculosis drugs, it is not as common as patients suppose.²⁰ There is thus an urgent need to properly inform patients about the potential side effects of anti-tuberculosis drugs, as most can be managed and do not need to lead to treatment interruption.⁶

The attitude of health care staff was mentioned by health workers and patients as an important factor contributing to default. Here again, health service factors and personal factors interact, as there were positive as well as negative experiences. Negative attitudes among health service personnel are often related to their perception of TB as a disease of the socially marginalised. General health service staff often do not welcome the idea of treating TB patients due to the perceived danger of infectiousness. Health workers pay a lot of attention to hygiene as a means of preventing TB transmission, and recommend irrational and stigmatising measures such as the use of separate cutlery and crockery.

Finally, mandatory hospitalisation during the first phase of treatment is an important health service factor that negatively affects adherence. Some patients do not start treatment at all to avoid being hospitalised; others leave the hospital either because they are appalled by the prevailing general and hygiene conditions or because they cannot afford to lose their income or need to take care of their families. They also incur substantial costs in buying additional non-TB drugs. In the days of the Soviet Union, income was

guaranteed and hospitals were well maintained and well supplied; hospitalisation was therefore not a major problem.²¹ The structural context has changed with the collapse of the Soviet Union; TB patients can no longer afford not to work and the underfunding of health services has resulted in poor conditions in hospitals.^{2,22}

Hospitalisation is often defended as a public health measure aimed at preventing TB transmission. The Madras study in 1959 clearly demonstrated that transmission to close contacts usually happens before the index case is diagnosed and that hospitalisation itself does not reduce transmission.²³ More recent studies from former Soviet Union countries show that the majority of admissions for TB are unnecessary when clinical and public health criteria are applied.^{24–26} Restricting hospitalisation to those cases where there is a clinical need or to the first 3–4 weeks for smear-positive patients would make the system much more client-friendly.

Among factors related to the social context, stigma was most often mentioned. Patients fear being ostracised both because TB is an infectious disease and because TB is perceived as a disease of criminals and other socially marginalised individuals. Often the stigma appears to be perceived rather than experienced, i.e., the fear of being stigmatised rather than actually being stigmatised.²⁷ Nevertheless, it is obvious that both the public and health workers have a low opinion of TB patients, as reflected in their surprise at the fact that even 'decent' people can have TB.

Limitations

This is a qualitative study, aimed to explain, and not quantify, the phenomena observed. The study took place in an urban setting; for some aspects, conditions prevailing in rural settings may be different.

CONCLUSION

We identified several factors that lead to default, many of which are related to the health system, often in interaction with personal factors. The current TB control system in Uzbekistan is still very much provider- and disease control-oriented. Conflicting guidelines lead to a lack of clarity, even among providers. An important underlying cause is the fact that health care providers are often not inclined to communicate with TB patients. As a result, TB patients lack a clear perspective on the disease and its treatment.

In response to the results of this study, a training programme on counselling skills for nurses of TB hospitals in Tashkent has been developed. These nurses were provided with standardised messages to be communicated to TB patients.

The underlying problem of non-uniform treatment guidelines still needs to be addressed. This includes the practices of prescribing additional non-TB

drugs and preventive anti-tuberculosis chemotherapy in spring and autumn.

Hospitalisation itself leads to default due to poor in-patient conditions and because patients need to earn a living or take care of their families. To structurally improve conditions in hospitals may prove to be very costly. A more feasible solution would thus be to promote ambulatory treatment earlier during the course of treatment.

Various structural and health system factors need to be addressed, but the key issue appears to be improving communications between health services staff and TB patients, allowing patients to make informed decisions about what is in their own best interest.

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RÉSUMÉ

CONTEXTE : Dans la ville de Tashkent (Ouzbékistan), la lutte antituberculeuse est organisée conformément à la stratégie DOTS. La phase intensive du traitement est administrée à l'hôpital et la phase de continuation est ambulatoire. En 2005, le taux d'abandon a été de 21%. Une étude quantitative antérieure avait révélé le moment de l'abandon des patients et identifié certains des facteurs

de risque associés avec l'abandon, mais n'avaient pas répondu à la question suivante : pourquoi les patients abandonnent-ils?

OBJECTIF : Investiguer plus en profondeur les raisons d'abandon et identifier les solutions potentielles.

MÉTHODES : Nous avons mené une étude qualitative de suivi comprenant 32 entretiens approfondis avec les

patients en abandon, les patients qui avaient achevé le traitement et les pourvoyeurs de soins de santé.

RÉSULTATS : La communication entre les patients et le personnel de services de santé est médiocre. Les patients n'ont pas une information adéquate sur la tuberculose (TB) et son traitement. La croyance de l'incurabilité de la TB est très répandue. L'hospitalisation pose problème en raison des conditions générales médiocres des hôpitaux TB, des coûts encourus par les patients pendant

leur séjour et en raison du fait que les patients TB doivent gagner leur vie ou prendre soin de leur famille.

CONCLUSION : La médiocre communication entre le personnel des services de santé et les patients TB constitue un problème clé à la base de plusieurs des causes d'abandon identifiées ; elle doit être corrigée. La réduction de la durée d'hospitalisation pourrait elle aussi améliorer l'adhésion au traitement de la TB.

RESUMEN

MARCO DE REFERENCIA: La lucha contra la tuberculosis (TB) en la ciudad de Tashkent (Uzbekistán) se ha organizado en conformidad con la estrategia de DOTS. La fase intensiva de tratamiento se administra en el hospital y la fase de continuación en forma ambulatoria. En el 2005, la tasa de abandonos fue 21%. Un estudio cuantitativo anterior puso en evidencia el momento del abandono y determinó algunos factores de riesgo asociados con el mismo, pero no respondió a la pregunta: ¿Por qué los pacientes abandonan el tratamiento?

OBJECTIVO: Investigar las razones del abandono terapéutico y las posibles soluciones.

MÉTODO: Se realizaron un estudio cualitativo de seguimiento que consistió en 32 entrevistas en profundidad a pacientes en abandono terapéutico, pacientes que completaron el tratamiento y a los proveedores de atención de salud.

RESULTADOS: La comunicación entre los pacientes y el personal de los servicios sanitarios es deficiente. Los pacientes no cuentan con la información adecuada sobre la TB y su tratamiento. Predomina la creencia de la incurabilidad de la TB. La hospitalización es problemática debido a las malas condiciones generales de los hospitales dedicados al cuidado de esta enfermedad, los costos a cargo de los pacientes durante la hospitalización y a su imposibilidad de devengar ingresos o cuidar a sus familias.

CONCLUSIÓN: La comunicación deficiente entre el personal de los servicios de salud y los pacientes tuberculosos constituye un importante factor subyacente de algunas de las causas de abandono detectadas y es necesario corregirla. Asimismo, disminuir el período de hospitalización también puede mejorar el cumplimiento con el tratamiento antituberculoso.
