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TB control: a matter of lifestyle

In the West, TB was controlled before there was medication on the market. In South Africa this is far from the case: the inheritance of apartheid, poverty among certain social groups, and an exponential increase in HIV/AIDS make TB control almost impossible. The co-existence of two medical traditions (the Western medical system and traditional healing) exacerbates the challenge of finding effective measures for TB control. This paper aims to understand the underlying patterns of the persistent spread of this disease. Its point of reference is Max Weber's notion of *Stilisierung des Lebens*, or lifestyle, in which the dialectic process of "chance" and "choice" plays an important role. In the category of chance, much can be done by policy-makers to create successful healthcare programmes, such as DOTS within TB control. Policy-makers, however, are not the only players responsible. Individuals must also take responsibility by opting for the chances provided. Even then, the spectre of the past may continue to bedevil the health outcomes of South Africans as they endeavour to build a new nation.

TB-controle: een zaak van levensstijl

In het Westen was TB onder controle alvorens effectieve medicatie op de markt kwam. In Zuid-Afrika was dit echter niet het geval: de erfenis van apartheid, armoede bij bepaalde groepen in de samenleving en de extreme exponentiële groei van HIV/AIDS maakt de controle over TB bijna onmogelijk. Daarenboven bestaan er twee verschillende medische tradities (de Westerse en de traditionele geneeskunde) die een uitdaging vormen voor een efficiënte TB-controle. De onderliggende patronen begrijpen van een blijvende verspreiding van de ziekte is het aandachtspunt in dit artikel. De referentie hiervoor is Max Webers notie van *Stilisierung des Lebens* of levensstijl, waarbij het dialectische proces van "kans" en "keuze" een belangrijke rol spelen. Het is in het aspect van kans dat beleidsmakers het verschil kunnen maken in gezondheidszorgprogramma's zoals DOTS bij TB-controle. Beleidsmensen mogen echter niet de enige sleutelfiguur zijn, ook het individu heeft verantwoordelijkheden door te kiezen voor de kansen die gegeven worden. Zelfs wanneer iedereen zijn of haar eigen verantwoordelijkheid opneemt zullen de spoken uit het verleden nog een lange tijd een vertekend beeld vormen voor de gezondheidstoestand van Zuid-Afrikanten die proberen een nieuwe maatschappij op te bouwen.

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DOTS (Directly Observed Treatment Shortcourse) has become the main strategy for combatting TB worldwide. This suggests a strong commitment from government, early case detection and standardised therapy. It also presupposes sufficient drug stocks at healthcare posts and correct data reporting with a view to efficient analysis of the TB control programme as a whole (Dept of Health 2000). Yet TB is far from being controlled, since one third of the world's population is infected and over two million die annually of the disease (WHO 2002). Biological aspects such as multi-drug-resistant TB (MDR-TB) and co-infection with HIV/AIDS also pose new challenges in terms of TB control. The increase in TB cases can also be ascribed to drastic cutbacks in health expenditure since the economic crisis of the 1970s in the West; the inaccessibility of health care, and non-compliance with treatment regimens (Gandy & Zumla 2002). As a strategy DOTS cannot control both the situational factors characteristic of a country and the circumstances faced by individual TB patients (Farmer 1999). Within the framework of a specific country and specific individuals, social scientists may provide relevant insights into the burden caused by TB.

In South Africa, TB still is a major problem and public health threat. The fact that two medical healthcare systems co-exist (the Western and the traditional) leads some researchers to believe that consulting traditional healers may counteract compliance with therapy. Others, however, refute this, revealing that different attitudes towards the cause of a disease do not necessarily interfere with compliance (Farmer 1999). Historical facts such as colonisation and apartheid cannot be denied either, since South African society has been built upon this history, thus the socio-economic outcomes and differences among her people derive from it.

The central questions in our research are to understand why, in a single community of similar demographic backgrounds, some people contract TB while others do not, and some comply with therapy while others do not. A theoretical framework has been set up that might explain preconditions relating to how people seem to avoid, escape or survive this disease. We shall make use of the concept of "lifestyle", first explained by the sociologist Max Weber. Thereafter, we shall evaluate TB control in this country.

1. History of TB control

1.1 Successes in the West

In the Western world, TB was under control before the first effective medication came on the market in 1944. Some researchers believe that the decline in mortality was due to a general improvement in food intake and an increase in the level of prosperity. Others ascribe the improvement to measures taken to achieve an efficient public health care by means of clean water, safe food and clean air together with patient segregation, proper housing and the control of bovine TB (Szreter 1988; Gandy & Zumla 2002). These results suggest that important social issues interact with the disease and that a purely medical approach, such as DOTS today, may be too short-sighted to combat TB successfully.

1.2 The “white plague” in South Africa

In South Africa tuberculosis was almost non-existent among Africans before 1860. In those days the African hinterland was inaccessible to the European coloniser and African tribes lived in small groups, remote from one another (Collins 1982). The conditions needed for the spread of TB bacteria were not yet present. Poverty in the rural areas and the discovery of various minerals made autochthonous men migrate from their homes in search of jobs. What evidence there is, tells us that among Blacks, during the last decades of the nineteenth century, TB was strikingly proportional to the length of their contact with Europeans (Packard 1992). The living conditions of migrant black miners deteriorated, housing was overcrowded, work in the mines was unhealthy. These factors, along with the resultant change in their diet, together with general malnutrition and poverty, may be counted among the reasons why the general health of these workers deteriorated drastically and their vulnerability to TB increased significantly. TB also spread to the countryside when infected black miners returned to their families and homelands (Marks & Anderson 1992). TB control in rural areas was further burdened by inadequate, insufficient isolation of patients and difficulty in case detection, due to cultural beliefs associated with the symptoms of TB such as coughing up blood, which were ascribed to the malevolent influence of an evil person. Only a traditional healer was thus thought to be expert in treatment of the disease (Cassel 1940).

2. Situational factors in South Africa

2.1 Socio-political inequalities

Due to colonisation, poverty already existed among the Blacks but with apartheid, it worsened. Blacks had no political rights and social policy was based on racial segregation. The result was inequality and inequity in the fields of schooling, economics, housing and health care (Klugman *et al* 2000: 147-81). The application of the Group Areas Act moved 40% of Blacks to inferior parts of the country, placing them in so-called “homelands” and “townships”. The best farming land and mineral resources, as well as the most advanced social and economic infrastructures were secured for Whites only. The politics of apartheid decided which job was destined for whom. The most inferior and worst-paid jobs were reserved for Blacks; so-called “Coloureds” were little better off (McIntyre & Gilson 2001: 191-209).

According to research done by McIntyre & Gilson (2001), the most significant indicators for poverty under apartheid were:

- race: 61% of Blacks and 38% of “Coloureds” were poor compared to 5% of Indians and 1% of White;
- gender (of the head of a family): 60% of families with female heads lived in poverty and 31% with maleheads population;
- unemployment rate and geographic differentiation: 71% of people in rural areas were poor, as against 29% in the cities; there was striking differentiation among the provinces as well.

This poverty also resulted in differentiation in health care among the various racial groups. Hardly any healthcare facilities were available in rural areas and the homelands were considered responsible for their own organisation, causing fragmentation and poorly developed care (Van Rensburg & Ngwena 2001). Access to medical treatment was difficult since few doctors worked in these remote areas. The ratio of traditional healers to clients was 1 : 500 while the doctor/patient ratio was 1 : 40 000 (Colvin *et al* 2003). High-quality healthcare (mainly private) was the privilege of the more affluent: mainly white. For most of the population such services were inaccessible, both because they were at a great distance from their homes and because treatment was extremely expensive. Public healthcare dealt with 81% of the population, although its budget

was by no means comparable to that for private healthcare (Yach & Martin 1993; McIntyre & Bloom 1998).

Besides the unequal financing of healthcare services, recurrent violations of human rights were a daily reality under apartheid. This was revealed during the hearings of the Truth and Reconciliation Commission (cf Baldwin-Ragaven *et al* 2000). The result was very poor quality of service delivery. Apartheid worsened the standards of living of many and increased the existing inequity and inequality in the area of healthcare delivery and thus of health in general. This neglect and disregard of certain social groups worsened the effects of the TB problem. Even basic facilities such as access to water, electricity and an adequate sewerage system were (and in some cases still are) unavailable to those from disadvantaged groups (Heunis *et al* 2003). In Europe and the USA, such public services, combined with proper access to adequate drugs, were largely responsible for the control of the TB epidemic (Szreter 1988; Packard 1992). The way in which apartheid was implemented, thus undoubtedly determined the future health prospects of many groups within South Africa.

The underlying patterns of the spread of TB may be partly traced to the unequal society which persists in South Africa: 50% of the population is living in poverty, and 27% below the poverty line. Three-quarters of the population reside in rural or underdeveloped regions where access to healthcare facilities is still minimal (Dept of Health 2001). However, poverty cannot be the only factor negatively affecting the combatting of the incontrollable TB, since not all poor people contract the disease.

2.2 Co-infection with HIV/AIDS

The country is also currently burdened with an HIV/AIDS pandemic. In 1994 some 5% of the South African population (about half a million people) had the virus (Van Rensburg 1999: 21). Ten years later some 5.3 million are infected and in the Free State province alone, three-quarters of the TB patients are HIV-positive (Peters 2004). According to a study by MacPhail & Campbell (2001), adolescents in South Africa are aware of the potential health risks related to sexual transmission. Despite this awareness, this group in particular experiences high rates of HIV infection and unsafe sex is standard practice among them. The availabi-

lity and delivery of anti-retroviral AIDS drugs alone will not solve the problem of co-infection with HIV/AIDS. More needs to be done to change mentalities in order to effectively prevent HIV transmission. Active case findings by health care workers serving this group can be very relevant indeed in controlling TB (Peters 2004).

2.3 Stigma relating to TB

One of the other underlying reasons why TB control is so difficult may be found in the universal stigma relating to the disease. In the Free State, this stigma is one of the main reasons why new cases often go undetected (Peters 2004). Because TB is infectious, patients and their families can easily become socially isolated due to fear of hostile reactions from friends and other members of the community (Baarnhoorn 1996). TB is also sometimes considered a sexual disease because it is thought that one must abstain from sexual contact with a TB-infected person. This belief is reinforced by the fact that one of the side-effects of some of the drugs is red urine. Women may feel unclean in relation to their sexual partners. Many patients reported thinking that the condition would put the partner off sex. They then chose to interrupt their course of medication rather than to abstain from sexual contact (Edginton *et al* 2002). The strong relationship between tuberculosis and HIV/AIDS also serves to heighten this sexual stigma.

Yet poverty, the biological aspects and the significant stigma still do not adequately explain how, despite the socio-political inequalities, people manage to exercise choices in order not to become infected, or to be cured. Max Weber's notion of lifestyle (*Stilisierung des Lebens*) may be useful in attempting to understand some of the other underlying patterns determining how people make such choices.

3. The concept of lifestyle

Weber believed that choice was the modifying factor in the concept of lifestyle: the realisation of life choices (*Lebensführung*) being influenced by life chances, or opportunities (*Lebenschancen*). He claimed that such chances are not pure chance, but occur because of the people's social situations. Although Weber's approach is important, he neglected to take into account key factors such as gender, age, race and ethnicity

(Cockerham *et al* 1997: 325). Pierre Bourdieu built on the idea of lifestyle with his concept of *habitus*. *Habitus*, according to him, is knowledge of the social structures and circumstances that create a constant orientation to actions that are more or less routine. When one reacts according to these orientations, the structures from which they are derived seem to repeat themselves (Cockerham *et al* 1997: 326). Although individuals choose their lifestyle they do not do so according to their own free will, since the *habitus* predestines them to certain options. People can have control over their own choices, but not over the principles and conditions that determine these choices (Bourdieu & Wacquant 1992). People with few life chances sometimes prefer not to aim at realising certain goals, as they believe them to be unrealistic. In short: life choices are not just limited, they are mainly conditioned by life chances. Anthony Giddens develops the concept of lifestyle further: "We have no choices but to choose" (Cockerham *et al* 1997: 335). To him, people from the lower social classes also have to make choices, but choices in order to survive. Preserving one's health necessitates action. Life chances influence lifestyle in two ways: through socio-economic possibilities and through the perceived boundaries which originate from one's socialisation and experiences in a certain social milieu. The relationship between choices and chances is in essence dialectic. Cockerham *et al* (1997: 321) derive the concept of lifestyle from the work of Weber, Bourdieu and Giddens and define it as:

Collective patterns of health-related behaviour based on choices from options available to people according to their life chances.

In the context of TB control in South Africa we will now proceed to investigate the choices and chances which people have in relation to preventing illness or regaining health. The choices people make may be associated with their belief in western or traditional medicine. The chances people have may be provided by the government and may include measures taken to improve TB control.

4. TB: a matter of lifestyle

4.1 Choices based on health beliefs

In Western medicine, diagnosis and therapy are very important for re-gaining health. Social relations do not have any influence on the origin of disease. The TB bacterium (*Mycobacterium tuberculosis*) is the cause of the disease and the recommended treatment is DOTS. According to Manning & Fabrega (1996: 58-60), social relations play an important role in health and disease in traditional medicine. The body is seen as an integrated whole involving both the “self” and one’s social relations. In the African context the concept of health (*mpilo* in isiXhosa) is much broader than the Western notion. It means living in harmony with cosmic forces to which ancestors have access. Only a few living people, like priests and traditional healers, can manipulate these powers for the well-being of the community. Treatment should not only cure the body, but needs to reconfirm the harmony between the body and the environment. The maintenance of this cosmological view derives from history, tradition, custom and the need for psychological well-being (Ngubane 1976). It can have two important consequences for people’s behaviour. One may be fatalistic: acceptance of disease and death may be induced by belief in an all-embracing power. People may perceive disease and death as part of their life, beyond their control. They then do not seek relief or a cure (Dennis *et al* 2001; Pretorius 2004). This can have implications for case detection and TB control. Western medicine is often unacceptable to this belief, because it cannot explain why the *bacillus* is active in only some cases, and why some people become infected while others do not.

The literature provides various answers as to the cause of TB in a coloured community in Cape Town. In order of importance, these are: the cold, wet weather; smoking; malnutrition and poor food intake; the shortage of housing; alcohol abuse; neglect, and, lastly, infection and *bacilli* (Metcalf *et al* 1990). Other research reports claim that a TB patient became the victim of witchcraft and was caught by the *impundulu* (the lightning bird). This disease was classified as an *ukufa kwama Xhosa* (a disease of the Xhosa-speaking people) (De Villiers 1991). In a rural area in the Limpopo province (Tintswalo) researchers uncovered even more relevant notions (Edginton *et al* 2002). Respondents gave different versions of the cause of TB. Sixty-three percent

(63%) said it was due to disobedience of traditional rules. Later research involving focus-group discussions revealed more information. Two different kinds of TB were described. One was known by the name *tindzaka*. The most recognisable reason for *tindzaka* was the violation of traditional rules. When someone within a family died, the other members were expected to abstain from sexual contact for a certain period. Eating food prepared by someone who had broken this rule would also cause *tindzaka*. The other type of TB, regarded as the Western TB, was identified with coughing blood, night sweats and loss of weight. According to these respondents the treatment of the two diseases differed since a traditional healer should treat *tindzaka*, while people with Western TB should be referred to hospitals.

4.2 Choices based on healthcare delivery

From the patient's viewpoint the choice between Western and traditional medicine involves more than different perceptions of the cause of the disease and its appropriate treatment. In most parts of southern Africa there is a tremendous contrast between the two traditions in relation to at least four domains of the doctor-patient relationship: communication, the preparation of the patient's history, information on diagnosis, and the attitude of the healer towards the other tradition. In modern medicine the patient is not on equal terms with the doctor, who acts as the authority. This may make the patient feel uneasy and, as a result, withhold some relevant information.

Other deterrents to the use of Western medicine could be the long distances patients have to travel to consult doctors or health care centres as well as the matter of payment. There are differences in the logic of exchange of goods and services. In more traditional societies, money is not the means of exchange, as the gift economy plays an important role. The custom of reciprocity is still highly regarded (Ngubane 1977). All these aspects may be of great importance in the decision-making of a patient as to which healer s/he consults. If a patient is rather reluctant to use western medicine, DOTS may not be effective unless modern medicine co-operates with traditional healers. Much still needs to be done with a view to such co-operation. Western practitioners should be informed that traditional healers can also have a positive impact on the treatment of TB patients, as DOT supporters (Colvin *et al* 2003).

The use of different healing traditions does not necessarily imply different outcomes of treatment, but might delay diagnosis of the disease since traditional healers tend to retain their patients instead of referring them to a hospital or clinic to start treatment (Edginton *et al* 2002). This diagnostic delay should be addressed since early case detection can vastly improve TB control. In many traditional communities, however, it is not the individual who decides on treatment, but rather the extended family, which may cause gender inequality (Helman 2001; Austin *et al* 2004).

4.3 Chances offered: the government approach

Since 1994 many changes have taken place. The main approach within the healthcare sector involves a transformation towards “health for all”: improvement of the health of the entire population. This notion was first articulated in the Alma-Ata Declaration of 1978, explaining the difficulties developing countries faced in providing health care.

The reforms implemented in South African health care were:

- Constitutional

“[E]veryone has access to [...] primary health care ...” (Heunis *et al* 2003: 14-6).

- Organisational

Strategic planning for the health system was described in 1997 in the *White paper for the transformation of the health system in South Africa*. While this did not affect the private sector, public health facilities were transformed in order to address the huge inequity in healthcare provision. This inequity has been rectified in various ways. First, the shortage of trained personnel in rural areas has been resolved by extra training of personnel, compulsory community service for recently graduated health practitioners, contractual obligations for those whose training was subsidised, attempts to attract personnel from the private sector to public health facilities, the importation of many Cuban doctors mainly for rural areas or understaffed health facilities, and the implementation of the Clinic Upgrading and Building Programme, which has resulted in the construction of 400 new hospitals and the expansion of 152 existing hospitals between 1995 and 1998 (Van Rensburg 1999; McIntyre & Gilson 2002). Secondly, control of re-

ferrals and of the flow of patients towards different facilities has been implemented in order to achieve a more equal spread of patients within public healthcare centres (Van Rensburg 1999). Thirdly, apartheid within the public sector has been dismantled by means of “affirmative action” providing managerial positions for women and black people. This was not always a step forward since some appointees lacked the necessary skills (Van Rensburg 1999). Fourthly, a new information system has been established, enabling policy-makers to access accurate data (Van Rensburg & Ngwena 2001). This was crucial to the transition.

- Financial

Efforts have been made to ensure a more equal spread of the health-care budget among the various provinces on, initially the grounds of population and relative poverty and later taking medical insurance into account. The government’s aim was to eliminate the discrimination that existed between the various provinces and among different areas (Pillay 2001). However, it did not take into account the fact that the provinces suffered from differing degrees of inequity, and it will thus be some time before real equity can be achieved among the provinces in South Africa (McIntyre & Gilson 2002). Besides the budgeting for services, social security for patients must also be considered. The Reconstruction and Development Programme recognised the need for a new social security system in the form of a “Comprehensive Social Protection Package”. However, the lack of knowledge of the existing provisions and the resultant inequity means that the basic protection is completely ineffectual (McIntyre *et al* 2003).

5. Evaluating TB control in South Africa

Various models may be used to evaluate the degree of success in combatting poverty and social exclusion. We shall now attempt to extrapolate these to TB control in South Africa. It is important to note at which level the cause of poverty (or TB in this case) is perceived to be located: the individual level (where culture can play an important role) or the societal level, as well as whether this cause is seen as an internal matter (involving guilt) or an external one (involving accident) (Table 1).

We use these models of poverty and social exclusion because of the vision expounded in the ANC's 1994 Reconstruction and Development Plan:

No political democracy can survive and flourish if the mass of our people remains in poverty, without land, without tangible prospects for a better life. Attacking poverty and deprivation must therefore be the first priority of our democratic government.

Table 1: Six models to explain poverty

Level of the cause	Nature of the cause	
	Internal	External
Micro: the individual	Personal deficit (individual culpability)	Personal accident
Meso: groups, communities, institutions, organisations	The structure and/or the functioning of groups, communities, institutions, organisations (culpability of, groups, communities, institutions, organisations)	External decisions
Macro: "the" society	The way the society is structured (societal culpability)	Changes in society and trade cycles

If one uses the individual culpability model to evaluate the efficiency of TB control, responsibility relates entirely to the "life choices" of the person. Examples include deviant behaviour such as alcohol abuse and smoking, bad eating habits, and non-compliance with therapy as well as the notion of patient delay and fatalistic attitudes towards health-seeking behaviour. If policy focuses on the individual as the responsible person, measures will be taken accordingly. Patients may be kept in hospital not only for the commencement of treatment, but mainly in order to re-educate them before they return to their community. This is often standard procedure with re-treatment patients or defaulters.

If, on the other hand, TB is viewed as similar to being involved in an accident, then policy is worked out as a purely medical insight into the problem, with social factors being largely excluded: a somewhat narrow view of TB. There are various vertical TB control programmes based on classical disease epidemiology, and aiming at a single purpose. Treatment occurs only through case detection, bacteriological diagnosis

and patient segregation while on treatment. By the end of the 1950s there had been no decrease in the incidence of TB in underdeveloped areas (Heunis *et al* 2003). This view on treating patients has been held for too long in South Africa, partly because data on some groups were totally underreported and policy was thus executed without a full grasp of the problem. An integrated health policy would probably influence TB control much more profoundly. In South Africa today, TB cannot be addressed in isolation from HIV/AIDS. But even merely providing anti-retroviral medication for pregnant women with HIV can be also seen as too medical an approach to the disease.

At the meso-level of groups and institutions, the inaccessibility of healthcare services comes to the fore. This inaccessibility may be seen in differences between rural and urban areas, varying distances to healthcare services, inequity in doctor/patient ratios, different attitudes towards the healing traditions (the perceived superiority of the Western doctor), and also in the diagnostic delays, which occur when doctors do not identify the disease quickly enough, as is often reported by patients using traditional healers (Edginton *et al* 2002; Colvin *et al* 2003), or when healthcare workers refuse a patient a sputum test despite clear symptoms of TB.

The external variant of this level can be seen in stigmatisation and stereotyping as well as the lack of policy for certain groups. The attitude of Western medicine towards traditional medicine is also pertinent here. Hospitals do not refer patients back to traditional healers, although research has demonstrated their positive outcomes as DOT supporters (Colvin *et al* 2003). Co-operation between the two health traditions might offer TB patients more chances and thus have better outcomes in terms of TB control.

At the macro-level the societal culpability model explains a great deal. The cause of the TB problem is to be found in society itself. The question to be asked is: why do some groups in society or in the community — and not others — fall victim to the disease? The structural changes and long-term policy plans required involve the reorganisation of society as a whole. However, dismantling an unequal society such as South Africa was under apartheid may take a long time and will demand courage from policy-makers. The most pressing need is to address poverty in all its facets.

The external variant of this model relates to the trade cycle and economic crisis. The worldwide economic crisis of the 1970s also affected South Africa, causing huge cuts in the healthcare budget. There was also a resurgence of TB in the West. With the dismantling of apartheid in 1994, migrant labourers from outside the country flocked to the major cities, causing overcrowded townships, an increase in illegal squatters, and a huge burden on already disadvantaged communities.

6. Conclusion

When one contemplates the staggering figures relating to TB and HIV/AIDS in South Africa, one must wonder: can TB be controlled, and if so, how? In this article we have tried to look for answers at the individual level as well as for relevant societal aspects of everyday life. For the individual approach we revisited the concept of disease, TB in particular, as it is generally perceived, in order to attempt to compare this picture with the Western medical notion of TB. Research demonstrates, however, that different perceptions need not pose problems in terms of compliance with therapy. So, in itself, traditional health beliefs should not be regarded as inimical to TB control. Such health beliefs can, however, exert a major influence on health-seeking behaviour. It is for such reasons that TB control seems particularly difficult in South Africa. Late case detection is one of the main preventable problems and should become a priority of healthcare policy. The burden of HIV/AIDS in this country makes active case-finding among this group another imperative.

At the macro-level, poverty alleviation should be prioritised, as should access to basic facilities. Race and gender will continue to distort the healthcare situation for some time, partly due to the legacy of apartheid, but also partly as a result of the progression of a particular type of health care in a system segregated by race and social class. The richer population resorts to private health care, while the most deprived have to rely on less effective public health care where overcrowding, shortages, poor working conditions, declining quality and even corruption relating to some scarce resources within the public service are everyday occurrences. Much needs to be done, and searching out scapegoats will not help. The measures taken by the government should be subjected to further scrutiny and, if necessary, roundly criticised.

At the meso-level of institutions, groups and communities, the socio-economic perspective is daunting but the concept of “health for all through all” might be possible by means of *ubuntu*. *Ubuntu* implies tolerance, humanity and understanding. Nelson Mandela has translated it as: “The transformation from disregard into regard”. South Africa and its people have inherited a very dark past on which to build a new nation and a new society. This entails the responsibility to combat TB and poverty, as well as other inequities. The concept of lifestyle introduced by Max Weber and further developed by other social scientists helps us to understand the patterns underlying why some people have a higher risk of becoming infected and others do not, as well as of why some people comply with treatment and others do not. It is the task of every level of government to provide the maximum number of options so that its people can make choices, rather than merely depending on chances. The private health sector must also take responsibility in this regard; it cannot simply sit on the sidelines. The people’s health is too important to neglect.

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