INFORMATIONAL ARTICLE

INCORPORATION OF CONTROL ACTIONS OF TUBERCULOSIS IN PRIMARY HEALTH CARE AND ITS CONTEXT

Maria Concebida da Cunha Garcia¹, Ilha Dantas Cirino², Bertha Cruz Enders³, Rejane Maria Paiva de Menezes⁴

ABSTRACT

Objective: to understand the factors those determine the incorporation of control of tuberculosis in primary health care. Method: a descriptive, informative study, using the theoretical framework of contextual analysis that characterizes the phenomenon in four interactive levels. The analysis was performed in a dialectical process between the literature, and the theoretical contribution and reflection, for building themes. Results: the issues related to the levels of context were: “The incorporation of control of tuberculosis in the APS: How does it happen?”; “The APS and the community - environments where the actions to controlling of TB develop,” “Stigmas, cultures and beliefs those permeate attention to tuberculosis”; “The policies those include attention to tuberculosis”. Conclusion: challenges are observed in the reorganization of TB care in the context of SUS services, related to the implementation, sustainability and integration actions in APS. Descriptors: Primary Health Care; Tuberculosis; Nursing.

RESUMO

Objetivo: compreender os fatores que determinam a incorporação das ações de controle da Tuberculose na atenção primária à saúde. Método: estudo descritivo, informativo, utilizando o referencial teórico de análise contextual que caracteriza o fenômeno em quatro níveis interativos. A análise foi realizada num processo dialético entre a literatura, o aporte teórico e reflexão, para a construção de temáticas. Resultados: os temas relacionados aos níveis de contexto foram: “A incorporação das ações de controle da tuberculose na APS: como ela acontece?”; “A APS e a comunidade - ambientes onde as ações de controle da TB se desenvolvem”; “Estigmas, culturas e crenças que permeiam a atenção à tuberculose”; “As políticas que englobam a atenção à tuberculose”. Conclusão: observam-se desafios na reorganização da atenção à TB no contexto dos serviços do SUS, relacionados à operacionalização, sustentabilidade e integração as ações na APS. Descritores: Atendimento Primário à Saúde; Tuberculose; Enfermagem.

RESUMEN

Objetivo: comprender los factores que determinan la incorporación del control de la tuberculosis en la atención primaria de salud. Método: estudio descriptivo, informativo, utilizando el marco teórico de análisis contextual que caracteriza el fenómeno en cuatro niveles interactivos. El análisis se realizó en un proceso dialéctico entre la literatura, la aporte teórico y reflexión, para la creación de temas. Resultados: cuestiones relacionadas con los niveles de contexto fueron: “La incorporación del control de la tuberculosis en la APS: ¿Cómo es el caso?”, “La APS y la comunidad - entornos en los que las acciones de control de la tuberculosis desarrollan”; “Estigmas, culturas y creencias que impregnan la atención a la tuberculosis”; “Las políticas que incluyen la atención a la tuberculosis”. Conclusión: se observan desafíos en la reorganización de la atención de la tuberculosis en el contexto de los servicios del SUS, en relación con las acciones de implementación, sostenibilidad e integración en la APS. Descriptores: Atención Primaria de Salud; Tuberculosis; Enfermería.

¹Nurse, Master of Nursing, Federal University of Rio Grande do Norte/UFRN. Natal (RN), Brazil. E-mail: concycg@yahoo.com.br; ²Nurse. Master of Nursing, Federal University of Rio Grande do Norte/UFRN. Natal (RN), Brazil. E-mail: illa_dantas@hotmail.com; ³Nurse, Professor Post-Doc, Postgraduate Program in Nursing/Federal University of Rio Grande do Norte/PGEnf/UFRN. Natal (RN), Brazil. E-mail: berthacruz.enders@gmail.com; ⁴Nurse, Professor Doctor, Postgraduate Program in Nursing, Federal University of Rio Grande do Norte/PGEnf/UFRN. Natal (RN), Brazil. E-mail: rejemene@terra.com.br
INTRODUCTION

Tuberculosis (TB) has been present as a public health problem in Brazil throughout the twentieth century, being known as “neglected calamity” still unresolved in the XXI century.1 In this scenario, Brazil occupies the 16th place among the 22 countries responsible for 80% of estimated cases of TB in the world, with priority in controlling the disease.2

Faced with the challenge of controlling the spread of the disease and improve epidemiological indicators, policies reorientation of primary care from the decentralization process transferred to municipalities the responsibility of primary care and recognize the actions of the National Tuberculosis Control Program (NTCP) competences as this level of complexity to improve access to stock control, diagnosis and treatment of disease.3 4 In this perspective, the NTP introduces new possibilities of intervention in its proposed work, allied to the Community Agents Program (PACS) and the Family Health Strategy (FHS). Emphasis is given to the performance of the ACS and FHS teams as a means to improve adherence and prevent abandonment, considering that these strategies have the family and the home as a work tool.3

It is proposed, therefore, that municipal managers, along with the state manager, acting in a planned and coordinated to ensure the implementation of actions to control TB. Actions include structuring the network of health services for the identification of respiratory symptoms; organization of the laboratory network for diagnosis and management of cases; guaranteed access to supervised treatment and/or self-administered cases, protection of healthy, feeding and analysis of databases for making decision.8 This implies the definition of strategies and actions to be taken by health staff working in primary care settings, for effective TB control nationwide.

Regarding the responsible development of these actions in primary care settings, there are the health team (physician, nurse, nursing assistant or technician and ACS), as elements of local demand organizers, planners of health, popular educators and essentially change agents social.7 Accordingly, the nurses as articulating element of control in primary care settings, plays an important role in this process in view of its responsibilities in this ESF and leadership in the development of many control actions as active search, supervision of community health workers in identifying patients with respiratory symptoms and treatment monitoring. Such actions help to ensure the effective expansion of access to diagnosis, treatment, prevention and control of disease.

Starting from practical reality, there are, in the organization of work and actions to control TB produced in Family Health Units (FHU) in a city in Northeast, challenges such as incompleteness of family health teams, limited resources materials, quantitative and qualitative deficiencies of human resources, work overload with concentration of decisions and responsibilities in a professional and unique to the fragmented view of the organization of these actions in the health system.

Such difficulties indicate that the incorporation of control of TB to that family health is a prodigious feat, considering the limitations and complexity of the health system. Suffering interferences from factors related to human resources, operation of the health system at the local level, and other factors and cultural stigmatization. Thus, it becomes important to understand the influences that affect the congregation of control of TB in the APS, the prospect of finding ways for the viability of this done and for the performance of responsibilities established by the NTCP for primary care.

In addressing the incorporation of control of TB as a phenomenon to be studied, it is understood that any problem under study is part of a reality that can have significant effect on the development or solution to this. This reality, when understood as context goes beyond the environment where it occurs. Encompasses dimensions that have meanings and interactions internal and external to the phenomenon, which should be included in any study process of the event. ie, the phenomena of reality are dependent contexts.8

According to the theoretical framework of contextual analysis proposed by Hinds, and Cypress9, Keys, context is conceptualized in four interactive levels (immediate, specific, general and meta-context), each containing meanings of the situation. In this sense, the context is a data source, and the integration of the four levels of reality and their meanings facilitates the description and understanding of the situation or event under study. Thus, the systematic and analytical approach of the researcher with these contexts results in a better understanding of the phenomenon.9 10

In the immediate context, the situation is observed and described as presented, showing an understanding of its occurrence in reality. The specific context focuses on concrete and qualitative aspects of the subject matter.
related to its occurrence, such as people, time and space. But the general context is characterized by a focus on the subjectivity involved in the site, which is acquired in the cultural interaction that permeates the situation. These three dimensions of context are related to the meta-context that brings together the socio-political and normorregulators acting on the phenomenon, often going unnoticed by the actors’ situation.9

Thus, the aim of this study is to understand the factors that determine the incorporation of control of TB in units of primary health care, based on analysis of contextual aspects of this process and the practical reality experienced. The performance analysis of this phenomenon is justified by the need to detect the elements and factors that need to be investigated and reassessed in practice to ensure their effectiveness at this level of attention.

Thus, we hope to contribute to a greater understanding about the actions to control TB and challenges of its incorporation and implementation in primary care, that would support the improvement and development of strategies for organizing, planning and management of multiple activities involved in controlling this disease, with the effective participation of all stakeholders involved in this process (managers, professionals and users) in order to achieve the goals and targets for TB control.

**METHOD**

A descriptive, informative study, developed in the period from March to June 2011 through narrative review of relevant literature and the analytical process of its contents based on the proposed framework. Data related to each contextual level were identified and discussed to compose the description of size, to detect relevant factors into focus.

This dialectical process between the theoretical, analytical reflection and literature resulted in the development of four themes that make up the phenomenon and its determinants.

**RESULTS**

The four themes were identified: “The merger of shares of TB control in primary care: how it happens?” (Immediate Context); “The Primary Health Care and community - environments where actions to control TB develop” (Specific context), “Stig mata, cultures and beliefs that permeate attention tuberculosis” (General Context) and “policies that include attention to tuberculosis” (Meta-context).

Together, the four levels of interactive meanings (of totally individualized to the universal) then provided the frame that allow the understanding of the phenomenon in focus and its determinants, and to direct their focus on research.

- **The incorporation of control of TB in primary care: how it happens?**

Actions to control TB, which include early diagnosis and effective intervention in the health- disease within the APS, with the search for respiratory symptoms, sputum smear microscopy, treatment and follow-up of cases, registration and observation of contacts prevention and control, were gradually incorporated into the activities of primary care units from the process of decentralization and integration of control of tuberculosis in the FHS.5

With this decentralization, besides adopting Observed Treatment Strategy (DOTS), the NTP reiterates the importance of increasing the combat TB to all health services in the Unified Health System (SUS). Therefore, the Plan aims at the integration of TB control in primary care, including the ESF, to ensure increased access to effective diagnosis and treatment. From this perspective, there is a strong policy of encouraging the MS so that actions to control TB are incorporated/ integrated in primary care. However, this process has been occurring gradually and diverse this level of care, understood by UBS and the strategies of PACS and ESF, with some contradictions, obstacles and difficulties of organizational, political, social and even cultural.

Aspects related to the health system are described factors such as poor access, inadequate care of the sick, low priority in the search for respiratory symptoms and intra - household contacts, and low level of suspicion for diagnosing TB. Those obstacles determine the increase in the period between the first visit to the health service and the initiation of antituberculous treatment.11,12 It is understood that these conditions can is associated with the form of organization of health services and care of patients with TB.

In addition to the aforementioned barriers, weak qualitative and quantitative human resources, characterized by lack of HR function overloading, inadequate qualification of teams to work on TB control and staff turnover also configured as obstacles to the merger of shares TB control in primary care. An aggravating factor is this reality; there is still centralized and fragmented vision of the
organization's efforts to control TB in the health system, in which activities related to TB are seen as unique centers of reference for treatment of disease, contributing to the lack of local accountability in the health system.\textsuperscript{13-14}

Additionally, the difficulty or lack of involvement of professionals with efforts to control TB can generate situations of abuse, lack of respect and humanization of care for TB patients, which compromises adherence to treatment, and control of the disease.\textsuperscript{13}

In this sense, despite the expectation that primary care, specifically the ESF, come check TB control, it is important to highlight that the transfer of responsibilities to this level of care should be carried out cautiously and especially gradual, in extent that the realization of control does not only depend on the goodwill and willingness of professionals. It needs qualified staff to deal with the complexity of disease involving social, economic, cultural and stigmatizing, inclusion and joint definition of priorities and strategies for action among key actors of this process in the central and peripheral levels of the system health, which is still not effectively observed in our reality.

- **The Primary Health Care and Community: environments where actions to control TB develop**

The ESF, as a structuring element of primary care in Brazil, proposes to organize practices at UBS, showing the character multidisciplinary and interdisciplinary teams of FHS, with the provision of comprehensive care in the primary care specialties, a territorial basis and bounded with a population enrolled. It is responsible for the planning and programming of activities based on situational diagnosis and risk, with a focus on family and community. Assume also the guarantee of health referral services to levels of greater complexity, allowing the recognition of health as a right of citizenship, to encourage community organization and seek the improvement of participation and social control of the population in the area health.\textsuperscript{15-16}

The approach to the reality of patients, nurtured by this strategy favors invited revival of professionals with the dynamics of illness and healing in the midst popular. Thus, the community environment, favors the confrontation with the complexity of the health problems of these populations, leading many professionals to seek to reorient their practices in order to address, in a comprehensive manner, the health problems identified, breaking thus with the verticality of the professional–usuário.\textsuperscript{17}

With the decentralization of TB control for primary care, which is expected from the ESF is that the health service is the gateway to the clientele, promoting access to the population and providing a good basic care, including making the diagnosis early tuberculosis and overseeing the treatment.\textsuperscript{18}

The proposal in the USF would give better resolution for cases of tuberculosis, reversing the logic of the organization of health care, that is, from the medical model for privatizing a way that creates new care practices in guided model of health surveillance.\textsuperscript{18}

Despite the efforts so far undertaken, may also be noted that epidemiological rates of TB remain in significant numbers and practically constant. Given this, some studies suggest that the decentralization of the NTCP offers both opportunities and risks to the continuity of actions. Regarding strengths concerning decentralization, are aimed at improving the efficiency and quality of services, which could result in benefits for the user, because, among other things, facilitate access, improve adherence and the relationship with health professionals, once that the local team would take on the responsibility of monitoring the cases, as well as collaborate with improving the analysis and use of data.\textsuperscript{17,19}

Decentralization may result in spraying of responsibility and lack of commitment, fragmentation of programs and treatment regimes. Moreover, the perpetuation of the program logic in the context of the ESF, with a “package” of technical actions to be undertaken by family health teams, the idea of falling TB control program in family health, with the induction of demand the offer, when the logic should be the reverse, also presents itself as an obstacle in this process.\textsuperscript{17,19}

Given the above, we can understand that the APS provides a conducive environment for the development of actions to control TB, considering the proximity of the work in the community, acceptance and bond built in this environment are fundamental to treatment adherence and disease control. However, it has its limitations regarding organizational issues and policies, which are observed obstacles in understanding the ESF, not as a program but as a strategy whose actions are based on a survey of problems in the territory and organized supply of services according to the demand. Besides these, there is a qualitative and quantitative deficiency in the labor force, disability resource materials, and the rotations of the team members in the health system, among others.
Stigmata, cultures and beliefs that permeate tuberculosis care

An analysis of TB care over time allows us to observe the methods and strategies that, over time, have been applied to fight tuberculosis, show historical correspondence with the models of existing health care resources and that science and technology made available in every critical moment of this struggle. These were influenced by the contexts and economic interests, social, political, cultural and religious prevalent in every age and the health problems that concerned health authorities of the country.

Tuberculosis, although a malady with the cure, still remains with its historic character of a stigmatized disease until today. Psychologists, anthropologists and sociologists, analysts note that this disease talk about it causes discomfort, especially in the poorer communities.20

The association of disease hunger, inability to provide minimal resources for survival or family, but also to excesses, such as the consumption of alcoholic drink and carouse, they show that the unruly behavior are still considerable cause of a disease that shames. The ideas of contagion are diffuse and observation of frequent relapses, these social groups causes disbelief in the possibility of curing tuberculosis. Even when he admits to being curable, TB carrier seems to carry a brand that profoundly alters their social insertion. Appear as outdated ideas that crystallized in the popular imagination.20-1

In the perception of the patient, tuberculosis remains a disease stigma charged. The stigma is presented in the individual patient, including reports that his bias and society are sometimes secret. The issue of discrimination and representation of private or individual disease, underlies itself historically primarily social in origin, but also the biological risk.22

The sense of isolation is shown to be still alive in the case of TB, represented by guilt and risk the disease poses to the environment in which the individual belongs. The fear of living with the disease and the risk of transmission to family and people around them, it becomes real. Furthermore, knowledge/ignorance of TB appears as a hindrance in daily life of all patients because the knowledge that have are riddled with taboos and misinformation about the life cycle of the disease. This makes it difficult to adapt these to society in the search for a better quality of life.22

The disease puts forth a series of feelings during the period of discovery, through treatment, to cure. Feelings are usually directly related to the impact of the disease on the process of social production, and all that it may come. Refer not only to the fact of being sick and in the experience of illness as an individual process, but the fact that the disease can ultimately determine breakdowns in conditions of existence.21

Observe that dreaded disease is yet to be an expression of something that is socially worthy of censorship and it represents the last stage of human wretchedness. Accordingly persists in the imagination and as a form of society's relationship with the patient, the process of stigmatization of tuberculosis and tuberculosis, which is a serious obstacle to the control of the disease today.24 Thus, allied to the factors discussed above, the barriers of historical, cultural, stigmatizing and prejudicial that permeate attention to this disease. This situation reinforces the barriers to incorporation of actions to control TB. Thus, addressing the problem as real data, both for the patient and for those around him is not an easy task as it might seem. Due to prejudice, obstacles come up, both for the patient to take and follow your treatment, and for health professionals in their actions to the pursuit of respiratory symptoms, treatment adherence, the meeting of contacts and, ultimately, to control the disease.20-21

It is worth noting another important aspect inserted in this issue, which refers to the difficulty of involvement and commitment of professionals with efforts to control TB and the patient. The relationships established by professionals with the control of this disease are permeated by prejudice, stigma, disgust and fear of contamination, present even in the imagination of this group more educated, which fulfill by compromising the development of measures for the diagnosis and control, as that depends on the bond and hosting provided by health professionals to patients.13

It should be emphasized that in the current political - legal environment of the SUS, much is bet in the articulation of the ESF, NTCP and PACS, as most feasible and advantageous in the early diagnosis and control of TB. However, give credit only to that joint, represented incurring the mistakes of the past, given that up would disregard other factors, such as socio-economic status of the different local contexts, ideology, stigma, prejudice and culture professional agents and the community, as well as the quality of
control of the disease developed, adopted and perfected over the years.

- **Policies that include attention to tuberculosis**

  In 1993, the World Health Organization (WHO) declared TB a global emergency, because many countries had high rates of prevalence and mortality from the disease. Brazil began in 1994 an emergency plan, with objectives to develop control actions in 230 priority municipalities in the country, which concentrated 75% of cases, in order to reduce transmission of the disease in the population until 1998. However, in 1998 the Ministry of Health launched the NTP, defining it as a priority in the governmental public health, establishing guidelines for actions and setting new goals for achieving your goals: diagnose 92% of expected cases and cure at 85% of those diagnosed.3

  In 2000, the National Coordination Pulmonology Clinic was integrated into the Department of Primary Care (DAB) and this formalized structure of the Ministry of Health has since become subordinate to the Department of Health Policy. Such integration has enabled new thinking also strategies for TB control in the country in line with the DAB.25

  In 2001, it established the Standard Operating Assistance (SUS NOAS/SUS/2001), with the goal of promoting greater equity in the allocation of resources and the population's access to health services and actions at all levels of care. This standard is to define the minimum responsibilities and strategies that municipalities must develop within primary care. Presents seven structural axes, including the control of TB.25 Thus, efforts to control TB are to be established as the competence of primary care and shall be implemented in family health units, but integrated with outpatient referral and other levels of complexity. In 2006, TB was included as a strategic action plan of the National Primary Care with indicators to be monitored and evaluated.

  The policy reorientation of primary care from the decentralization process, with a set of specific measures and programs (PACS and PSF), transfers to municipalities the responsibility of primary care. According to MS, the effort for the reorganization of health care in Brazil introduced new perspectives since the proposition of the ESF as structure of primary (replacing the traditional model of health attendance).

  The Family Health Strategy has prioritized the prevention, promotion and restoration of health, in full and continuous. Is based on the principles of Brazilian health reform and becomes the focus of this reorganization of primary care, ensuring service delivery and strengthening the principles of universality, accessibility, comprehensiveness and equity of SUS. 25 This perspective, what is expected of the ESF is that the health service is the gateway to the clientele, promoting access to the population and providing a good basic care, including making an early diagnosis of tuberculosis and supervising the treatment. The proposal in the USF would give better resolution for cases of tuberculosis, reversing the logic of the organization of health care, that is, from the medical model for privatizing a way that creates new care practices in guided model of health surveillance.18

  Given the above it is noted that the NTP has introduced new possibilities for intervention in their work proposal, noting that the insertion of control of tuberculosis within the ESF could promote integration of services, meaning an opportunity to expand activities of disease control. In this direction, it has been proposed that health services are organized so that the ESF incorporate in their activities responsibility for the development of control of tuberculosis. They must be trained to perform suspicion and diagnosis of cases; treat and monitor the drug intake, track contacts, keeping the information system; perform preventive actions (BCG, chemoprophylaxis) and educational activities in the community.6,26

  The partnership entity the NTP, ESF and PACS is identified as an instrument transformer and relevant to TB control in the country and could contribute to the expansion of control of tuberculosis established in NTCP. The strategies adopted in this partnership have the family and the home as a work tool, helping to improve adherence and prevent treatment abandonment.

  **FINAL REMARKS**

  This study allowed us to reflect on the strengths, barriers and challenges that arise in the operation, sustainability and effective integration of these actions on primary, fundamental reorganization of tuberculosis care within the NHS services.

  In the analysis of each of the levels of interactive context were identified organizational problems of character, political, technical, operational, stigmatizing, cultural and social dimensions of several contributing to the discussion from becoming actions aimed at seeking solutions that result the transformation of work processes and
organizational management of services and programs TB care and, consequently, improving the indicators of disease control strategies, from the insertion of all the key actors in this process - managers and health professionals aware and trained, patient, family and society involved us central and peripheral levels of the health system, so as to effectively build a new paradigm for health TB patient.

The challenge lies in the organization of TB care and adoption of management mechanisms that include actions for health practice participatory, collective, comprehensive, linked to the reality of the community and able to push the boundaries of health facilities. That are family focused and community orientation, recognizing the different determinants of incorporation of control of TB in primary care, which require a system of health surveillance to prioritize the surveillance of space/ environment, population, family, community occurrence of disease. As well as values the historical, cultural, stigmatizing and prejudicial that permeate TB care and TB, and no more traditional monitoring and little effective, focused only on the individual.

We conclude this study aware that it may not contain complete and ready answers to many questions that could be asked about the difficulties for the incorporation of actions to control TB in primary care, given the complexity of these issues, but we believe contributed to a greater understanding of the significance of this phenomenon. This implies that further research should be encouraged and carried out by filling the gaps in knowledge in order to face and overcome barriers to the development of the control of this disease that spreads for centuries in Brazil and around the world.

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REFERENCES


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