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ORIGINAL ARTICLE

ADHESION AND QUALITY OF LIFE IN PULMONARY TUBERCULOSIS PATIENTS

ADESÃO E QUALIDADE DE VIDA EM PACIENTES COM TUBERCULOSE PULMONAR

ADHESIÓN Y CALIDAD DE VIDA EN PACIENTES CON TUBERCULOSIS PULMONAR

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ABSTRACT

Objective: to evaluate the adherence to tuberculostatics and the quality of life of patients with pulmonary tuberculosis. ***Method:*** this is a quantitative case series study with 18 patients using a questionnaire, the SF-36 quality of life scale and the Morisky and Green test. Data were stored in Excel 2013 worksheets and analyzed using descriptive and inferential statistics using SPSS 24.0. ***Results:*** were presented in tables. Results: 12 patients (66.7%) had high adherence and six (33.3%) had medium adherence to tuberculostatics. The social aspects (68.75 ± 25.28) and mental health (80.00 ± 16.09) reached the highest means of quality of life. ***Conclusion:*** it is concluded that tuberculosis compromises the quality of life of infected people, since, in addition to the physical implication, there is emotional and psychic impairment. It is relevant to train health professionals for the early diagnosis of tuberculosis, aiming at improving the quality of care, with gains for users' quality of life and greater adherence to treatment. ***Descriptors:*** Pulmonary tuberculosis; Adhesion to Medication; Quality of life; Risk Group; Health services; Socioeconomic Factors.

RESUMO

***Objetivo*:** avaliar a adesão aos tuberculostáticos e a qualidade de vida de pacientes com tuberculose pulmonar. ***Método*:** trata-se de um estudo quantitativo, do tipo série de casos, com 18 pacientes, utilizando-se um questionário, a escala de qualidade de vida SF – 36 e o teste de Morisky e Green. Armazenaram-se os dados em planilhas do *Excel* 2013 e os analisaram com recurso de estatística descritiva e inferencial, utilizando o SPSS 24.0. Apresentaram-se os resultados em de tabelas. ***Resultados*:** pontua-se que 12 pacientes (66,7%) tinham alta adesão e seis (33,3%) tinham média adesão aos tuberculostáticos. Avalia-se que, acerca da qualidade de vida, os domínios aspectos sociais (68,75 ± 25,28) e saúde mental (80,00 ± 16,09) alcançaram as médias mais elevadas. ***Conclusão*:** conclui-se que a tuberculose compromete a qualidade de vida das pessoas infectadas, pois, além da implicação física, há o comprometimento emocional e psíquico. Torna-se relevante capacitar os profissionais de saúde para o diagnóstico precoce da tuberculose, visando à melhoria da qualidade do atendimento, com ganhos para a qualidade de vida dos usuários e a maior adesão ao tratamento. ***Descritores*:** Tuberculose Pulmonar; Adesão à Medicação; Qualidade de Vida; Grupo de Risco; Serviços de Saúde; Fatores Socioeconômicos.

RESUMEN

Objetivo: evaluar la adhesión a los tuberculostáticos y la calidad de vida de pacientes con tuberculosis pulmonar. ***Método:*** se trata de un estudio cuantitativo, del tipo serie de casos, con 18 pacientes, utilizando un cuestionario, la escala de calidad de vida SF - 36 y la prueba de Morisky y Green. Se almacenaron los datos en hojas de cálculo de Excel 2013 y los analizaron con recurso de estadística descriptiva e inferencial, utilizando el SPSS 24.0. Se presentaron los resultados en tablas. ***Resultados:*** se puntualiza que 12 pacientes (66,7%) tenían alta adhesión y seis (33,3%) tenían media adhesión a los tuberculostáticos. Se evaluó que, sobre la calidad de vida, los dominios aspectos sociales (68,75 ± 25,28) y salud mental (80,00 ± 16,09) alcanzaron las medias más elevadas. ***Conclusión:*** se concluye que la tuberculosis compromete la calidad de vida de las personas infectadas, pues, además de la implicación física, hay el compromiso emocional y psíquico. Se torna relevante capacitar a los profesionales de salud para el diagnóstico precoz de la tuberculosis, buscando la mejora de la calidad de la atención, con ganancias para la calidad de vida de los usuarios y la mayor adhesión al tratamiento. ***Descriptores:*** Tuberculosis pulmonar; Adherencia a la medicación; Calidad de vida; Grupos de riesgo; Servicios de salud; Factores socioeconômicos.

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INTRODUCTION

It is known that several elements are related to tuberculosis (TB) infection such as immunological and sociodemographic factors, housing, inadequate lifestyle and Human Immunodeficiency Virus (HIV) infection. It is pointed out that these conditions have favored the sickness and the spread of the disease. It is also important to emphasize that TB is a neglected disease, contributing to the difficulty in the early diagnosis and appropriate treatment of infected individuals.[1]

It is understood that, among the factors that contribute to the persistence of TB, there are situations of vulnerability that can increase the probability of becoming ill. In this sense, the population living in the street is characterized by poverty, unemployment, lack of knowledge of the disease, absence of fixed residence, low immunity, immigration, use of psychoactive substances and HIV coinfection.[2] It is argued that these factors contribute to the fact that this population is 48 to 67 times more likely to become ill due to TB when compared to the general population.[3] In addition to people living on the streets, persons deprived of their liberty (PDL), children living with people infected with TB, hospitalized elderly and health professionals are examples of risk groups that are prone to TB disease.[4-5]

The difficulties in diagnosis and treatment in a timely manner are observed, and one of the factors that help or favor delayed diagnosis is the cultural practice of self-medication. It is evaluated that, in terms of treatment, drug adherence is one of the main obstacles faced by patients due to adverse reactions, prolonged therapy and early perception of cure, which weakens adherence and contributes to treatment abandonment; therefore, adherence to tuberculostatics has been a challenge for patients, as well as for health services, and it is necessary to formulate strategies that minimize the difficulties encountered.[6]

Thus, one of the main goals in the control of tuberculosis is to reduce the rates of treatment abandonment, since the interruption leads to a greater spread of the bacillus, because the patients remain as sources of contagion, contribute to the resistance medication and to increase the time and cost of treatment, compromising patients' quality of life.[7]

It is therefore important to take into account the social and clinical repercussions that the disease causes, mainly in relation to the decrease of the quality of life. It is necessary to understand that the quality of life in people with TB is a complex meeting of elements, such as illness, poverty and stigma, which is negatively reflected in family life, work and social activities. It is therefore considered fundamental to create the professional-patient-family link in care and follow-up, and it is necessary to implement health actions that seek to increase adherence to medications.[8]

It is suggested, based on the exposed literature, that adherence to tuberculostatics leads the individual with TB to a better quality of life, providing a cure for their disease. It is known that TB infection can generate psychological, physiological and social changes in the individual; moreover, the lack of knowledge about its pathology is a factor that can influence this adherence.

It is observed that, taking into account the situations of vulnerability and the factors that contribute to the acquisition, the spread of the disease and adherence to the treatment, it becomes relevant to conduct studies that go deeper into the analysis of how people diagnosed with TB pulmonary adherence to treatment and the repercussion of the disease on the quality of life of infected individuals.

OBJECTIVE

- To evaluate the adherence to tuberculostatics and quality of life in patients with pulmonary tuberculosis.

METHOD

This is a quantitative case-series study carried out in a polyclinic classified as a regional reference center with an outpatient care service for tuberculosis patients in the city of Recife, Pernambuco. The data were collected between September and December 2017.

It is recorded that the population registered in the unit was of 38 patients; of these, 11 (28.9%) did not make direct contact with the service, being attended through the street office or used the service to rescue medication through their relatives, and nine abandoned treatment during the data collection period, adding up to 20 exclusions, being included, in this study, only 18 patients. The difficulty in capturing participants for the study is justified by these aspects. Patients of both sexes with a diagnosis of pulmonary tuberculosis who had been in treatment for at least two full months, older than 18 years and who had no cognitive alterations or

neurological diseases that prevented participation in the interview.

The sociodemographic and clinical data were collected and the validated scales were applied: the Morisky and Green test and the SF-36 Quality of Life Scale. The Morisky and Green test is known to be an instrument used to measure the adherence to the use of drugs, composed of four questions to identify attitudes and behaviors before the taking of medicines and that has been useful for the identification of patients adherent or not to the treatment. The patient is considered adherent to the treatment that obtains the maximum score of four points and non adherent, which obtains three points or less.[9]

It is recognized that the SF-36 quality of life scale consists of 36 items and evaluates eight health dimensions: Physical Function; Physical Performance; Body Pain; General Health; Mental health; Emotional Performance; Social Function and Vitality, thus providing eight different indicators ranging from zero to 100, indicating the latter value the best quality of life / health status.[10]

The primary data was stored using spreadsheets of Microsoft Excel 2013 software. Data were analyzed using a descriptive and inferential statistics feature using SPSS 24.0 software. Descriptive information was studied by means of absolute and percentage frequencies for categorical variables and mean, standard deviation, median and 25th and 75th percentiles for numerical variables. We used tests to evaluate the significant differences between the categories in relation to the SF-36 domain scores: in the comparison of two categories, Student's t-test instances were used with equal and unequal variances, as well as the Mann test -Whitney and, in the comparison of more than two categories, the Kruskal-Wallis test.

It was emphasized that the choice of Student's t-tests with equal or unequal variances occurred when the normality hypothesis was verified in each category, and the Mann-Whitney and Kruskal-Wallis tests were used when normality was rejected in at least one of the categories. Normality was verified by the Shapiro-Wilk test and the equality of variances by means of the Levene test. It is noted that the margin of error obtained in the decision of the statistical tests was 5%.

The ethical precepts of Resolution 466/2012 of the National Health Council were respected and the research protocol was approved by the Research Ethics Committee of the Otávio de Freitas Hospital under the Ethics Assessment Presentation Certificate (CAAE) nº 73142217.0.0000.5200 and Opinion No 090012/2017.

RESULTS

The study participants are shown in table 1, regarding their sociodemographic and clinical characteristics. Most of the interviewees were male, aged between 19 and 95 years ± 45.56 years, with a standard deviation of 18.31 years and a median of 42.50 years; had ≥ nine years of study (eight, 44.4%); was self-employed (eight, 44.4%); declared to receive up to a minimum wage (eight, 44.4%) and did not have his own address (eight, 44.4%). It is pointed out, with regard to alcohol and tobacco use, that four (22.2%) reported using the substances and that, for illicit drugs, 5.6% (one), 11.2% (two) and 22.2% (four) used glue, crack and marijuana respectively.

It was observed, in relation to the clinical aspects observed in table 2, that the majority of patients interviewed were in the third or fourth month of treatment (nine, 50% and four, 22.2%, respectively). As the main previous symptoms, coughing was ≥ 3 weeks (17; 94.4%), productive cough (17; 94.4%), weight loss (15; 83.3%) and night sweats (13; 72.2%). The current symptoms were weight gain (eight; 44.4%) and persistence of cough (nine; 50%). It should be noted that, in HIV testing, ten (55.6%) patients were offered tests, three (16.7%) of which were reagents. Only five diseases were present in the diseases / clinical manifestations associated with tuberculosis, with hypertension (4, 22.2%) and HIV (4, 22.2%).

Fifteen 15 samples of bacilloscopy (BK), one and two, respectively, were submitted to the tests, showing positive results in seven (38.9%) cases in the first sample, and two (11.1%) in the second sample; seven (38.9%) had no results for the first BK and 15 (83.3%) for the second BK. It should be noted that only two (11.1%) culture samples were requested, and their respective results were not recorded during the study period. It was emphasized that chest X-ray was requested in 17 (94.4%) patients, and pulmonary tuberculosis was suspected in 14 (77.8%) cases, normal, in two (11.1%) and its results in medical records did not appear in another two (11.1%), as observed in table 2.

Table 1. Socio-demographic characterization of people in the treatment of pulmonary tuberculosis at a reference outpatient clinic, Recife (PE), Brazil, 2017.

Variable	n	%
Sex		
Male	13	72,2
Female	5	27,8
Age group		
18-39 years	7	38,9
40-49 years	5	27,8
50 or more years	6	33,3
Amount of children		
Wihtout children	5	27,8
One or more children	7	38,9
Three of more children	6	33,3
Laboral activity		
Unemployed	6	33,3
Retired	4	22,2
Employed/autonmous	8	44,4
Origin		
Recife	18	100
Education		
Up to eight years of education	6	33,3
≥ nine years of education	8	44,2
Illiterate	4	22,2
Marital status		
Single	12	66,7
Married	3	16,7
Divorced	3	16,7
Religion		
Without religion	5	27,8
Catholic	8	44,4
Evangelical	3	16,7
Spiritist	2	11,1
Home situation		
Home owner	4	22,2
Non home owner	8	44,4
Homeless	6	33,3
Use of alcohol/tobacco/illicit drugs		
Alcohol	4	22,2
Tobacco	4	22,2
Glue	1	5,6
Crack	2	11,2
Marihuana	4	22,2

Table 2. Clinical characterization of people in the treatment of pulmonary tuberculosis at a reference outpatient clinic, Recife, Brazil, 2017.

Variables	n	%
Tuberculostatic therapy time in months		
Three months	9	50
Four months	4	22.2
Five months	2	11.1
Six months	3	16.7
Previous symptoms		
Coughing ≥ three weeks	17	94.4
Productive cough	17	94.4
Weightloss	15	83.3
Night sweats	13	72.2
Evening fever	12	66.7
Cough with hemoptotic presence	4	22.2
Dry cough	1	5.6
Current symptoms		
Weight gain	8	44.4
Weight loss after starting treatment	6	33.3
Joint pain	1	5.6
Cough	9	50
HIV Test		
Yes	10	55.6
No	8	44.4
Test result		
Reagents	3	16.7
Non reagent	7	38.9
Associated diseases		
Hipertension	4	22.2
HIV	4	22.2
Diabetes Mellitus	3	16.7
DPOC	3	16.7
Asthma	1	5.6

The evaluation of adherence to tuberculostatics was fragmented as follows: 12 (66.7%) had high adherence and six (33.3%), mean adherence. As regards the association of the degree of adhesion to tuberculostatics to sociodemographic and clinical variables, a significant association was found only between the degree of adherence and the marital status (p value 0.054). It was observed that those with medium adherence were female (three, 60.0%), were in the age range of 18 to 39 years (three, 42.9%), were unemployed (three, 50.0%), had one to eight years of study (three, 50.0%), were single (six, 50.0%), without their own home (five, 62.5%), without income (three, 50.0%), and used alcohol (three, 75.0%) and tobacco (three, 50.0%).

It was observed, in relation to those classified with high adherence, the predominance of male patients (ten; 76,9%), in the age group of ≥ 50 years (five, 83.3%), with three or more children (five, 83.3%), retired (four, 100%), ≥ nine years of schooling, married / divorced (six, 100%), with their own domicile (four; 100%), receiving more than one minimum wage (four, 100%), who did not use alcohol (11, 78.6%), did not consume tobacco (nine, 75%), who used illicit drugs (three, 75%) and presented as current symptoms weight gain (five, 62.5%), weight loss (three; 50%) and cough (six, 66.7%). It should be noted that there were no significant associations (p> 0.05) between the degree of adhesion and the variables analyzed, as shown in table 3.

In terms of the quality of life of patients undergoing treatment for pulmonary tuberculosis, mean values ranged from 5.56 to 80.22, being higher in the social aspects and mental health domains, which presented results on average of 71.53 ± 26.36 and 80.22 ± 14.22, respectively. It is important to emphasize, however, that the domains limited by physical aspects and emotional aspects had very low averages of 5.56 ± 23.57 and 16.67 ± 34.77, in this order, as explained in table 4.

Table 3. Association of the degree of adherence to tuberculostatics to sociodemographic and clinical variables of people in the treatment of pulmonary tuberculosis at a reference outpatient clinic, Recife, Brazil, 2017.

Variable	Average		High		Total		P Value
	n	%	n	%	n	%	
Sex							P(1)= 0,268
Male	3	23.1	10	76,9	13	100	
Female	3	60	2	40	5	100	
Age group (years)							P(1)=0,689
18-39	3	42.9	4	57,1	7	100	
40-49	2	40	3	60	5	100	
50 or more	1	16.7	5	83,3	6	100	
Number of children							P(1)=0,689
No children	2	40	3	60	5	100	
One or two	3	42.9	4	57,1	7	100	
Three or more	1	16.7	5	83,3	6	100	
Work activity							P(1)=0,363
Unemplyed	3	50	3	50	6	100	
Retired	0	0	4	100	4	100	
Employed or autonomous	3	37.5	5	62,5	8	100	
Degree of instruction							P(1)=0,683
Illiterate	1	25	3	75	4	100	
One to eight years	3	50	3	50	6	100	
Nine or more years	2	25	6	75	8	100	
Marital status							P(1)=0,054
Single	6	50	6	50	12	100	
Married or divorced	0	0	6	100	6	100	
Home situation							P(2)=0,062
Home owner	0	0	4	100	4	100	
Non home owner	5	62.5	3	37,5	8	100	
Homeless	1	16.7	5	83,3	6	100	
Family income (MW)							P(1)=0,363
Up to one minimum wage	3	37.5	5	62,5	8	100	
More than one minimum wage	0	0	4	100	4	100	
No income	3	50	3	50	6	100	
Use of alcoholic beverages							P(1)=0,083
Yes	3	75	1	25	4	100	
No	3	21.4	11	78,6	14	100	
Use of tobacco							P(1)=0,344
Yes	3	50	3	50	6	100	
No	3	25	9	75	12	100	
Use of drugs							P(1)=1,000
Yes	1	25	3	75	4	100	
No	5	35.7	9	64,3	14	100	
Current symptoms							
Weightgain							P(1)=1,000
Yes	3	37.5	5	62,5	8	100	
No	3	30	7	70	10	100	
Weightloss							P(1)=0,344
Yes	3	50	3	50	6	100	
No	3	25	9	75	12	100	
Cough							P(1)=1,000
Yes	3	33.3	6	66,7	9	100	
No	3	33.3	6	66,7	9	100	

(1) Using Fisher's exact test

Table 4. Characterization of the quality of life of people in the treatment of pulmonary tuberculosis at a reference outpatient clinic, Recife, Brazil, 2017.

Domain	Average	Standard deviation	Minimum	P25	Median	P75	Maximum
Functional capacity	49.17	33.09	5	10	52.5	76.25	100
Physical aspects limitation	5.56	23.57	0	0	0	0	100
Pain	51	21.81	10	41	52	64.5	100
General health status	57.39	25.11	5	37	62	78.25	95
Vitality	44.72	19.51	15	25	45	61.25	75
Social aspects	71.53	26.36	25	50	68.75	100	100
Emotional Aspects	16.67	34.77	0	0	0	8.33	100
Mental health	80.22	14.22	44	71	80	92	104

(1) Using Fisher's exact test

It is observed, on the quality of life and the adherence of the people in treatment of pulmonary tuberculosis, in table 5, that the averages varied from 8.33 to 80.00. In relation to the average adherence to treatment, it was observed that the social aspects and mental health domains remained with the high means (80.67 and 77.08, in this order) and the limitation by physical aspects and emotional aspects presented the averages (zero and 16.67, respectively). It is pointed out that, for patients with high adherence to tuberculostatics, the social aspects (68,75) and mental health (80) were the highest, and the domains of limitation due to physical aspects (8.33) and emotional aspects (16.67) had lower levels.

Table 5. Association of the quality of life to the adherence of people in the treatment of pulmonary tuberculosis of a reference outpatient clinic, Recife (PE), Brazil, 2017.

Domain	Average Average ± SD	High Average ± SD	P value
Functional capacity	51.67 ± 19.41	47.92 ± 38.93	$p^{(1)}$=0.945
Physical aspects limitation	0.00 ± 0.00	8.33 ± 28.87	$p^{(1)}$=1.000
Pain	48.50 ± 17.28	52.25 ± 24.38	$p^{(1)}$=0.801
General health status	68.67 ± 16.02	51.75 ± 27.45	$p^{(1)}$=0.185
Vitality	47.50 ± 17.54	43.33 ± 21.03	$p^{(1)}$=0.699
Social aspects	77.08 ± 30.02	68.75 ± 25.28	$p^{(1)}$=0.402
Emotional Aspects	16.67 ± 40.82	16.67 ± 33.33	$p^{(1)}$=1.000
Mental health	80.67 ± 10.86	80.00 ± 16.09	$p^{(1)}$=0943

By means of the Mann-Whitney test

DISCUSSION

It is the predominance of young, single and male adults that contributes to greater vulnerability and increase in the rate of abandonment of treatment, and is discussed in similar studies already reproduced.[11-2] It is believed that the characterization of the interviewees was extremely relevant, since people with higher levels of schooling are more likely to adhere to treatment because of greater understanding and access to information about the disease.[13] It is thus perceived that tuberculosis is a neglected disease, which is related to living conditions and socioeconomic.

Low monetary income is measured as one of the factors that can influence the quality of life of these people, who often do not have the conditions to pay for transportation to health services. In addition, food shortages, unfavorable housing conditions, as individuals in the street, as factors that increase the probability of acquisition of tuberculosis, late diagnosis and difficulty accessing health services.[14]

There are positive results for alcohol and drug use, since a small percentage of the participants used these substances. The use of these determinants is considered for a high drop out of tuberculostatic therapy, as well as for the late search for treatment, since individuals who use alcohol and drugs are

more likely not to know that tuberculosis is curable or its forms transmission. It can also be affected by the continuous use of alcohol and drugs, therapeutic efficacy and drug interactions, thus providing greater adverse reactions and the probability of abandonment to treatment.[15-6]

It is noted that, in some cases, TB can occur without any specific symptoms. It is explained that cough, when present, can be with or without mucus or blood, accompanied or not with other symptoms such as: chest pain, weakness or tiredness, weight loss, evening fever and night sweats, and may be common before the beginning of treatment and, when they remain for a time, further complicate the adherence of these patients to therapy.[17] It was evidenced, on the clinical aspects, that half of the participants were at the beginning of the maintenance phase of treatment against tuberculosis. A majority of the patients reported coughing for ≥ 3 weeks, productive cough, weight loss and night sweats at the onset of the disease. However, despite the initiation of treatment, weight gain, weight loss, joint pain and cough still occur.

It is important to take into account that such initial clinical manifestations can be confused with other diseases, causing the treatment to be erroneous and, consequently, the diagnosis and treatment for tuberculosis late. For these aspects, the reflection on the importance of the professional qualification for the suspicion, diagnosis and treatment of tuberculosis is brought to light. It is fundamental, as far as manifestations after the beginning of treatment, the health professional's action regarding the incentive to the continuity of the treatment by the patient, besides, making available alternative measures for the reduction of these manifestations that can drug adherence, which may even lead to abandonment.

HIV positive results were presented for a small percentage, emphasizing the importance of offering rapid HIV testing to all individuals diagnosed with tuberculosis in the health services, thus aiming at the early initiation of treatment for coinfection TB, as well as to reduce the transmissibility of diseases and the acquisition of other opportunistic infections. It is demonstrated in the literature that coinfected patients have a lower survival rate and present twice the risk of clinical progression of HIV when they do not immediately initiate antiretroviral therapy and treatment for tuberculosis in a timely manner.[18]

It was asked, in relation to examinations, about the two samples of recommended bacilloscopy and also the chest radiographs for almost all patients, however, it is possible to perceive the great difficulty in obtaining the results in an adequate time, evidencing the failure of the health system, impairing the treatment and care provided to the patient. As for compliance, the study shows relevant results, since most of the interviewees had high adherence to tuberculostatics and none were classified as low adherence. It is evidenced, taking into account these aspects, that social and clinical factors influence the drug adherence to tuberculostatics.

It is noted, in this context, that the factors associated with abandonment are diverse, whose difficulties may be related to the user and the treatment itself. Low risk factors for non-adherence to tuberculostatics include low purchasing power, unemployment, illiteracy, and low schooling, leading to a lack of information about the disease, alcohol / tobacco use and other drugs, to be male, single, have no domicile or are in a street situation, in addition to prolonged treatment, which corroborates the results found.[19]

Patients presented higher quality of life in the domains of social aspects and mental health. However, in the others, there were low results, mainly in the domains related to physical and emotional aspects. It is seen in the association of this with adherence that, in those with high and medium adhesion, there were higher results also in the social and mental aspects and lower in the physical and emotional aspects. It is confirmed by these results the perception that tuberculosis compromises the quality of life of the infected people, since, besides the physical implication, there is the emotional and psychic commitment, since, despite being a treatable and curable disease, there is the stigma, lack of information and the fear on the part of the society to acquire the disease, causing the change in the daily life of these people.[20]

In view of the foregoing, it is understood that it is extremely important to create a patient-professional relationship, as well as the implementation of street clinics and multidisciplinary teams in the active search for new cases, promoting, to these individuals, access to health, diagnosis, treatment and follow-up, consequently reducing the number of cases of abandonment and transmission of the disease. It is important to emphasize the need to qualify these health professionals to

expand and build actions aimed at TB control through interventions and creation of new educational and care technologies. In addition, it is also aided by these patients in accepting their diagnosis, encouraging the continuity of treatment and creating mechanisms to increase adherence and improve their quality of life.

CONCLUSION

It is assessed that tuberculosis is a disease that affects all population levels. It is observed, however, that the infection is still predominant in individuals in situations of social and clinical vulnerability and with the lowest socioeconomic power. It was evidenced in this study that socioeconomic factors are directly related to adherence to tuberculostatics and that the participants presented unsatisfactory results in the domains related to quality of life. The importance of the creation of the professional-patient bond in the continuity of treatment, the increase of the drug adherence and, consequently, of the improvement of the quality of life, mainly in the physical and social aspects, is perceived.

There are gaps in the knowledge about the proposed theme, and it is of great importance to develop new studies that will deepen the analysis of how people diagnosed with TB adhere to treatment and how it can influence their quality of life. It is hoped, further, that this study will inspire new research on the subject and also strategies for training health professionals to suspect, early TB diagnosis and treatment in a timely manner, aiming to improve the quality of care with focus on the profile of patients and their risk factors.

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