ABSTRACT
Objective: to briefly describe the tuberculosis control policies in Brazil over the years. Methodology: descriptive study addressing Tuberculosis control policies through the years until today. Data was collected through reading and analyzes of articles, also through manuals of the Ministry of Health and from Master Dissertations. Results: the first effective public action for tuberculosis control in Brazil was in 1907, in that time, TB treatment was exclusively undergone into the hospital. Later, health campaigns were adopted aimed to avoid diseases that threaten the population productivity. Although the use of various drugs since the 1980s, tuberculosis has been increased significantly in all communities, including developed countries. One of the triggering factors was the widespread use of antibiotics, the HIV pandemic, increase of poverty, alcohol consumption and smoking. Conclusions: it was observed that there was a substantial advance regarding to Tuberculosis assistance policies since its beginning, either by increasing the technological apparatus, or through the discovery of new drugs. However, there is still a need for greater investment, especially for training the professionals working in the Family Health Strategy (FHS). Descriptors: public policy; tuberculosis; family health program.

RESUMO
Objetivo: descrever sucintamente as políticas de controle da tuberculose no Brasil ao longo dos anos. Metodologia: estudo descritivo acerca das políticas de controle da tuberculose ao longo dos anos até os dias atuais. As informações foram coletadas a partir da leitura e análise de artigos, bem como de manuais do Ministério da Saúde e Dissertações de Mestrado, que abordassem aspectos históricos sobre as políticas públicas de saúde ligadas à tuberculose. Resultados: a primeira ação pública efetiva no combate à tuberculose no Brasil foi em 1907, no qual o tratamento da tuberculose era exclusivamente hospitalar. Tempos mais tarde adotaram-se as campanhas sanitárias que objetivavam reter as doenças que ameaçavam a produtividade da população. Apesar da utilização de diversos medicamentos a partir da década de 1980, a tuberculose aumentou significativamente em todas as comunidades, inclusive em países desenvolvidos. Um dos fatores desencadeantes foi o uso indiscriminado de antibióticos, a pandemia de HIV, aumento da pobreza, do consumo de álcool e do tabagismo. Conclusões: observa-se que houve avanço substancial no tocante às políticas de assistência à tuberculose desde a sua gênese, seja pelo aumento do aparato tecnológico, seja pela descoberta de novas drogas, no entanto, ainda há a necessidade de maiores investimentos, principalmente na capacitação dos profissionais que atuam na Estratégia de Saúde da Família (ESF). Descriptors: políticas públicas; tuberculose; programa saúde da família.
INTRODUCTION

Despite the government’s current concern with tuberculosis, it is not a recent illness. The first public action effective in the fight against tuberculosis in Brazil was in 1907, with the Director General of Public Health, Dr. Oswaldo Cruz. In 1920, he created the Prophylaxis Inspection of tuberculosis, prioritizing the discovery and appropriate treatment for the ill.1

At that time, tuberculosis treatment was exclusively at hospitals, using the pneumothorax and other surgical techniques. However, these techniques did not have the expected effect. Therefore it was decided, by the clinics, outpatient units responsible for the diagnosis and treatment of this disease. Dating from this period the radiological examination and oral BCG vaccination vaccine for all infants.1

In the beginning of the nineteenth century almost a third of the deaths were due to this illness affecting mainly the Negroes.2 It was responsible for the growing number of deaths, especially in the city of Rio de Janeiro.3

With respect to the health policies at the time, they adopted new sanitary measures for the initiation of tuberculosis control, such as the reorganization of healthcare services in the cities of the empire in 1876.4

However, health issues at that time were treated by interventions, given the limited knowledge about the diseases that afflicted the majority of the population.3,2

At a later date they adopted the Health Campaigns that aimed to retain the diseases that threatened the population’s productivity, ensuring the sale of food and other products.3,2

In the nineteenth century healthcare was provided by the Holly Houses of Mercy, functioning in some Brazilian cities, in which the sick remained with others in the same ward, without isolation.1

In 1907, Oswaldo Cruz has instituted a plan of action against tuberculosis, obtaining, however, little impact. This plan was vetoed by the National Congress, because the disease did not directly threaten the structure of the State or the economy, since it was a working class endemic.6

In the year of 1920 the National Department of Public Health was created, by which time the State started to integrate the fight against tuberculosis, creating the Tuberculosis Prophylaxis 6

In 1926, the Department created the centralized model of preventives, hospitals, dispensaries and laboratory data, coordinated by the public sector.

In the two decades following, that is, in the 30s and 40s, where there was a strong health revolution. The oral BCG vaccine was introduced, as well as the creation of a large number of dispensaries, construction of sanatoriums, whose aim was the patient’s hospitalization and/or specialized surgical procedures.3

As hospitals, sanatoriums and dispensaries were not able to include all the hospitalizations and the patient could not remain without observation and medical care, in 1934 the home visit policy was created, where nurses were going to the patient’s house to check their economic, social and family structure. Tuberculosis once again began to be considered a public health problem, making to the treatment and prophylaxis a societal and family affair.6

In 1941 the National Tuberculosis Service (NTS) was created that promoted prophylactic actions and care. Around the year 1946 the National Campaign against Tuberculosis was instituted, assuming as the expansion of hospital and healthcare infrastructure in Brazil. After two years, it included the mandatory radiological examination and oral BCG vaccination as components which comprised the control actions of this disease.4

The introduction of tuberculosis drugs, streptomycin (1948), para-amino-salicylic (1949) and Isoniazid (1952), as well as the use of these drugs in standardized treatments, since 1964, they determined important impact in combating the disease.8

The treatment in the years 1950 and 1960, with the discovery of these drugs, went primarily to be ambulatory, making it unnecessary, in their great majority, the hospitalization of patients.5

In this period, the Brazilian Society of Tuberculosis SBT recommends priority to this modality of outpatient treatment, while the public power, through the National Campaign against Tuberculosis - TNSC, increased the beds for the patients with TB in 30 %. These actions have made the diagnosis and treatment sooner.1

But at the end of 1950, studies from the Central Laboratory of Tuberculosis, conducted in 1959, showed resistance to at least two medications in 68% of hospitalized patients and in 66% of the outpatients treated. Such resistance, combined with high in-hospital mortality, very low cure
percentage and high hospitalization costs, made it that the TNSC would define the standardized norms for the fight against the disease. From this strategy, the notification/information system was organized, this was fundamental to the knowledge of the problem’s magnitude and the effects of actions carried out.1

Therefore, tuberculosis was included among the Diseases of Compulsory Notification (ONC) throughout the national territory, establishing as a mechanism of notification the National Disease Notification System (SINAN) of the National Center for Epidemiology (CENEPI) of the National Health Foundation (FUNASA) Ministry of Health (MS).1

From 1960 onwards, with the discovery of streptomycin (S), isoniazid (H) and other antituberculosis chemotherapy, it was possible to ensure the cure for the majority of the patients who fulfilled the therapeutic regimen properly. The treatment in this period had 18 month duration, being indicated for sensitive patients. In 1965 the treatment time was reduced to 12 months, reducing the quantity of medication.1

The impact of the discovery of these medicines had brought hope for medical communities and general population. The conception of an incurable disease took another course, another direction. However, the medicated patients, believed that the end of symptoms was the end of the disease.6

In the year 1970, the SNT was transformed into National Division of tuberculosis and the embryo for the emergence of National Tuberculosis Control Program - PNCT. A year later the Central of Medicinal Products was created, responsible for the free acquisition and distribution of drugs to the entire Country.4

In 1973, the intradermal BCG vaccine was implemented and from 1976, it was determined as mandatory for all newborns. In that year the Division of Pulmonology Health was also organized.8

In the year 1975, the II National Development Plan was created by integrating various government levels, with the aim of reducing the morbidity, mortality and the socio-economic problems arising from tuberculosis.5

In 1979 the short term treatment regimen was introduced, completed in 6 months, with the administration of oral drugs, such as rifampicin, isoniazid and pyrazinamide. Most of the users performed the self-administered treatment, receiving the medicines in monthly quotas at the health unit.2,3,8

However, despite the use of various medicines during this period, tuberculosis significantly increased in all communities, from 1980 onwards, even in developed countries.10

One of the triggers was the indiscriminate use of antibiotics, the pandemic of HIV, increase of poverty, alcohol consumption and smoking.11,12 From 1981 onwards, TB control decentralization began for the states and subsequently for the municipalities.8

In that same decade the short term therapeutic regimen began to be gradually introduced in the country, which favored program operational cost reduction. It started to be done during 6 months with the use of oral drugs.3

With the introduction of this new therapeutic regimen, the vast majority of patients started the self-administered treatment, receiving the drugs at the health units for monthly consumption, being responsible for their own intake.3

However, the author comments that this drug administration model transferred the responsibility of treatment to the patient, taking them away from health care services and reducing their contact with healthcare professionals. Measures such as the “home visitation”, although recommended, are no longer priorities for healthcare services.

In 1990 the implementation process of the Unified Health System (SUS) began. At this same time period, due to actions to control public spending and the decentralization of state and municipality administration, the Tuberculosis Control Program became unstructured, extinguishing the National Campaign against Tuberculosis. This led to the weakening of the Program’s supervision, almost resulting in the collapse of the PNCT.2,8

Important actions in the international sphere tried to encourage governments and civil society to expand actions to control the disease, such as the statement made by the World Health Organization in 1993, warning about the state of urgency of tuberculosis, appealing governments, the scientific community and civil society to double their efforts in controlling this disease.13,1

In 1996, implanted the Emergency Plan, with the objective to implement specific actions in 230 priority cities, where the disease had the greatest epidemiological...
The year 1998 was marked by the institution of the National Tuberculosis Control Plan (PNCT), whose action’s goals are as follows: (1) implement Tuberculosis Control Program coverage for 100% of the municipalities; (2) diagnosis at least 92% of expected cases and be successful in at least 85% of the diagnosed cases; (3) reduce the incidences by at least 50% and the mortality rate by two-thirds. 14

This plan introduces, in addition to other innovations, the Directly Observed Treatment Short-Course (DOTS), already defined in 1993 by WHO, as a fundamental strategy in the treatment of tuberculosis. 14

In 2000, a new Tuberculosis Control Program (PCT) was produced for the 2001 to 2005 period, introducing new possibilities for intervention with the Family Health Program (FHP) and Community Health Agent Program (PACS) strategies in the expansion process of the PCT actions, because these strategies have a healthcare conception focused on family and community, with practices that point to the establishment of new relations between the involved health professionals, individuals, their families and territory. 14, 15

This partnership established from 2000 between the PCT with the PSF and the PACS decentralizes the tuberculosis control actions in the basic care sphere, enabling the promotion of better care for the TB patient, once which strengthens the participation in the community, contributing in treatment compliance and in search of respiratory symptoms. 14, 16

Thus, the PSF and the PACS propose a new dynamic and structuring of the services and health actions and these as their main characteristics and differential in relation to traditional programs. 15

In 2001, the Ministry of Health implemented the National Mobilization Plan and intensification of the actions for the Elimination of Leprosy and Tuberculosis Control, which sought greater technical, political and social mobilization to achieve the goals of tuberculosis control. The improvement of monitoring systems for cases and household and institutional contacts, the expansion of the network of public laboratories or collaborators, in the training of health professionals and in surveillance and control actions, in addition to supervised treatment, were regarded as key components of this program. 14

During this period it also encouraged, the care model change, guiding the expansion of the Family Health Program. It stands out from there, the importance of this program with the active participation of community health agents, allowing the implementation of supervised treatment in the country. 15

Three years later, the National Tuberculosis Control Program was reorganized and restructured, establishing the new goals for the triennium 2004-2007 and including the expansion of the DOTS strategy (Directly Observed Treatment Supervised) to three hundred and fifteen priority cities (PC), responsible for approximately 70% of tuberculosis cases. 17

DOTS DOTS is a set of political-administrative strategies which includes actions to search for respiratory symptoms with laboratory support, monitoring actions of the treatment, political commitment, record systems a drug supply. 18

Currently the main elements of public policies for the control of tuberculosis in Brazil and the world, are: 1 - Early diagnosis and treatment; 2 - BCG vaccination in children under one year of life and 3 - focus on the problem in the most vulnerable populations in the municipalities with high endemic rates. 19

For both, the main guidelines are: (A) outpatient treatment available, in low complexity health units, including the participation of family health care teams; (b) hospital care, and (c) access to images resources, surgeries, laboratories and more specific drugs for multi-resistance cases. 19

It is understood that to make everything concrete which was outlined in the last few paragraphs, the humanization of health care practices in the family and its social space becomes the reference of this new coping strategy that uses Family Healthcare Teams and the Community Agent Program, which certainly will bring the proposed objectives into reach. 3

These professionals must be empowered and trained for treatment, registration, notification and other activities to effectively fulfill their specific responsibilities with the appropriate supervision. 14

CONSIDERATIONS

With the passing of years an evolution in public health policies on assistance for tuberculosis has been observed. Also new drugs were created and new administering methods, which has brought the control and/or elimination of the disease closer to the desired, in addition to substantially improving the patients’ quality of life.
However so that these changes will be implemented and advance even more, it is necessary to train professionals who are directly involved in this process, in regards to the humanization of their health practices, is the knowledge about the records and reports.

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