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Bond in the management of tuberculosis in Primary Health Care: the perspective of health professionals

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Abstract

The way in which health units belonging to Primary Health Care (PHC) are organized is considered a potential element in promoting the construction of bond between professionals and tuberculosis (TB) patients. The objective was to analyze the bond TB patients have with the care management in PHC in the city of Porto Velho, RO, from the perspective of health professionals. This is a descriptive, survey-type study, carried out cross-sectionally from a quantitative approach, with nurses, doctors, nursing technicians/assistants and Community Health Agents, through an interview using the dimension concerning bond in the questionnaire Primary Care Assessment Tool (PCATool), which has the Likert scale as response categories, and was analyzed by classifying the average scores as unsatisfactory (values between one and two), regular (around three), or satisfactory (between four and five), after complying with the ethical precepts. 266 health professionals were interviewed, whose perspectives, regardless of the professional category, was generally satisfactory toward bond, in relation to the co-responsibility of TB cases, acceptability and need for incentives, as well as the evaluation of the health team work process. However, it was shown to be regular regarding the stigma of the disease, which makes it difficult to change the teams' work process in order to enhance bilateral relationships. In view of these findings, the need to recognize that TB affects all aspects of life and that the focus of longitudinal care must underlie all other factors related to treatment is identified.

Keywords: Tuberculosis. User Embracement. Professional-Patient Relations. Health Services Research. Primary Health Care.

INTRODUCTION

The way in which health units belonging to Primary Health Care (PHC) are organized is considered a potential element in promoting the construction of bond between professionals and tuberculosis (TB) patients, since it allows contact between users and families with the service through the decentralization of disease control actions[1,2], which facilitates the process of health promotion and disease prevention[3].

Thus, strengthening the bond in PHC

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is considered a therapeutic resource that expands the effectiveness of TB management, enabling the user to understand the meaning of self-care through listening, dialogue, respect, integrality, humanization, autonomy, and citizenship[4,5], which suggests interdependence and depends on how teams are responsible for people's health[6].

However, the role of PHC as an ordering and care coordinator in the Health Care Network (HCN) and its resolution are questioned, as in the municipality of Porto Velho, in the period from 2014 to 2016, 50.30% of TB diagnoses were made at the tertiary referral service in the state[7]. This could have contributed to the low cure rate (67.4%), the third highest dropout rate (18.6%), and the second lowest rate to perform the Directly Observed Treatment (DOT) (1.3%) in the country[8]. All of this reveals a disconnect between management and health services for the recognition of the registered population, comorbidities in the area, and the influence of social determinants of health, which requires the development of health surveillance actions in health territories through an articulated service-offering network.

A study that sought to describe how the bond has contributed (or not) to the management of TB care in PHC, proved, based on an integrative literature review, that the guidelines regarding the disease, treatment, side effects, and other health problems; being attended by the same professionals; Health education; the operationalization of the DOT; home visits (HV); training of the interdisciplinary health team; the family and social support network; the supply of inputs and incentives; the importance of Community Health Agents (CHA); as well as the communication with other health services are constituted as potentializing elements for the construction, establishment, and strengthening of the bond. On the other hand, the stigma of the disease; social and psychological problems during treatment, such as drug and alcohol use; difficulties in accessing TB diagnosis and treatment; destruction, fragmentation of services; and failures in the referral and counter-referral system are cited as elements that hinder and do not contribute to the bond created in the management of TB[9].

This study is justified by the identification that the health actions developed during the management of TB in PHC still occur in a discontinuous and disjointed way between health professionals (horizontal integration) and services (vertical integration) of the HCN, which shows the predominance of a fragmented health care model[4]. In this sense, the importance of identifying bottlenecks in the organization and performance of health services is highlighted, based on the understanding of aspects that hinder the reorientation of practices and services offered for planning and comprehensive care that chronic conditions require, TB being one of these[9].

Therefore, the aim of this study was to analyze the bond the care management has with TB patients in PHC in the city of Porto Velho, RO, from the perspective of health care professionals.

METHODS

This was a descriptive, survey-type study, carried out cross-sectionally using a quantitative approach, developed in Porto Velho, capital of the state of Rondônia, located in the North of Brazil belonging to the territory of the Legal Amazon.

Currently, the PHC network in the municipality is composed of 17 Basic Health Units (BHU) and 37 Family Health Units (FHU), making a total of 54 health establishments, distributed in urban (20) and rural (33) areas, which are subdivided into land (18) and riverside (15) units, as well as one river mobile unit[10]. In this study, only health units distributed in the urban area were considered.

TB care in the city is decentralized to PHC, considered the gateway and the first contact for Respiratory Symptoms (RS) patients. Therefore, in the face of a suspected case of TB, PHC is responsible for the clinical evaluation and request for diagnostic tests to investigate the case, as well as for all care management that involves treatment, such as monthly monitoring and control, DOT, investigation of contacts, and ensuring flow of this patient with the referral services, when necessary.

As for the support network, in the municipality there is only one Extended Nucleus for Family Health and Primary Care (ENFH-PC) and one street office. In addition, it has the support of referral services, on an outpatient basis, for the treatment and monitoring of childhood TB, of co-infected TB/HIV patients, and with the extrapulmonary clinical form; and at the tertiary level, there is support for the treatment of drug-resistant TB (DR-TB) and in cases of hospitalization due to possible complications, if necessary. As for the laboratory diagnosis, there it the support of a municipal laboratory for sputum smear samples and the performance of the Rapid Molecular Test for TB (TMR-TB), as well as the state laboratory, in charge of analyzing the samples for sputum culture and sensitivity tests.

The study population consisted of health professionals working in 76 Family Health teams (FHt), located in the urban area of the city, including nurses (75), doctors (77), nursing technicians and assistants (188), as well as the CHA (397) who deal with the care management of TB patients in the PHC services.

As inclusion criteria, we used all those who exercised their function for at least 12 months and who had experience in approaching at least one TB case since their graduation/training - not necessarily in the same unit where they worked at the time of the interview. All those who were on vacation and/or leave during the data collection period were excluded.

To calculate the sample of professionals to be interviewed, a survey was carried out of the number of professionals who worked in PHC health services through the National Register of Health Facilities (NRHF). For this, considering the total population of 737 professionals working in these units, the sample's n was estimated by the sample calculation formula for a finite population:

$$n = \frac{z_{\frac{a}{2}}^2 * N * P * (1 - P)}{\varepsilon^2 * (N - 1) + z\frac{a^2}{2} * (1 - p)}$$

Therefore, considering an error ($\mathcal{E}$) of 5%, a confidence interval (Z) of 95%, sample proportion (P) of 50% of the population (N=737), 253 professionals needed to be interviewed, based on proportionally dividing each professional category, comprising 136 CHA, 65 nursing technicians/assistants, 26 doctors, and 26 nurses.

For data collection, the Primary Care Assessment Tool (PCATool) questionnaire[11] was used as an instrument, which was adequate and validated for Brazil[12] and, later, adapted for TB care[13]. It is emphasized that, in order to meet the objectives of this study, only the bond dimension of the version for health professionals was considered, with 16 issues related to the co-responsibility of TB cases, disease stigma, acceptability and the need for incentives, in addition to the evaluation of the health team's work process.

The instrument categorizes responses according to the Likert scale, with values between zero - for the answer "does not apply"; and from one to five, referring to the degree of preference or agreement with the statements: never, almost never, sometimes, almost always, and always.

Data were collected from May 2018 to February 2019, through individual interviews by appointment and were carried out exclusively at the workplace of these health professionals, safeguarding their privacy. Thus, this study starts from the concept that the bond is a light technology that is fundamental to the consolidation of comprehensive healthcare, by allowing the participation of users as autonomous and empowered subjects for their self-care, with feelings and needs that should be valued by professionals, in order to optimize actions and services aimed at needs and vulnerabilities, with a view to building a new paradigm of care for TB patients.

The collected data were stored in Microsoft's Excel and analyzed using Statsoft's Statistica 13.0 software, through a descriptive analysis. For the analysis of the scores, an average score was determined for each variable that corresponds to the sum of all categories of responses divided by the total number of people interviewed. In a complementary way, the average score of the dimension listed for this study was defined, which corresponds to the sum of all the average scores of the variables, divided by the total number of variables[13].

The classification of the average scores obtained was performed as follows: unsatisfactory (values between one and two), regular (around three) or satisfactory (between four and five)[14], which made it possible to analyze the bond dimension within the context of PHC in perception of health professionals.

For the dimension listed in this study, two forms belonging to the CHA category had six or more variables answered as "Does not know" and/or "Refuses", which were replaced by "zero", in order to preserve the total number of professionals interviewed and not interfere with the mean scores, whether they are of variables or overall.

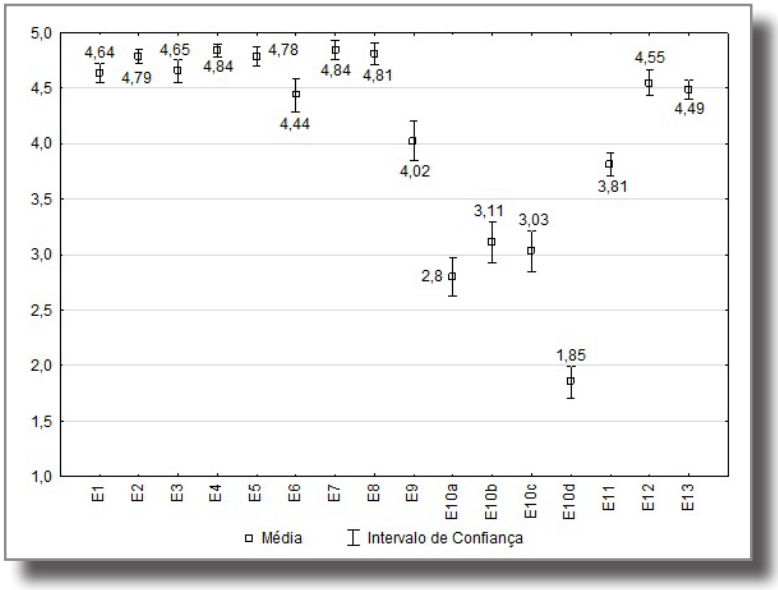
Some variables like "E10a. Suffering from some kind of prejudice on the part of the family; E10b. By co-workers; E10c. By friends; E10d. By the unit's health professionals", they were classified inversely on the Likert scale, and the answers "never" or "almost never" were considered a satisfactory classification in relation to "always" or "almost always".

In compliance with the recommendations contained in resolution 466/12 of the National Health Council[15], the project was submitted and approved by the Research Ethics Committee according to opinion number 2.585.934, and the Informed Consent Form (ICF) was delivered in two copies for each interviewee.

RESULTS

401 PHC health professionals from the municipality were approached, of whom 120 were excluded, since, during data collection, 73 had not had experience with at least one TB case since their graduation/ training, 29 were on vacation, 14 were on leave, four had not exercised their function for at least 12 months, and there were 15 refusals. A total of 266 health professionals were interviewed.

Regardless of the professional category, the general average score of the bond dimension was considered satisfactory (4.09) from the perspective of health professionals who deal with the management of TB in PHC. Since consultations occur with the same health professional, there is the clarification of doubts about the treatment of TB, understanding of questions by patients, clarity in answering doubts and making time available for that, concern on the part of professionals with other problems or health needs of TB patients, explanations concerning the drugs used to treat the disease, requests concerning information on other medications used by the patient, and recommendation of services for TB patients. In addition, it was identified from the perspective of professionals that patients do not suffer any prejudice by the health professionals of the unit, there is acceptability and the need for incentives to face the disease and continue treatment, and the health team's assistance to TB patients is well evaluated. On the other hand, the response was regular in relation to prejudice on the part of family, co-workers, and friends (Figure 1).



Legend – E1. Consultations with the same health professional; E2. Clarification of doubts about TB treatment with the same health professional; E3. Understanding of TB patients' doubts/ questions by the professionals who care for them; E4. Clarity in answering doubts; E5. Time allocated for the patients to explain their doubts or concerns; E6. Professionals' concern with other health problems or patient needs; E7. Explanation of the drugs used to treat TB; E8. Request for information on other drugs used by the TB patient; E9. Recommendation of services to friends by the TB patient; E10a. Suffering from some kind of prejudice on the part of the family; E10b. By co-workers; E10c. By friends; E10d. By the unit's health professionals; E11. Acceptability of treatment by the TB patient; E12. Need for incentives to face the disease and continue treatment; E13. Evaluation of the health team's assistance to TB patients.
Response categories: 1 - never; 2 - almost never; 3 - sometimes; 4 - almost always; 5 - always.

Figure 1 – Distribution of the mean scores and confidence intervals of the variables of the bond dimension, according to the PHC professionals interviewed from May 2018 to February 2019, Porto Velho, Rondônia, Brazil.

DISCUSSION

Within the context of PHC, the bond is capable of generating mutual cooperation, contributing to access and adherence to treatment, because the fact of being attended by the same professional culminates in feelings of reception, bilateral respect to those who accompany them during consultations, and trust[16]. Moreover, they will be more comfortable and feel safe to expose and resolve their doubts, difficulties, and expectations regarding their therapeutic process[17-19], offering continuity of care beyond the disease and meeting other users' needs[7].

Effective communication with a focus on subjectivity allows the creation of an environment so that the patient can reflect on their suffering, recognize the importance of continuity of treatment, risks, and side effects[16], as well as assuming their role as a protagonist and those co-responsible for their health[14,19]. However, it is still questioned how the guidelines are being carried out regarding possible drug interactions that may impair the efficacy of treatment for TB, given the number of hospitalizations at the tertiary level for complications of the disease.

During data collection, it was identified that some professionals were divided in some opinions regarding the co-responsibility of the cases, when they affirmed that it occurred even in the face of barriers, such as the reception that should be more careful and organized, since some professionals made it difficult; the thought that the units do not omit care, but the patient should be responsible for their own search; and that certain approaches embarrass the patient during diagnosis and treatment.

This goes against a study[7], which asks whether TB patients, in addition to having their doubts heard and answered, were considered in their silence, since the difficulties, fear or shame of expressing themselves - most of the times caused by power relationship established by the knowledge holder/ professional - resulted in their passivity in self-care.

Some professionals during the interviews, mostly nursing technicians/assistants and CHA, stated that the questions should be directed to nurses and/or doctors, especially those related to monitoring, guidance, and questions about medications and other health problems. Others stated that questions regarding guidelines for doubts and questions should be given to users.

This reveals the view of the performance of these professionals particularly focused on the biological and critical situations of the disease and treatment, without taking into account health actions for the promotion and prevention of TB, in addition to exempting themselves from the responsibility of being the facilitator of the care process and a member of the team responsible for cases and surveillance of diseases, such as TB.

Regarding the recommendation of the services for a friend to be attended to, a satisfactory result was identified in this study for all professional categories of the FHt, which demonstrates that longitudinal responsibility for the user occurs with continuity of professional/team/health unit-user relationships, regardless of the presence or absence of the disease[3]. This generates a feeling of resoluteness and, consequently, dissemination of health actions and their results obtained to the community.

An example of this refers to a FHU located

close to the riverside community of the municipality, which experienced the impacts of the flood on the bed of the Madeira River in 2014, interfering in the daily life and health of the population close to that place, forcing them to live in shelters with conditions of poor sanitation and subsistence. According to the professionals of this unit, some of these people, for having become more vulnerable to infection and, consequently, for having acquired TB while surviving/living in places distant from the unit, continued treatment with the unit team, in addition to recommending services to family and friends. This reflects the establishment of bond and co-responsibility between professionals and the community, as well as the longitudinal focus of care.

For this accountability to be efficient, it is necessary that FHt professionals recognize their role within PHC as they are inserted as those responsible for TB cases. In some interviews, professionals reported the difficulty of knowing whether the bond is created due to the incentive of other professionals seeking other health units or even referral services for treatment, which can delay the diagnosis and start of medication intake, worsen health status, and culminate in unfavorable outcomes.

Considering the regular score related to the stigma of the disease by the family, co-workers and friends, it was possible to identify the persistence of the social and exclusive content of TB patients, which is a problem surrounded by taboos and beliefs of a symbolic nature bound by stigmas and prejudices[6,20]. This causes suffering and negative impacts on self-esteem, emotional disorders, and barriers to adherence to treatment by TB patients[16,21].

In this sense, it can be seen how the stigma of the disease influences the bond due to some practices within the family, work, and circle of friends, especially with regard to the wrong forms of precaution against contagion and the lack of understanding of the disease, which interferes with the individual's social, economic, and spiritual dimensions[22], and highlights the need for health education about TB[23].

Some professionals stated that questions related to TB stigma should be directed to patients to answer, as they did not know their friends, co-workers, and some family members, which questions the extent to which professionals address other aspects besides TB, recognizing that it is part of the care process. This reflects the way the teams act in health education activities with the family and community regarding TB, in order to minimize the stigma about the disease.

In this perspective, it is evident that the support and participation of the family in coping with the disease helps to strengthen the bond, adherence to treatment, change of habits, emotional comfort and encouragement for the progress of treatment[6,21], but this should not exempt health professionals from their own support responsibilities[24].

As for coworkers and friends, studies indicate that the stigma of TB is high within the community in general and, because of this, some patients do not reveal their clinical condition to any member of their social circle - work, leisure - for fear discrimination in relation to the patients themselves and/or their families, losing their jobs and social isolation[24]. This questions the extent to which the community understands what TB is and how the FHt could intervene in these cases.

Even the satisfactory variable related to the stigma of TB by health professionals, most of them in the study reported that “almost never” or “never” have TB patients

suffered prejudice by the professionals of the unit, especially those responsible for their reception. However, during the data collection, some speeches were divergent from such findings were found, which characterize the stigma by health professionals due to the lack of TB prevention and contagion actions, segregating and reductionist attitudes, which reflect the lack of self-criticism as the stigma persists in the treatment today. This shows a socially imposed distance between the patient and the professional, in addition to looking at the others and not at oneself.

The acceptability of TB treatment by patients was considered satisfactory in this study. However, some risk factors for unfavorable outcomes were highlighted by health professionals in the interviews, such as alcoholism, drug addiction, low income, comorbidities, homeless people, or TB/HIV co-infection, which questions how actions have been carried out that contribute to providing access to health services. This is mainly because these are risk groups for the contagion of the disease when compared to the general population, as well as the availability of incentives, such as basic food baskets and transportation vouchers, to strengthen adherence and disease control.

During the collection, some professionals reported the growing number of abandonment cases as a reflection of the care provided, due to the lack of incentives for patients, such as psychosocial support, especially to drug users, alcoholics and homeless people, insufficient information during treatment, and difficulty in monitoring patients from areas not included in the coverage area of the Family Health Strategy (FHS). This contrasts with the satisfactory findings of this study for the bonding factor, since, according to the professionals' statements, it is possible to identify the impact on PHC to that extent as it fails to fulfill their responsibilities and resolutions.

It is questioned the way that the units have communicated with the support network of the municipality, especially the ENFH-PC and the street office. Since the municipality has unsatisfactory operational indicators, their deficiencies, in the view of the professionals, make it difficult to monitor the cases by a multiprofessional team that develops the actions in the community and that requires intersectorality and shared case management.

In addition, the disease is still recognized as neglected, particularly due to the flaws of actions that should be aimed at addressing the social determinants that accompany it[8], such as socioeconomic and cultural factors, living and working conditions, availability of food, social security, population behaviors, and barriers to the adoption of a healthy lifestyle[25,26]. Through the improvement of services offered in the HCN, such as the expansion of decentralized services, allow the implementation of DOT and optimization of the flow of referral and counter-referral.

An example of this is the operationalization of the DOT, which could contribute to the cure and abandonment rates, in addition to the availability of incentives to expand the therapeutic possibilities[22]. This suggests the reorientation of care models practiced in the reality of PHC health services towards the management of TB cases, since it is the sick individuals who suffer from the flaws of the public system with greater frequency and intensity[27].

Most professionals during data collection, stated that TB patients accept treatment, but that for this it is necessary to offer incentives to face the disease and continue therapy, as well as the focus on the family and the control

of contacts. This should be done by the FHt who, in many moments of the interview, had stigmatizing statements against the disease, in addition to not feeling responsible for TB surveillance and control actions in the community, in families, and with the patients themselves.

According to the Ministry of Health (MH), for the continuity of treatment, social incentives must be identified and guaranteed to TB patients[28], which was observed in two studies that demonstrate that the provision of incentives, such as coffee kits in the morning, basic food baskets and milk[29,30], contribute to adherence to the treatment of the disease, considering the socially vulnerable state of the TB patient and his family, as well as the individual's own condition.

In the municipality, even though social incentives were not offered to TB patients, it was observed that some professionals reported that, acting independently, they organized themselves as a team to provide breakfast to some patients undergoing treatment, as an opportunity to perform the DOT treatment. Others daily provided private transport, especially for cases diagnosed as DR-TB, which demonstrates the concern with the bond formed, confidence building, and insertion as an integral and responsible part of the care from the individual and collective point of view.

Considering the support groups of TB patients as other support activities for adherence[28], it was observed that PHC did not do them. Some professionals justified this on the grounds of non-adherence/ attendance of patients on the days of the group, focusing on the health of woman and children, in addition to the unavailability of a professional to carry it out. This demonstrates the obstacles that permeate the offer of individual and collective health education actions, and this influences access to information, participation, exchange of experiences and, consequently, the way in which the patient is inserted and perceives his role in the health-disease process.

The health team's care for TB patients was considered satisfactory from the perspective of the PHC FHt professionals in the city. However, during the interviews, it was possible to identify at various times that the "optimal" service referred to by the nursing technicians/assistants and CHA was that performed by the nurse or doctor. This questions how the surveillance of the FHt activities and actions have been performed, the way other professionals see their work process, how much they feel part of the team and act as such to justify possible dissatisfaction, as well as the centrality of care based on biological and medicinal aspects, all contributing to the flaws of teamwork.

It is emphasized that the teamwork within the FHS proposal is important for the strengthening and monitoring of disease control measures. Moreover, because of difficulties in the workplace, such as work overload, few spaces for training procedures in view of permanent education in health associated with the hegemonic and fragmented health model, the teamwork process is affected[7].

Such aspects were cited by some of the professionals interviewed, except for the frequency of trainings offered by PHC teams, which, although they are constantly offered by the (municipal and state) health departments, some professionals, mainly technicians, nursing assistants and ACS, said that due to work overload and extramural activities, they were unable to participate in these times for learning and updating. This was especially the case for those who had more than one job, as happens with most

professionals in the studied scenario.

These professionals also identified the need for constant updates and activities to raise awareness about TB, as well as the importance of health education, when claiming that their routine promotes outdated TB management and often "forgets" about the disease. Others pointed out that there is a neglect and flaw in offering these updates for TB control to all professionals in health units, such as the fact that they are not released from their service to attend and that there is a focus only on treatment and not on health promotion and prevention of health problems.

However, it is questioned how the multiplication of training within teams by those who participated has been carried out, and what they do to change a model of care that is often based only on the treatment of the disease. It is worth mentioning that even though the training offered for the FHt is offered, the fact that only making more vacancies available to favor the inclusion of more professionals in the qualification processes, will not solve the challenges of TB since it is still based upon the a fragmented flexner model and focused on biological and technical aspects[31].

These issues limit TB control in PHC services, since there are flaws in the involvement of professionals in the actions recommended by the TB Control Program, due to the compartmentalized performance focused on a single professional[4], routinely the nurse. This is reflected in vertical and centralized actions, considering the number of weekly hours of the PHC teams, extensive territorial areas, and the distance between the patients' residence and the unit.

CONCLUSION

The results highlighted in this study allow for analyzing the quality of health action performance. Moreover, there are situations within the management of TB in PHC that characterize the existence of a bond in general, although not homogeneously, from the perspective of health professionals. Even though the dimension was categorized as satisfactory, the experience obtained in the fields and in the interviews, in addition to the epidemiological indicators observed in the municipality, point to a divergence between the professionals' perception and what actually occurs in practice.

Considering the regular classification in relation to stigma by the family, co-workers and friends, it was observed that in these cases the professionals answered the questions without taking into account self-criticism concerning the persistence of the stigma in the treatment today. This demonstrates their looking at others and not at themselves, which makes it difficult to change the teams' work process in order to enhance bilateral relations.

This study is limited by not having evaluated the perceptions of TB patients and managers and can be complemented by studies that include these perspectives, in order to analyze the difficulties and facilities in accessing and adhering to treatment. It is important to recognize that TB affects all aspects of life and that the focus of longitudinal care must underlie all other factors related to treatment.

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