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Original Article

DISCOURSES OF MANAGERS RELATED TO BARRIERS TO ACCESS TUBERCULOSIS DIAGNOSIS AND TREATMENT

DISCURSOS DOS GESTORES RELACIONADOS ÀS BARREIRAS DE ACESSO AO DIAGNÓSTICO E TRATAMENTO DA TUBERCULOSE

DISCURSOS DE LOS GESTORES RELACIONADOS CON LAS BARRERAS DE ACCESO AL DIAGNÓSTICO Y TRATAMIENTO DE LA TUBERCULOSIS

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Objective: to identify in the discourse of managers aspects related to barriers to access and treatment of people with tuberculosis in Primary Health Care services. Method: this is a qualitative study, with the participation of six coordinating managers of the tuberculosis control program. Data collection was performed using the interview and for data analysis was used the theoretical-methodological basis in French Discourse Analysis. Results: barriers that have hindered the access of patients are organizational, lack of professional, service hours, active search, delay in marking and delivery of tests. Information: lack of awareness of symptoms and stigma. In addition, the geographical accessibility that makes it difficult to move to health services. Final considerations: access to the diagnosis of tuberculosis in Primary Health Care services has weaknesses. It is necessary to make aware all those involved in the actions of care for tuberculosis, to turn their eyes to the aggravation.

Descriptors: Access to Health Services. Tuberculosis. Health Management. Primary Health Care. Nursing.

Objetivo: identificar no discurso dos gestores aspectos relacionados às barreiras de acesso e de tratamento das pessoas com tuberculose em serviços da Atenção Primária à Saúde. Método: trata-se de um estudo qualitativo, contou com a participação de seis gestores coordenadores do programa de controle de tuberculose. A coleta dos dados foi realizada utilizando a entrevista e para análise dos dados foi utilizada a fundamentação teórico-metodológica na Análise de Discurso de matriz francesa. Resultados: barreiras que têm dificultado o acesso dos pacientes são organizacionais, falta de profissional, horário de atendimento, realização de busca ativa, demora na marcação e entrega dos exames. Informação: desconhecimento dos sintomas e estigma. Além disso, a acessibilidade geográfica

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que dificulta o deslocamento até os serviços de saúde. Considerações finais: o acesso ao diagnóstico da tuberculose nos serviços da Atenção Primária à Saúde apresenta fragilidades. É necessário conscientizar todos os envolvidos nas ações de cuidado à tuberculose, que voltem seus olhares para o agravo.

Descritores: Acesso aos Serviços de Saúde. Tuberculose. Gestão em Saúde. Atenção Primária à Saúde. Enfermagem.

Objetivo: identificar en el discurso de los gestores aspectos relacionados a las barreras de acceso y de tratamiento de las personas con tuberculosis en servicios de la Atención Primaria de la Salud. Método: se trata de un estudio cualitativo, contó con la participación de seis gestores coordinadores del programa de control de tuberculosis. La recolección de los datos fue realizada utilizando la entrevista y para análisis de los datos fue utilizada la fundamentación teórico-metodológica en el Análisis de Discurso de matriz francesa. Resultados: barreras que han dificultado el acceso de los pacientes son organizacionales, falta de profesional, horario de atención, realización de búsqueda activa, demora en la cita y entrega de los exámenes. Información: desconocimiento de los síntomas y estigma. Además, la accesibilidad geográfica que dificulta el desplazamiento hacia los servicios de salud. Consideraciones finales: el acceso al diagnóstico de la tuberculosis en los servicios de la Atención Primaria de Salud presenta fragilidades. Es necesario concientizar a todos los involucrados en las acciones de cuidado a la tuberculosis, que vuelvan sus miradas hacia el agravio.

Descriptores: Acceso a los Servicios de Salud. Tuberculosis. Gestión en Salud. Atención Primaria de Salud. Enfermería.

Introduction

Primary Health Care (PHC) comprises the level of care that is closest to the population, is characterized by identifying the needs and problems of users, offers various services, and organize health care in networks, enabling coordination of care[1]. PHC services are also characterized as a gateway, and should be easily accessible and provide adequate and problem-solving care[1]. The term access can be understood as the user's entry into the health system. Access occurs when the individual identifies a health need and seeks specific care[2].

In the case of tuberculosis (TB), with the decentralization of care for PHC, it is up to the Family Health team (eSF, *equipe Saúde da Família*) to elaborate and develop actions and activities that can ensure care with resolution, through the problems presented by the population[3]. However, health services still have weaknesses as a gateway to the provision of some care, especially for the diagnosis of TB.

A study shows that of people who sought PHC services as a gateway to perform the diagnosis of TB, less than half were able to obtain the diagnosis. It also revealed that PHC services are not the most sought after by people with TB, and are not the first to be effective in performing diagnostic confirmation[4].

TB is still considered a serious public health problem. About 10 million people fall ill with TB each year in the world, being one of the top 10 causes of death and the main cause by a single infectious agent. It disproportionately affects males, adults, youth and low-income countries. Brazil is among the 30 countries with high burden for TB and TB-HIV coinfection, being considered a priority for disease control[5]. Despite being a disease with diagnosis and treatment offered by the Unified Health System (SUS), there are still barriers to access.

It is estimated that in Brazil, in 2021, 68,261 new cases of TB were diagnosed. Presenting an incidence coefficient of 32.0 cases/100,000 inhabitants (inhab.). In 2020, 4,543 TB deaths were recorded, resulting in a mortality rate of 2.1 deaths/100,000 inhab. In the same year, Pernambuco was one of the states that presented the highest mortality coefficients and Recife, the capital, also recorded one of the highest mortality coefficients, presenting 3.1 deaths/100,000 inhab. and 5.0 deaths/100,000 inhab. respectively[6].

The services find it difficult to provide adequate access to the diagnosis of TB, due to factors

such as low diagnostic capacity of professionals and the transfer of responsibility to other health services, lack of human resources, restriction of the hours of attendance at health units and the need for the use of motorized transportation by TB patients to travel to the health unit[4-7]. These barriers end up generating a break in the link between the user and the health professional, delaying the obtaining of the consultation, leading people with TB to seek other health services, further harming their displacement, causing more financial delaying the diagnosis of TB, favoring the spread of the disease, in addition to overloading other health services[8].

In this context, it is understood that access barriers are a major challenge for management. Some points can be considered to overcome these barriers, such as: greater articulation and exchange of information between managers, health professionals and users, planning of TB control actions, offering training for health professionals[9].

Given the importance of identifying access barriers that TB patients face in health services, scientific production on the subject has become increasingly expressive, contributing to the improvement of health services. In the specific case of the relationship between barriers to access to health services and TB, the studies, for the most part, address the view of TB patients and those who point to the view of managers deal only with barriers to access to health services without specifying TB[8-10-11]. This study aims to identify in the discourse of managers aspects related to barriers to access and treatment of people with tuberculosis in Primary Health Care services.

Method

This is an exploratory study, with a qualitative approach, based on the guide Consolidated criteria for Reporting qualitative research (COREQ). The study analyzes the discourses of health professionals who work in the role of managers, coordinators of the Tuberculosis Control Program (TCP), from the perspective of identifying the barriers of access of people with TB to PHC services in the city of Recife-PE.

The research was developed in the Sanitary Districts (SD) I, II, III, IV, V and VIII of the city of Recife-PE. It was decided to carry out the research in the SD, with the coordinators of the TCP, to know the vision of the managers who work at the most decentralized level of program management.

With a diverse territorial composition, the city is divided into 94 neighborhoods grouped into six Political-Administrative Regions and eight SD. In 2017, Recife had a population coverage by PHC estimated at 73%. Population coverage by the family health strategy reached 58%, Community Health Agent teams reached 14.5%, and oral health teams coverage was approximately 37%[12].

The participants of the research were managers, coordinators of the TCP of the SD of the city of Recife-PE. The initial forecast was eight participants, but only six interviews were conducted, considering that it was not possible to schedule two of the interviews due to unavailability of the managers' hours. The inclusion criterion used was the choice of professionals who worked in the coordination of the TCP of each SD in the period of study collection. As exclusion criterion was used the following cut: vacations professionals, leave or any other reason that prevented them from exercising the profession in the period of collection of empirical material.

The collection was carried out from April to June 2019, at the workplace of each participant, the semi-directed interview was used for the production of empirical material, which had an average duration of 18 minutes. They were recorded with the aid of audio recorder and transcribed in full. The interviews were conducted after contact by telephone with the participants for prior scheduling of time and place. During the interviews, only the researcher and the interviewee were present at the site. At the beginning of each interview, participants were informed about the objective of the research, after the participant's agreement, the signature of the Informed Consent Form (ICF) was requested, all managers were identified with the letter M (M1 to M6, of "manager").

For analysis of the corpus was used the theoretical-methodological foundation in Discourse Analysis (DA) of French matrix. In DA, the passage from the raw material (transcribed interviews) to the discursive object is undertaken, following the steps, presented by Orlandi, from the linguistic surface to the text (discourse); from the discursive object to the discursive formation and from the discursive process to the ideological formation[13].

The concept-analysis present in the research is related to the "access barriers faced by people with TB in PHC services". Established the concept-analysis, as well as obtaining the discursive corpus through the guiding question: "What aspects of the speeches of managers are related to the barriers of access and treatment faced by people with TB in PHC services?" identification of the textual marks in relation to the concept-analysis. From the textual marks emerged the following discursive formations: barriers related to the organization of health services; barriers related to information; barriers related to geographical accessibility and, consequently, revealed the following Discursive Block (DB) - Access barriers faced by tuberculosis patients in Primary Health Care services. From the DB sought to know what speech belongs to linguistic brands.

Following Resolution 466/12 of the National Health Council (NHC), the project was submitted to the Research Ethics Committee (REC) of the *Faculdade Pernambucana de Saúde* (FPS). The research was approved with the opinion N. 3.231.075 and CAAE N. 09260019.1.0000.5569.

Results

The study included six participants, who were coordinating managers of the TCP of the SD. When characterizing these managers, all were nurses. Regarding the time in which they performed the role of manager, one (G3) was seven months, five (G1, G2, G4, G5, G6) were more than a year. To better present and analyze the testimonies, the following discursive block was constructed: access barriers faced by tuberculosis patients in Primary Health Care services. This block emerged from the textual marks identified in the managers' discourses, as shown in Chart 1.

Chart 1 – Discursive block: Access barriers faced by tuberculosis patients in Primary Health Care services. Recife, Pernambuco, Brazil – 2019.

(continued)

DISCURSIVE FORMATIONS	TEXT SEGMENTATION
Barriers related to the organization of health services	*In my reference today I have no nurse in the TB program* [...] *the program itself is a little stopped because of that* [...] *I think that it lacks more active search from the units, although we talk,. They get to wait a lot for the patient to arrive* [...]. (M2); [...] *sometimes the laboratory also takes a long time to deliver the result* [...]. (M1); *The opening hours of family health units, as some patients may be in their working hours* [...]. (M3); [...] *difficulty to schedule an x-ray, which was supposed to be a spontaneous demand and sometimes you have to regulate that patient* [...]. (M6); *When he* [the patient] *simply arrives outside reception hours and some units don't have this sensitivity of perception that he is a respiratory symptomatic* [...] *this patient, sometimes, he doesn't get this access and returns home.* (M5); *We have a serious problem with the laboratory, the laboratory is going through an absurd dismantling, there's no professional* [...]. (M4)

Chart 1 – Discursive block: Access barriers faced by tuberculosis patients in Primary Health Care services. Recife, Pernambuco, Brazil – 2019. (conclusion)

DISCURSIVE FORMATIONS	TEXT SEGMENTATION
Barriers related to information	[...] *of the patient, recognize himself as a patient* [...] *and then, when he gets here, it's already very advanced* [...]. (M3); [...] *what's difficulty in this access is often the unawareness of the symptoms or simply the stigma still present* [...]. (M5); [...] *some believe that the disease's hereditary, so the delay in the diagnosis comes from unawareness, lack of advertisement* [...]. (M5)
Barriers related to the geographic accessibility	[...] *when the area is unshaded or when the team needs a doctor specialist, we have to refer* [...] *sometimes we find patients without conditions to go so far* [...] *difficulty of access we have in x-ray* [...] *it's too far from our territory* [...]. (M1); [...] *there's the issue of the patient going to those units, this place to undergo the x-ray* [...] *will need to displace and go to that unit, this hospital to undergo the x-ray, we can also mention the patient's socioeconomic issue* [...]. (M3); [...] *difficulty to schedule the x-ray* [...] *there's none in your territory and says that it's going to send far away, there's also the ticket issue* [...]. (M6); [...] *the exams issue today, I don't really have* [...] *the patient sometimes has no ticket to undergo the x-ray* [...]. (M2)

Source: Created by the authors.

Discussion

It is possible to identify in the discursive segments of all managers, that the barriers faced by TB patients are related to human resources, hours of care, active search, identification of respiratory symptomatic, delays in marking and delivery of exams, reflecting the way the services are organized.

Organizational factors such as the hours of operation of health units and the lack of professionals in these services, as well as inadequate reception, are issues that in addition to contributing to a discontinued and quality assistance. Thus, they favor the delay in the diagnosis of TB, as well as the worsening of the clinical picture and the spread of the disease[8].

Conducting active search allows the identification of respiratory symptomatic and early detection of pulmonary forms. The active search is an activity that should be performed permanently by all health services, aiming to identify early bacillary cases, initiate treatment and stop the transmission of the disease[14].

The passive search for TB occurs when a person, recognizing the signs and symptoms of the disease, seeks health services to receive proper care, or when the health professional identifies the signs and symptoms of TB and refers the person with the suspicion for diagnosis. Even the active search being an activity of extreme importance for the identification of the respiratory symptomatic of TB, the passive search also collaborates with the identification, verification and diagnosis. It is worth noting that a person does not always associate the characteristic signs and symptoms of TB with the disease and hardly seeks health services at the beginning of symptoms, leading to delays in diagnosis and early treatment[15].

The delay in having access to the results of diagnostic tests may be related to fragility in the organization of health services. The lack of professionals in the laboratories and resources

necessary to perform the diagnostic tests of TB ends up generating delays in the receipt of these tests. Thus, health services do not perform the diagnosis effectively, causing a worsening of the disease and increasing its power of transmissibility[16].

The speeches of M1, M2, M3, M4, M5 and M6 sign that the lack of professionals, delay in scheduling and performing diagnostic tests, failure to perform active search and the hours of operation of health services, factors that lead to increased time for the user to get care, also affecting its quality, also interfere in the identification of respiratory symptoms, delay diagnosis and favor the spread of the disease. The discourses show that the subjects position themselves much more as nurses than as managers, responsible for solving or minimizing these factors that interfere with access to health services. It is up to the manager of the SUS to make decision based on evidence and, in this aspect, it can be strategic to combine both views, nurse-manager, to face the barriers of access.

The statement of M2, when stating that the TB program is performing activities in a reduced way due to the absence of nurses, points out the nurse as a facilitator of the process, planning and carrying out activities that involve from the identification to the cure of TB.

Still about the organizational barriers, there is a silencing in the speech of the subjects about the active search and identification of the respiratory symptomatic, unveiling a distancing on the part of the managers in their responsibility for carrying out training with the professionals of the health units.

Managers still report as a barrier, lack of knowledge of symptoms and stigma, being related to the lack of information, evidenced in the textual segments of M3 and M5, respectively: "[...] r*ecognize himself as a patient* [...]" and "[...] *is the unawareness of the symptoms or simply the stigma* [...]".

The unawareness of the signs and symptoms of TB causes patients to seek alternative means such as home remedies or non-prescription drugs, seeking care in health services only when they did not obtain the cure. The delay in diagnosis can happen due to lack of perception of the health professional, leading the patient to seek health services several times to obtain the diagnosis. The unawareness of TB causes several consequences, including the abandonment of treatment when symptoms are relieved, increasing the chances of reinfection and multiresistant TB[16].

Poor knowledge about the cause, transmission and duration of TB treatment leads the patient to stop treatment[17]. Thus, educational actions can be used as a tool for knowledge about the disease to reach the TB patient and the community. However, the health professional must be qualified and committed to the patient and to the control of TB. In order for educational actions to have a better acceptance, the health professional can carry them out in community spaces, strengthening the bond with the patient and the community, generating security for the TB patient, for being a carrier of a stigmatizing disease[18]. The participation of the population is fundamental for the control of TB[19].

Patients undergoing TB treatment face numerous social challenges. They are often stigmatized due to fear of disease transmission. In order to minimize these challenges for fear of being excluded, TB patients often hide that they have been diagnosed and are undergoing treatment, in addition to not adhering to treatment because they have to attend health services to take the supervised dose[16].

The stigma experienced by TB patients often ends up producing more suffering than the disease itself, which can lead to low self-esteem, poor adherence and even treatment abandonment[20]. A study conducted in China showed that the stigma related to TB was high among patients with TB, being associated with the family relationship of patients and knowledge about TB. Family support is one of the main means for reducing stigma in TB patients[21].

In this study, managers point out as barriers the lack of knowledge of signs and symptoms and the stigma that still accompanies TB patients. However, it is not perceived a position of these as social actors responsible for implementing strategies capable of increasing knowledge and minimizing stigma about TB. It is the manager's role to support, guide and cooperate with the

process of implementing health policies in order to guarantee the entire population the full enjoyment of the right to health. In addition, insufficient management performance can contribute to the maintenance of low resolution services in the control and treatment of the disease.

It is possible to identify barriers that are related to geographical accessibility. Evidenced in the textual segments of M1 "[...] *difficulty of access we have in x-ray* [...] i*t's too far from our territory* [...]" and M6 "[...] *there's none in your territory and says that it's going to send far away, there's also the ticket issue* [...]". The socioeconomic condition of TB patients influences the demand for health services, since individuals with low income will not be able to move to health services far from the territory[7]. This situation can cause a distancing of the patient with the health service, making it difficult to return. Thus, it is important to create a bond with the health professional and to carry out the reception in health services[22]. Performing diagnostic tests in the same place of care is seen as facilitating access[23].

In Ethiopia, a study showed that the highest rates of non-adherence to TB treatment are related to the distance between the treatment center and the individual's home, as well as the cost of transportation and lack of knowledge about the disease and treatment[24]. TB is a disease directly related to living conditions and can be better understood when associated with the model of social determination of health, enabling the identification of factors that can cause the illness of the individual by TB[25].

Even with the decentralization of TB care actions to PHC, the reports of managers show a centralization of this care. The fact that most TB patients are an economically vulnerable population and have to perform diagnostic tests outside the territory of their SD ends up delaying the diagnosis, since these patients will not be able to travel to the health unit to perform the tests. Managers report the patient's difficulty of displacement, but there is silence in the discourses about the alternatives to enable this displacement to the units where the tests are performed.

The discourse of managers is linked to a traditional model of management. There are indications of non-recognition of managers as co-responsible for the access barriers identified in the discourses, since they refer to the other, whether health professional/nurses, whether users.

In this management model, care is offered in a fragmented way and centered only on the individual, instead of providing holistic care. Care is performed only when the individual is in health services[26].

Among the literature researched, it was evidenced that the studies that approach the view of users and health professionals indicate, mainly, which are the most sought after health services by TB patients and which are the most efficient in performing the diagnosis of TB, organizational and geographic aspects[8-22]. Unlike the present study, which, in addition to presenting organizational and geographical aspects, points out aspects related to information barriers.

Final Considerations

Access to PHC health services has weaknesses. From the analysis, it was observed that the discourses were influenced by the conditions of production, individuality of its historicity, as a social subject, memories and ideologies. It is possible to notice, on the part of the managers, a silencing of their accountability about the development of strategies that can eliminate or minimize the barriers of access.

The different positions occupied by the subject, as nurse and manager, can be understood as an important aspect, since they present the knowledge about the barriers that hinder access to health services and hold the power to develop and articulate coping practices to these barriers.

The study has important implications, enabling managers to reflect on the need for reorganization of health services and the work process, focused on the needs of the local population. It is also possible to qualify and sensitize health professionals to perform the diagnosis, monitoring, treatment of TB and develop health education actions with the theme TB, in order to contribute to increase information and reduce

the stigma that still surrounds the disease. In addition to articulating with other sectors means that can promote the displacement of users to health units that perform diagnostic tests, as well as coping with the various obstacles.

It is highlighted as a limitation of this study the inclusion of coordinating managers of the TCP in the SD. Therefore, studies on the theme addressing municipal coordination of the TCP, municipal coordination of the SANAR program (Program for Coping with Neglected Diseases), area coordinators should be carried out, providing a broader view on access barriers.

Collaborations:

1 – conception and planning of the project: Adriana Maria da Silva, Anne Jaquelyne Roque Barrêto

2 – analysis and interpretation of data: Adriana Maria da Silva, Anne Jaquelyne Roque Barrêto

3 – writing and/or critical review: Adriana Maria da Silva, Silvana Carvalho Cornélio Lira, Alcieros Martins da Paz, Anne Jaquelyne Roque Barrêto

4 – approval of the final version: Adriana Maria da Silva, Anne Jaquelyne Roque Barrêto

Conflicts of interest

There are no conflicts of interest.

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