REME • Rev Min Enferm. 2019;23:e-1158
DOI: 10.5935/1415-2762.20190005

RESEARCH

POLICY TRANSFER OF DIRECT OBSERVATION OF THERAPY FOR TUBERCULOSIS: PRIMARY HEALTH CARE PROFESSIONALS' SPEECHES

TRANSFERÊNCIA DE POLÍTICA DO TRATAMENTO DIRETAMENTE OBSERVADO DA TUBERCULOSE: DISCURSOS DE PROFISSIONAIS DA ATENÇÃO PRIMÁRIA

TRANSFERENCIA DE POLÍTICA DEL TRATAMIENTO DIRECTAMENTE OBSERVADO DE LA TUBERCULOSIS: DISCURSOS DE LOS PROFESIONALES DE LA ATENCIÓN PRIMARIA

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Funding: No funding.

Submitted on: 2018/01/28
Approved on: 2018/12/12

ABSTRACT

Objective: to analyze the speeches of health professionals about the motivational aspects related to the policy transfer of the direct observation of therapy for tuberculosis in the city of João Pessoa, Paraíba, Brazil. **Method:** descriptive and qualitative study developed in the Municipal and State Health Departments and in five Sanitary Districts of João Pessoa. The sample consisted of 26 health professionals who participated in a semi-directed interview from June to December 2013. The empirical material produced was analyzed according to the theoretical-analytical basis of the French discourse analysis by Pêcheux. **Results:** the motivational aspects for the policy transfer were benefits from the decentralization of actions of the direct observation of therapy strategy to the primary care service; reduction of epidemiological indices associated with treatment abandonment; increase in cure percentage and closure of cases; strengthening of therapeutic bond between professionals and users based on shared responsibility for general health care and treatment; and improvements in users' accessibility to health services. **Conclusion:** although efforts and political will of the key actors involved in policy transfer are visible, our data tend to support that that the municipal government still needs to implement strategies to overcome the broad challenges posed by the disease and thus achieve diagnosis, treatment and cure of tuberculosis cases

Keywords: Health Primary Care; Health Personnel; Tuberculosis.

RESUMO

Objetivo: *analisar os discursos de profissionais da saúde acerca dos aspectos motivacionais relacionados à transferência de política do tratamento diretamente observado da tuberculose no município de João Pessoa, Paraíba.* ***Método:*** *estudo descritivo, qualitativo, desenvolvido nas Secretarias Municipal e Estadual de Saúde e em cinco distritos sanitários de saúde de João Pessoa. A amostra foi composta de 26 profissionais de saúde que participaram de uma entrevista semidirigida no período de junho a dezembro de 2013. Os dados empíricos foram analisados por meio do dispositivo teórico analítico da análise de discurso (AD) de filiação francesa pecheutiana.* ***Resultados:*** *observaram-se como aspectos motivacionais para a transferência de política: benefícios da descentralização das ações da estratégia TDO para o serviço de atenção primária; diminuição dos índices epidemiológicos relacionados ao abandono no tratamento; aumento no percentual de cura e encerramento dos casos; o fortalecimento do vínculo terapêutico entre profissionais e usuários a partir da responsabilidade compartilhada pelo tratamento e cuidados em geral de saúde; e melhorias na acessibilidade dos usuários aos serviços de saúde.* ***Conclusão:*** *embora sejam visíveis esforços e vontade política dos atores-chave envolvidos na transferência da política, verificou- se que o município necessita ainda implementar estratégias a fim de superar os amplos desafios impostos pela doença e, assim, alcançar a detecção, tratamento e cura dos casos de tuberculose.*

Palavras-chave: *Atenção Primária à Saúde; Pessoal de Saúde; Tuberculose.*

How to cite this article:
Oliveira RCC, Adário KDO, Barrêto AJR, Barbosa KKS, Videres ANR, Nogueira JA, Palha PF. Policy transfer of direct observation of therapy for tuberculosis: primary health care professionals' speeches. REME – Rev Min Enferm. 2019[cited _____ ___ ___];23:e-1158. Available from: _____ DOI: 10.5935/1415-2762.20190005

RESUMEN

Objetivo: *analizar el discurso de los profesionales de salud sobre los aspectos motivacionales vinculados con la transferencia de la política de tratamiento directamente observado de la tuberculosis en la ciudad de João Pessoa, estado de Paraíba.* ***Método:*** *estudio descriptivo, cuantitativo, llevado a cabo en las secretarías municipal y estatal de salud y en cinco distritos sanitarios de salud de João Pessoa. La muestra consistió en 26 profesionales de salud que participaron de una entrevista semidirigida entre junio y diciembre de 2013. Los datos empíricos fueron analizados mediante el Análisis del Discurso (AD) en la línea Francesa Pecheutiana.* ***Resultados:*** *se observaron los siguientes aspectos motivacionales para la transferencia de la política: beneficios de la descentralización de acciones de la estrategia TDO para los servicios de atención primaria; disminución de los índices epidemiológicos relacionados con el abandono del tratamiento; aumento en el porcentaje de cura y cierre de casos; fortalecimiento del vínculo terapéutico entre profesionales y usuarios a partir de la responsabilidad compartida del tratamiento y cuidados en general de la salud; mejora de la accesibilidad de los usuarios a los servicios de salud.* ***Conclusión:*** *a pesar de los visibles esfuerzos y voluntad política de los actores clave involucrados en la transferencia de la política, es necesario implementar estrategias con miras a superar los retos de la enfermedad y poder detectar, tratar y curar los casos de tuberculosis*

Palabras clave*: Atención Primaria de Salud; Personal de Salud; Tuberculosis.*

INTRODUCTION

Tuberculosis (TB) remains one of the leading causes of death by infectious diseases in the world, especially in developing countries, despite the efforts of the World Health Organization (WHO) since the 1970s to ensure its eradication or even control. Factors such as poverty, poor living conditions, wide geographical spread, emergence of multi-resistant cases, co-infection with Human Immunodeficiency Virus (HIV) and deficiencies in health systems contribute to its aggravation.[1]

TB is a curable disease in almost 100% of reported cases, provided that the basic principles of drug therapy and adequate compliance with the pillars that make up the Directly Observed Treatment-short course (DOTS) are met. The DOTS was launched in 1993 by WHO as a global response to TB.[2]

Direct Observation of Therapy (DOT) is one of the five pillars of DOTS and consists of supervising the daily intake of drugs by a trained health professional, aiming at strengthening therapeutic adherence, preventing the emergence of resistant strains, reducing abandonment rates and increasing the probability of cure.[2]

Since 2001, due to the decentralization of the *Sistema Único de Saúde* (SUS), the municipal governments have become responsible for the management and implementation of TB control actions.[3] From this perspective, the government of João Pessoa, capital of the state of Paraíba, Brazil, implemented in 2007 the policy transfer of DOT for Primary Health Care (PHC) services, previously centralized in the Clementino Fraga Infectious Disease Hospital, a reference in that state.

Policy transfer has been studied in the international context since the 1940s and comprises a process that takes place through time and space, in which managers and professionals participate in the development and evaluation of certain public policies. It is, therefore, greatly important for the analysis of these policies in different contexts, especially considering information, knowledge and innovative actions aimed at significant changes in the systems and services in which such policies can be effectively experienced.[4,5]

In this light, considering the complexity involved in this transfer process and considering that participation, negotiation and commitment of the managers and health professionals between the state and municipal instances may favor or not the transfer of actions associated with the policy transfer of DOT for tuberculosis, the following research question was elaborated to guide the development of the present study: Which motivational aspects were favorable to the policy transfer of DOT for tuberculosis in the city of João Pessoa, Brazil?

This questioning arose from the need to analyze how this process of policy transfer between the state and municipal instances associated with the DOT occurred, since the DOT has a main role in the decentralization of the actions of the Tuberculosis Control Program for the primary care. This study is relevant for favoring reflections to managers and health professionals about tuberculosis coping strategies based on the knowledge of aspirations that motivated the implementation of the policy transfer of DOT.

The purpose of this study was to analyze the speeches of health professionals about the motivational aspects related to the policy transfer of DOT for tuberculosis in the city of João Pessoa, Brazil.

METHODS

This is a descriptive study, with a qualitative approach, developed in the Municipal and State Health Departments and in five sanitary districts of João Pessoa, Brazil, considered a priority by the Brazilian Ministry of Health (MoH), in the development of control actions of TB.

In this city, the primary care network is organized regionally in five sanitary districts that administer 192 health teams distributed in 110 Family Health Units, accounting for 85% of the population coverage. Each district unit has its own management, direction, team of professionals, including the matrix supporters that make up the Family Health Support Center and the technical supporters that make up the working groups, including the tuberculosis and leprosy working group.

Twenty-six health professionals, including nurses (16), physiotherapists (4), psychologists (2), physical educator (1), social worker (1) and pharmacist (1) were intentionally selected to participate in the study. The inclusion criteria were being a manager

and/or coordinator of actions associated with the organization, surveillance and monitoring of tuberculosis control in the state and/or municipality; being actively working during data collection; and expressing interest in participating in the study.

The empirical material was collected from June to December 2013, using a semi-directed interview technique, composed of two sections. The first one concerns the characterization of the sample and included the variables gender, date of birth, training, position, time of work in the current position and level of education. The second section discussed the motivational factors that favored the policy transfer of DOT between the state and municipal instances for the primary care service.

According to participants' availability, the interviews were conducted individually with the help of an MP4 audio device in the facilities of the Municipal and State Health Departments and in five sanitary districts.

After due clarification of the ethical aspects, the participants were requested to sign the Informed Consent Form. To preserve anonymity, they were identified throughout the text with the capital letter E of Enunciator, followed by Arabic numerals representing the order of the interviews (E1 to E26).

The empirical data were analyzed according to the theoretical-analytical basis of the French discourse analysis by Pêcheux, which proposes clarifying meaning processes production in the relation between language, ideology and subject, understanding how the language produces meanings by and for subjects, since there is no discourse without subject and there is no subject without ideology.[6]

The analysis plan of the data occurred with the circumscription of the concept-analysis, object of analysis that seeks to investigate how a text produces a certain meaning on the researched topic. This plan involved the choice, interpretation and (discursive) analysis of the *corpus* (empirical material) through three heuristic questions: What is the concept-analysis present in the text? How does the text build the concept-analysis? What discourse does concept-analysis belong to?[6,7]

In the present study, the *corpus* was consisted of texts transcribed from the interviews performed with 26 participants, named as enunciators in discourse analysis, having as concept-analysis defined *a priori* the motivational aspects associated with the policy transfer of DOT for tuberculosis in the city of João Pessoa, Brazil. Repeated readings of the *corpus* were carried out, in a constant coming and going between theory and analysis, in order to understand the processes of meaning production.[6,7]

Discursive analysis consisted of a passage of the empirical material, which is characterized here as the transcribed interviews, for the discursive object, through the following steps: a) from the linguistic surface to the text (discourse); b) from the discursive object to the discursive formation; c) from the discursive process to ideological formation.[6]

In the first stage, the conditions of production of the speeches that fundamentally comprised the enunciators and the situation of the circumstances of the enunciation to the wider socio-historical and ideological context were observed.[6] In this stage, the paraphrases, synonymy, polysemy, metaphor and the circumstances of saying and not saying were identified. Attention was paid to the configuration of the discursive formations, which determined what could be said in the ideological formation, that is, there was analysis about what was said, how it was said, who said it and what the specific discursive circumstances were. It was sought to answer the second heuristic question: How did the text build the concept-analysis?[7]

In the second stage, it was sought to disclose contradictions, identify silences, faulty acts, repetitions, and hesitations in the discursive universe of enunciators. The discursive subject was assumed to be inscribed in different discursive formations because it occupies different positions and, therefore, there is no linearity. The discursive formation may help, in our discursive analysis, understanding, in the discursive functioning, different senses.[6]

Discursive formation is defined as that which, in a given ideological formation, determines what can and must be said. Thus, "everything we say has, therefore, an ideological trait in relation to other ideological traits", being in the essence of discursiveness, in the way in which, in discourse, an ideology produces its effects, materializing in it.[6:43]

In the third stage, the relations between the discursive formations and the effects of the ideology were observed. Ideological formations leave linguistic-discursive marks, which the discourse analyst seeks to interpret. The marks allowed observing the texts that were left out, the properties of the discourse, the discursive formation to which they belonged and, finally, the ideological formation that gave them support.[6] The third heuristic question was: what discourse the constructed concept belongs to?[7]

Based on these considerations, interpretations were performed about statements regarding the motivational aspects related to the policy transfer of the DOT occurred in the city of João Pessoa, Brazil. Every statement is linguistically described as a series of possible drift points, giving way to interpretation. The statement is always susceptible of being/becoming another one. This place of the other statement is the place of the interpretation, manifestation of the unconsciousness and of the ideology in the production of meanings and in the constitution of subjects.[6,7]

The study met the formal requirements contained in national regulatory standards for research involving human subjects in accordance with Resolution 466/12 of the National Health Council, with approval by the Research Ethics Committee of the Health Sciences Center of the *Universidade Federal da Paraíba* (Protocol 0301/2012).

RESULTS

Through the conditions of the production of the speeches, the enunciators were characterized as predominant female professionals, working as managers in the health departments and sanitary districts for a period of time ranging from four months to four years (mean of 16 months).

They developed activities as coordinators linked to the Tuberculosis Control Program, Basic Care and Epidemiological Surveillance. Most had postgraduate studies aimed the area of public health and collective health; two had master's degrees in nursing, while two others were only graduates.

The analytical reading enabled understanding textual marks that composed four discursive formations, named: a) benefits of decentralization of the actions of DOT strategy to the primary care service; b) abandonment and non-adherence to the DOT; c) strengthening the therapeutic bond based on shared responsibility; d) accessibility to health services. These formations composed the discursive block that expresses the concept-analysis investigated (Table 1).

DISCUSSION

A study on policy transfer emphasizes that the motivation for this transfer can happen through different aspects, such as perceived conflict with technical efficiency, coercive pressures for implementation, or multiple and contradictory pressures on the organization.[8]

The term "motivation", as a word, is conceptualized as a neologism that is directly related to motive (from the Latin *motus* – movement). Motive is presented as the cause or origin of something or also as reason, what drives someone to do something.[9]

In the context of TB in the city of João Pessoa, the enunciators evoked from their discursive memories motivating factors of the policy transfer of DOT, such as the benefits of decentralizing the actions of DOT strategy to the PHC service, reduction of the epidemiological rates associated with treatment abandonment, increase in percentage of cure and closure of cases, strengthening of the therapeutic bond between professionals and users from shared responsibility for general health care and treatment, and improvements in users' accessibility to health services.

Table 1 - Discursive block: motivational aspects associated with the policy transfer of DOT of tuberculosis in the city of João Pessoa, Paraíba, Brazil; 2013

Discursive Formations	Textual Segmentation
Benefits of decentralizing the actions of the DOT strategy to the primary care service	*[...] The teams will have more opportunity for this user affected by tuberculosis, thus guaranteeing complete treatment and discharge due tocure using the DOT strategy in primary care* (E20); *[...] I believe that the appreciation of the bond, of the knowledge, of the appreciation of the day-by-day user* (E14). *[...] In the DOT strategy, health professionals are closer in this awareness of the importance of taking the drug, making proper treatment to combat this disease* (E16). *[...] the decentralization of the actions of the DOT will provide an increase in the percentage of cure and reduction of abandonment* (E17). *I think one of the potentialities of the DOT was that we are guaranteeing the treatment of the user until the end. Another potentiality was the active search for respiratory symptoms that, with this, we sought more, became more attentive, see who they are, and also examine the contacts of those patients. All of these were improvements, lessons from this strategy, the DOT* (E01).
Abandonment and non-adherence to treatment.	*[...] What motivated us at the time when we implemented DOTS in the state in 1999 was the high abandonment rate we had here; we had more than 20% of abandonment, while the Ministry advocates 5% [...]* (E25). *[...] I think what motivated it was the low cure rate of TB [...]* (E19). *[...] What motivated, I think, was the difficulty in treating tuberculosis patients who, over the years, have been greatly resistant to completing treatment, right?* (E15). *[...] The city of João Pessoa adopted this strategy so that the users had a greater adherence to the treatment and could conclude it as a proven cure [...]* (E23).
Strengthening the therapeutic link from shared responsibility.	*[...] I think the strongest bond of these users is with family health. Their bond, today, due to the DOT, is the greatest message one has, the bond of treatment adherence* (E02). *[...] It is necessary to call the responsibility for all and not only to the manager or just the user or the professional, it belongs to all the actors involved* (E12). *[...] It was a way for us to take responsibility for the cases in our territory, to monitor, to take responsibility and to monitor the follow-up actions of these users, [...]* (E21). *[...] It is of utmost importance that we decentralize treatment because primary care strengthens the issue of the bond of these users with this family health team [...]* (E22).
Accessibility to health services.	*[...] Having easier access, accessibility to the user through the district and from the district to the health units [...]* (E6). *[...] The need for follow up of users with bacillus [...]* (E10). *[...] there was a partnership, a truly interpersonal involvement, even to achieve this goal* (E24). *[..] It is one of the experiences that we will never forget, you know ... when the users report that they were inserted as citizens, as users within the service due to this whole process, to that policy that favored them* (E24).

Regarding the benefits of DOT mentioned by the enunciators, it should be pointed out that the choice of DOT modality should be decided jointly between the health team and the patient, considering the reality and structure of the existing health care. The intake of the drug should be daily, from Monday to Friday, under the supervision of a health professional who may be a nurse, nursing technician and/or nursing assistant, or community health worker.[2]

The MoH establishes that, if DOT is not performed by professionals of the health team, it will not be considered for operational and notification purposes in the Disease Notification Information System.[2] For the implementation of DOT, the MoH also advocates that four types of supervision should be taken into account: *home supervision*, through observation at the patients' residence or at a place requested by them; *in the health unit*, through observation in Family Health Strategy units, HIV/AIDS care services or hospitals; *prison system*, by the observation of the drug intake in that place; *shared mode*, when the patient receives the medical consultation in a given health unit, despite doing the DOT in another one closer to the home or work.[2]

Exceptionally, when it is not possible to choose any of the aforementioned modalities, the unit may propose to the patient that the observation be performed by a person from the family or community trained or supervised by a health professional to perform it, and this strategy will be considered DOT. In such cases, the unit and their manager should visit the patient weekly to monitor the treatment.[2]

One of the great obstacles to success in tuberculosis control is precisely the deficiency in the implementation of DOT, the low adherence and the high abandonment rates, as was stated by E25, who experienced the whole transfer process during the period from 1999 to 2007 in the said city. As a consequence, cure rates were unfavorable to the WHO goals, which estimated that the cure rate should be above 85% and the reduction in the abandonment rate should be less than 5%.[3]

In 2010, the proportion of cure in Brazil was 73.4% and in 2011 reached 71.6%, still failing to reach the goal stipulated by the MoH, that is, curing at least 85% per year. Regarding the abandonment rate, studies show indices around 14 to 17%, but in some regions and capitals, this index reaches 30 to 40%.[10]

Epidemiological data indicate that abandonment rates of TB treatment in Brazil is high, which results in the risk of occurrence of resistant forms of the disease and persistence of the transmission chain. Faced with this, knowledge of the factors associated with the high abandonment rates of TB treatment is essential for the identification of barriers to treatment adherence.[11,12]

A study carried out in the state of Paraná, Brazil, between 2006 and 2010 found that the young age, alcoholism, unemployment, low schooling, chemical dependency and readmission after treatment abandonment were the factors responsible for abandoning therapy.[13]

The poorer the knowledge about TB, the higher the risks of not completing the therapeutic scheme. Health education is an important strategy for reducing treatment abandonment rates, since the lack of information or its inadequate assimilation contributes to the non-use of medication and/or early interruption of treatment.[14]

The health services should provide the necessary subsidies to ensure adequate and early treatment for every individual diagnosed with tuberculosis. Patient adherence, reception in the service, and provision of information about the disease and treatment are basic conditions for a successful treatment.[3]

Concomitantly, the strengthening of the therapeutic bond based on shared responsibility between professional and patient emerged from the discourses of participants E21 and E22 as one of the drivers of the policy transfer of DOT. Meanings related to the monitoring, follow-up and accountability suggested their desire for a more affective and effective care, which culminated in the construction of long-lasting interpersonal ties that could positively interfere in the treatment of TB.

Other meanings have surfaced and interlinked with the therapeutic bond, as cited by E12, regarding the shared responsibility of all those involved in the process, and not just the manager or just the user, or the professional. This shared responsibility evoked by the participant, through inter-discourse, brings meanings that suggest the commitment of all team professionals in the process of transfer and/or decentralization of DOT.

It is known that the success of treatment adherence is closely linked to the humanized relationship between the professional and the person with TB, allowing both to understand the context of the disease, and to be co-responsible for this success.[15]

A study about the abandonment of TB treatment and the relationship with the Family Health Strategy emphasized that the bond favors continuity of care and that knowledge of the social, economic and cultural environment of the sick person and his or her family by the health team contributes to non-abandonment of treatment, through a relationship of commitment and trust.[16]

By bringing to the discursive memory the desire to follow and monitor more intensively the treatment of people with TB, the participants E21 and E22, by a flawed act, slip and express the unspoken: the relationships were not solidly constructed throughout the process of illness, contributing to a fragmented assistance, in which they do not see themselves as a fundamental part of the success of the treatment. This fact contradicts the dimension of bond advocated by PHC.

A bond is understood as the close and lasting personal relationship between the health professional and the user, allowing, over time, that the ties become stronger and that they know each other more and more, facilitating the continuity of

treatment and, consequently, avoiding unnecessary consultations and hospitalizations. This relationship requires the mutual cooperation between family members, the community and the professionals.[17]

In addition, the bond allows a more effective approach between the user and the professional in order to establish relations of listening, dialogue and respect. In this case, the user feels safer with the health unit, because they feel accepted and close to the professionals who are responsible for their well-being.[17]

It is necessary to consider actions that, in the PHC services, contemplate the reception, the bond and the active search of respiratory symptoms. The reception is one of the main ethical and political guidelines of the National Humanization Policy in Brazil, defined as a light technology and that should be used in the perspective of implementation of new health practices.[18]

Reception actions are part of the work process of Family Health Strategy professionals and are essential for building a bond between them and the user/family. Reception can be characterized as a relationship of complicity, materializing in the scope of the welcome and being the starting point to building trust bonds between those involved. In this sense, it is important to note reception and bond as important devices for the establishment of health care.[18]

In the meantime, the improvement of the accessibility of users to health services was mentioned as a meaning extracted from the speeches of the participants E6, E10 and E24, associated with the motivations of policy transfer of DOT in João Pessoa, Brazil. Ensuring access and equity of the person with TB in PHC means being attentive to the location of the unit where care is intended, choosing an easily accessible place to take the medicine, and observing the time and means of transport used for user's displacement, in an attempt to minimize the obstacles.

Access to health services is the essential dimension of PHC in TB control. However, the term PHC sometimes causes a divergence of interpretations by the population, which associates the word primary to initial, fragile, or shallow in the establishment of care for the individual's health.[19]

Such interpretations cause disbelief in the actions promoted at this level of care, making the population choose to seek care at secondary and tertiary health care levels, which have medium and high complexity for diagnosis and treatment of diseases.

The follow up of TB cases (research, diagnosis and treatment) is one of the priorities of PHC, crucially important in articulating procedures for accessing TB patients to health services. The articulated actions between the TB Control Program and PHC managements should be part of the routine of the managers, causing impact in the territories, since they have an overview of the health-disease process that is determinant in the combat to the disease.[20]

Notably, care must be taken in relation to the obstacles that hamper the management of care in each dimension and between dimensions, in order to make care flows.

The strategies for the person with TB to have access to treatment and, from there, can reach cure must be in accordance with the reality of the difficulties encountered for adherence to treatment, such as stigma of the disease, lack of social support, and the need to develop actions in partnership with areas outside the health sector.[20]

This study reveals some barriers to access to diagnostic confirmation of TB in PHC, including family health units operating hours, transfer of responsibilities, home visits without contact control, delay of the health service in suspecting the disease, and repeated visits by the user with respiratory symptoms to the health service to obtain the diagnosis.[21]

The control of TB treatment consists in the execution of the programmatic activities that allow following the evolution of the disease, the correct use of the medicines, and the therapeutic success. These control actions should be based on the guarantee of accessibility to health services and the availability of qualified professionals, incorporating in their work process the knowledge necessary to organize care from the suspicion of illness to discharge due to cure.[3,15]

Primary Care is guided by the principles of universality, accessibility, bonding, continuity of care, comprehensive care, accountability, humanization, equity and social participation, and the subjects are seen in their singularity and socio-cultural insertion. So, it is observed in the participants' speeches a fragility in the foundation of this policy in the city under study, which hinders the effectiveness of the comprehensive care.

CONCLUSION

The policy transfer of DOT for tuberculosis control was voluntary and negotiated between the state and municipal health departments of João Pessoa, Paraíba, Brazil. Strategies involving management, professionals, the community and the person with TB were used to implement the actions of DOT in the health units.

Although the efforts and political aspirations of the key actors involved in the transfer and/or decentralization of actions aimed at implementing the DOT are visible, there is a need to review the existing obstacles in the care network of the said city and introduce effective strategies in the work process in an attempt to overcome the broad challenges posed by the disease.

It is suggested that both managements prioritize, together with the coordinators of the TB Control Program, the Epidemiological Surveillance and the family health teams, the re-signification of care practices in the perspective of permanent health education. This may positively influence the TB scenario

in Paraíba state, offering to the user a quality assistance directed at the comprehensiveness of human care.

The development of this type of research can contribute to the elucidation of important questions and deepening of knowledge on the health policy transfer related to the planning, organization, monitoring, and evaluation of the DOTS strategy in the PHC management institutions.

ACKNOWLEDGEMENTS

We thank to Lenilde Duarte de Sá (*in memoriam*) for the impact of her scientific contributions developed over more than 30 years of academic activities in the field of nursing and Brazilian public health.

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