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CASE ON BRAZILIAN HEALTH CARE UNIT ON PULMONARY TUBERCULOSIS

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Abstract

This case aimed to describe the trajectory of Pulmonary Tuberculosis (PT)-intensive users to be inserted into the Brazilian Health Program of a Basic Health Unit, through Merleau-Ponty's framework applied to N= 11 patients. The analysis was distributed in: description of the information; systematic reflection, and interpretation. The reception for the user proved to be attention and affection, Guidance and communication about the disease, problem-solving of the case and free access to the drug. The trajectory of the user begins the moment he feels sick. Although coughs one of the characteristic signs of PT, only its presence is not enough to go to the search for a health service. The search for care only occurs when it is associated with other symptoms such as fever, back pain, tiredness, among others. The search for the unit does not always guarantee the user the service and the resolution of their problem. We found that interaction involving attention, affection, guidance and communication between professionals and users are fundamental for the recognition of the identity of these users. We envision the need for changes in care for these people.

Keywords: Health information system, Management, Nursing

1.Introduction

The present work comprises archival research with a descriptive case study, which unit of analysis is the Brazilian health care system on pulmonary tuberculosis (Yin, 1988). The objective is to discuss the effectiveness of the health policies adopted by the National Health Ministry.

From the beginning of humanity, care depart from birth to allow not only the awakening to life but also the insertion of man in the social and cultural environment, making possible its existence. These difficulties act as obstacles to the non-satisfaction of basic needs that would lead to well-being those who are the goal of our professional activity (Santos, 2004).

The present case is useful for a variety of fields of research, such as Health care cooperatives (Dias, M.O., 2019, Dias, M.O., and Albergarias, 2019; Dias, M.O. & Teles, 2019; 2019b; Dalacosta, Dias, M.O., Meirelles, 2019; Dias, M.O., 2018; Dias, M.O. & Craveiro, 2019; Dias, M.O., Krein, Vilhena, 2018; Dias, M.O. & Ramos, 2018; Dias, M. & Teles, 2018). Other businesses such as craft beer industry (Dias, M.O. & Falconi, 2018; Dias, M. O., 2018); and debt collection negotiations (Dias, M.O., 2019, 2019b; Dias, M.O. & Albergarias, 2019), public administration (Dias, M. O., 2018);agricultural debt collection negotiations (Dias, M.O. 2019, 2019a; Dias, M.O. and Albergarias, 2019, 2019b; Dias, M. O. & Teles, 2018); retail business (Dias, M. O., et al., 2015; Dias, M. O. et al., 2015, 2014); mining industry (Dias, M. O., & Davila, 2018); e-business negotiation (Dias & Duzert, 2017); streaming video industry (Dias, M. O., & Navarro, 2018), business negotiation generational interactions (Aylmer & Dias, M. O., 2018); (d); (e) non-market forces (Dias & Navarro, 2018); carmaker industry (Dias, M. O., Navarro and Valle, 2013, Dias, M. O., et al., 2014; Dias, M. O., et al., 2013); aircraft industry (Dias, M., Teles, and Duzert, 2018; Dias, M.O. and Duzert, 2018); copier industry (Dias, M.O., 2012); Non-governmental organizations (Paradela, Dias, M. O.; Assis; Oliveira, J.; Fonseca, R. (2019); business civil construction (Dias, M.O., 2016); governmental negotiation (Dias, M. O. & Navarro, 2017).

2. Methodology

This is a descriptive study, in which qualitative research approach has been adopted because we understand that this phenomenon interconnects both cognitive, social, cultural and economic fields. This reality is neither evident nor easily given birth; there may be a difference between what appears at first sight and what we find in depth (Demo, 2005). This investigation is be based on the search for the meaning of the phenomena in the space of the encounter between the subjectivity that is inscribed in the experience of the user informants and the experience of the researcher himself, through shared understandings and interpretations (Uchimura & Bosi, 2004). Archival research and content analysis were conducted. Primary data was gathered through qualitative interviews, applied to N= 11 patients, with 100 percent response rate, through semi-structured interviews. Raw data was then codified and further analyzed, through content analysis. This case is limited to the Brazilian Public Health system. Private health systems are not encompassed in this single case study.

3. Theoretical Framework

Tuberculosis

Tuberculosis is a disease caused by *Mycobacterium tuberculosis*, also called Koch bacillus (BK). Although the pathogenicity of this agent is relatively low among those infected by bacillus, the power of infection or bacillus ability to lodge is very large. About 1 in 10 of the infected people with healthy immune systems will develop symptoms of PT. Illness does not occur for everyone, in many cases, this contagion does not go beyond a primary stage and the acquisition of natural protection of man against Tuberculosis (Kritiski, 2005).

PT bacillus is an aggressive bacterium with high power of social dissemination. High aggressiveness and transmission power transform tuberculosis into a significant public health problem, especially for people who integrate vulnerable groups**:** the poor, the street population, patients with immunosuppressive conditions, those of advanced age and children (Teixeira, 2002).

Tuberculosis is one of the most important causes of suffering and death ever imposed on humanity. Approximately one third of the world's population is infected with *Mycobacterium tuberculosis* (PT) or at risk of developing the disease. Each year, more than 08 million people develop active tuberculosis (PT) and approximately 1.9 million people die. Of these, 75% of the cases are among the economically productive age group, between 15 and 54 years (WHO, 2006).

Abandonment of treatment or abandoned patient

Reflection on situations that have emerged in our daily lives makes us think that somehow the abandonment of treatment is not causal. We believe that problems that interfere with the resolution of PT programs may be related to the abandonment of the user by professionals, institutions and public health policies. From empirical observations we understand that the main subject involved, as emphasized in practice, may not be the patient: "Oh! He didn't come... He did not or there for his treatment" (this was the justification that a professional attributed to the patient for not having attended the consultation).

According to Lima et al (2001) communication and information are not sufficient to increase interaction between professionals and users. The author points out a series of obstacles in bureaucratic stages that interfere with care. For service users there is a need to "improve service to decrease queues". They pointed to the intricate bureaucracy that subjected them to queues, inflexible schedules and filling out forms that made it impossible to provide fluent and quality care. They emphasized that the non-compliance of the schedules by the professionals reflected in the quality of the clinical examination and the interaction with the client.

3 A humanization in the care of PT users

Welcoming encompasses solidarity attitudes capable of contributing to the establishment of a relationship of trust between system professionals and users. It is about

designing and redefining the citizen as a center, aiming at their well-being and the effectiveness of the service provided. During care, attitudes of solidarity and dedication to good problem-solving capacity should be observed and translated into attention to the conditions of the environment and work processes, in order to preserve the well-being of the user and his companions, ensuring knowledgeable and oriented (Brasil, 2004b).

It is necessary to eliminate physical barriers (such as glass, grids in counters), which distance the user from the professionals who serve him. It should also be avoided long waits and in inappropriate places, as well as poor signage, lack of information, the exchange of professional or team without proper explanation and presentation. These and many other aspects that qualify the reception can be frequently solved with the good disposition and attention of the team and the leaders of the Health units (Brasil, 2004b).

Through caring for man can be able to cross barriers, communicate life, compensate for what puts obstacle to it, accompany the great passages, help to be born and reborn, accompany death and more. None of this would be possible without the establishment of a harmonious interaction between him and the middle and between him and the daily action of the health professional (Collière, 2001).

This Area presents as macro-objective the understanding of the process that generates health and disease in the light of the paradigm: work - income - consumption, considering health as a right of citizenship historically and determined. Unit 06 points out as a micro-objective the performance in the recovery of patients with infectious diseases at the hospital level, aiming to break the chain of transmission of diseases, through planning, implementation, evaluation of nursing care and control of hospital infections.

We observed in this institution, in particular, cases of patients with Tuberculosis. In general, these patients were debilitated and, in partial or total dependence for nursing care (HORTA, 1979). Tuberculosis is an infectious disease transmitted by pathways superior areas through cough, sneezing, and even the speech of a sick individual to a healthy (Kritiski, 2005).

Specifically, we were concerned two cases of PT in non-HIV patients; active workers, aged between 20 and 30 years. One of these patients was a case of PT, which the patient (woman) was treated in an advanced phase of the disease, with frank hemoptysis. His trajectory in search of care and diagnostic elucidation was approximately 06 months. During this time the patient remained following the guidelines of the units visited and remained in her work as a maid.

The other case was a male patient, worked as a Mason until the signs and symptoms of the disease began. He remained for approximately 30 days between visits to the health unit and returning to his residence. After this period, she evolved with loss of consciousness and was referred to a reference unit, where a Tuberculous Meningitis was diagnosed. It evolved with irreversible neurological sequelae.

In this context, it seemed clear to us the non-compliance between health practices and the current policies of the Ministry of Health (MS) for the diagnosis and treatment of PT-bearing users. The errors in assessing the problems presented by these people with different

forms of Tuberculosis resulted in timid measures to implement and put in operation all the resources available for their attention, such as user's health services (Ruffino-Netto, 2002).

Although some authors want to compare PT to emerging diseases, such as AIDS or reemerging, such as Dengue, Ruffino - Netto (1997) understands that this statement is not valid for Brazil. Tuberculosis is a present problem, which has lasted for a long time. We have not reached a significant reduction in its magnitude to the point of not considering it another problem.

He adds that in many places the authorities left the problem aside as if it were a matter resolved, because it was already notorious the knowledge produced about the disease: pathophysiology, diagnosis, therapeutic regimens and medications available. It was not considered that the existence of all this previous knowledge or resources would do nothing if they were not placed within reach of the general population and, above all, that this population needs to make effective use of resources when they exist on site (Ruffino - Netto, 2002).

Tuberculosis is known as known to be preventable, easily diagnostic, treatable and curable disease, it could be said that the knowledge achieved, if not enough, is at least very effective when well applied (Dalcomo, 2000). It is worth remembering that the impact of therapeutic regimens on the treatment of the disease will only be obtained with the existence of a demand. The establishment of care with agile, easy and low-cost diagnostic means, speeding up services and increasing adherence is another factor that can contribute to these situations (Ruffino - Netto, 2000).

In the observed cases we understood that the demand for the service was characterized, however the care only occurred when the patients already presented themselves with greater complexity, in a hospital unit. Some authors have been concerned about welcoming, as a strategy for services to be guided by the search for greater knowledge of the needs that the user is carrier and the ways of satisfying it (Teixeira, 2005) and as a strategy for the production of links between health service and users (Campinas, 2004).

For Campinas (2004) the reception is of fundamental importance for the establishment of care for patients with Tuberculosis. It is based on a relationship of commitment and mutual trust between health services and users and promotes the positive impact of tuberculosis-related actions. It should be understood not only in the sense of access to spontaneous demand, but in the sense of acceptance of the patient as a subject of rights and desires; for which good communication and professional-patient relationship becomes necessary.

The absorption of patients who require medical care in a health unit for Ruffino – Netto (2000) depends on the organization of services and current health policy. On the other hand, the diagnosis of tuberculosis depends on the technical capacity of the services, whether in equipment and/or human resources. The author remembers that for this disease the diagnostic tests are relatively simple, of low complexity and low cost; easily integrated into health services. He points out that health services do little to research this pathology. This shows in a way the belief in a false myth created that tuberculosis is a disease of the past.

For PT control, in addition to the need for reception, diagnosis and treatment new challenges emerge in the new century. Among them is the need for studies on treatment adherence (Ruffino-Natto, 2002). At the same time, resistance to multidrug, which comes

from poorly controlled PT treatments, is a growing problem of serious interest in many countries around the world (WHO, 2006).

On this, Oliveira, Collet and Vieira (2006) emphasize that the precarious quality of care is the result of extremely fast consultations, without valuing the other and the different knowledge. The relationship between user and professional, was also highlighted by these authors and, this occurs in a disrespectful, impersonal and aggressive way. As a consequence of these professional conducts, the subject becomes a simple object of technical intervention, without being heard in his anguish, fears and expectations or even informed about what is being done with him (Brasil, 2004a).

One of the fundamental principles of the National Humanization Policy is integrality. This has as its characteristics the actions of promotion, prevention, treatment and rehabilitation, with guarantee of access to all levels of complexity of the Health System; which should be made available to tuberculosis patients (Brasil, 2004). According to Law No. 8,080 (1990) the integrality of care is understood as an articulated and continuous set of preventive and curative services actions, individual and collective, required for each case at all levels of complexity.

The human being ceases to be the main focus on the health and disease process to the detriment of the acceleration of the technological process and the advanced search for scientific knowledge, in which the recognized object becomes the disease, providing a technical, mechanical and dehumanized practice of health professionals (Backes, Lunardi and Lunardi, 2006). According to the National Humanization Policy, the dehumanizing dimension of science and technology occurs, therefore, to the extent that we are reduced to objects of our own technique and objects depersonalized from an investigation that proposes cold and objective (Brasil, 2004).

Faria (1998) in his study on user satisfaction about the services provided in the Health Units, identified that 60% of users are dissatisfied with the communication that occurred with the health team. This lack of communication has been reflecting on the process of self-care apprehension and compliance with the prescriptions of the team. Consequently, the average hospitalization and hospital stay has been increasing means. In view of this, the smaller the integration, communication, bond and mutual recognition between professionals and users, between teams of professionals and managers of the various instances of the health system, the lower the possibility of effectiveness in the care of the population and consequently lower will be the resolution of services (Brasil, NHP, 2004).

Dehumanized care is a multidimensional problem favored by situations arising from the precarious quality and low problem-solving capacity of care, the lack of technical conditions that permeate the process of training professionals and the scarcity of material resources. Involving issues such as access, technical quality and care, sensitization of professionals to more respectful and cordial postures and behaviors (Oliveira, Collet and Vieira, 2006).

4. Discussion

This study reflects the trajectory of PT-intensive users and their perception about welcoming in the Basic Health Unit. The trajectory presented as meanings the signs and symptoms of PT, the access to the health service and the diagnosis. The reception for the user proved to be Attention *and affection,* Guidance *and communication* about *the disease,* problem-*solving of the case* and Free access to *the drug.*

The trajectory of the user begins at the moment when he feels sick, with the expression of the disease in his body. Although cough is one of the characteristic signs of PT, only its presence is not enough factor to go to the search for a health service. The search for care only occurs when it is associated with other symptoms, such as fever, back pain, tiredness, among others.

Our attention turns to the possibility of PT transmission, at the moment the user does not seek care, continues to propagate the disease. Above all there is a desire, understood as the most *ineffable content of the human* way of being (AYRES, 2005), to boost the user in the search for care. It is he who makes the user endowed with and possibility of choice between whether or not to treat himself to the disease.

Searching for the health unit does not always guarantee the user the service and the problem of their problem. In the units there is still difficulty in elucidating the diagnosis of PT, although this is an easily diagnostic disease. Obtaining access and elucidative diagnosis were fundamental for the insertion of the user in the health unit, but their permanence in the Program occurs when they feel welcomed

A striking trait in the relationship of these users, human beings, is the union between the technological arrangement represented by the improvement of the general state, problem-solving of the case, gratuity of the drugs destined to this disease with the issues proper to the human being: attention, affection, communication among other aspects. Future research is encouraged on enhancing the current epistemology on such investigations regarding PT treatment in Brazil.

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