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RESEARCH

Speeches of managers about the policy of the directly observed treatment for tuberculosis

Discursos de gestores sobre a política do tratamento diretamente observado para tuberculose

Discursos de gerentes sobre la política del tratamiento directamente observado para tuberculosis

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ABSTRACT

Objective: to analyze the managers' speeches about the policy transfer of the directly observed treatment (DOT) for tuberculosis control in the city of João Pessoa, Paraíba, Brazil. **Method:** this is a qualitative study developed in May and June, 2013 through semi-directed interviews with twenty health professionals in five health districts in João Pessoa/PB. The empirical material produced was analyzed according to the theoretical-analytical basis of the French Discourse Analysis by Pêcheux. **Results:** the study demonstrated weaknesses in the conduction and organization of actions in relation to the DOT. It revealed that the lack of knowledge of the managers about this policy has direct implications to the care of tuberculosis patients. **Conclusion:** the management should trace strategic plans to rethink the care practices and thus, reorganize the entire care network to users in order to effectively contribute to user adherence in the fight against tuberculosis.
Keywords: Tuberculosis; Public Policies; Health Management.

RESUMO

Objetivo: analisar os discursos dos gestores, acerca da transferência de política do tratamento diretamente observado (TDO) para o controle da tuberculose no município de João Pessoa/PB. **Método:** trata-se de estudo qualitativo, desenvolvido em maio e junho de 2013, por meio de entrevista semidirigida, com vinte profissionais de saúde nos cinco distritos sanitários de saúde em João Pessoa/PB. O material empírico produzido foi analisado conforme o aporte teórico-analítico de Análise de Discurso da linha francesa pecheutiana. **Resultados:** o estudo evidenciou fragilidades na condução e organização das ações em relação ao TDO. Revelou que o desconhecimento desses gestores acerca dessa política traz implicações diretas para o cuidado ao doente de tuberculose. **Conclusão:** sugere-se que a gestão trace planos estratégicos para repensar as práticas de cuidado e, assim, reorganize toda a rede de atenção ao usuário, de modo que possam efetivamente contribuir para a adesão deste ao combate à tuberculose.
Descritores: Tuberculose; Políticas Públicas; Gestão em Saúde.

RESUMEN

Objetivo: analizar los discursos de los gestores, acerca de la transferencia de política del tratamiento directamente observado (TDO) para el control de la tuberculosis en el municipio de João Pessoa/PB. **Método:** se trata de un estudio cualitativo, desarrollado en mayo y junio de 2013, por medio de entrevista semi-dirigida, con veinte profesionales de salud en los cinco distritos sanitarios de salud en João Pessoa/PB. El material empírico producido fue analizado conforme el aporte teórico-analítico de Análisis de Discurso en la línea francesa pecheutiana. **Resultados:** el estudio evidenció fragilidades en la conducción y

organización de las acciones en relación al TDO. Reveló que el desconocimiento de esos gestores acerca de esa política trae implicaciones directas al cuidado del enfermo de tuberculosis. **Conclusión:** se sugiere que la gestión trace planes estratégicos para repensar las prácticas de cuidado y así reorganizar toda la red de atención al usuario, de modo que puedan efectivamente contribuir para la adhesión de este al combate a la tuberculosis.
Palabras claves: Tuberculosis; Políticas Públicas; Gestión en Salud.

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INTRODUCTION

The object of investigation in this study is the policy transfer of the Directly Observed Treatment (DOT) for tuberculosis (TB) control in the city of João Pessoa, state of Paraíba (PB). Data of this study are part of a larger corpus of a multicenter study - *Evaluation of the Health Policy Transfer of the Directly Observed Treatment in some municipalities of the southern, southeastern, northeastern and northern regions* (CNPq - Notice No. 14/2011) – linked to the Group of Studies and Qualifications in Tuberculosis in Paraíba.

The policy transfer comprises a process with the participation and involvement of managers and professionals for the development and evaluation of the transfer of certain public policies in different contexts, considering, above all, information, knowledge and innovative actions focused on changes in the periphery of systems and services, where such policies can be experienced[1-3] effectively.

The DOT is one of the five pillars of the Directly Observed Treatment-Short Course (DOTS) strategy, launched in Brazil in 1996 by the Ministry of Health to improve some indicators related to tuberculosis[4]. It consists in observing the ingestion of medication, preferably every day, aiming to strengthen patients' adherence to treatment and prevent the emergence of drug-resistant strains[5].

Tuberculosis remains one of the public health issues on the world scenario. However, it is curable in virtually 100% of new cases sensitive to antituberculosis drugs, as long as the basic principles of drug therapy are observed, and there is proper implementation of the DOT in primary health care services[5]. Given the decentralization process of the Unified Health System since 2001, tuberculosis control actions have become the responsibility of municipalities[6] and priority commitments of the municipal management through the Pact for Health[5] in 2006.

The DOTS was implemented from 1999 in the state of Paraíba[7]. The policy transfer of the DOT occurred throughout the year 2007 in primary care services. Previously, it was centered in the Clementino Fraga Infectious Diseases Hospital, reference unit of the state. While some teams already conducted the DOT in the family health units, in 2007 the local management actually took steps towards the policy transfer of actions for tuberculosis control, among which, the DOT for the Family Health Strategy. This transfer process is a significant advance, despite the several challenges such as the coordination of actions among the various technical, administrative and managerial levels of the health system.

The transfer of actions of the Tuberculosis Control Program (TCP) for primary care involves its recognition as a central point of attention within the organization of the health care system[8]. A study on the implementation of the Family Health Strategy in large urban centers in Brazil indicated advances in the transfer of actions and public health programs. However, it also demonstrated that in one of the municipalities, the care for tuberculosis was considered one of the most difficult actions to be decentralized[9].

Other studies[10-11] on the implementation and sustainability of the DOTS, particularly in relation to the DOT, found that the implementation of this strategy had a positive impact on cure and abandonment rates. However, some operational factors and the geopolitical context acted as barriers to offering this treatment modality. As a result, the regional specificities deserve singular attention because of the health actions pact made between the management institutions of SUS – Brazilian Unified Health System (at state and municipal levels), since the DOT is the protagonist in the TB decentralization policy for primary care.

The policy transfer of DOT for primary care requires coordination and negotiation between the management team members in the administrative and technical spheres, in order that the objectives of this policy transfer are understood, providing better disease control. Thus, the managers assume important responsibilities in face of TB control actions in the city. Dolowiitz[1] asserts that these transfer processes can be facilitated or inhibited by several factors, including political complexity, the effects of interaction between management, professionals and users, institutional restrictions and, lastly, the language.

As our study is focused on the development status of the policy transfer of DOT[3,12-14] in health care, we conducted a literature review in national and international journals. Despite the numerous previous studies on tuberculosis control, we did not find studies aimed at analyzing from the speeches of managers, the policy transfer of DOT between the state and municipal health levels in our country.

Therefore, it is necessary to investigate the policy transfer of DOT from the discourse of managers, since this policy has been implemented in the county and deserves an analysis of how it has been conducted, given its relevance to tackle tuberculosis. In this regard, we direct this research from the following guiding question: Which discourses are mobilized by managers about the policy transfer of DOT for tuberculosis control in the city of João Pessoa (PB)? In order to answer this question, we aimed to analyze the speeches of managers about the policy transfer of DOT for tuberculosis control in that municipality.

METHOD

This is a qualitative study carried out with twenty health professionals: Director-general (5), Chief Science Officer (5), Technical of the Epidemiological Surveillance Service (5) and Support Technicians (5) selected for exercising management activities related to coordination, organization , surveillance and monitoring of actions for TB control in five Health Districts in João Pessoa/PB. The interviews were conducted between the May and June 2013 with use of a semi-directed script. Sessions were recorded and carried out in a private place allocated inside the district premises. The individuals' rights of anonymity and privacy were guaranteed. The study subjects were identified by the letters G (Manager) and arranged in sequence (G1 to G20), according to the order of the interviews. This study was approved by the Research Ethics Committee of the Federal University of Paraíba.

We used the theoretical and methodological assumptions of the Discourse Analysis of Pêcheux for the analysis of the selected corpus. The Discourse Analysis started in the 1960s with the work of Michel Pêcheux called *Analyse automatique du discours*[15]. It consists of three areas of knowledge: linguistics, historical materialism and psychoanalysis. Linguistics is substantiated, among other theoretical basis, by no transparency or opacity of language and the significant materiality concept. In historical materialism, there is the assumption of a real of history, man-made and that is not transparent to men. Psychoanalysis incorporates the Lacanian understanding that the unconscious is structured like language and there is a displacement from the notion of man for the notion of subject, by taking into account that the discursive subject works by the unconscious and the ideology[16-17].

According to Orlandi[17], the discursive subject is:

> Crossed by language and history under the imaginary mode, the subject only has access to part of what he says. He is physically divided since his constitution: he is the subject of and is subject to. He is subject to language and history, since, to constitute himself, to produce meanings (himself), he is affected by them. Thus, he is determined this way because, if he does not suffer the effects of the symbolic, that is, if he is not subject to language and history he is not constituted, he does not speak, he does not produce senses.

The discursive perspective of analysis attempts to grasp the processes of meaning production in the relationship between language, ideology and the subject, and understand how the language produces meanings by and for the subjects, since there is no discourse without the subject and there is no subject without ideology[17]. From this point of view, the language is understood as linguistic materiality and, due to its semantic porosity, produces multiple meanings, unfinished and partially open; it offers almost endless possibilities of interpretation; it enables the unveiling of other meanings[17]. The discourse analysis does not seek the true meaning, but the real of the meaning in its materiality or linguistic and historical constitution. Thus, the act of interpretation reveals the discourse of the subject.

In this study, we seek to interpret the discourse, that is, the senses and meanings contained in the materialization of actions of policy transfer of DOT under the management of the health districts in João Pessoa (PB). In the discursive analysis plan, there is a transition from the raw material such as transcribed interviews, for the discursive object through the following steps proposed by Orlandi: 1) from the linguistic surface to the text (speech); 2) from the discursive object to the discursive formation; and 3) from the discursive process to the ideological formation[17].

The first step addresses the production conditions that comprise fundamentally the subjects and the situation of the enunciation of circumstances to the broader socio-historical and ideological context. In this moment of analysis, working with paraphrases is essential, as well as with the synonymy, polysemy, metaphor, relationships of saying and not saying. At this stage, the analyst must be aware of the configuration of discursive formations that dominate the discursive practice in question, that is, considering what is said, how it is said, who says it and what are the specific discursive circumstances[17].

In the second step, the discursive formation is constituted in the relation with the interdiscourse and intradiscourse. The interdiscourse refers to the speakable, a 'set of formulations made and already forgotten that determine what we say'[17]. It presents itself as an unnamed voice that means in our words. The intradiscourse alludes to materiality (oral or written text), the wording of the text, and the conduction or linearization of the discourse. The main difference between them is that the interdiscourse corresponds to the constitution, as a vertical axis where are presented all the sayings already spoken and forgotten. The intradiscourse corresponds to the formulation and is the horizontal axis in which, at a certain moment, in a given discourse situation, one says[17].

By taking into account that the language meanings escape, the concept of discursive memory stands out, observing the crossing of the language by the historicity of the language itself, as well as by the history of discursive subjects. The discursive memory touches the 'discursive knowledge that makes any saying possible and that returns in the form of preconstructed, i.e., what was already said that is on the base of the speakable and sustains each take of the word'[17].

Thus, at this level of analysis, one should consider that the discursive subject is inscribed in different discursive formations due to occupying different positions and therefore, there is no linearity. By the discursive formation, in our job of discourse analysts, we intend to understand different meanings in the discursive operation. The discursive formation determines what can and should be said in a given ideological formation. Thus, 'everything we say has an ideological trace in relation to other ideological traces', being the essence of discourse, in how the ideology produces its effects on the discourse, materializing itself in it[17]. Therefore, at this stage, contradictions should be unveiled, identifying silences, slips, repetitions, hesitations and analyzing the weakening of dissonant and minority discourses in the discursive universe of managers on the policy transfer of DOT in the city of João Pessoa (PB).

In the third step, we must consider the relationships of the discursive formations with the effects of ideology, noting that ideological formations leave linguistic-discursive brands,

which the discourse analysts search for on their interpretation tools. Thus, textual fragments were identified in this analysis, and when grouped, they integrated two discursive formations present in the discourses of managers: FD1 - Favorable aspects related to the policy transfer of DOT in João Pessoa and FD2 - Barriers to the operation of DOT in health units in João Pessoa, shown in Box 1 and 2.

RESULTS

Box 1 - Discursive formation 1 – Favorable aspects related to the Policy Transfer of the Directly Observed Treatment in the city of João Pessoa, Paraíba, Brazil, 2013

Textual fragments
The importance of creating the bond, the continuous monitoring of users, of being closer, since, in most cases, users are quite complicated. (G5)
It is the matter of co-responsibility of all actors involved in this process. It's actually the co-responsibility of all, and not just the manager's or just the user's or the professional's, it's of all actors involved [...]. *So, when there is a conversation, communication, and when there is observation of this treatment, adherence happens much more easily.* (G12)
It's an active search, we will not let patients run loose, right? We're always behind, to see if they're following the treatment normally, properly, correctly, if they're taking the drugs. That was the improvement, to be always searching. (G9)
There are many positive things, first, the patients ... they're more in loco, closer to their residences. (G2)
It's the guarantee of treatment until the end. (G1)
They (the professionals) *used to have a great difficulty with the closure, and after the DOT, they* (the professionals) *are actually seeing more results at the completion of the monitoring.* (G3)
We are increasing the cure rate and there is a higher treatment rate. I think these would be the favorable aspects of decentralization, by increasing the access of users to treatment. (G14)
The monitoring of users each day and on weekends, trying to provide this coverage, then, it's a favorable point for the DOT. (G6)
The community health agent's view, especially at the time of medication administration. Usually many CHAs visit the home of users early to check if they are really taking the medication, you know, and we see this as a real improvement. (G4)
Everyone (the professionals) *should have the knowledge and know how to deal with this treatment.* (G13)

Notes: DOT: Directly Observed Treatment; CHA: Community Health Agent.

Box 2 - Discursive formation 2 – Barriers to the implementation of the Directly Observed Treatment in the health units in João Pessoa, Paraíba, Brazil, 2013

Textual fragments
I identify as a barrier when the family health team has no bonds with the user; then, they (professionals) *create a barrier and this complicates the process of monitoring that user.* (G1)
Mostly, what people (users) *report is the difficulty with monitoring, they complain a lot, for example, of the units opening hours, the user wakes up much earlier, has to go to work and cannot wait for the health agent's visit to watch the medication intake.* (G5)
There are some professionals who resist to adhere to the policy, you know? (G2)
Involvement is more complicated. We have a lot of difficulty; for example, the dentists' adherence compared to other promotional activities that are not specific of oral health. (G5)
I think it's more a question of bureaucratization of this process. Often, when we are more attached to the bureaucratic aspect of the paper, sometimes, when we demand only that part of the paper, there may be weaknesses in the process. (G12)
The issue of drugs, which is what we experience on a daily basis with our users with tuberculosis, the majority, you know? We've faced a lot of difficulties here, with monitoring; these users' difficulty with completion, since they are already associated with other social and economic problems. (G8)
The main barrier I see is the fact that nowadays the health units do not have eating facilities inside, to provide for users, you know? (G3)

DISCUSSION

When asked about the policy transfer between the state and the county to decentralize the DOT to family health units, in the speeches of managers we found that they seemed insecure to answer the question. The managers (G5, G8 and G9) showed ignorance about the DOT, a strategy considered by the Ministry of Health as a priority for tuberculosis control. They were also silent about the transfer of guidelines for the implementation of the DOT, and about the decentralization of control actions to the periphery of the system. These evidences may undermine the disease control actions related to patient care.

> *I think it's a way to really check if the user is really being monitored by the units, you know? Each district was held responsible, right?* [...] *Actually, I don't participate, who does is 'J', who's the program coordinator of the district. I only receive, so to speak, the spreadsheets here in the district. So, I don't participate.* (G5)

> *Is it the treatment? Let me take a look* [...]. *I guess by the type of user we notice that, for the most part, they come with other problems too, you know?* (G8)

> *I think it's like, it's like these referrals, the monitoring, the meetings, the incentive* (food basket for the underprivileged) *for the DOT offered by the city.* (G9)

From the socio-historical context interrelated to the discursive memory and the empirical place socially occupied by these managers (technicians responsible for tuberculosis control actions), a denial of this place is linguistically clear when they state in their speech: 'I guess, I do not, I think it is like that, I do not participate'. These statements evoke contradictory meanings in relation to the Tuberculosis Control Program policy because they indicate that managers have an inconsistent discursive position in relation to the official discourse of the World Health Organization, which points the DOT as one of the five essential components of the DOTS strategy.

Such statements correspond to the imaginary projections that function in the discourse and are part of the functioning of language. In this discursive relationship presented here, the images constitute the different positions of managers. Thus, what works in their discourses is not the subject seen empirically, but the subject as a discursive position produced by the imaginary formations.

In this regard, Orlandi[17] differentiates place and position by stating that:

> Are not the physical subjects nor their empirical places as such, i.e., how they are written in society and could be sociologically described that function in the discourse, but their images that result from projections.

Thus, in the language 'there are projection rules that allow the subject to move from the empirical situation to the discursive position' and, according to the socio-historical context and memory, these positions mean the discursive knowledge, what has already been said.

In relation to the discursive fragments shown in Box 1 and 2, in the managers' discourses contained in FD1 (G5) and FD2 (G1), the word 'bond' is included in the language, presenting positions that cause different meaning effects for the implementation of the DOT. In the FD1 it is a favorable aspect for the 'creation of the bond', while in the FD2, it appears as a barrier for the implementation of the DOT, when 'the family health team has no bond with the user'.

As part of this discussion, Orlandi[15] states that 'the same word in the same language has different meanings, depending on the subject's position and the inscription of what is said on either discursive formation'. The search for words should make sense in the production of discourse, which, in turn, is not defined by simple transmission of information, but represents the effect of meanings between interlocutors[17].

When we talk about bonding, we relate it to connection and ties, and within the context of the relationship between health professionals and users of services, the commitment, trust and responsibility are not different. They favor the strengthening of the professional/user relationship, contributing in many ways and unique situations in the attention to users with tuberculosis.

Another discursive fragment shown in FD1 relates 'the co-responsibility of all actors', indicated by G12 as a positive aspect in the process of policy transfer for implementing the DOT. The co-responsibility evoked by this subject through the discursive memory, brings meanings that suggest the commitment of all team members in the process of transfer or decentralization of the DOT.

The policy transfer is a development policy aimed at giving meaning to a process or set of processes, in which the knowledge and information about institutions, policies, programs and services are of great value for assessing the policy transfer occurring between different services and levels of governance[1]. It includes the participation of managers, administrators and professionals, especially during its decentralization stage in health services[2].

Still about the interpretations of the positive aspects in the DOT implementation, we present the following speech of manager G12:

> *When there is a conversation, when there is communication, and when there is observation of the treatment, adherence occurs much more easily.* (G12)

In the line of this discourse, the expression 'conversation and communication' evokes the essential constituents of humanized care in our discursive memory.

The offer of humanized care does not happen spontaneously. The intention of achieving a care model focused on the needs and risks of users has to be combined with the ability to identify resources, and combine these into hundreds of possible variations, in a planned and agreed way among those responsible for the supply of these resources in the services[18].

In the discursive analysis of G12, the word 'adherence', cited by him, denotes meanings as a result of positive attitudes of the team, who use this 'conversation' during user embracement to communicate with users during their presence in the service throughout the DOT. Thus, user embracement will also contribute to adherence of users to tuberculosis treatment.

Another important issue identified in the FD1 concerns the 'active search', which was pointed by G9 as a favorable aspect in the implementation of DOT after the policy transfer. However, in the line of discourse, G9 attributes senses and different meanings for the active search, presenting it as a form to:

> [...] *see if he* (the user) *is doing the treatment normally, properly, correctly, if he's taking all the medications.* (G9)

when, in fact, the active search is an activity for early identifying people with cough for three or more weeks, aiming to discover cases of active tuberculosis and thus, avoid delays in the diagnosis of TB[5].

This understanding of manager G9 corroborated a study conducted in 2010 with matrix support managers of integrated units in the city of João Pessoa. By analyzing the discourse of managers, it was found that they also confused the active

search for new cases with therapeutic monitoring or with the cases related to abandonment of treatment[19]. As the responsible professional for management actions for TB control in the district, G9 should know the meaning of active search established by the Tuberculosis Control Program. However, in his speech, there are contradictory meanings about the guidelines established by the Ministry of Health for tuberculosis control.

Another aspect of the DOT highlighted as a positive point addresses the treatment, monitoring and closure of cases for cure, when managers state in their speeches:

> [...] *they used to have a great difficulty with the closure, and after the DOT, they are actually getting to see more results at the completion of the monitoring.* (G3)

> *We are increasing the cure rates.* (G14)

> [...] *and the guarantee of treatment until the end.* (G1)

The monitoring and closure of TB cases due to cure is a constant challenge of primary care. To succeed in treatment, health services should seek the 'optimization and adaptation of the existing resources to the diverse needs of sick individuals with tuberculosis'[20].

Among the discursive fragments shown in FD2 as barriers to the implementation of DOT, the G5's speech mentions the 'opening hours of the units' as a monitoring difficulty, when users need to leave home to go to work before the arrival of community health agents to observe the ingestion of medication. The opacity of the speech shows problems in terms of access and equity in the care of tuberculosis patients.

The guarantee of access and equity to tuberculosis patients means having attention with the location of the unit destined to patient care; choosing a place of easy access for medication intake, located near the patients' residences and/or units close to their workplace, without the expense of time and transportation means for their displacement, minimizing any possible difficulties faced by patients[5].

The expectation from this point of view is reducing or eliminating the differences originated from avoidable and unjust factors, creating equal opportunity in health and reducing the possible differences, that is, allowing the timely and equitable use of services by TB patients[21].

Primary care is the gateway to SUS and to the strategy of DOT within the scope of the Family Health Strategy. For this reason, the integrality of actions of all health professionals involved in user assistance is fundamental, so the Tuberculosis Control Program can move forward ensuring the quality of actions. However, this action was not perceived in the discourse of managers:

> *There are some professionals who resist to adhere to the policy, you know?* (G2)

> *Involvement is more complicated. We have a lot of difficulty; for example, the dentists' adherence compared to other promotional activities than those specific of oral health.* (G5)

The professionals' responsibility in caring for users during the DOT is given by the continuous search of understanding and resolution of their demands and needs at individual or collective levels. The management plays a key role in this process, by providing care for the people under their responsibility. By contrast, managers G8 and G17 state that for the most part, the monitoring of these users in the unit is done by nurses or community health agents.

> *I think who's very involved are the nurses and health agents, who are much closer. We see that nursing in the family health ... has a very effective action.* (G8)

> *There's a strong resistance, then, this ends up more in charge of the health agents or the nurses.* (G17)

As members of the health team, nurses play an important role for the effectiveness of TB control actions to the extent that they manage the control actions and understand the complexity involved in the process[22], as it happens in the identification of respiratory symptoms, diagnosis, treatment, performance in the implementation of DOT, as well as support and care for the sick person, the family and the community[5].

Another relevant issue in FD2 concerns the speech of G12, which identifies the aspect of 'bureaucratization' that leads to weaknesses in the process of professional awareness about the DOT. This bureaucratization refers to informational, normative and traditional tools used by health management and that are part of the health care team work process. This also happens in this municipal management, where filling out these 'forms' such as the disease worsening form, monthly monitoring reports, TB cases monitoring book, respiratory symptoms book, among others, is also performed by the unit nurses in most times.

Although the manager G12 considers 'the more bureaucratic issue of the papers' as a barrier to implementation of the DOT, these activities are clearly part of the protocol for tuberculosis control, and represent a registration and information system of monitoring the cases for treatment evaluation, which is identified as one of the five components of the DOTS strategy.

The filling of these papers will feed the data reporting system. Thus, the meaning perceived by this manager on the use of this tool should not be understood simply as a mere bureaucratic activity, but as a tool that will generate data to be used by managers and health professionals in the routine of services for monitoring and evaluation of actions, and to guide the adoption of measures that will be implemented[23].

Therefore, we see the need to reorganize the team's work process, making them all aware of the commitment of comprehensive care to users, with the knowledge and adoption of effective actions that comprise the DOTS strategy. To this end, investments will be needed through the Continuing Education Policy[24], both for the professional qualification of workers in this area and for changing the health practices toward meeting the fundamental principles of SUS (political and administrative decentralization, equality and comprehensiveness of health care, community participation, universal access to services health, among others).

Still in discursive analysis, we found issues of social and economic order involving users with TB as a barrier to the implementation of DOT, as in the speech of G8 on the association of the disease with

> [...] *the issue of drugs and* [...] *social and economical problems*. (G8)

This association indicates that tuberculosis is strongly influenced by social determination and bears a direct relation to poverty and social exclusion. Hence, these problems favor the non-adherence of these patients to the therapy offered, becoming chronic patients, both of the disease and the service[25].

Such a statement on the use of drugs is evident in the Municipal Health Plan of João Pessoa, showing an increase in the number of new cases of TB associated with alcoholism from 2008, demonstrating a situation that compromises treatment efficacy[26]. Some municipal health teams face this problem of drugs more frequently and, in the case of users affected by tuberculosis, the adherence and continuity of the DOT become even more challenging because there are weaknesses that contribute to abandonment of treatment, from both the point of view of health services integration and individual health care, as suggested by GD8.

Another aspect identified as a barrier to the DOT relates to the irregular provision of food assistance by the unit. In the discursive memory of G3, the association of 'food... provided to users' will ensure the success of the policy transfer of DOT, showing the reductionist view of the DOT of this manager. This reveals that for him, the food assistance strategy may be linked to poverty, and not to tuberculosis control, as in fact the strategy proposes.

The benefits offered in the DOT contribute to continuation of treatment, to create bonds and to make TB patients active participants and autonomous in their own treatment, since they tend to remain alert to the end of medication, which implies receiving a new basket of food (food assistance benefit). Hence, encouragement is necessary, but the benefit alone is not enough. In addition to the benefit, it is important to ensure quality of life for sick people, so the welfare actions do not prevail in detriment to intersectoral policies and actions that are the foundation for the design of health promotion and comprehensive care[27]. Therefore, the managers must assign meanings to the food benefit within the DOT, which will mean a concern truly focused on tuberculosis control and not the solution to social problems.

FINAL CONSIDERATIONS

From the speech of district managers, the study showed that the policy transfer process of DOT for the control of tuberculosis in João Pessoa is a challenge and needs to be reconducted and innovated by the health management in the municipality. Weaknesses were identified in the conduction and organization of actions in relation to DOTS and more specifically, to the DOT. The study also found that the lack of knowledge of managers on this theme, considered by the Ministry of Health as a priority for tuberculosis control, has direct implications to the management of patient care.

In the production conditions under which we contextualized the analysis, from the perspective of discourse analysis, were found silences and contradictions regarding the knowledge about tuberculosis, the Tuberculosis Control Program and strategies employed in the process of policy transfer of DOT. In short, the management must trace strategic plans to rethink the care practices and thus, reorganize the entire care network to users with the qualification of professionals through the continuing education policy, in order to effectively contribute to user adherence in the fight against tuberculosis.

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