

The concepts of bonding and the relation with tuberculosis control*

AS CONCEPÇÕES DE VÍNCULO E A RELAÇÃO COM O CONTROLE DA TUBERCULOSE

LOS CONCEPTOS DE ENLACE Y LA RELACIÓN CON EL CONTROL DE LA TUBERCULOSIS

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ABSTRACT

This study analyzed the concepts of bonding that guide the practice of Family Health Program (FHP) teams in terms of tuberculosis (TB) control measures in the public health setting, in the city of Bayeux, Paraíba, Brazil. Using a qualitative approach, the study involved 37 health care professionals. Data collection took place using the focal group technique, in April 2007. Data analysis was performed based on discourse analysis. It was observed that FHP team concepts about attachment were in agreement with the studied theoretical concepts, with evidences of trust, commitment, intimacy, and responsibility in the team/patient relationship. The following aspects strengthen the bond: the time that FHP teams work in the community; the number of home visits and consultations and the involvement with TB control. Bond weaknesses: insufficient intersectorial measures, the patient's socioeconomic situation, and family abandonment. It is emphasized that there is a need for changes that would strengthen the relationship between the FHP team/patient. This way there would be a concrete care founded on the integrality of health care service routine

KEY WORDS

Tuberculosis/prevention & control.
Health family.
Primary attention to health.
Patient care team.

RESUMO

O estudo analisa as concepções de vínculo que norteiam as práticas das Equipes de Saúde da Família (ESF) com relação às medidas de controle da Tuberculose (TB) no âmbito da APS, no município de Bayeux – PB/Brasil. Mediante abordagem qualitativa, envolveu 37 profissionais de saúde, sendo os dados coletados pela técnica de grupo focal em abril de 2007 e analisados conforme análise de discurso. As concepções das ESF sobre vínculo revelaram coerência com os conceitos teóricos estudados, sendo evidenciadas, na relação equipe/doente, confiança, compromisso, intimidade, e responsabilidade. Aspectos potencializadores do vínculo: o tempo de atuação da ESF na comunidade; número de consultas e visitas domiciliares e envolvimento com o controle da TB. Fragilidades no vínculo: insuficiência de medidas intersectoriais, situação sócio-econômica do doente e abandono da família. Ressaltamos a necessidade de mudanças que fortaleçam a relação ESF/doente, e que, desse modo, concretize um cuidado fundamentado na integralidade do cotidiano dos serviços de saúde.

DESCRITORES

Tuberculose/prevenção & controle.
Saúde da família.
Atenção primária à saúde.
Equipe de assistência ao paciente

RESUMEN

El estudio analiza las concepciones de vínculo que orientan las prácticas de los Equipos de Salud de la Familia (ESF) con relación a las medidas de control de la Tuberculosis (TB) en el ámbito de la APS, en el municipio de Bayeux–PB/Brasil. Mediante un abordaje cualitativo, en que participaron 37 profesionales de la salud, siendo los datos recolectados por la técnica de grupo focal, en abril de 2007 y analizados conforme el análisis del discurso. Las concepciones de las ESF sobre el vínculo revelaron coherencia con los conceptos teóricos estudiados, siendo evidenciados, en la relación equipo/enfermo: confianza, compromiso, intimidad, y responsabilidad. Aspectos de potenciación del vínculo: el tiempo de actuación de la ESF en la comunidad; número de consultas y visitas domiciliares, participación en el control de la TB. Fragilidades en el vínculo: insuficiencia de medidas intersectoriales, situación socioeconómica del enfermo, abandono de la familia. Destacamos la necesidad de efectuar cambios que fortalezcan la relación ESF/enfermo y de ese modo, concretice en lo cotidiano de los servicios de salud, un cuidado fundamentado en la integralidad.

DESCRIPTORES

Tuberculosis/prevenición & controle.
Salud de la familia.
Atención primaria de salud.
Grupo de atención ao paciente.

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INTRODUCTION

The concept of bonding is polysemous. It encompasses both the social sciences and the health science areas, assuming several approaches, such as: dimension, guideline, strategy, technology, purpose and relation. In addition, it presents an interface with other well-known concepts in public health such as those of humanization, user embracement, responsibility, integrality and co-administration.

Bonding connects people, indicates interdependence, relations with double meaning lines, and the commitment of the professionals towards users and vice-versa⁽¹⁾. It is dependent on the manner in which health care teams take responsibility for the health of the group of people living in a certain micro-region. Furthermore, the bond of the population with the health unit requires the establishment of strong interpersonal ties that reflect the mutual cooperation among the people in the community and the health professionals⁽²⁾.

Bonding is still considered a dimension of Primary Health Care (PHC) and presupposes the existence of a regular care source and its use over the years⁽³⁾. Thus, it is recognized that the primary health care unit constitutes:

the first contact level of the family and community individuals with the national health system, taking the health care as close as possible to the place where people live and work, constituting the first element of a process of continued health care⁽²⁾.

In Brazil, there is a national proposal of investment in PHC that aims to reorganize the model of health care and services based on the daily bonding with the population. This bonding has the function of enabling a health care system that strengthens the care relation dimension and allows a broader approach of the Single Health System (SHS) towards the population needs⁽⁴⁾. In this perspective, the humanization policy of the SHS stands out, established

as the construction/activation of ethical-aesthetic-political attitudes in tune with a project of co-responsibility and qualification of bonding among professionals and between professionals and users of the health care system⁽⁵⁾.

From the perspective of PHC, there must be an intimate relationship between bonding and the other dimensions that encourage its success, such as the access, the entrance door, the casting of services, the family focus, the guidance for the community and the professional development and coordination. Nowadays, in Brazil, the strategy of Family Health (FH) is considered a thriving modality of the PHC that, together with the Health Community Agent Program (HCAP), are responsible for the development of TB control actions in this health care area⁽⁶⁾.

Therefore, the organization of the FH strategy promotes the production of bonds between health professionals and persons with TB, since the FH units favor the first contact

of the communities with the service, which allows the Family Health Teams (FHT) to adapt themselves to the different needs of the community under their responsibility; this promotes a closer and longer relationship between the health services and the users of these services. The national guidelines for disease control are currently operated by the FHT through the *Directly Observed Treatment Short-Course* (DOTS), which reinforces the decentralization policy of the services established by the SHS⁽⁷⁾.

The DOTS strategy has been considered successful due to the positive change in TB cure rates, since it contributed to both abandonment and mortality reduction. In addition, DOTS allows the participation of the user with TB as a subject in the therapeutic process, a fact that promoted the construction of bonds between users and health professionals through the establishment of a relationship of trust, affinity, responsibility and mutual commitment⁽⁷⁾. However, even though this strategy has shown success in cities where TB control actions were decentralized by the PHC, the disease is still a serious public health problem, since its prevalence has increased because of its association with HIV and its resistance to drugs due to the issue of treatment abandonment⁽⁸⁾.

Twenty-two countries around the world are responsible for 80% of the diagnosed cases of tuberculosis. Brazil stands in 16th place on this list, with an incidence of 28 cases (positive bacilloscopy) per 100,000 inhabitants, a prevalence of 92 per 100,000 inhabitants, a co-infection rate with Human Immunodeficiency Virus (HIV) of 3.8% and cases of multi-drug-resistant (MDR) tuberculosis of 0.9%⁽⁶⁾. In the Brazilian scenario, Paraíba has the 13th highest incidence of TB cases⁽⁹⁾, a situation that made the Health Department elect six important cities for the control of the disease in this state: João Pessoa, Bayeux, Santa Rita, Campina Grande, Patos and Cajazeiras⁽¹⁰⁾. The first three cities are located in a region named Zona da Mata, and are part of the metropolitan region of João Pessoa – capital of the state. Campina Grande belongs to the region of Borborema. Patos and Cajazeiras are located in the area known as Sertão.

The social and economic reality of each city in Paraíba, the political commitment of each administrator and the involvement of professionals in tuberculosis control determine the heterogeneity of the epidemiological characterization and influence the way the relationship between FHT and persons with TB is established. In this context, this study considers that the establishment of bonds provides a therapeutic resource that determines the way teams take responsibility for the health of the group of people under their supervision, and on their involvement according to the singularities of each case⁽¹⁾. Furthermore, it is important to highlight that the notion of integrality as a SHS principle must guide professionals to listen, comprehend and then meet the demands and needs of the people, groups and communities in a new health care paradigm⁽¹¹⁾.

This article aims to analyze the bonding concepts that guide the practices of FHT regarding TB control measures

in Bayeux – PB/Brazil, recognizing that TB combat actions assume different formations due to the singularities of the individuals and scenarios, and that the patient care, from the integrality perspective, requires the establishment of a relationship of trust and commitment among the people involved in the therapeutic process.

METHOD

Study type

This exploratory and descriptive study uses a qualitative approach. At first, the field to be studied was observed during the entire month of March, in 2007, with the purpose of understanding the primary health care services in the city of Bayeux – PB/Brazil, as well as the operation of DOTS strategies by the local FHT. The theoretical-methodological reference is based on the concept of bonding as a PHC dimension⁽²⁾ and on the discourse analysis technique, which aims to identify the world view of a certain social class and the social position of the subjects, through themes and figures shown in statements⁽¹²⁾.

Study location

Bayeux was the elected study location. It belongs to the 1st Regional Health Center of Paraíba, and is located in the micro-region of João Pessoa – PB, having the cities João Pessoa and Santa Rita on its respective east and west borders. According to The Brazilian Institute of Geography and Statistics (IBGE), its population was estimated at 95,004 inhabitants in 2006. This city has been determined to be under the full administration of systems since 2003, and has 28 FHTs that are responsible for the operation of DOTS in TB cases. Bayeux also has two polyclinics, one maternity clinic, where the BCG vaccine is applied, one city lab, responsible for the control and diagnostic bacilloscopies and five centers for sputum collection, one per health district.

Studied population

The study included the participation of professionals from 16 FHTs that, up to March 2007, had been monitoring persons in treatment for TB. There were five doctors, thirteen nurses, thirteen nursing assistants and six health community agents (HCA). The participants were coded with alphabetical letters and Arabic numbers in order to guarantee their anonymity, as well as to meet the requisites proposed by the Resolution 196/96, which sets regulations and guidelines for studies involving human beings⁽¹³⁾.

Data collection technique

Seven focus groups were formed, with six to twelve participants per group. The meetings took place between April 24 and May 08 in 2007, at the Human Resources Development Center (Centro de Formação de Recursos Humanos - CEFOR) of Bayeux – PB, and each one of them took approximately 2 hours. Discussions in the focus groups were

led by the researcher, according to a script previously constructed with the following guiding questions: How does the team take care of the TB patient and his/her family? What are the difficulties encountered by the team in caring for the TB patient and his/her family? What is the nature of the relationship between the team and the TB patient? What is the nature of the relationship between the team and the TB patient's family? What is the nature of the relationship between the team and the community in their covered area?

Data was collected using a voice recorder and spreadsheets for the recording of relevant points, determined by the observers. The criterion used to select these observers was the condition of belonging to the TB/PB Group - Group of Studies and Qualification in Tuberculosis of Paraíba (Grupo de Estudos e Qualificação em Tuberculose da Paraíba – GRUPO TB/PB). The discussion was encouraged through the presentation of three situations involving FHT actions in TB patient care and preceded by the stages of participants' introduction, explanation of the meeting purpose, and reason for using a voice recorder, as well as an explanation of confidentiality of the obtained information, according to the description of the project approved by the Ethics Committee of the Health Science Center from the Federal University of Paraíba - CCS/UFPB, under the protocol number 936/07.

Data analysis technique

The recorded statements were transcribed and organized according to the guiding questions, using the discourse analysis technique, which allowed the identification of the concepts FHT professionals have regarding bonding and how these concepts influence their practice regarding the care of people with TB. The analysis of the produced empirical material allowed the summarization of the subjects of the statements into two empirical categories: *the bonding concepts and the involvement of the FHT with TB patients and their families; and aspects that weaken the bonding between the FHT and the TB patient.*

RESULTS AND DISCUSSION

The bonding conceptions and the involvement of the FHT with TB patients and their families

After analyzing the material produced by the discussions in the focus groups, it was possible to identify the involvement of FHT professionals who are directly responsible for the operation of DOTS in Bayeux - PB. The discussion also allowed the identification of concepts about bonding, integrality, responsibility of the care given to the TB patient, FH strategy, operation of TB control actions in the PHC scope and work relations existing in the FHT. The results produced during the discussion will be presented as follows.

The bonding is dependent on the way teams take responsibility for the health of the group of people who live

in a certain micro-region. The FH strategy is currently considered as a powerful strategy in the PHC scope for promoting the construction of bonds between professionals and persons with TB, since the Family Health Units (FHU) are responsible for the identification and treatment of these persons, constituting the first access to the SHS. A nurse admitted:

We are with that patient every day. We know how to recognize when he is a little sad or concerned. Then we sometimes talk, and the patient opens himself up to us (E12).

Regarding the bonding concepts presented by the FHT, a prevalence of the theorized ideas of *connection* and *link* was observed, according to the following statement:

It's a link, a connection, intimacy [...] it becomes even a friendship relationship, between the patients and us. They trust us very much (TE10);

Bonding is a kind of dependence, a connection that you may have with something, a link (M4).

Professionals also associated the bonding concept with relationships that involve trust, affinity, commitment and responsibility, as a participant stated:

I understand bonding as the trust the patient acquires with the health professional for stating his problem, and not being ashamed to tell it. [...] a trust relation [...] They trust us. We make them feel safe, we guide them (TE6).

Regarding the bonding meaning, an interesting fact was that some professionals relate it to the care concept, as it may be observed in the statements of an HCA:

It is a care bonding, it is about becoming a friend of the patient and knowing by heart whatever it is that you have to say about him. That is bonding for me (ACS4);

and a nurse, whose conception of bonding is close to the integrality discourse:

It is about knowing the patient's story, treating them well and making them feel at home. I believe that is bonding (E12).

This conception suggests the broadening and development of care in the health profession, in order to form professionals who are more responsible for the results of care practices, more capable of creating a bond with the health service users and embracing them, as well as more sensitive to understanding the health/disease process registered in the epidemiology or therapeutics areas⁽¹⁴⁾.

The exercise of integrality constitutes an intersubjective practice, in which the health professional relates to a subject who thinks, feels, judges, and wishes. In other words, health professionals must develop intersubjective relationships, in which the health care user assumes the condition of subject rather than object⁽¹⁵⁾. This means teams must know/identify the users' needs so that they can understand and support the situations they experience. The reference to the need to *know the story* of the subject shows that this *connection* happens from the knowledge and identifica-

tion of some aspect of this subject, involving approach, intimacy, interest in this person and affinity. In this context,

the bonding allows a more effective approach between health care user and professional, at times even leading to a transfer process, in which the professional starts to represent someone of importance in the patient's life, as well as the patient in the professional's life⁽⁷⁾.

It is also recognized that the bonding process means the establishment of strong interpersonal ties that reflect the mutual cooperation between the community people and health professionals through the processes of listening, dialog and respectful relations, in which the patient comes to understand the meaning of the care he is given and his co-responsibility in this process⁽³⁾. In this manner, the bonding allows health professionals to meet the needs, to advise, to share opinions, and to promote psychological support; in other words, it allows them to push the development of actions aimed at the relief of the patient's anxieties, needs and pain.

It is worth highlighting that the stigmatizing character of tuberculosis and the unfavorable social conditions of most of the patients require the involvement and commitment of the FHT with these patients during the treatment, since the impact caused by the disease on people's lives is still very strong and may interfere in several dimensions of the human being: physical, social, psychological, economical and spiritual. A nurse made the following statement regarding this idea:

He gets down, depressed and isolated from society; he becomes aggressive and suffers a series of changes in his behavior (E10).

From the perspective of the integrated care of the subject, it is fundamental for health professionals to be more sensitive, listen to the other, and understand what he thinks, in an approach that cannot be distant or impersonal⁽⁴⁾. The knowledge of reality and the health care user's life context is essential, considering that the health concept involves life quality, and that the latter is determined, among other aspects, by the biological, psychological and social well-being. Therefore, the strengthening of bonds between users, family and community with the team may be considered to be a therapeutic resource and one of the most suitable means to have a clinical practice of quality⁽¹⁾. At the same time, the ability of the team to take responsibility for the integral care of those who live in a certain territory must be considered as a basic condition for the bonding construction.

The possibility of identifying the needs demanded by users allows the establishment of a relationship of trust and responsibility with the team which, in the case of a person with TB, becomes essential to the production of bonding and, consequently, for the success of treatment. This reality may be evidenced by the following statement:

...and when we achieve this bonding, it is easier to proceed with the whole treatment..., I find this moment very

important, because when we achieve this trust, we see results in the treatment (E8).

In this context, it is noted that the FHT professionals' behavior influences the way the patient is able to understand the disease, accept or abandon the treatment and move on with his life from that moment. This is why it is important that the teams are technically prepared to support and favor this process, being available always to support so many needs, because the knowledge and meanings constructed and introjected by different subjects during their lives influence their actions.

Regarding the involvement with the disease control actions, FHT professionals state that nursing professionals stand out mainly in the treatment supervision activities and search for missing patients:

[...] patients trust the professional a lot, mainly the nurse and the assistant who are close to him (TE6).

A nurse explains:

Whenever a TB patient arrives, they say: look for the nurse over there. It is only with her, you can look for the nurse for everything you need (E12).

The treatment supervision activities and search for missing patients are fundamental for the control of TB, and require the establishment of trust and intimacy between patients and health professionals; in other words, the production of bonding relationships are crucial for the success of the therapeutic process. Besides, such activities favor the identification of the patient with TB and the conclusion of the disease treatment, and require the establishment of a trust and intimacy pattern between patients and health professionals; in other words, the production of bonding relationships.

According to the professionals' statements, it was observed that the involvement with the DOTS operation, mainly the treatment supervision, has favored the construction of bonds between the FHT and the patient, since the responsibility and commitment required from professionals take them closer to the patient's life context. At times, the patient is so well supported in the care relationship that this feeling of trust evolves into a greater feeling of passion or love, as may be observed in the following statement:

They may even fall in love, because once I had a patient who fell for me [...] Then he said: *I am in love with you* [...] (E13).

And further explains:

It is that bonding you created, you treated him so well that he grows fond of you, isn't it? (E13).

The statements that follow were selected to demonstrate the trust patients with TB have in the FHT:

In my team, the relationship was great, this patient had so much trust in me that his wife and children looked for me as soon as they got to the unit (E3);

[...] in my community they listen to me. As I have been there for a long time, they respect everything I say a lot (M2).

The next statements show how the bonding construction is strengthened by other factors, such as the period of time the professional has worked in the community, the consultations and home visits, the trust relation established between the patient and the team and their contact:

[...] I created a bond. I have worked there for six years (M2);

Then when the patient realized I was worried about her case, she started acting differently with me. She arrives at the unit smiling, talking to me... there is an interaction between patient and professional (E11).

Even though the presented concepts are close to the bonding concept on which this study is based, when it refers to a link, professionals articulate the bonding concept to that of integrality, humanization and user embracement. However, they also described situations that involve structural, administrative and family aspects that may weaken bonding relationships, such as the demands of health care users, and the lack of interest of some professionals in the TB problem and situations that express vulnerability.

Aspects that weaken bonding between the FHT and the TB patient

Despite the fact that FHT defends a practice based on the caring approach of the TB patient and his family, and on their effective participation during the treatment, this study identified situations that weaken the relationships between these health care users and the FHT, and that compromise the construction of bonds between them. There are situations, although rare, in which professionals do not even meet the patient, believing that this fact does not interfere in the care given by the team.

I didn't have any contact with him. Maybe there is something that I don't know. Everything is ok for me. I don't know so far (TE 8);

I have a patient who has been with us for four months and the doctor hasn't met him yet (ACS 1);

The assistants, do I know them by their names? I don't think so. We don't have that kind of involvement. But they visit, you know? We are more often present, but they are aware of it. They don't get involved like we do. It is generally with the ACS, the nurses (E12).

The statements of the professionals are supported by a study developed regarding the involvement of primary health care teams in the control of tuberculosis in cities in São Paulo, in which the authors demonstrate the qualitative weakness of the health care professionals, indicating the quality of the professional-user interaction in handling the disease properly⁽¹⁶⁾.

Furthermore, other aspects such as family abandonment and social differences, related to the chemical depen-

dence and vulnerability situations – low income, unhealthy housing conditions, TB/HIV co-infection, malnutrition, immigration and restricted access to basic rights such as health and education – have contributed not only to the increase in exposure and susceptibility, but also to the weakening of the relationship between user and FHT⁽¹⁷⁾. These aspects are even more significant when the patient abandons the treatment, since the bonding precariousness makes the patient's achievement and his return to treatment more difficult.

I talked to him yesterday; he doesn't want to stop drinking and he can't stop drinking, because if he does, he has seizures all the time (E5).

Another nurse highlights the fragility of the interaction among the family, patient and FHT:

In my FHT, the relationship of our team with the family of this patient is very complicated. Because this family abandoned the patient [...] we ask them to go to the unit but they won't go. They don't go. Not even his mother or his brother. We try through insistence and perseverance. The ACS stands at the door, because they won't let him in (E6).

Another aspect to consider is that the medical professional seemed to be the FHT member who was the least involved with the TB patient, as if he were behind the action. The distance between doctor and patient was emphasized at several points during the group discussions, since the performance of these professionals is particularly related to the biological and physical situation of either the disease or the treatment, such as clinical irregularities and drug reactions. Therefore, even though some doctors recognized that their relationship with TB patients was precarious, nothing was proposed to improve this situation and, once again, the *reification* aspect of the patient was reinforced, as if the only alternative they had was conformation:

Mine is horrible! (laughs). I am straightforward. It is because I have seen the patient only once, the freak (M3).

The attitude of FHT professionals is highlighted when they are exposed to different behaviors of the patients, who are often aggressive and disrespectful with those who are in charge of their health and that of the community. Critical situations show the limitations of the professionals, as well as the weakness of their relationships with these patients. The following statement presents an extreme situation of ineffective bonding with a TB patient:

I escaped from being hit by him several times. Fifteen days ago, I think, he did it. My God! He started to offend everybody. Then I left and said: - 'No! Let me out, he will hit me! He is a big man!' The health agent who supervises the unit every day was verbally threatened, physically assaulted, and I notified the coordination, just because I didn't know what else to do. Actually, I don't know what to do. He gave up again (E1)

A person from the lab treated the inconvenient patient... he came back to me and he looked like a mentally disabled

patient, he almost hit me. He came back mad, he would have hit me because of what happened in the lab if my agent wasn't there, who is 1.8m tall (E9).

This study showed the impotence of the team in terms of managing situations in which the patient does not recognize neither his limits as a citizen, nor the rights of the health professional. It seems that FHT professionals are hostages of a fragile social control that has not managed to force the State to comply with its constitutional duties, even though they vehemently demand that health professionals provide answers that they are not able to give. After all, given the health/disease process' complexity and the unfavorable situation experienced by a great proportion of the Brazilian population, particularly TB patients, health policies establish the need for coordination among the several areas of society aimed at promoting life quality.

In addition, a quality health care system requires a new process and working conditions with emphasis on the humanization of the relationship between professionals and health care users – citizens suffering, with risks and rights, who humanize health professionals, also as citizens with rights⁽¹⁸⁾. It must be considered that *civil servants become citizenship institutors as soon as they take on the job, whose results are the citizenship rights of everyone, including the servants, since people take care of people in the health area*⁽¹⁸⁾.

Therefore, the bonding process may promote a new logic in the FHT working process, allowing care to be given from the perspective of integrality, so that health services begin to consider the user as the subject of his own therapeutic process, and value his autonomy, feelings and needs. In this context, health care user embracement, bonding and responsibility are recognized as integral practices in the strategies of access improvement and development of integral practices. The value of these aspects gives origin to

a formulation exercise of an operational definition of integrality as a democratic way to behave, of knowing how to integrate, in a care system that is based on an ethical-political commitment relationship of sincerity, responsibility and trust⁽¹⁵⁾.

It is also worth highlighting that the commitment and co-responsibility bonding concept was proposed to the FHT, aimed at achieving strategic purposes such as: helping the transformation of the hospital-centered biomedical model into a social and health production model at the PHC level, broadening the responsibilities of professionals and users in the administration of health services and humanizing health care practices⁽¹⁶⁾. Thus, the practice performance can only achieve integrality by the effective exercising of team work, by embracing health care users, by establishing bonds with the responsibility regarding a health problem, and by relating to them as integral subject-citizens, with rights and abilities to participate and to be the subject of their own therapeutic process.

The existing weaknesses in the construction of bonding between FHT and patients with TB have caused a decrease

of quality and efficacy in the TB control actions in the PHC area. The situation requires the adoption of intersectorial measures by the local administration, a greater involvement of the family and medical professional with the DOTS operation, and the improvement of FHT working conditions and changes in the working process of the teams, in order to strengthen the relations of trust and commitment existing so far.

FINAL CONSIDERATIONS

This study showed that FHT concepts about bonding present relations with the concepts of integrality and humanized care, which reinforces the polysemous character of the term. The meaning attributed to bonding showed

the prevalence of the ideas of connection, approach, intimacy and involvement, as well as the cohesiveness with the bonding concept of the PHC used in this study. Nevertheless, there are situations in which the relationships among some users with TB and health professionals are fragile and precarious, a fact that has decreased the quality and efficacy of the control actions in the family health strategy. Even though statements showed that the family health strategy favors the construction of bonding, professionals revealed that in practice, there are difficulties and limits to making guidelines and policies that lead the disease control action in the city concrete. Therefore, the study stresses the need for changes that promote and strengthen the relations of FHT/TB patients, and in this manner, concretize a care system based on integrality and according to the current health policies, in the routine of PHC services.

REFERENCES

- Campos GWS. Saúde paidéia. São Paulo: Hucitec; 2003.
- Starfield B. Atenção primária: equilíbrio entre necessidades de saúde, serviços e tecnologia. Brasília: Ministério da Saúde; 2002.
- Almeida C, Macinko J. Validação de uma metodologia de avaliação rápida das características organizacionais e do desempenho dos serviços de atenção básica do Sistema Único de Saúde (SUS) em nível local. Brasília: OPAS/OMS; 2006.
- Schimith MD, Lima MADS. Acolhimento e vínculo em uma equipe do programa saúde da família. Cad Saúde Pública [periódico na Internet]. 2004 [citado 2007 jun. 20];20(6):[cerca de 8 p.]. Disponível em: <http://www.scielo.br/pdf/csp/v20n6/05.pdf>
- Brasil. Ministério da Saúde. Política Nacional de Humanização. Humaniza SUS: a humanização como eixo norteador das práticas de atenção e gestão em todas as instâncias do SUS [texto na Internet]. Brasília; 2004. [citado 2008 jul. 2]. Disponível em: http://dtr2001.saude.gov.br/editora/produtos/impressos/foheto/04_0923_FL.pdf
- Teixeira GM. O controle da tuberculose e a saúde da família perspectivas de uma parceria [texto na Internet]. [citado 2008 jul.1º]. Disponível em: <http://scielo.iec.pa.gov.br/pdf/bps/v8n2/v8n2a01.pdf>
- Arcêncio RA. A organização do tratamento supervisionado nos municípios prioritários do estado de São Paulo [tese]. Ribeirão Preto: Escola de Enfermagem de Ribeirão Preto, Universidade de São Paulo; 2005.
- Kristski AL, Villa TS, Trajman A, Lapa e Silva JR, Medronho RA, Ruffino-Netto A. Duas décadas de pesquisa em tuberculose no Brasil: estado da arte das publicações científicas. Rev Saúde Pública. 2007;41 Supl 1:9-14.
- Brasil. Ministério da Saúde. DATASUS. Sistema de Informação de Agravos e Notificações [texto na Internet]. Brasília; 2005. [citado 2005 nov. 10]. Disponível em: www.datasus.gov.br
- Sá LD, Figueiredo TMRM, Lima DS, Andrade MN, Queiroga RP, Cardoso MAA, et al. A experiência da implantação da estratégia DOTS em seis municípios paraibanos. In: Ruffino-Netto A, Villa TCS. Tuberculose: implantação do DOTS em algumas regiões do Brasil. histórico e peculiaridades regionais. Ribeirão Preto: FMRP/REDE TB-USP; 2005. p.141-66.
- Machado MFAS, Monteiro EMLM, Queiroz DT, Vieira NFC, Barroso MGT. Integralidade, formação de saúde, educação em saúde e as propostas do SUS- uma revisão conceitual. Ciênc Saúde Coletiva [periódico na Internet]. 2007 [citado 2007 jul. 12];12(2):[cerca de 8 p.]. Disponível em: <http://www.scielo.br/pdf/csc/v12n2/a09v12n2.pdf>.
- Fiorin JL. Elementos da análise de discurso. 7ª ed. São Paulo: Contexto/EDUSP; 1999.
- Conselho Nacional de Saúde. Resolução n. 196, de 10 de outubro de 1996. Dispõe sobre diretrizes e normas regulamentadoras de pesquisas envolvendo seres humanos. Bioética. 1996;4(2 Supl):15-25.
- Mattos RA. A integralidade na prática (ou sobre a prática da integralidade). Cad Saúde Pública. 2004;20(5):1411-6.
- Pinheiro R, Mattos RA, organizadores. Os sentidos da integralidade na atenção e no cuidado à saúde. 4ª ed. Rio de Janeiro: IMS/ABRASCO; 2006.
- Monroe AA, Gonzales RIC, Palha PF, Sassaki CM, Ruffino Netto A, Vendramini SHF, et al. Envolvimento de equipes da atenção básica à saúde no controle da tuberculose. Rev Esc Enferm USP. 2008;42(2):262-7.

17. Muñoz Sanchez AI, Bertolozzi MR. Operacionalização do conceito de vulnerabilidade à tuberculose em alunos universitários. *Cienc Saúde Coletiva* [periódico na Internet]. [citado 2008 jul. 1°] Disponível em: http://www.abrasco.org.br/cienciae_saudecoletiva/artigos/artigo_int.php?id_artigo=1935
18. Santos NR. Organização da atenção à saúde: é necessário reformular as estratégias nacionais de construção do “Modelo SUS? [texto na Internet]. [citado 2008 jul. 3]. Disponível em: <http://www.sms.rio.rj.gov.br/servidor/media/modelosus.doc>.

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