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ACCESS TO THE DIAGNOSIS OF TUBERCULOSIS FROM THE POINT OF VIEW OF HEALTH PROFESSIONALS[1]

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ABSTRACT

Objective: to understand the aspects that influence the access to the diagnosis of tuberculosis. from the point of view of health professionals.

Method: a exploratory descriptive, qualitative study. The data were collected between June and July 2013, through semi-structured interviews, with 20 nurses and ten physicians in charge of tuberculosis cases in the municipalities belonging to the 15th Health Region of Paraná (Brazil) and subsequently submitted to content analysis, thematic modality.

Results: three categories emerged which show the factors that positively influence access to diagnosis, the difficulty in this access and the characteristics of the organization of this service. It also points out that the *Estratégia Saúde da Família*'s performance favors early diagnosis, although professionals report difficulties in identifying patients with signs and symptoms of the disease, either due to lack of preparation or lack of knowledge about the disease.

Conclusion: therefore, it is considered essential to inform the community about the disease and to strengthen multi-professional work.

DESCRIPTORS: Tuberculosis. Diagnosis. Nursing. Primary health care.

ACESSO AO DIAGNÓSTICO DE TUBERCULOSE SOB A ÓTICA DOS PROFISSIONAIS DE SAÚDE

RESUMO

Objetivo: conhecer os aspectos que influenciam o acesso ao diagnóstico de tuberculose, na ótica dos profissionais de saúde.

Método: estudo descritivo, exploratório, qualitativo. Os dados foram coletados nos meses de junho e julho de 2013, por meio de entrevistas semiestruturadas, com 20 enfermeiros e dez médicos atuantes no controle da tuberculose nos municípios pertencentes a 15ª Regional de Saúde do Paraná e, posteriormente, submetidos à análise de conteúdo, modalidade temática.

Resultados: emergiram três categorias que mostram os fatores que influenciam positivamente o acesso ao diagnóstico, as fragilidades neste acesso e as características da organização deste serviço. Aponta ainda que a atuação da Estratégia Saúde da Família favorece o diagnóstico precoce, embora os profissionais relatem dificuldades para identificar os pacientes com sinais e sintomas da doença, seja por despreparo ou por falta de conhecimento da população sobre a doença.

Conclusão: considera-se imprescindível informar a comunidade sobre a doença e fortalecer o trabalho multiprofissional.

DESCRITORES: Tuberculose. Diagnóstico. Enfermagem. Atenção primária à saúde.

ACCESO AL DIAGNÓSTICO DE TUBERCULOSIS BAJO LA ÓPTICA DE LOS PROFESIONALES DE SALUD

RESUMEN

Objetivo: conocer los aspectos que influyen en el acceso al diagnóstico de tuberculosis, en la óptica de los profesionales de salud.

Método: estudio descriptivo, exploratorio, cualitativo. Los datos fueron recolectados en los meses de junio y julio de 2013, por medio de entrevistas semiestructuradas, con 20 enfermeros y diez médicos actuantes en el control de la tuberculosis en las municipalidades pertenecientes a la 15ª Área de Salud de Paraná (Brasil) y, posteriormente, sometidos a análisis de contenido en la modalidad temática.

Resultados: emergieron tres categorías que muestran los factores que influyen positivamente en el acceso y las características de la organización de este servicio. Apunta además, que la actuación de la Estrategia *Saúde da Família* favorece el diagnostico precoz, aunque los profesionales relaten dificultades para identificar a los pacientes con señales y síntomas de enfermedad, sea por falta de preparo o por falta de conocimiento de la población sobre la enfermedad.

Conclusión: se considera imprescindible informar a la comunidad sobre la enfermedad y fortalecer el trabajo multiprofesional.

DESCRIPTORES: Tuberculosis. Diagnóstico. Enfermería. Atención primaria de salud.

INTRODUCTION

Tuberculosis (TB) is a global public health problem due to the high prevalence in many countries, including Brazil. This disease is closely related to the socioeconomic conditions of the population and the main factors that hinder its control are related to the prevention, diagnosis, treatment, quality of health services and the characteristics of the patients affected.[1]

Since 2003, TB has been part of the agenda of priorities of public health policies of the World Health Organization (WHO) and the Ministry of Health, due to it being the largest cause of death due to infectious disease in adults.[2] This fact imposes, among many challenges the timely diagnosis of cases, especially in the services that act as a gateway to the health system.[3]

Diagnosis of the disease is essential to reduce morbidity and mortality and eliminate sources of infection in the community.[3] However, inefficient detection suggests that individuals will continue to be ill without being identified by the health services, resulting in the continuous transmission of the disease. With the non-detection of the cases, the delay in diagnosis is evident, which, in addition to affecting the persistence of bacillus in society, influences the prognosis of individuals with illness, which may lead to the occurrence of drug resistance and even death.[4]

It should be pointed out that in order to promote early diagnosis and adequate treatment, the *Programa Nacional de Controle da Tuberculose* (PNCT) highlights the need to decentralize care for people with TB to municipalities and the importance of recognizing the difficulties in this process.[5] However, faced with the difficulties, the Ministry of Health permits that in some small municipalities, care for people with TB can remain centralized in outpatient referrals, according to the supply and availability of resources.[6]

On the other hand the decentralization of care is in line with the goals of the Family Health Strategy (*Estratégia Saúde da Família*-ESF), prioritizing actions to prevent, promote and recover health in an integral and continuous way and by expanding access to services the ESF is expected to be the gateway for users, promoting access and providing qualified care, including early diagnosis and treatment of tuberculosis,[7-8] in addition to allowing the integration and the organization of activities in a defined territory and also strengthen the inclusion character of users, previously deprived of access to the service.[7]

However, in municipalities where attention to people with suspected or diagnosed TB has not yet been decentralized to the Basic Health Units (BHU), the ESF does not assume responsibility for the care of these people, which is aggravated by the fact that the referral and counter-referral system still functions in an ineffective way, since it itself is responsible for a large part of the service demand, maintaining the assistance verticality.[9]

Considering that early diagnosis is one of the most important factors for disease control, the decentralization of diagnosis and treatment for primary care becomes an important strategy that needs to be strengthened and consolidated. Thus, given the historical trajectory of TB, its control may be indicative of advances and challenges to other conditions and diseases of the same nature.

Therefore, in order to provide access and quality services to users, aiming to fulfill the principles of equity and integrality of the Brazilian Unified Health System (*Sistema Único de Saúde* - SUS), this study is justified by the need to give a voice to the health professional, who acts as the protagonist of the system and actions of the health network,[10]

being aware of the main difficulties to guarantee access to the diagnosis and consequently to implement the PNCT. Thus, the objective of this study is to understand the aspects that influence the access to the diagnosis of tuberculosis, from the point of view of health professionals.

METHOD

An exploratory descriptive study of a qualitative nature, performed with nurses and physicians working within the scope of the 15th Regional of Health (RS) of Paraná (Brazil), which integrates 30 municipalities. In 22 of these municipalities, the follow-up service of patients with TB is decentralized to the BHU and incorporated into the activities of the ESF teams. In the other eight municipalities, this service is centralized in an outpatient clinic.

This study is linked to a larger project titled "Assistance and control of Tuberculosis in the state of Paraná", which involved two methodological aspects, one quantitative and the other qualitative. In the present study, the data come from interviews with 30 of the 134 individuals chosen randomly to be included in the quantitative study. Those who were more receptive, welcoming and interested in the purpose of the study were invited to participate, and the participation request was made by telephone. The inclusion of new participants occurred until the time the data became repetitive and the purpose of the study had already been reached.

Data were collected between June and July 2013, through interviews which were previously scheduled and performed in the workplace of the health professionals, guided by the questions: how do you evaluate diagnosis time of tuberculosis in this municipality? Why? For data analysis, the interviews were transcribed in their entirety and then submitted to content analysis in thematic modality, which analyzes the words and their meanings, describing the content of the messages and allowing for inferences.[11] This stage consisted of a pre-analysis and exploitation of the material, followed by the systematic data organization.[11]

Afterwards, the results were grouped into thematic categories according to similarity in the statements, which gave rise to three categories: Factors that positively influence access to diagnosis, in the access to diagnosis and The form of service organization: the two sides of the same coin.

The development of the study occurred in accordance with the guidelines established by Resolution N. 466/12 of the National Health Council and the project was approved by the Standing Committee on Ethics in Research of the *Hospital do Trabalhador* of the Secretariat of Health of the State of Paraná, according to opinion N. 311,964 / 2013. All study participants signed two copies of the Free and Informed Consent Form. For the differentiation of the participants and preservation of their identity, the following codes were used: the letter C for municipalities with centralized care and the letter D for decentralized, followed by the letter E for nurses and the letter M for physicians, accompanied by the order number of the interviews and the time of professional performance, according to the following example: D-M1, 14 years

RESULTS

Thirty health professionals participated in this study, of which 20 were nurses and 10 were physicians, five of whom attended municipal referral outpatient clinics and the other worked in the ESF, with length of service ranging from six months to 28 years. When asked about the duration of tuberculosis control actions, most of the professionals answered that they had been involved in this activity for more than four years and that they had already followed a suspected or confirmed case of TB.

Most of the municipalities are small, with only one BHU and, consequently, only one place to treat tuberculosis cases. However, four municipalities have a different organization, three of which offer the first service in any of the health units of the municipality and the follow-up of the disease only by the outpatient clinic. The fourth municipality has an outpatient clinic that is also the gateway for patients, with no need to go through health facilities. The health professionals who were interviewed reported several factors that may be related to the access to the diagnosis of TB, considering, however, the specifics of each municipality.

Factors that positively influence access to the diagnosis of tuberculosis

Health professionals report that the ESF team, principally, the Community Health Agent (*Agentes Comunitários de Saúde* - ACS), allows for the early diagnosis of some diseases, such as TB.

Through the family health program and the community agents who investigate for us, we try to identify those patients with chronic coughs, weight loss, what we see or the community comments or what the ACS says, because they are in contact with the population (D-M1, 14 years).

The ACS bring the cases to the ESF nurse and depending on the case, she passes it on to me and then I go investigate this patient (C-E12, 20 years).

Another positive aspect reported by the professionals was the greater ease in making the diagnosis when the patient searches for the health unit with complaints and the health professional is able to associate the symptoms with TB and thus requests the exams.

From the moment the patient comes to the unit, I think it becomes easier. It's difficult to locate the patient. Now, if he comes with symptoms, it's a lot easier (D-E14, 19 years).

It is according to the patient's demand, he needs to come to the unit and if the doctor suspects anything, he will order all the exams (D-E4, 13 years).

Only a few professionals reported conducting the active search in the community and reported that the entire team is prepared to identify the suspected cases. This activity is essential for early diagnosis.

We search for respiratory symptoms, both in the demand, and in the groups that we attend to or during the visits. All team members are oriented to identify, I don't mean to diagnose, but identify the respiratory symptoms (D-E11, 1 year).

The active searches are done by the ESF staff, and what I think is important is that we have 100% ESF coverage. So, this active search is done and there have been no cases for us and so, I think we could be doing more actions on the issue of prevention, of warning the community. It could improve this issue of spreading the disease, because not everyone is at home when we visit, many people work and end up not having access to this information (D-E6, 6 months).

The girls (ACS), visit during the week and on Friday, we get together and they pass everything that happened during the week on to me: what the complaints were, what the people complained about and such. And they say that so-and-so is losing weight, has been coughing, coughing for more than three weeks, is having a fever at night, sweating a lot and such. That's the patient we're going to investigate (D-E19, 6 months).

Difficulty in the access to the diagnosis of tuberculosis

Regarding access to diagnosis, the professionals highlighted that the main factor that contributes to the delay is the fact of not considering the possibility of the TB diagnosis, even when faced with complaints related to the signs and symptoms of the disease, or due to lack of information and knowledge of the professionals or due to the difficulties of the population to report their symptoms.

No matter how much we identify, we always think of other diseases first. Tuberculosis is always left last and everything passes in front of it [...]. The difficulty, perhaps of the doctors, is in identifying. I think that's it, the diagnosis, because they look for other things, and TB is left for last (C-E16, 7 months).

Only if we realize that the person has respiratory symptoms will they be taken from the reception and it will hardly be suspicious of tuberculosis [...] (C-E3, 2 years).

The difficulty is in the clinical part itself, you can identify, talk to the patient and know the symptoms (D-M7, 12 years).

They also noted a great difficulty in finding respiratory symptoms in the community, due to lack of coverage of the ESF and at the same time, due to lack of knowledge of the population about the disease and the banalization of symptoms.

The diagnosis is fast, but finding the individual can be very difficult (C-M6, 28 years).

We do not have these publicity campaigns. Many patients think it is nothing, and they get this prolonged cough. Unfortunately, I think we leave much to be desired in Brazil as a whole. Often, people do not see it, I think they see other diseases out there, influenza A, among others and end up forgetting about TB and forget that, in fact, it not only has a large prevalence but it still has high national incidences, and we all end up being guilty in relation to the issue of prevention, which is very simple (C-M4, 4 years)

The form of service organization: the two sides of the same coin

Some municipalities do not have ESF coverage throughout their territory, a fact that results in the continuity of care for patients with TB occurring in a referral outpatient clinic, without due expansion to primary care. Decentralization is considered by professionals as the most adequate strategy for the diagnosis and care of tuberculosis cases and, consequently, for the control of the disease.

The fact that it is centralized makes it easier, we were able to make a quick diagnosis (C-E1, 6 months).

The best thing that was done here in the municipality, was to focus attention on TB, because in the UBS the professionals did not attend and did not do the treatment correctly, at least here, everybody receives care and is treated (C-M6, 28 years).

However, some professionals working in the ESF are not in favor of centralizing TB

care services because they believe that this strategy is not conducive to early diagnosis, as the professionals working in the PHC do not receive training to identify suspected cases. *Here in the municipality, it is not decentralized to the UBS, there is nothing in the unit, no examination pots, no medicine, nothing. And no unit here is prepared to treat tuberculosis, none* (C-E3, 2 years).

It should be noted that full access to diagnosis includes access to the tests (smear and x-ray) recommended and prioritized by the PNCT. Regarding this access, the opinion of health professionals also diverged, especially regarding the sputum examination (smear microscopy).

We have the lab here in the municipality, which does not happen in other municipalities, so it's much easier for us [...], *this "ah, have to wait for such a day", we do not have that problem* (D-E7, 16 years).

We don't have a laboratory, but from the moment that a pre-diagnosis is made and the bacilloscopy is sent and the result is positive, it does not take long (D-E15, 18 years).

Regarding bacilloscopy, the professionals had different opinions about the length of time required to receive exam results. The professionals consider the wait for the results too long, since there are specific delivery days for the collected material and protocols to be followed, which do not always correspond to the needs of the municipalities.

I think it takes time, because we depend on the LEPAC (Laboratory of Teaching and Research in Clinical Analyzes) *and have the specific days to send the samples... until the patients produces the sample and then the driver takes it to the laboratory, it is usually very difficult, it takes quite a long time to get the result* (D-E19, 6 months).

*The laboratory could be a little faster, the collections are only done on Monday and Tuesday, or sometimes on Wednesday, and patients on Thursdays and Fridays have to wait for Monday, and it takes awhile for the result to arrive from the LEPAC (*D-E2, 1 year).

The biggest difficulty we have is the delay of the exams, our reference laboratory is the LEPAC, there is a whole bureaucratic protocol to get the exam [...], *but if the patient is very symptomatic, with weight loss, night fever, we end up getting it faster, but still, it's never less than three or four weeks, three or four weeks is considered getting the exam results quickly (*D-M3, 6 months).

Others, however, evaluate that this same laboratory is primarily responsible for the agility in getting the test result and speed up the diagnosis along with medical suspicion.

Doctors can quickly identify the respiratory symptom, we can quickly collect the exam, the LEPAC result comes fast and we can make that diagnosis (C-E5, 2 years).

Here the exams are sent to the LEPAC, which is excellent and does everything to release the reports as soon as possible (D-E8, 19 years).

I think the issue of the laboratory, after we send the material, is just waiting for the report, so I think it's the LEPAC that speeds up the process (D-E18, 6 months).

Still with regard to diagnostic exams, according to professionals, most of the municipalities have the infrastructure to perform imaging (x-ray) available in their own territory. However, the organization of services in each municipality differs, with some giving priority to patients with signs and symptoms of TB, while in others it is necessary to limit resources.

*We have priority for x-rays here, we have this advantage, it's not a stipulated number, it's not like in the UBS (*C-M6, 28 years).

We have x number of exams, because we know that the resource that comes to the community is a limited resource. So to be investigating this, we are limited because of the exams, really because of the resources (D-M5, 23 years).

DISCUSSION

The early diagnosis of TB may be related to the type of health service sought by the user as a gateway. Thus, in order for an early diagnosis to occur, it is essential that the health professional is able to identify suspected cases, diagnose and treat patients, and have a good integration and knowledge of the routine and functioning of the service.[3] In addition, it is necessary to offer services and the availability of diagnostic tests.[3]

Thus, it was observed that in the scope of the 15th Health Region there are professionals with longer service in the same team and / or in the same service and others that are more recent. This can interfere with the way they deal with the disease and also how they evaluate the service, such as the time to get the diagnosis. It is worth noting that the turnover of professionals, regardless of the reason, reinforces the precariousness and / or absence of links with the patients and community, as well as interfering in the process of training and continuing education of the professionals, in which results in the actions not being completed.[3,12]

The new dynamism and structuring of health services and actions proposed by the ESF show

this as a differential in relation to traditional programs,[12] in the way that the foundation of the ESF is the reorientation of the care model, with the aim of strengthening preventive care, prioritize health promotion and education, as well as to reorganize health services in the search for compliance with SUS guidelines, occupying a privileged place to understand individuals, identify problems and risk situations, and provide complete care and attention to families.[13] The patient with suspected TB requires unique actions which allow for rapid access to diagnosis. Therefore, care for the patient with tuberculosis becomes complex and specific, since it requires a differentiated point of view due to the magnitude of a socially produced disease.[5]

In order to ensure good care, it is essential that the health professional, especially the nurse, understands the actions which are included in care management, which consists of three dimensions: professional, organizational and systemic. In the first, there is the meeting between worker and user with the purpose of solving the needs listed by the user. The second is understood as a space of the technical and social division of labor, with the professional implications and care practices. And finally, the systemic dimension refers to the set of services with their different functions and degrees of technological incorporation and the flow to the service with quality and resolubility.[14]

In order to do this, access must be easy and must provide adequate and resolute attention, as well as ensuring continuity of care in specialized services when necessary.[3] Therefore, it is essential to develop the capacity to accept, empower, resolve and autonomize services by incorporating light technologies that are materialized in relational practices such as user embracement and creating connections. User embracement proposes to reverse the logic of the organization and the functioning of health services, with principles to serve all those who seek the service, reorganize the work process based on multiprofessional teams and qualify the professional-user relationship. Thus, it acts as a powerful tool to meet the requirement of access, triggering integral care and creates bonds.[15]

User embracement presupposes a regular source of attention, with the formation of interpersonal ties and mutual cooperation between users and health professionals, since the permanence of the users in the service depends on how they are received and the capacity for resolution.[16] In the specific case of TB, a connection or bond with the health professionals is essential, because the disease is still stigmatized and the patient feels constrained to seek help.

The active search for respiratory symptoms is considered a public health activity and should be performed permanently by all health professionals. It is a multiprofessional activity, with the objective of early diagnosis of the cases and interruption of the chain of transmission of the disease.[12] Even though it is a multiprofessional activity, the health team counts on the ACS as the main professional to identify cases in the community, since it is the professional that accompanies the users and is the one who is really aware of the reality of the population,[13] thus facilitating the early detection of cases, which depends on the organization of services.[7]

However, the need to prepare these professionals to carry out their work within the programmed actions of the policy is evident. It is important to emphasize the involvement of the health team, especially nurses and doctors, in the training of these professionals,[5] who are the main actors in the search for respiratory symptomatic in the community and can perform directly observed treatment. Therefore, it is extremely important that the teams take control of TB and does not consider the ESF as a mere executor of the diagnostic exams and supervised treatment.[17]

Some studies have pointed out that TB patients seek health services countless times and are treated for other ailments; it is a vicious cycle of repeated visits to the care network without obtaining a correct diagnosis, which results in non-specific antibiotic treatment, delayed diagnosis and difficulty in accessing the specialized service.[3,18]

Thus, TB patients often go unnoticed in services due to excessive demand and the lack of doctors in some teams,[17] or because of the lack of capacity of professionals to identify the respiratory symptomatarios.[14,17] As reported, the greatest difficultly is to identify the cases that escape the classic symptoms of the disease, requiring the physician to have a high degree of diagnostic suspicion. It is important to highlight that the professional qualification to attend TB cases leaves a lot to be desired, since there is a lack of systematization in the training for the team.[3] Thus, the construction of contextualized strategies are necessary to promote the dialogue between the national guidelines and the singularity of the health centers' services, through the continuous training of health professionals, aiming at identifying gaps in care.[3]

It should be emphasized that the protagonist of TB's actions of control should be the health professional, who despite being the target of some training

and sensitization to deal with patients with special difficulties and also vulnerable, impoverished and stigmatized groups,[19] are still unable to put the principle of the integrality of health actions and the free access to information and care in to practice, presenting limitations in the capacity to deal with cases of tuberculosis.[3,17]

The difficulty in finding suspected cases of TB is consistent with WHO's assertion that the problem of TB is not in diagnosis and treatment, but the organization of the service to detect cases, which may be flawed due to insufficiency of material and human resources, as well as a lack of professional training, which compromises patient care.[20] Difficulties in identifying the respiratory symptomatology, the lack of preparation of the professionals due to the low percentage of suspicion and the request for exams for the diagnosis of TB can also be mentioned.[21]

SUS still continues to have low levels of coverage in Brazil, characterized by an uncontrolled decentralization, aggravated by structural and organizational problems,[18] even expanding to insufficient professional qualification due to limited human resources. This is in agreement with the findings of this study, which points out that some municipalities are not able to offer full attention to patients with TB in a decentralized manner. Due to a common weakness in the coordination of care network services, low solvency and poor quality of primary care services,[3] centralizing care in a municipal reference outpatient clinic was chosen with the goal of better care.

However, decentralization is essential to ensure the easy access to patient diagnosis,[12] reorganizing care and making TB control actions available for all health services,[16] allowing access to many individuals who were previously excluded from such care.[14] However, the different assistance models present in the municipalities, which add local specificities, make heterogenous actions in the dynamics of dealing with the disease.[4]

According to the PNCT, the decentralization and horizontality of TB control actions constitute the main challenges of primary care, which should offer accessible, equitable and better quality services, as a determinant factor to guarantee access to the early diagnosis of the disease,[3,16,18] counting on the ESF as a partner for the expansion of the control actions.[22] These challenges could be evidenced from the reports of the professionals listing the centralization of the services, the need to send the exams to other locations, and the delay in making the results available.

It is worth emphasizing that for the diagnosis, it is necessary to perform specific tests; thus, UBS or the outpatient clinic receives the patient's examination material and sends it to the clinical analysis laboratory in the referenced municipality,[5] which for many professionals delays the diagnosis. The immediate availability of bacilloscopy, besides collaborating in the agility of the diagnosis, guarantees the integrality of the assistance.[21]

The laboratory referred to by health professionals, LEPAC, is the only responsible laboratory for the public network for conducting diagnostic tests for TB in the region and, in addition to serving the thirty municipalities of the 15th Regional Health, serves four more regional, totaling 120 municipalities.[23] The only municipality that performs the bacilloscopy, does it by contracting a private laboratory, which was referred to by D-E7, 16 years.

Almost all professionals reported that the time to receive the smear examination result is approximately three weeks. However, it was observed that the perception of delay or agility in receiving the result of the examination differed among the professionals, although the time was the same. It was noticed that the perception of delay was more frequent among the professionals with less time of operation, which leads them to value the operation of the service as recommended by the PNCT, whereas the professionals with more time in the same position demonstrate that they had already become accustomed to the delay of public health services.

It should be noted that the time of three or more weeks is too long, since the PNCT considers it opportune that the result of the bacilloscopy be available in the outpatient network within a maximum of 24 hours. In a study carried out in Rio de Janeiro (Brazil), it was found that the average time to make the result available to the health team was two weeks, considered to be unacceptably long.[24]

However recommended by the Ministry of Health, sputum smear microscopy is not common for all municipalities,[3] since they are small and do not have the structure for specialized diagnostic consultations. Therefore, the actions need to be operationalized and developed among the different actors, due to the insufficient offers for sputum collection and material analysis often requires the displacement of patients and cases to other services.[19] It is emphasized that when transferring the patients to other services and, consequently, transferring responsibility, the planned action of the integrality of the attention is jeopardized, making it difficult

to access the examination, which may impair the control of the disease.[19]

Imaging which allows the differentiation of images suggestive of TB from another disease, is a method of great importance in the investigation process and should be requested for all patients with clinical suspicion, with sputum smear microscopy remaining indispensable.[6]

In view of the above, it is essential to qualify professionals to receive, respond, communicate, listen, make decisions, support and guide users, and then assume the responsibility to intervene, based on identified health needs.[15] In addition, professionals need to be able to act when they have suspicions, perform case diagnosis; treat and supervise medication intake; follow the contacts; maintain the information system up to date and carry out preventive and educational actions in the community.[19]

The health unit should indeed have professionals capable of providing clear information to the patient, and carry out health education, understood as a set of knowledges that aims to transfer the scientific knowledge, mediated by professionals, to the daily life of the people, since the understanding of the determinants of the health-disease process can subsidize the adoption of new habits, behaviors and behaviors.[12]

As for the study limitations, the difficulty in interviewing health professionals is highlighted, this was due to the limited availability of time, which restricted the duration of some interviews, and even made it difficult for them to participate in the study, and sometimes required the need to reschedule some interviews. Another limitation was the fact that only nurses and doctors were included in the study, as it would also be important to understand the perspective of users, managers and other professionals involved in care, in order to identify all the complexity involved in the TB more comprehensively, which could possibly contribute to the decision-making related to the improvement of actions for the control of tuberculosis.

CONCLUSION

The findings of the study bring to light issues inherent in society as a whole, of a political and social order, as well as of the health system and the organization of the health services that comprise it. However, the importance of the ESF in the process of decentralization of primary care services, and in the equitable and integral access of the patient, is highlighted.

The professionals' discourses show that there are still obstacles to full access to TB diagnosis, largely due to the incompleteness of municipality decentralization. Decentralization allows equitable and integral access to the patient which is close to his / her residence, however, centralization has offered greater availability of resources for diagnosis. Among the other factors, the team's difficulty in suspecting TB, even in the presence of signs and symptoms, and in finding the respiratory symptoms, is due to the lack of information about the population or the lack of team preparation.

Nonetheless, it is necessary to educate the population about the disease, specifically about signs and symptoms, form of transmission and treatment, including highlighting the possibility of a good prognosis when performing the appropriate treatment. Such clarifications are needed to alleviate the stigma regarding the disease and decrease the patient's delay in seeking care, thus achieving a rapid diagnosis and consequently a treatment with fewer complications.

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