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Treatment adherence under the foucauldian perspective: knowledge/powers in tuberculosis control manuals in Brazil

Adesão terapêutica sob o olhar foucaultiano: saberes/poderes nos Manuais de Controle da Tuberculose no Brasil

Adhesión Terapéutica bajo la mirada foucaultiana: conocimientos/poderes en Manuales de Control de Tuberculosis en Brasil

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ABSTRACT

Objective: Investigate which knowledge emerges in the Tuberculosis Control Manuals and how power relations are established for treatment adherence.

Method: Documentary and qualitative research on five Manuals published between 2002 and 2019, available on the Ministry of Health's Website, based on Michel Foucault's theoretical and methodological framework.

Results: 1. Knowledge: emerges as human resource training; health surveillance actions; medicalization; and multifunctionality of nurses in addressing the social determinants of tuberculosis. 2. Power relations: occur through articulation between different subjects and establish disciplines on the body and the behavior of the person undergoing treatment.

Conclusions: Certain knowledge/powers constitute the actions of treatment adherence to tuberculosis treatment and normalize the "correct/true" way of conducting disease control. Such behaviors refer to self-responsibility, autonomy and empowerment of the subject and do not consider the countless conditions of vulnerability existing in the history of people with tuberculosis.

Keywords: Tuberculosis. Treatment adherence and compliance. Health promotion. Address. Politics.

RESUMO

Objetivo: Investigar quais saberes emergem nos Manuais de Controle da Tuberculose e como as relações de poder são instituídas para adesão terapêutica.

Método: Pesquisa documental, qualitativa, que analisou cinco manuais publicados entre 2002 e 2019, disponíveis no Website do Ministério da Saúde, a partir do referencial teórico metodológico de Michel Foucault.

Resultados: 1. Saberes: a capacitação de recursos humanos; ações de vigilância em saúde; medicalização; e multifuncionalidade dos enfermeiros no enfrentamento dos determinantes sociais da tuberculose. 2. Relações de poder: se articulam entre diferentes sujeitos e instituem disciplinas sobre o corpo e o comportamento da pessoa em tratamento.

Conclusões: Determinados saberes/poderes constituem as ações de adesão terapêutica ao tratamento da tuberculose e normalizam a forma "correta/verdadeira" de se conduzir o controle da doença. Tais condutas remetem à autorresponsabilização, autonomia e empoderamento do sujeito, mas não levam em consideração as inúmeras condições de vulnerabilidade existentes no histórico das pessoas com tuberculose.

Palavras-chave: Tuberculose. Cooperação e adesão ao tratamento. Promoção da saúde. Discurso. Política.

RESUMEN

Objetivo: Investigar qué conocimientos surgen en los Manuales de Control de la Tuberculosis y qué relaciones de poder se instituyen para la adherencia terapéutica.

Método: Investigación documental, cualitativa, que analizó cinco Manuales publicados entre 2002 y 2019, disponible en el sitio web del Ministerio de Salud, desde el marco teórico y metodológico de Michel Foucault.

Resultados: 1. Conocimiento: la formación de recursos humanos; acciones de vigilancia de la salud; medicalización; y multifuncionalidad de las enfermeras para abordar los determinantes sociales de la tuberculosis. 2. Relaciones de poder se dan a través de la articulación entre diferentes sujetos y disciplinas del instituto sobre el cuerpo y el comportamiento de la persona a tratar.

Conclusiones: Ciertos conocimientos/poderes constituyen las acciones de adherencia terapéutica al tratamiento de la tuberculosis y normalizan la forma "correcta/verdadera" de realizar el control de la enfermedad. Tales comportamientos responden a la autorresponsabilidad, autonomía y empoderamiento del sujeto y no toman en cuenta las innumerables situaciones de vulnerabilidad existentes en la historia de las personas con tuberculosis.

Palabras-clave: Tuberculosis. Cumplimiento y adherencia al tratamiento. Promoción de la salud. Discurso. Política.

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INTRODUCTION

In the most recent Guidelines for Tuberculosis Control in Brazil, Treatment Adherence is defined as – "a collaborative process that facilitates the acceptance and integration of a certain therapeutic regimen in the daily life of people undergoing treatment, assuming their participation in decisions about it"[1]. This same document reinforces that adherence does not require articulations to face the Social Determinants of Health (SDH) - social, economic, cultural, ethnic-racial, psychological and behavioral aspects - which are related to the occurrence of diseases in the population[2]. This is because most cases of the disease, as well as the greater risk of illness, both in the international scenario[3], and in Brazil[4] are concentrated in people in situations of vulnerability resulting from and/or aggravated by social inequities[1,3–4]. These are aspects that justify the importance of analyses such as the one presented here, as they allow us to problematize how intensely the success of treatment adherence can be related to the ability or commitment of these people who live in contexts of poverty to "collaborate" with the proposed treatment. And how narrow the possibility seems to be that "the patient's decisions (whatever they may be)" are respected, since it is an infectious disease transmitted by air.

Based on this understanding, treating adherence as a collaborative behavior meets the assumptions of the neoliberal aspect of Health Promotion. From this perspective, discourses proliferate from which new strategies of self-responsibility would be capable, even if in isolation, of improvements in the population's health conditions[5]. In the same way, health sector interventions in the SDH would be sufficiently capable of preventing a socially based disease[3–4]. From this, coping with diseases starts to converge towards a supposed autonomy and empowerment of individuals to reduce vulnerabilities through individual actions such as awareness of the risk of the disease and changes in behaviors[5].

From the above, and in compliance with the Foucauldian framework explored in this research, we understand that a certain way of defining Treatment Adherence is constituted (at the same time as it is constituted) by emerging discourses from a certain historical and political period[6]. From this perspective, the different knowledge recommended for adherence, emerging from power relations of one over the other, become products of the conditions of possibility of our time. A time when, despite the affirmation that health promotion should move towards ensuring equal opportunities for all people to have access to better living and health conditions[2], are recommendations based on the exaltation of self-responsibility and the paradigm of risk behavior[5] that gain legitimacy today.

In this research, the recommendations of the TB control manuals, constructed by specific knowledge, and in power relations, were analyzed as discursive practices under the Foucauldian perspective[7]. This leads to the understanding that practices of normalizing the body and life, by emphasizing prescriptive behaviors, arising from scientifically defined good health habits[5–6,8] start to delimit, constitute and legitimize the "best/adequate/desired" ways in which nurses should conduct TB care.

From this perspective, it becomes relevant to think about how much a certain way of "saying and understanding" Treatment Adherence, constructed from local powers and knowledge, in compliance with the values of current science and according to governmental priorities[6], seems to run into the little emphasis given to the causes that prevent people from "collaborating": unfavorable social contexts, income inequalities, among others[3–4]. Adherence from a collaborative behavior, therefore, can be understood, based on the Foucauldian framework, as a possible discourse in our current political and historical context so that the cure for TB depends on how much the individual is able to plan; to gain autonomy to make good choices; to empower themselves in the face of disease prevention and to take responsibility for their health conditions and risks assumed. This prerogative is based on the culture of valuing health produced by a neoliberal rationality in which the adoption of good practices is related to how successful the individual is in society.

It should be noted that, in a scope review[6] on the occurrence of health promotion practices in the national and international scenario based on the Foucauldian framework, eight studies were detected, published in Brazil and in European and Oceania countries, which despite of approaching treatment adherence as an object of study, none analyzed the TB control manuals.

From this problem, the following questions arose: What knowledge emerges in the Tuberculosis Control Manuals? And how are power relations established for treatment adherence? Therefore, this study aimed to investigate which knowledge emerges in the Tuberculosis Control Manuals and which power relations are established among users and health professionals for treatment adherence.

METHODOLOGY

This is a documentary research with a qualitative approach inspired by post-critical methodologies in education and health[9], from the perspective of Michel Foucault's theoretical-methodological framework[6,7]. The manuals are documents with recommendations to health professionals that aim to assist in decision-making in the care of a health problem. It is noteworthy that, despite the non-existence of the obligation that professionals must follow the Manual's recommendations, these documents are considered as important assistance and management tools, from the perspective of training human resources in the health area[1]. Such tools, as discursive practices[6–8], when used and replicated, they begin to legitimize the way professionals conduct, today, the care of a given health problem.

The corpus of analysis consisted of five Guidelines for Tuberculosis Control in Brazil published in 2002, 2008, 2011 and 2019[1,10–13]. As inclusion criterion, manuals aimed at health professionals were used and they were easily accessible by internet. The process of searching and selecting the Manuals analyzed took place by consulting the Ministry of Health (MH) website. First, three Manuals were included, two published in 2011[12–13] and one published in 2019[1]. These three documents were elaborated by the National Program for Tuberculosis Control (PNCT) of the MH, responsible for formulating guidelines and recommendations for TB control in the national territory. With the intention of expanding the search for Manuals prior to the creation of the PNTC, publications were included from 1993 - the year in which TB was recognized as a public health problem by the World Health Organization - until 2019 - the year of conducting the research. Thus, the two manuals prepared by the Health Care Department (SAS/MS), from the collection "Primary Care Booklets" were also included: one published in 2002[10] and the other published in 2008[11]. The extraction and obtaining of information in these Manuals were performed by the main researcher in the first half of 2019. We emphasize that, sometimes, the terms Treatment Adherence and TB control are used as synonyms, as it corroborates the idea that strengthening adherence to treatment is the main strategy for disease control[1].

Data analysis was based on Michel Foucault's work[7], and theoretical-methodological strategies were elaborated that involve: 1. composition of the object of analysis based on problematization; 2. formulation of a way of interrogating the empirical material in order to obtain the information; 3. organization of analyses in two pre-established analytical axes: a) the knowledge capable of adherence and b) the established power relations. The choice of this framework and, in particular, this author, is justified by the lack of research[6] on TB control manuals, based on the Foucauldian methodological theoretical framework. Furthermore, the originality of Foucault's thinking, not only in the field of health, allows us to make use of tools and unique concepts that allow us to critically understand such themes. In addition, the strategies proposed for the analysis of discursive practices[7] allow us to deconstruct certainties and ask new questions to produce other possible knowledge in relation to TB.

It is noteworthy that the composition of the research object from the problematization, as well as the formulation of a way of interrogating the empirical material as discursive practices[7] in the Foucauldian framework, made visible the political dimension of the constitution of knowledge and relations of power established in the determination of what is taken as true in a given historical period[6, 8]. To this end, a main question was elaborated for each of the analytical axes and auxiliary questions in order to identify possible answers (other truths). For the first analytical axis – the formation of knowledge capable of Adherence – the question was: What is said about adherence? The auxiliary questions were: What knowledge emerges in the manuals to control TB? What knowledge is in the order of discourse as capable of TB control? What events emerge as facts from the discourses to strengthen Adherence through TB control? Such questions aim to identify facts or events that emerged in the manuals as an indispensable condition for the disease control, based on discourses taken as true (validated by science) in our historical and political moment.

The power relations exercised in Adherence (second analytical axis) were investigated through the question: how does Adherence occur? The auxiliary questions were: what relationships are involved in TB control? How do these relationships/actions take place on one another?

The organization of the analysis strategies was based on the description of the information obtained in an articulated way with the questions mentioned above. This methodological resource made it possible to visualize the "more of the discourse"[7], opening possibilities for the construction and organization of other truths about adherence to TB treatment. This is because it is understood that the recommendations on adherence, in the documents analyzed, emerge from

possible discourses originating from our current historical and political context. Context in which what is said about health never refers only to health dimensions, as it relates to the production and legitimation of economic, political and social interests, which must be sustained and replicated[5,8].

Regarding the ethical aspects, it was not necessary to submit the study to the Research Ethics Committee assessment, as these are documents in public domain. However, all documents researched were cited to preserve the copyright of those responsible for the works.

RESULTS AND DISCUSSION

About the knowledge capable of adherence

In Chart 1, "knowledge capable of adherence" is presented in two sub-axes. The first refers to the emergence of the various elements that constitute themselves as knowledge capable of adherence. The second refers to the way in which these recommendations aim to shape a certain way of knowing, classifying and systematizing TB control actions.

Emergence of different knowledge capable of Adherence	Excerpts from the analyzed Manuals
The training of human resources in the health area appears as the only knowledge necessary for the control of tuberculosis[10].	"The training of health professionals is the crucial issue for these objectives to be achieved, since the other necessary conditions are already created, highlighting the updating of technical knowledge and the availability of financial resources, [...] perfectly possible [...] to control tuberculosis"[10–5].
Performing actions within the scope of territorially based health surveillance[11] is seen as fundamental in TB control.	"In order to qualify health care based on the principle of integrality, it is essential that work processes are organized with a view to facing the main health-disease problems of communities and with health promotion and surveillance actions [...]"[11:5].
The discovery of new drugs emerges as necessary for the elimination of the disease[12].	"[...] there is still no perspective of obtaining its elimination as a public health problem in the near future, unless new vaccines or medicines are developed"[12:17].
Strengthening adherence depends on how much the professional is able to develop their activities in a systematic way, according to a specific protocol[13].	"This publication is therefore dedicated to the systematization of the work of those professionals who have the fundamental role of guaranteeing the supervision of the entire treatment and avoiding intercurrences that favor abandonment [...] ensuring patient adherence and successful treatment"[13:11].
The need to face SDH emerges as a new fact to be considered for TB control[1].	"The new strategy [...] brings the confrontation of social determinants and [...] the use of social protection as a support tool [...] Brazil has been seeking in intersectoral articulations the response to the centered epidemic [...] on those living in a situation of extreme poverty [...]"[1:23].
The classification and systematization of a certain way of knowing about tuberculosis	**Excerpts from the analyzed Manuals**
Some recommendations aim to classify in order to systematize a way of conducting care in TB treatment.	"[...] organization of records and information of users under investigation and under treatment for tuberculosis, namely: registration of respiratory symptoms, patient registration and treatment, tuberculosis notification, contact registration [...] and follow-up form of daily medication"[13:91].

Chart 1 – First analytical axis: knowledge capable of adherence
Source: Authors, 2020

Regarding the emergence of different knowledge capable of adherence, the training of human resources in the health area emerges as the only necessary condition still not reached for TB control, according to the 2002 Manual[10]. This statement is related to the implementation of the Permanent Health Education Policy in 2004, whose objectives emphasized the need to reorient the training of professionals in the Unified Health System (*Sistema Único de Saúde* - SUS)[14]. Although the proposal of Permanent Health Education is configured as a political-pedagogical strategy capable of improving access and quality of services, its effectiveness in coping with TB has limitations[4]. This is because delegating the control of this disease to the training of professionals tends to reduce the complexity of the challenge of controlling a health problem closely related to poverty contexts.

Besides, dealing with health issues of a multidimensional nature, such as TB, without considering critical reflections with other fields of knowledge, reinforces the false idea that Permanent Education is potentially capable of controlling diseases only through the technical skills of professionals in performing end procedures[5]. In addition, the problematization/learning proposed by Permanent Education does not find space within the presuppositions of the neoliberal aspect of health promotion, because even though it emerged from a context of need to strengthen the model of comprehensive care, the "educating in health" continues to be articulated from the idea of knowledge transmission[14]. This creates the conditions for us to think that the emphasis on the sufficiency of professional training for TB control is configured more as a possible and desired discourse based on governmental priorities of the early 2000s[6] than a recommendation by which one could achieve great benefits in coping with the disease.

In the 2002 Manual[10], it is highlighted the importance of territorially based health surveillance, which is related to organized ways of conducting actions within the scope of the SUS as a public policy. From this perspective, TB control would not only depend on how well the professional is trained to treat a disease, but on how much he/she performs his/her activities according to a specific "work model". In this situation, we can see how much the legal-political discourse is associated with the biomedical discourse (as scientific knowledge) to add legitimacy and add forces in the recognition of a truth[7]. The emphasis given to health surveillance, based on the search for TB cases in the ascribed territory, is related to the expansion of the Family Health model in Brazil in 2008. Although this model is the gateway to SUS health services, it is understood that the recommendation of extramural activities for TB control was not a "natural" process, as they were related to the objective of strengthening the implementation of a certain health model in Brazil[10].

In the manual published in 2011[12], arises the need to develop new drugs for the TB elimination. Placing TB control in dependence of "new" drugs is to corroborate the medicalizing discourse exalted by a simplistic logic that, to combat a socially based disease, it is enough to take the drugs. This exaltation of medication ends up disregarding those situations of vulnerability resulting from inequities[2–4] existing in the context of life of people with TB and are the obstacles to the much recommended uninterrupted use of medication.

Added to this, the same manual[12] reinforces that existing and available drugs, despite the adverse effects that constitute a difficulty in treatment adherence, have a 100% chance of curing TB, since they are taken regularly. What happens here, therefore, is not the need for new drugs, but the articulation of "new possibilities" so that people – with difficulties in dealing with the disease – are provided with resources to do so[15]. As another possibility, we can mention a research that proved the positive effect in curing TB from existing drugs, through social protection interventions, such as income transfer programs conducted by the government[16]. Therefore, perhaps betting on the need for new drugs, if not contradictory, consists in the possibility of certain discourses circulating to the detriment of others[6,8].

Also in 2011, in the Nursing Protocol[13] we observe the emergence of discourses that exalt the role of nurses in strengthening Adherence, based on the need for this professional to put into practice a systematic way of supervising and controlling the treatment: manage and observe the taking of medication, make the records in the treatment portfolio, among others. Such recommendations are configured as discursive practices that seek to homogenize nursing actions from procedures and techniques considered normal/correct/adequate. Although this homogenization meets the strengthening of the Systematization of Nursing Care as a method that organizes and enables the implementation of the Nursing Process, it is necessary to consider that such aspects aim to highlight the practice of nursing from the valuation of the scientific and methodological character given to these processes[17].

It is also important to consider that, although the document addresses the "role of nursing" in TB control[13], the construction/determination/standardization[8,18] of the recommendations is organized by biomedical knowledge. Such knowledge advocates care with an emphasis on protocols as part of a managerial management model based

on delimiting health goals[5]. Although this model does not prove to be effective in countries affected by extreme poverty and high TB burden, such as Brazil[1–2,4], it is still emphasized in these manuals, operationalized and replicated by health professionals and services. That is, from the moment that the clinical discourse of biomedical knowledge puts into operation a certain rationality (general health norms) about the TB treatment, the construction of a Nursing Protocol[13] comes in the sense of strengthening the recommendations that exalt the individual aspects of health promotion, institute disciplines on the sick body and shape behaviors desired by the neoliberal way of living[5].

In the manual published in 2019[1], the need to face SDH emerges as a new fact to be considered from the point of view of actions for adherence to TB treatment. It emerges as a new fact because, despite the recognition of this disease as a long-standing social problem, it is the first time that this has been formalized in a manual aimed at health professionals. This fact creates the conditions for the potential of intersectoriality as the main tool to face the SDH and the poverty conditions of the population to be in the order of discourse[7], that is, the moment when intersectoriality emerges as a possible and necessary discourse. It so occurs that attributing to intersectoriality the potential to reduce these determinants is to assume that the strategies and resources of each sector are aligned and operative with the objectives of the other sectors[2], which is not operationalized in practice. It is understood that the care we have to take here is precisely to highlight that the reduction of inequalities involves more than the set of actions from different sectors that, unfortunately, still remain isolated[19]. This is because such a reduction would imply changes in the relations of power and knowledge[18] that establish the current norms that govern health care, such as the strengthening of social protection policies, based on a new political and social institutionality[2].

Finally, it is noteworthy that regarding the classification and systematization of a certain way of knowing about TB, all the analyzed manuals highlight the importance of developing criteria that allow defining a way of naming the types of disease, classifying the risk of illness, to categorize the cases in terms of transmission, among others. In these recommendations, it is notable the concern to homogenize[18] the practices of those who work in TB control, based on the regulation of health actions. It is also observed that such classifications are part of a way of control and government of the body as an object of political investment, through the ordering of a series of criteria constituted from validated knowledge[8] that aim to identify, categorize, diagnose, treat, monitor and record everything that is done at all times. These recommendations, therefore, take materiality as discursive practices that constitute not only a way of acting as a nurse in the TB care, but mainly the "correct/scientifically validated" way[1,10–13].

About the powers established in adherence

Regarding the second analytical axis (the powers established in Adherence), in Chart 2, the power relations are presented as actions of the different actors of the three governmental bodies in health - municipal, state, and federal - and as the action of the professional, which take place through specific attributions and certain disciplines about the body and behavior of the person undergoing treatment.

Regarding power as an action of government bodies instituted to strengthen adherence to TB treatment, the manuals present attributions to the federal level, responsible for elaborating policies and guidelines, and to the state and municipal levels that must implement and execute the proposed actions. Such recommendations begin to organize a social practice historically constructed, without the need for a centralizing State, but through articulations and relationships of the different actors involved. This is related to the way in which, from the 20th century, a hygienist health policy was organized to deal with diseases that were (and still are) public health issues[6]. The establishment of this health policy, which took place through the construction of norms and rules, was only possible due to the legitimation of a clinically strong medicine, focused on diagnosis and with specific therapies, in order to determine decisions regarding the health of collectivities. In this context, the very recommendations of the End TB Strategy[1] emerge as a powerful discourse for including the fight against SDH in the TB control plan. However, it is necessary to consider that such strategy, despite contributing to break the vertical character of health policies, is conditioned to different governmental policies and actions according to the current social and historical context.

Although the manuals do not present the recommendations as mandatory, but as tools for the qualification and instrumentalization of professionals for the TB control, sometimes they appear as a duty and competence of the professional category[12–13]. This fact instills the idea that ensuring the safety of the population in relation to the risk of contamination by TB will depend on how committed the professionals who work in the control of this disease are. Such discourse associates the recommendations of the manuals with the development of a sanitary morality[5], in which the performance of health actions outside these recommendations could be seen as a moral danger to the maintenance

Power as an action of government bodies	Excerpts from the analyzed Manuals
Actions for Adherence to TB occur through the determination of attributions to the three governmental health bodies – municipal, state and federal – according to the regionalization and hierarchy of the Unified Health System[1].	"The Ministry of Health is the body of the Federal Executive Branch responsible for the organization and elaboration of plans and public policies aimed at the promotion, prevention and health care of Brazilians [...]"[1:281]. "In certain states and municipalities, the administrative structure includes an intermediate level defined as "regional health". For such cases, this structure should promote greater proximity between the central state level and the local levels [...]"[1:283].
Power relations and disciplines established between the professional and the person undergoing treatment	**Excerpts from the analyzed Manuals**
Nurses' actions occur as a duty of the professional category, which must comply with certain rules[13].	"The role of the tuberculosis control program nurse is to organize and comply with the recommendations of the Ministry of Health [...]. The diagnosis of tuberculosis in health services is implicit in the duties of this professional, according to protocols or other technical regulations established by the municipal manager or the Federal District, observing the legal provisions of the profession, performing nursing consultations, requesting additional tests and prescribing medications"[13:36].
The nurses' actions are performed according to an extensive list of interventions (previously established) both in the body and in the behavior of the person undergoing treatment[10].	"[...] guide the patient regarding the collection procedure: when waking up in the morning, wash mouth without brushing teeth, inhale deeply, hold breath for a moment and spit up after forcing a cough. Repeat this operation until get two sputum eliminations, preventing it from running down the outside wall of the bowl; guide the patient to wash hands after this procedure. [...]"[10:14].
The organization/operationalization and monitoring of Directly Observed Treatment (DOT) is the main discipline established for Adherence[13].	"Directly observed treatment control consists of the application of means that allow the nurse to monitor the evolution of the disease through the analysis of the follow-up form of the daily medication intake[...]. The nurse must pay attention to: [...] perform frequent and systematic assessment of the instruments for registering tuberculosis cases in the health unit [...]; check the name and dose of the drugs prescribed for the patient and his/her weight; make sure the patient is regularly taking the medication[13:96].

Chart 2 – Second analytical axis: the powers exercised in Adherence to TB treatment
Source: Authors, 2020

of the health of the collectivity. In this regard, both in the Brazilian scenario[4] and in other countries with a high TB burden[3], for example, even if the conditions associated with the illness of populations in situations of vulnerability are widely known, there are no changes in the paradigm of care for neglected diseases[15]. That is, even in the face of the current scenario of inequities, TB control continues to be attributed more to the potential of the nurses' way of working in dealing with SDH[1,13] than in the implementation of social protection policies[16]. Acting according with the recommendations of the manuals, therefore, emerges as an attitude of responsibility and commitment of those who, governed, subject themselves to the discourses[5–6,8] that emphasize changes in lifestyles and the adoption of healthy behaviors. This is the effect of sanitary morality, if professionals showed themselves to be "capable/competent/

resolutive" they would be protagonists in the formation of "disciplined/behaved/collaborative" subjects.

It is also necessary to consider that the self-responsibility, autonomy and empowerment of the subject[5] emerge from a neoliberal context in which the improvement of technical skills and multifunctionality of workers are overvalued. This valuation is based on the proposal of Permanent Health Education[14], even in the case of socially based diseases. This leads us to think that the apparent neutrality of manuals can be understood from the notion of relational power, by which the correct thing to be said and to be performed is inscribed in a discursive order as something necessary and decisive, since the truths contained there are accepted, reproduced and reiterated without anyone needing to continually repeat them[7].

As for the power relations and disciplines established between professionals and people undergoing treatment, there is an extensive list of recommendations to health professionals on how to manage TB control. It is observed that, although some guidelines focus on the body of the person undergoing treatment, such as submitting to tests and performing procedures[1,10–13], others are aimed at shaping their behaviors. Among these, it is reinforced the need to abstain from habits that are harmful to health, such as smoking cessation and the adoption of healthy lifestyles. In this context, the analysis of power conducted by Foucault[6,18] allows us to understand that several mechanisms inscribe the body in a political technology, in a process by which certain knowledge about it is constituted according to the science of its time.

However, it is noteworthy that certain "imposed" disciplines are sometimes desired, as they put into operation several surveillance and control techniques that meet the culture of valuing health. That is, the exaltation of the desire to maintain the life and safety of the population, a powerful discourse of health promotion in its neoliberal aspect, sometimes shows itself sufficiently capable of individualizing the multiplicity of patients, so that each individual accept and submit to the established treatment[5,8]. From this understanding, it would not be possible to locate power in a specific subject, or in an institution, but rather to understand it through strategies, whose effects do not occur through domination, appropriation, but through dispositions, desires and subjectivations[18].

It is worth mentioning that, among all nurses' actions, the organization, implementation and operationalization of Directly Observed Treatment (DOT) is set as the main TB control strategy through a discourse anchored in the importance of epidemiological surveillance[1,10–13]. O TDO DOT consists of observation, supervision and recording taking of the medication by the health professional, preferably from Monday to Friday at the Health Unit[1]. The supervision of treatment in this process is configured as an important mechanism of observation and control of the body, which is hierarchically watched over by the nurse; that is regulated by a normativity (the recommendations of the "Nursing Protocol"); and that it is constantly examined, by means of the observation of the taking of the medication. Surveillance, standardization and examination allow for inscribing disciplines of body control, while putting into operation a network of relationships established between discourses, laws and truths of a certain scientific rationality established[5,7–8].

It is important to consider, however, that DOT as a disciplinary mechanism also does not operate by subjecting the body to the obligation to obey, but by the production of subjectivities of the individual in taking a discourse as a truth[7–8]. That is, when the patient shares the idea that obedience to certain rules will reward his/her health, he does not hesitate to agree to do so, even though he/she does not have the resources to do so. And without resources to change lifestyle, the sick subject should be able to trigger (based on awareness and better "life planning") mechanisms to reduce vulnerabilities[5]. What we see, however, given the growing numbers of TB cases, is that neither one – established disciplines – nor the other – individual desire – has managed to change practices and the epidemiological picture of TB[1,3–4].

Finally, it is worth noting that the potential of the nurse[13] as a trigger of the disciplines and the desired appropriate behaviors[8] is related to the historically constructed role of the nurse as a health educator[14, 19]. That is, it is intended to consider at this point that the role of health educator, so present in nursing, is not something *a priori* or natural of the profession, but is also produced by discourses that inscribe it from the individual's awareness of the risk of illness[5,20]. This makes visible the fact that certain professional behaviors can be at the service of a certain end, "guided" by different beliefs, constituted by different knowledge and specific interests of the neoliberal rationality of our present time.

The performance of health professionals who, more immediately, lead the way people face TB, in which nursing stands out, can be an important aspect to be explored in future research and debates. Especially, such research could explore the conditions of possibility of other truths about treatment adherence, in order to make visible the types of knowledge and power relations that could trigger disease control mechanisms that are more consistent with what is

in fact considered urgent in the TB control. As a limitation of the study, it stands out the non-inclusion of official documents edited by health departments of Brazilian states and municipalities, which could expand the analyses performed here presented.

FINAL CONSIDERATIONS

This research identified elements that were constituted as knowledge capable of strengthening adherence to TB treatment emerging in the guidelines for disease control in Brazil: training of human resources; health surveillance actions; medicalization; and nurses' multifunctionality in dealing with the social determinants of TB. It was also possible to identify that the recommendations of the Manuals constitute a certain social practice, based on the power relations that are established through articulation between different government bodies and between health professionals and the person undergoing treatment. The attributions and duties of such institutional actors aim to normalize/conduct/converge the actions of adherence to TB treatment to the current neoliberal rationality of health promotion: self-responsibility, autonomy, and empowerment of the subject.

Therefore, it is noteworthy that the problematization of the recommendations of the TB control manuals, currently in Brazil at different times, intended to deconstruct truths that can be seen as universal, fixed, and secure knowledge. What is at stake, therefore, is not just the control of TB, through the technical skill of the professionals involved, but the appreciation given to the culture of health from the exaltation of neoliberal precepts of health promotion that emphasize individual self-responsibility. It is highlighted the importance of reinforcing that, more than seeking solutions in the light of scientific knowledge, this research made visible other truths about urgent problems of our current time.

Finally, it is emphasized and reiterated that the manuals analyzed here - as well as other documents produced within the scope of government public policies - are dated documents - published and disseminated in a certain space and time. Therefore, the analyses produced on them, in particular the one in this research, do not intend to constitute themselves as truth for all time, as such documents were constructed in accordance with the current technical guidelines. It is hoped that the issues addressed here are (above all) fertile and useful to produce other analyses, with a view to reviewing or strengthening what has been postulated here.

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