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## PROVIDING HEALTH CARE TO WOMEN WITH TUBERCULOSIS: THE FAMILY FOCUS PERSPECTIVE

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**ABSTRACT:** To analyze the relationship between the practice of family health team workers and women with tuberculosis, according to the family focus dimension. The participants were eight family health team workers from a city in the João Pessoa metropolitan area (Paraíba -PB). Data were collected through semi-structured interviews, and then subjected to thematic content analysis. The workers recognize the critical social condition that women with tuberculosis live in, as well as the prejudice they face. They suggest that these women require care based on the concept of comprehensiveness in health. They also highlight the importance of Directly Observed Therapy - Short Course, the existence of incentives, and the women's poor adherence to educational activities and groups. Few workers recognize the inclusion of relatives in the care of women with tuberculosis, which implies the need for discussion regarding this fact with the purpose of improving tuberculosis treatment effectiveness.

**DESCRIPTORS:** Tuberculosis. Women's health. Family health.

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## O CUIDADO À SAÚDE DA MULHER COM TUBERCULOSE NA PERSPECTIVA DO ENFOQUE FAMILIAR

**RESUMO:** Analisar a relação entre a atuação de profissionais de Equipes de Saúde da Família e a mulher com tuberculose, segundo a dimensão de enfoque familiar. Participaram oito profissionais de Equipes de Saúde da Família de município da região metropolitana de João Pessoa-PB. As informações foram coletadas por meio de entrevistas semi-estruturadas e analisadas segundo a técnica de análise de conteúdo, modalidade temática. Os profissionais reconhecem a precariedade social e preconceito vivenciados pelas mulheres com tuberculose, sugerindo a necessidade de um cuidado baseado no conceito de integralidade em saúde. Ressaltam ainda a importância do Tratamento Diretamente Observado de Curta Duração, da existência de incentivos, e a pouca adesão das mulheres às atividades educativas e à formação de grupos. Poucos profissionais reconhecem a inclusão de familiares no cuidado à mulher com tuberculose, o que indica a necessidade de discussão desse fato para potencializar o êxito do tratamento dessa doença.

**DESCRIPTORIOS:** Tuberculose. Saúde da mulher. Saúde da família.

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## EL CUIDADO A LA SALUD DE LA MUJER CON TUBERCULOSIS EN LA PERSPECTIVA DE ENFOQUE FAMILIAR

**RESUMEN:** El objetivo fue analizar la relación entre el desempeño del profesional de la salud de la familia y la mujer con tuberculosis, según la dimensión de enfoque familiar. Investigación cualitativa que involucró ocho profesionales de los equipos de salud familiar del municipio de la región metropolitana de João Pessoa-PB. La información se obtuvo a través de entrevistas semi-estructuradas y fue analizada según la técnica de análisis de contenido, modalidad temática. Los profesionales reconocen la fragilidad social y los prejuicios que sufren las mujeres con tuberculosis, lo que sugiere la necesidad de atención basada en el concepto de salud integral. Son resaltadas la importancia del Tratamiento Breve Bajo Observación Directa, la existencia de incentivos y la falta de compromiso de las mujeres a las actividades educativas y grupos de formación. Pocos profesionales reconocen la inclusión de familiares en el cuidado de las mujeres con tuberculosis, lo que indica la necesidad de un debate de este hecho para mejorar el éxito del tratamiento de esta enfermedad.

**DESCRIPTORIOS:** Tuberculosis. Salud de la mujer. Salud de la familia.

## INTRODUCTION

Tuberculosis (TB) is a disease which has been around for centuries, but it is still considered a critical public health problem today<sup>1</sup>. Currently, TB is distributed across five continents, affecting men and women regardless of their age. Brazil currently ranks as 19<sup>th</sup> among the 22 countries with the highest reported disease burden worldwide.<sup>2</sup>

Although TB is a disease more common in men, it is the main infectious cause of death among women.<sup>3</sup> Yearly, there are about 700,000 deaths resulting from TB among women, and another three million women become infected. Because TB usually affects women who are at an economically active and reproductive age, the burden of the disease also affects their relatives.<sup>4</sup> In the state of Paraíba (PB), according to data from the State of Paraíba Health Department (SES-PB), 1421 TB cases were reported in 2010, distributed among 994 men and 427 women.<sup>5</sup> Therefore, it is observed that 30% of the TB cases affect the female population.

The current reality of economy, under neoliberal guidelines, determines situations that affect women's quality of life. Factors such as the growing proportion of women who are heads of the household with juridical and financial support that differs from that of men, the critical undervaluing process of the female workforce, enduring a workload three times greater than men to be able to provide for the family, and the lack of goods and services that would provide support to female activities are seen as destructive to women's lives<sup>6</sup> and can determine women's disease processes. Regarding TB, it is known that the disease is associated with strong social and economic components. Women with a low income living in dense urban communities, with inappropriate housing, poor nutrition and poor hygiene have a greater chance of becoming infected.<sup>7</sup>

The social condition that TB assumes in the neoliberal context, and the expressive mortality in the female population justify the need for a TB study focused on women, specifically concerning the reality of a Paraíba city within the metropolitan area of the state capital, which, as a port, imposes a state of vulnerability over the women who live there.

It should also be emphasized that although in countries considered to be low income the number of TB cases among men is twice that reported for women, the World Health Organization (WHO) has encouraged the production of gender-

centered studies. This was one of the reasons that influenced the decision to conduct the present study. In this sense, the results should be used to improve TB control, prioritizing, above all, the successful treatment of women.<sup>3</sup>

In the care of women with TB, it is emphasized that care planning should be designed in agreement with the National Policy of Women's Health<sup>8</sup> under the gender focus. The meaning of gender presupposes understanding the relationships between the genders and differentiates biological gender from social gender. The former refers to the biological differences between men and women. The latter concerns the form these differences take in different societies and throughout the course of history.<sup>9</sup>

The gender concept pervades the health-disease process and is important to consider in order to provide care according to the health promotion concept. Health promotion is supported by the statement that health is a result of a broad spectrum of factors associated with quality of life<sup>10</sup>, which includes an appropriate standard of nutrition, housing and sanitation, dignified working conditions and income i.e., portrays the broader concept of health. In relation to this positive concept, health promotion suggests a professional healthcare practice oriented towards changing situations of inequity, so that through equity it is possible to grant each human being social justice, respect for their biological difference, and the right to freedom of choice, while also guaranteeing the minimum conditions necessary for a dignified life.<sup>11</sup>

In Brazil, TB is considered one of the strategic areas of the National Primary Healthcare Policy<sup>12</sup>, of which the Directly Observed Treatment Short Course (DOTS) is established as the official strategy for disease control. The DOTS is operationalized by family health teams, which, in compliance with the concept of Primary Healthcare, is accountable for the care to TB patients and their families.<sup>13</sup> The DOTS aims at curing 85% of the diagnosed cases.

Although the Directly Observed Treatment (DOT), one of the pillars of the DOTS, is employed by the Family Health Strategy (FHS) to strengthen therapeutic success, healthcare professionals, besides considering the family context in which the woman with TB lives, should take into consideration the integration of one person from the family - or from the community - in the therapeutic

project, someone with whom the patient has some form of trust/affective relationship.<sup>7,14</sup>

Primary healthcare involves dimensions that should guide health care, including: accessibility, first contact care, bond, range of services, coordination, family focus, community centeredness and professional training. This study, specifically, is founded on the family focus dimension, as it contemplates the individual in their everyday life, and, in this sense, the health needs assessment should take into consideration the family context and the exposure to health threats of any kind, in addition to the challenge of having limited family resources.<sup>15</sup>

In terms of comprehensive healthcare to women, it is recognized that there is a set of actions for the promotion, protection, care, and recovery of health provided at the different healthcare levels i.e., from primary healthcare to high complexity services, and the provision of comprehensive healthcare to this specific group consists of providing women with care from a broader perception of their life context, as well as considering their uniqueness and capability as subjects accountable for their own decisions.<sup>8</sup>

Considering the range of healthcare actions focused on women, healthcare professionals, particularly those working with the FHS, should keep a vigilant eye on the variety and complexity of factors that make this specific group vulnerable to several disease processes, most of which are socially determined or favor biologically acknowledged diseases.

Considering that TB is a chronic disease that has existed for centuries and demands significant changes in the everyday lives of the people affected and, in relation to women, is uniquely related to the gender issue, it is imperative to recognize that the care to this specific group must be founded on comprehensiveness. Notably, comprehensive healthcare should be considered as the consolidation of healthcare practices that guarantee women's accessibility to problem-solving actions developed based on the specificities of the female life cycle and the context in which the needs emerge. With this aim, care should be permeated by health surveillance actions, valuing the influence of gender relationships, ethnicity/color, class and generation in women's health and disease processes.<sup>16</sup>

The National Health Policy ranks both women's health and TB control as priority areas. Based on the presupposition that the care to women with TB cannot be restricted to the clinical aspects of

the disease, a question emerged: considering the family focus dimension, what are the relationships that Family Health Strategy workers establish between comprehensive care and the needs of women with TB? To answer this question, the following objective was proposed: to analyze the relationships that family health strategy workers establish between comprehensive care and the needs of women with TB in a priority city of Paraíba, according to the family focus dimension.

## METHODOLOGY

This study was conducted considering the framework of qualitative research, and content analysis was used as the analytical approach<sup>17</sup>; the latter is defined as a set of analysis techniques for communication which aim to obtain, with the use of systematic and objective procedures for describing the content of the messages, indicators that permit the inference of knowledge related to the conditions in which these messages were produced/received.<sup>18</sup>

To better define the purpose of this investigation, a review was performed of the TB literature and its relationships with the gender issue, as well as the recognition of the setting being studied.

The study was performed in a city in the metropolitan area of João Pessoa (PB), which is considered a priority city for TB control in the state. In addition, the city is a port and therefore includes a recognized area of prostitution, thus increasing vulnerability to sexually transmitted diseases. In this particular case, special attention is given to AIDS, considering its relevance for studies related to TB/HIV co-infection.

Among the 19 Family Health Units (FHU) in the city identified in the Municipal Health Department, four were selected for the present study because they had workers who followed women undergoing self-administered TB treatment. Subjects were included in the study if they were directly involved in supervising the therapy and worked at FHUs whose coverage areas included women undergoing TB treatment. It was observed that nurses and Community Health Agents (CHA) were the healthcare professionals who developed attachments with these women. Eight subjects were selected (four nurses and four CHAs), three women and one man of ages between twenty and fifty years.

The local Health Department collaborated with contacting the workers. The researchers

called the subjects and scheduled the dates and places for the interviews, all of which were performed at the FHUs. The interviewers were a nursing undergraduate and a master's student of the Nursing Graduate Program of the Federal University of Paraíba. Both students were part of the original research proposal.

In order to produce the empirical material, semi-structured interviews were used, utilizing a script having eight subjective questions. The interview script is an instrument that guides the conversation, making it easier for participants to open themselves up, thus broadening and extending the communication.<sup>17</sup> The interviews were performed between August and November of 2009, lasting on average 17 minutes. The audio of all interviews was recorded and fully transcribed in November 2009.

The participants were coded using letters and numerals so as to guarantee anonymity and, thus, comply with Resolution 196/96 of the National Health Council, which states the norms and guidelines which must be followed for research with human beings. The original study proposal was approved by the Research Ethics Committee of Hospital Universitário Lauro Wanderley, at the Federal University of Paraíba – CEP/HULW (protocol number 171/09).

Thematic Content Analysis was used to analyze the empirical material.<sup>18</sup> Among the content analysis techniques, thematic analysis is among those that better adjusts to qualitative research in the area of healthcare, based on the notion of theme.<sup>17</sup> Theme is the meaning unit that naturally stands out in a text being analyzed, according to criteria regarding the theory that guides the reading.<sup>18</sup> It is emphasized that thematic analysis unfolds operationally in a sequence composed of three basic stages that permits researchers to better organize and explore the data from the interviews: initial reading (pre-analysis), exploration of the material and/or coding and treating the results, and inference and interpretation.<sup>17-18</sup> The analytical trajectory was conducted in the following manner.

The eight interviews with the nurses and CHAs were selected for pre-analysis phase and corpus comprising. Later, in the phases of material exploration, treatment and interpretation of the results, all of the content of the recordings was heard and then transcribed. To guarantee the quality of the empirical material, the interviews were heard one more time, so it was possible to make any corrections necessary. After being transcribed, the

contents of the recordings were analyzed in terms of the exhaustivity, homogeneity, representivity and pertinence of the information.

Next, the pre-analysis, the longitudinal and the transversal readings were performed. The first (pre-analysis) reading was performed individually by one researcher; the second (longitudinal) was performed by three members of the research team, which was followed by a discussion among them about the consistency and pertinence of the contents. The transversal reading marked the beginning of the coding, based on register units and the formulation of pre-hypotheses.

In order to achieve the proposed objective, by means of a previous analysis of the statements made by the nurses and CHAs during the interviews, the register units were highlighted, which comprised the following meaning units: the social needs of women with TB and the care provided by family health teams to women with TB.

Next, the meaning units identified in the statements with converging, diverging and repeated contents were considered. Thus, excerpts were removed from statements corresponding to each meaning unit. This conformation permitted the researchers to elect the central thematic unit: Comprehensive healthcare to women with tuberculosis, under the family focus perspective.

## RESULTS AND DISCUSSION

Next, the central thematic unit of the study is discussed— Comprehensive healthcare provided to women with tuberculosis, under the family focus perspective. This unit is comprised by the meaning units: social needs of women with TB and the care provided by family health teams to women with TB, and addresses the TB problem in a port city, emphasizing the relationship between vulnerability and deprived social conditions, as well as the importance of family participation in the treatment of women with TB.

### The social needs of women with TB

The main premise of health surveillance is the principle of territoriality, which is why health practice should be immersed in the territorial context.<sup>19</sup> Based on the principles guiding health surveillance, it is possible to define problems and priorities and to seek resources to meet unique health needs for individuals as well as human collectivities. From a personal perspective, the main

purpose of health surveillance actions should be to consider the patient as part of the family, community, social system and environment. It must be understood that in order to improve quality of life and promote the health of an individual, it is necessary to act within the context in which that individual is inserted, the space in which that individual lives.

Therefore, for a treatment to be effective, it must take into consideration the social reality of the woman with TB and adjust the control strategy to her needs. It is known that women with poor quality of life are more vulnerable to becoming infected by TB.<sup>7</sup> Literature reveals that social problems such as unemployment and financial burdens contribute to the TB patients' noncompliance with the treatment.<sup>14</sup> In the following statements, the workers reiterate that the lifestyles of women with TB, such as the social environment in which they live, has a direct relationship to the disease: *deprived [the patients' life conditions]. Our city is a port area and there is a large flow of tourism ships and these women have many relationships with these people [...]. There is unemployment [...]. Their work is basically prostitution and this makes the treatment more difficult (N1); the control of this disease is far less than ideal, especially because it concerns a port city, with considerable promiscuity. Alcoholism and drugs also build a barrier for us (N4).* Based on the content of the statements, it is observed that these women have numerous social needs, which motivates reflection regarding the challenges inherent to the practice of healthcare in the perspective of comprehensive care and from the gender issue.

The city where the study was conducted is a port city and, according to information from the State Health Department Center for Endemic Diseases, the city has the highest number of cases of TB/HIV co-infection. Considering the vulnerability of the population, and particularly of women to sexually transmissible infections, this fact should determine women health surveillance actions to be developed in association with TB control activities, mainly to identify patients with respiratory symptoms and request HIV tests when TB is diagnosed.

It should be highlighted that more than meeting their needs, these women deal with psychological and family problems because TB is a stigmatizing disease, steeped in prejudice. In view of the cruel social reality they have to face, women often turn to an escape mechanism, primarily alcohol and drugs. Alcoholism, smoking and drug

abuse are conditions that, when undergoing TB treatment, hinder achievement of an effective outcome, as they worsen the clinical condition of the disease, increase the chances of noncompliance to treatment, and compromise cure.<sup>20</sup>

Regarding the stigma that accompanies TB patients, it is recognized that they experience situations that can be traumatic and embarrassing, often pushing them towards giving up on treatment because of issues rooted in the social imaginary.<sup>21</sup> Because TB is a disease surrounded by prejudice, healthcare professionals of the Family Health Team must use strategies to clarify and inform the population about the disease.

The prejudice related to TB patients is made explicit in the following statements: *patients with TB issues, they feel like people excluded from society (C3); they complain there is still prejudice from part of the population, from society and they eventually withdraw; after this [the TB diagnosis] she realized that she, herself, wanted to withdraw so she wouldn't transmit the disease to her grandchildren and daughters, but then we talked to her and instructed her saying that she wouldn't transmit it (N3); because her husband at the time discriminated against her, because she had tuberculosis, so it was a serious problem! And she [TB patient] was telling me that she was expecting a cancer diagnosis because she was losing weight but she didn't expect it to be tuberculosis. She thought she would be better off if it was cancer and she even told me: really, it's because I think that there isn't so much prejudice against cancer like there still is for tuberculosis (N3).*

Analyzing the excerpts above, two fundamental aspects are noted which permeate the stigma associated with TB: society's prejudice towards the TB patient and the patient's own prejudice in view of the disease. Both situations are a reflection of a lack of knowledge regarding the process of the disease. However, the prejudice that the patient has towards him or herself is highlighted, because it drives them away from their family and from society. In being discriminated against, all that is left for patients is to withdraw from the everyday life among those they consider to be healthy. This calls for vigilance from healthcare professionals so that in the face of situations in which prejudice is identified, they can develop strategies to motivate for cure.

With the purpose to demystify the infection and reduce prejudice, the health service should also be organized in order to educate people about TB and other diseases that are also stigmatized.<sup>21</sup> Health education is an opportunity to effectively

achieve the objectives of orientation, aiming at practices that include the citizen in the process as an advocate of change, so they can contribute in the process of the treatment and social change.

In TB control, the interaction between healthcare professionals and the community, as well as with the family while undergoing treatment should be emphasized in order to guarantee comprehensive and problem-solving healthcare. Therefore, including the relative in the treatment is an extremely important intervention that should always be considered.<sup>22</sup> It is necessary for the Tuberculosis Control Program to interact with the FHU teams, as well as the FHU with the patients' relatives. The nurses recognize this: *this patient's mother was the one who encouraged her the most [to follow the treatment] because she leads a life that is, like, somewhat disordered, she enjoys drinking, partying, going out [...]. She would bring her [the patient] to the unit... make her follow the treatment, it's who cooks, right? (N2); so she needs support from the family, the health unit is providing the medication, the basic food basket, they visit, but she has this need, it's an affective need, of support, of being with your family... I identify it as being the most difficult issue for them, the lack of family support (N1).*

In the statements, although few of the interviewed professionals recognized it, it is observed that the family is important for a successful treatment outcome. To achieve this goal, there must be shared commitment between the health service, the woman and her relatives by creating agreements that address the needs of all those involved, and make them the main actors in their roles.<sup>22</sup>

It should also be emphasized that the studied city provides free medication and the necessary supplies for treatment. However, despite these guarantees, women with TB in the referred city need family support, a fact that affects their adherence to the treatment. Health services, by considering the family focus dimension, tend to reinforce the commitment by healthcare professionals in making them aware of the Tb patients' need for, as well as involving relatives, making them active participants in the care of one of their own.

### **The care of family health teams to women with TB**

Regarding their social roles, men and women appear to have different behaviors in regards to TB treatment. According to the statements of the interviewed workers, it is observed that there

is higher treatment compliance among women. The analyzed content shows that women, besides spending more time with personal care, are more committed to the health of their relatives and the community, and generally seek treatment faster than male patients: *she feels more responsible for her own treatment, she is an active participant in the treatment. It is easier because I believe she is concerned about it, she feels responsible about treating herself in order to be cured, right? Because she thinks about her husband, her children, so she takes more care in the treatment (N3); they want to take care of their lives. Men don't. They only want to drink, smoke, they don't follow the treatment (C1).*

Different from women, studies show that men are at a greater risk for becoming infected with TB, which is likely due to their lifestyle, thus favoring the higher incidence among men.<sup>23</sup> Regarding the accessibility to healthcare services, there is evidence that, despite the fact that the health service makes no distinction between men and women who need care, frequency of care is higher among female patients. This fact is similar to a Mexico study involving TB and gender relationships.<sup>3</sup>

In Brazil, TB is considered to be a disease that marks the male population, because the number of TB cases among men is almost twice that of women. One important factor to be considered in the TB Control Program is to develop actions that are geared towards men's health.<sup>24</sup> The health surveillance actions focused on the male population should involve TB control interventions for all men rather than just the population in prisons, contacts, HIV-positive individuals and the homeless.

The central role of the FHS in the field of health education is aimed at health promotion, with a group of guided activities to improve well-being and accessibility to social goods and services. These guided activities include educational activities, because it is common in lectures/classes, groups or individual appointments for professionals to suggest the idea that the disease is caused mainly by a lack of care and the negligence of the population towards their health, imposing a feeling of guilt on "victims" because of the perceived social problem they have.<sup>25</sup>

Some of the problems caused by this practice are: low attendance of the population to health services, poor adherence to programs and treatments, and the frustration of health care professionals.<sup>25</sup> Similar problems are stated by the workers: *since*

*I've come here I have found it really difficult to form groups of either women or adolescents, because there is a strong connection to their culture, and they still see the FHS as an outpatient clinic (N1); the women come to the unit frequently, but they come for family planning, for a doctor's appointment, to take their children to see the doctor, for vaccinations, but never to participate in a group, to take care of herself is less common (N4); when this patient comes for a regular appointment, the girls [the health team] are always delivering lectures, and they are able to gather the people from outside, because if you schedule a lecture they [patients] never come (C2); we have to provide something for the walk-in [patients], so they feel interested and come to us. For example: a raffle, a gift, a snack, some form of attraction that we offer to them[...] (N1).*

It is possible to observe the weakness of a health education strategy founded on care that is purely medical and technical; for instance, providing medical appointments and delivering medications, considering that at the onset of the disease there is an involvement of all the socio-cultural spheres of these women, and all should be taken into consideration, of which being infected with TB is only one of them.<sup>26</sup> Therefore, it is essential for the health sector to provide education based not only on the transmission of historically accumulated knowledge, such as delivering lectures, but also to work from the perspective of developing knowledge and improving the quality of life of all those involved.<sup>25</sup> In the excerpts above, it is observed that the community does not value health education actions, perhaps because they consist of guiding activities centered on scientific knowledge, on the biological focus of the disease and on medicalization; which do not take into consideration the social reality in which this community exists. Therefore, without this focus that marks the concept of health comprehensiveness, it is difficult to establish an effective attachment that would promote change. In this case, the difficulties reported by N1 and N4 tend to persist.

One element seen as a promoter of TB control actions, as stated by the participants, is the offer of incentives, such as the basic food baskets provided for TB patients: *in the city "N" we have the incentive of a basic food basket for people who are being treated (N1); and now, with the help from a popular street market, they feel obligated to come for treatment (C2); she [the woman with TB] receives one basic food basket every month and it is a very good one, and she leaves happy and satisfied and says it is great help for her and her children (N4).*

It should be emphasized that, according to the statements of the three workers above, providing basic food baskets is important, as it contributes to the patients' compliance to treatment and establishes bonds, in addition to providing a means of making the patient an active and autonomous participant in their own treatment, as they tend to pay attention to when they will run out of the medication, which means they will receive a new basic food basket. It should be emphasized, however, that while the incentive is necessary, alone it is not enough. In addition to the benefit, it is necessary to guarantee the patients' quality of life, to avoid the prevalence of curative actions instead of intersectoral actions and policies that provide the foundation for the concepts of health promotion and comprehensive care.

The interviewed workers were part of the DOTS strategy for a positive factor for TB control. The service must be provided to the patients in a timely and continuous fashion, and healthcare professionals should always be available, serving the real demand, including a reference system that guarantees easy access to healthcare at the necessary level of complexity.<sup>21</sup> The elements that increased adherence to TB treatment, as ranked by the DOTS strategy, include laboratory support and the provision of free supplies. The following statement reveals the organization of the service for diagnosing Tb: *here in "N" there is one easy aspect, we [the team] already receive prescriptions and exam requests authorized by the laboratory, so the patients doesn't have to deal with any paper work. We just hand them the cups and the day they collect the material, they take it straight to the laboratory (N3).*

Analyzing the statement by participant N3, it is understood that the accessibility to exams important for TB diagnosis and treatment is being provided to the patients in the studied city. This fact improves treatment because it is essential for the service organization to be appropriate so that the activities are effective and in agreement with the local reality.<sup>27</sup>

Although women's health is part of the list of services provided by the FHUs of the studied city, none of the interviewed professionals stated any elements that revealed strategies that associate TB control and women's health. This means that the actions are developed individually, without any association with policies, and are performed by default of a care rhetorically emphasized as being comprehensive.

## FINAL CONSIDERATIONS

The present study results highlight the TB problem in a port city, revealing the relationship that health professionals establish between the deprived conditions in which women with TB live and the vulnerability of this group, not only to centenary disease, but also to other morbidities, including TB/HIV co-infection. From a social point of view, prejudice, rooted in the disease, contributes to interruption in treatment, thus increasing the noncompliance problem.

When healthcare professionals recognize the social deprivation in which women with TB live, they reveal that they consider the context in which these women live, thus suggesting that care should be based on the concept of health comprehensiveness.

It is highlighted that the workers believe that women comply with TB treatment more often than men. This statement agrees with the recommendation for health surveillance actions for the male population focused on TB signs and symptoms, which should be supported by the National Policy for Comprehensive Care to Men, recently created by the Brazilian Ministry of Health.

Regarding the family focus, the workers establish a relationship between the women's needs and the TB treatment. In addition, it is observed that nurses and CHAs recognize the importance of family participation in the treatment of women with TB. It is emphasized there is no association between TB control actions and comprehensive care in women's health. It appears that the healthcare professionals do not make any association between these two important strategic areas of the National Policy for Primary Healthcare.

## REFERENCES

- Hijjar MA, Procópio MJ, Freitas LMR, Guedes R, Bethlem EP. Epidemiologia da tuberculose: importância no mundo, no Brasil e no Rio de Janeiro. *Pulmão RJ*. 2005 Dez; 14(4):310-4.
- Organização Pan-americana de Saúde. Tuberculosis en las Américas: reporte regional; [sl.]: OMS; 2009.
- Jiménez-Corona ME, García-García L, DeRiemer K, Ferreyra-Reyes L, Bobadilla-del-Valle M, Cano-Arellano B, et al. Gender differentials of pulmonary tuberculosis transmission and reactivation in an endemic area. *Thorax*. 2006 Abr; 61:348-53.
- World Health Organization. Tuberculosis and gender [página na internet]. [acesso 2010 Ago 07]. Disponível em: <http://www.who.int/tb/challenges/gender/en/index.html>
- Sistema de Informação de Agravos de Notificação (SINAN-NET). Secretaria de Estado da Saúde da Paraíba. Indicadores que caracterizam a situação da tuberculose na Paraíba. João Pessoa (PB): Secretaria de Estado da Saúde da Paraíba; 2011.
- Fonseca RMGS. Equidade de gênero e saúde das mulheres. *Rev Esc Enferm USP*. 2005 Mai; 39(4):450-9.
- Ministério da Saúde (BR). Controle da tuberculose: uma proposta de integração ensino-serviço. 5ª ed. Rio de Janeiro (RJ): FUNASA/CRPHF/SBPT; 2002.
- Ministério da Saúde (BR). Política Nacional de Atenção Integral à Saúde da Mulher. Departamento de Ações Programáticas Estratégicas. Princípios e diretrizes. Brasília (DF): Ministério da Saúde; 2004.
- Fonseca RMGS. Equidade de gênero e saúde das mulheres. *Rev Esc Enferm USP*. 2005 Mai; 39(4):450-9.
- Buss PM. Saúde, sociedade e qualidade de vida [página da internet]. Fiocruz: 2003 [acesso 2005 Fev 06]. Disponível em: <http://www.invivo.fiocruz.br/cgi/cgilua.exe/sys/start.htm?sid=8&inford=34>
- Bydlowski CR, Westphal MF, Pereira IMTB. Promoção da saúde: porque ainda não! *Saúde Soc*. 2004; 13(1):14-24.
- Ministério da Saúde (BR). Secretaria de Atenção À Saúde. Departamento de Atenção Básica. Política Nacional de Atenção Básica 4ª ed. Brasília (DF): Ministério da Saúde; 2007.
- Sá LD, Oliveira AAV, Souza KMJ, Palha PF, Nogueira JA, Villa TCS. Abandono do tratamento e elenco de serviços no cuidado ao doente de tuberculose. *Rev Enferm UFPE [online]*. 2010 Jul-Set [acesso 2010 Set 03]; 4(3):178-86. Disponível em: [http://www.ufpe.br/revistaenfermagem/index.php/revista/article/view/1216/pdf\\_150](http://www.ufpe.br/revistaenfermagem/index.php/revista/article/view/1216/pdf_150)
- Sá LD, Souza KMJ, Nunes MG, Palha PF, Nogueira JA, Villa TCS. Tratamento da tuberculose em unidades de saúde da família: histórias de abandono. *Texto Contexto Enferm*. 2007 Out-Dez; 16(4):712-8.
- Almeida CM, 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 (DF): Organização Panamericana da Saúde; 2006.
- Coelho EAC, Silva CTO, Oliveira JF, Almeida MS. Integralidade do cuidado à saúde da mulher: limites da prática profissional. *Esc Anna Nery Rev Enferm* 2009 Jan-Mar; 13(1):154-60.
- Minayo MCS. O desafio do conhecimento: pesquisa qualitativa em saúde. 8ª ed. São Paulo/Rio de Janeiro (SP/RJ): Hucitec-Abrasco; 2004.
- Bardin L. Análise de conteúdo. Lisboa (PT): Edições 70; 2009.
- Campos CEA. O desafio da integralidade segundo as perspectivas da vigilância da saúde e da saúde da família. *Ciênc Saúde Coletiva*. 2003 Jan; 8(2): 569-84.

20. Lima MB, Mello DA, Morais AP, Silva WC. Estudo de casos sobre abandono do tratamento da tuberculose: avaliação do atendimento, percepção e conhecimentos sobre a doença na perspectiva dos clientes (Fortaleza, Ceará, Brasil). *Cad Saúde Pública*. 2001 Jul-Ago; 17(4):877-85.
21. Silva ACO, Sousa MCM, Nogueira JA, Motta MCS. Tratamento supervisionado no controle da tuberculose: potencialidades e fragilidades na percepção do enfermeiro. *Rev Eletr Enf [online]*. 2007 [acesso 2010 Jul 03]; 9(2):402-16.. Disponível em: <http://www.fen.ufg.br/revista/v9/n2/pdf/v9n2a09.pdf>
22. Oliveira SAC, Ruffino Netto A, Villa TCS, Vendramini SHF, Andrade RLP, Scatena LM. Serviços de saúde no controle da tuberculose: enfoque na família e orientação para a comunidade. *Rev Latino-am Enfermagem*. 2009 Mai-Jun; 17(3):361-7.
23. Arakawa T, Arcêncio RA, Scatena LM, Villa TCS, Ruffino Netto A. A acessibilidade de doentes de tuberculose ao tratamento em serviços de saúde ao município de Ribeirão Preto - SP (2006-2007). In: Ruffino-Netto A, Villa TCS, organizadores. *Tuberculose: pesquisas operacionais*. Ribeirão Preto (SP): FUNPEC; 2009. p. 48-55.
24. Ministério da Saúde (BR). *Política Nacional de Atenção Integral à Saúde do Homem (princípios e diretrizes)*. Brasília (DF): SAS/DAPE; 2008.
25. Besen CB, Souza Netto MS, Ros MA, Silva FW, Silva CG, Pires MF. A estratégia saúde da família como objeto de educação em saúde. *Saúde Soc*. 2007 Jan-Abr; 16(1):57-68.
26. Gazzinelli MF, Gazzinelli A, Reis DC, Penna CMM. Educação em saúde: conhecimentos, representações sociais e experiências da doença. *Cad Saúde Pública*. 2005 Jan-Fev; 21(1):200-6.
27. Queiroz R. *Diferenças na adesão ao tratamento da tuberculose em relação ao sexo*. [dissertação]. São Paulo: Universidade de São Paulo, Faculdade de Saúde Pública; 2008.

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