

The Adherence for the Tuberculosis Treatment: the Mark of Stigma in the Discourse of Nurses

ORIGINAL

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Abstract

Introduction: One of the issues considered today as an obstacle for the control of tuberculosis in the world scenario, regards the non-adherence of the patient for the treatment of the disease, resulting in complications to the health of the individual and negative implications for public health.

Objective: To analyze the speeches of nurses working in the Family Health Strategy, about the difficulties in adherence to Directly Observed Treatment (DOT) of tuberculosis in the city of João Pessoa, state of Paraíba, Brazil.

Method: Qualitative study and discursive approach, developed in August and October 2012. Through the technique of interview guided by a semi driven script, thirteen nurses working in the Family Health Strategy were interviewed in the city of João Pessoa, state of Paraíba, Brazil. The empirical material produced was analyzed according to the theoretical and methodological device of Discourse Analysis of pecheutiana French line.

Results: The discursive analysis made from the textual marks present in the speeches of enunciators indicates that the difficulties in joining the directly observed treatment of tuberculosis in the city of João Pessoa, bind to patients, health professionals and treatment. In relation to the patient, the analysis points to discursive formations linked to the stigma, commitment in the treatment and low level of education. As for healthcare professionals, fear of contagion of the disease -reinforced by the stigma- and the transfer of responsibility in caring to other professionals were observed. Notably, the spoken relapse, in

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addition to the fear of health professionals themselves in treating the TB patient, reveals the prejudice that runs through the speeches of the subjects in relation to the exposure of the patient and the duration of treatment made in the Directly Observed Treatment modality.

Discussion: The effects of produced senses show that nurses relate the difficulties of adherence to directly observed treatment, among other factors, to the fear of acquiring the disease, which affects not only the patients but also the health professionals themselves, provoking discrimination and contributing to justifying the non-adherence to therapy. It is observed that this fear is affiliated to the historical and social memory of the disease, marked by stigma, prejudice, segregation and exclusion.

Conclusion: It is not only enough for the medication to be available. Innovative measures should be designed and implemented not only in relation to the qualification of health professionals to run the DOT. The coordination of tuberculosis control in all health management spheres, must be concerned in fighting the stigma, in a way in which it will demystify the prejudices of professionals and enlighten them about the meaning of this treatment modality to control the disease in the current days.

Keywords

Tuberculosis; Nursing; Directly Observed Treatment.

Introduction

A significant barrier for the control of tuberculosis (TB) is related to the non-adherence of the patient for the treatment of the disease, which results in complications for the health of the individual and negative implications for public health on the world scenario [1]

Annually, about six million new cases of TB are reported worldwide, causing more than a million people to die. Brazil currently occupies the 16th position among the 22 countries with the highest burden of disease, accounting for 80% of cases worldwide [2].

The Directly Observed Treatment (DOT) makes up one of the five pillars of the strategy Directly Observed Treatment-Short Course (DOTS), established in Brazil in 1996 by the Ministry of Health (MOH) for

the improvement of some TB-related indicators. The DOT consists of supervision in taking the medicinal product preferably every day by a trained health professional, aimed at strengthening adherence to treatment, as well as prevention of emergence of resistant strains, reducing dropout rates and increasing the probability of cure [3].

In the state of Paraíba, the DOTS was implemented since 1999 [4]. However, the transfer of the DOT policy for the services of Primary Health Care Attention (PHCA) in João Pessoa, proceeded during 2007. Previously, therapeutic modality was referred and centralized in the Hospital Complex of Infectious Diseases Clementino Fraga (CHCF), State Reference Unit. This transfer process constitutes of a significant advance and was in line with the

decentralization and municipalization policy for the organization of services in the APS [5].

With regard to TB, it is observed that Joao Pessoa has not shown in the last five years (2010-2014) a satisfactory epidemiological situation, once rates of cure are verified from 67.3% to 69.4%, abandonment cases from 19% to 14.2% and coverage of DOT from 22.6% to 26.6% [6]. These rates contradict the recommendations of the World Health Organization (WHO) which is to achieve a cure rate higher than the 85% of cases detected, reduce dropout rates to less than 5% of cases and ensure that all TB cases are treated in the modality of DOT [8].

Developed research [8-12] on the DOTS and DOT strategy express that non-adherence to TB treatment, is linked to use of alcohol and other drugs; to illiteracy; to lack of medications; to low social conditions; to the extent of treatment; to lack of social support; to non treatment supervision; to the weakness in the bond between patient and professional; lack of teamwork in health services and the stigma that keeps the patient from looking for the nearest health service because of the fear of discrimination.

The DOT as a care technology is more than just monitoring the intake of medicines. For it to be effective, it's necessary to build rapport between the patient and the health professional, as well as between the patient and the health service [3]. It is conceivable to think that the management mode of DOT can strengthen or weaken the performance of health services in the control of TB.

The Ministry of Health (MH) [7] calls on the nursing protocol for DOT in the PHCA, that nurses supervise or monitor the intake of drugs by the TB patients in DOT. This supervision will preferably occur every day, or from Monday to Friday in the attack phase, or at least three times per week during the maintenance phase of treatment. This way, nurses will receive special importance in the execution of TB control actions, such as promoting the adherence to this treatment modality.

Considering this problematic related to TB therapy and that the nurse, as one of the professionals committed to the control of the disease, who establishes more relationship with the patient [13], can in his speech, point out evidence related to non-adherence of the patient to treatment of TB in the PHCA. Such evidence is far too necessary and evaluative to map out innovative strategies for the operation of the DOT, in order to make TB control effective.

From the above, the question is: which speeches are mobilized by nurses about the difficulties in adherence to Directly Observed Treatment of tuberculosis in the city of João Pessoa, state of Paraíba (PB)? In a consistent manner, this study adds further discussions to the elaborate knowledge on the treatment of TB and will help to fundament nursing care practices across the network of attention that provides assistance to tuberculosis patients in DOT mode in Primary Health Care Attention.

Therefore, this study aimed to analyze the speeches of nurses working in the Family Health Strategy, about the difficulties in adherence to Directly Observed Treatment of tuberculosis in the city of João Pessoa, state of Paraíba (PB).

Method

This is a descriptive, qualitative and discursive study. In the context of qualitative methodologies applied to health researches, its used concepts borrowed from human sciences, where the phenomenon itself its not studied, but search to understand their individual or collective meaning to people's lives. The aim is, in fact, the significance that this phenomenon gains for those who are experiencing it [14].

In accordance with the qualitative method, the researcher seeks to understand the how people construct meanings and describe what these are. It is intended to deeply understand their experiences and representations about life experiences [14].

João Pessoa was elected as the setting of this study, capital of Paraíba State, Brazil, considered by the Ministry of Health as a priority in TB control actions. In João Pessoa, the network of primary health care attention is distributed in a regionalized way featuring five sanitary health districts that administer 192 health teams, distributed in 110 health units of the family, making up 85.5% of population coverage. Each district unit has its own administration, management, professional staff, including Matrix Supporters (MS), which make up the Core of Support for Family Health (CSFH) and Technical Supporters that make up the Work Groups (WG) among them, are the WG of TB and leprosy.

Study participants were thirteen nurses, considered enunciators (subjects) selected for work in the Family Health Strategy with activities related to the registration of DOT in the notification form of aggravations in the Information System of Aggravation Notification (Isan), as well as monitoring of the patient in DOT mode in their work unit.

The duties of nurses in tuberculosis control actions in Primary Care include: Identification of respiratory symptoms during home visits in the health unit or by the reports of the Community Health Agents (CHA); bacilloscopy request for diagnosis; notifying the case of tuberculosis; call the contacts for research; supervise the treatment, follow the supervision form of treatment when performed by CHS; advise on the use of medication and answer questions from patients demystifying taboos and stigmas; carry out educational activities by the staff who attends the facility and at home; refer the patient to a unit of reference when needed; request monthly control smear; in addition to planning, along with the staff and municipal coordination, TB control strategies in community [15].

Data collection was conducted from August to October 2012, and was done by the interview technique, with the contribution of a semi driven script. In this script the enunciators were invited to discourse on the monitoring done by the team to

the TB patient at the clinic of the family; accession difficulties of TB patient to DOT mode; the difficulties of staff to meet the needs of the patient of TB in DOT.

The interviews were conducted individually after the due clarification of the ethical aspects to the subjects by reading and collecting the signature of the Term of Consent. They were recorded by the recorder and in a reserved place chosen by enunciators identified throughout the text by the letter N (Nurse), followed by Arabic numerals representative of the order of interviews (N1 to N13).

The empirical material was analyzed by the analytical theoretical device of Discourse Analysis (DA) of pecheutiana French affiliation introduced in the 1960s with the work *Analyse automatique du discours* [16]. The DA is constituted on three areas of knowledge: linguistics, history Materialism and Psychoanalysis. The language is embodied, among other theoretical basis, by no transparency or opacity of language and by the significant materiality concept. The Historical Materialism assumes the existence of a reality made by human that is not transparent. Psychoanalysis incorporates the Lacanian understanding that the unconscious is structured like language and there is a shift of man's notion to the subject when taking into account that the subject discursive works by the unconscious and ideology [16-17].

As asserts Orlandi [17:49] the discursive subject is crossed by language and history, in the imaginary mode, the subject only has access to part of what it says. It is physically divided from its constitution: it is subject from and is subject to. It is subject to the language and history, to produce sense it is affected by both of them.

In DA, the grasping of the processes of production of senses is proposed, in the relationship between language, ideology and the subject, understanding how language produces senses from and to the subject, since there is no speech without the subject and there is no subject without ideology [17].

The discursive analysis plan set itself up in a passage from the empirical material, which is characterized here as the transcribed interviews, to the discursive object, through the following steps [17]: 1) the linguistic surface to text (speech); 2) the discursive object to the discursive formation; and 3) the discursive process for ideological formation.

In the first stage, the conditions production of discourse were observed. It includes subjects (enunciators) and the situation. The situation, can be considered in their broadest sense and in the strict sense. In a broad sense, the situation includes the socio-historical context, broader ideological. In the strict sense it understands the circumstances of enunciation, in other words, the immediate context [17].

In the following stage, the DF constitutes itself in the relationship with the interdiscourse and intradiscourse. The interdiscourse refers to the speakable, a "set of formulations made and already forgotten that determine what we say" The intradiscourse refers to materiality (speech), the wording of the text, the cord or linearization speech [17:33]. At this level of analysis, it must be considered that the discursive subject is inscribed in different DF, once occupying different positions and therefore there is no linearity [18].

The discursive formations are manifestations of ideological formations in the speech in a specific enunciation situation. Ideological training consists of a complex set of attitudes and representations that are neither individual nor universal but relate to class positions in conflict with each other [19]. Meanings "circulating in the ideological formations are made and remade on the basis of our history and of the mind that we practice in our history" [18:12].

Considering that the meanings of the language escape, the concept of discursive memory is presented, observing the crossing of language through the historicity of the language itself, as well as the history of the discursive subject. The discursive memory refers to "discursive knowledge that makes possible all say and returns in the form of the pre-built, the already-said that is in the speakable base,

holding each word taken" [17:31]. Thus, we sought to identify silences, slips, contradictions, repetitions and hesitations in the discursive field of the nurse enunciators.

In the third stage, the relationship of discursive formations with the effects of ideology was observed. The ideological formations leave linguistic-discursive marks, which the discourse analyst seeks to interpret. By means of textual marks, understood as entries in the discourse through language, observations were made on texts that were left out, which were the properties of the discourse, to which discursive formation they belong and at last which ideological formation supports it [17,18].

Thus, gestures of interpretation were made on enunciators about difficulties related to adherence to directly observed treatment of tuberculosis in the city of João Pessoa. Every enunciator is linguistically describable as a series of possible drift points, providing the interpretation. It is always likely to be/become another. This place of the other statement is the place of interpretation, the unconscious manifestation and ideology in the sense production and constitution of subjects [17:59].

Based on these considerations the enunciators in the discourse of nurses conformed a Discourse Block: Difficulties related to adherence to directly observed treatment of tuberculosis in the city of João Pessoa, presented in **Table 1**.

The study was approved by the Committee of Ethics and Research of the Center of Health Sciences of the Federal University of Paraíba (UFPB), under the number 069/2011 Protocol, in consideration of ethical and legal guidelines relating to research procedures involving human subjects, contained in the National Health Council Resolution 466/12.

Results

The textual fragments used in the results of this study were gathered and are arranged and analysed as it follows in **Table 1**.

Table 1. Discursive Block: difficulties related to adherence to directly observed treatment of tuberculosis in the city of João Pessoa, Paraíba, Brazil, 2015.

Textual Fragments
<i>Because we see the impact of knowing that you have tuberculosis, despite being such an old disease, but it is still a disease that practically is the same thing of the past when related to the stigma.</i> N10
<i>It is difficult to realize the DOT! They (patients) sometimes do not accept because of the same prejudice.</i> N8
<i>I say that the DOT ends up exposing that person even more.</i> N12
<i>Sometimes it is also the hosting of professionals. We know that there are professionals who are still afraid.</i> N1
<i>It is because people have not yet made a commitment to be treated properly.</i> N12
<i>His commitment with his (TB patient) therapy is what makes it difficult for him to understand the importance of getting better.</i> N13
<i>The difficulty I have found so far in these seven years was only one, it was the resistance. And we made the medication, the health agents went there... and when we went to check on them, the medication was moldy because they didn't take it.</i> N5
<i>The irresponsibility of the health agent made it difficult sometimes.</i> N4
<i>Even the community health agent doesn't know they are doing the treatment. From one thing or another is that we (the team) find out about it.</i> N10
<i>Some patients complain. Now the amount of medication decreased and improved, but the duration of treatment is what they really complain about.</i> N8
<i>Difficult is the education, his school level, only the school level. This is the difficulty, because they have no instruction, they do not understand. Then it gets complicated!</i> N6
<i>They (the patients) do not like the DOT system so much.</i> N2

Discussions

The discursive analysis made from the textual marks present in the speeches of enunciators indicates that the difficulties in joining the directly observed treatment of tuberculosis in the city of João Pessoa, bind to patients, health professionals and the therapeutic modality. In relation to the patient, the analysis points to discursive formations linked to stigma, commitment to treatment and low education levels. To healthcare professionals, it was also the stigma - associated with what had been said about the fear of contracting the disease - and the transfer of responsibility in caring to other professionals. As for therapy, what had been said falls upon the duration of treatment and pa-

tient exposure due to the DOT mode, linking the vulnerability of the patient to the prejudice associated with the disease and its carrier.

Regarding the interpretations of stigma, the following text fragments stand out: [...] Because we see the impact of knowing you have TB, despite it being such an old disease, but still, a disease that is practically the same thing of the past concerning the stigma. [...] (N10); [...] It is difficult [to perform DOT]! They [patients] sometimes do not accept it from the prejudice itself [...] (N8); [...] and I say that the DOT ends up exposing that person even more [...] (N12); [...] Sometimes it is also the hosting of professionals, we know there are professionals who are still afraid [...] (N1).

These fragments show how this phenomenon marks the position of nurses. This element appears as one of the main barriers to treatment adherence and is surprising from the fact that the stigma appears on the health professional when it is common in the studies to appear linked to the patient [20-21]. This is an aspect that is added to studies on prejudice towards TB, since observance of the patients shame to assume having TB and the population for discriminating and fearing him.

The textual marks: [...] we know there are professionals who are still afraid [...] (N1) indicates that there is fear of spread of the disease by professionals and this interferes with the non-adherence to treatment. In the interdiscourse perspective, that is, in memory of saying, it is clear that even if the professional knows the way the disease is transmitted and that with treatment the patient ceases to contaminate, the fear of contamination persists. It is observed that this fear is affiliated to the historical and social memory of the disease, marked by stigma, segregation and exclusion. In the understanding of the authors of this study, there are flaws in training of professionals in relation to coping with management of the treatment, according to knowledge already accumulated about TB.

This representation in DA attributes to discursive memory, or memory senses, where the crossing of language from social history of the disease takes place. The "being afraid" is played by effects of discursive memory.

Considering the thought of Erving Goffman [22], while the patient is attended by the health professional, attribute that make him different from others may rise, thus including him in a "less desirable species - in an extreme case, a completely evil person, dangerous or weak. (...) This way, we no longer consider him a common and complete creature, reducing him to a damaged and diminished person. This characteristic is a stigma..." [22:6].

It is appropriate to state that such professional conduct, characterizes stigma and, when examined

in the light of Goffman's thoughts [22], counter to current precepts that qualify care as integral and humanized, as well as the prospect of inherent hosting to attention paid to professionals in the Primary Health Care Attention services.

As it is known, TB is a disease shrouded in taboos and beliefs of symbolic nature and surrounded by stigma and prejudice [21] From the perspective of the unsaid, the signs lead to the interpretation that the patient chooses, out of fear, not to expose himself and ends up not looking for a health service and carrying out the treatment properly. On the other hand, the professional avoids this because he lacks knowledge, and compromises the performance of the treatment.

According to the speech of nurses, the position of the patient with regard to treatment adherence is crossed by the stigma, atavically millennially to the disease. The TB patient therefore is interpreted by the subject as a being cleaved by care when not revealing himself as TB patient, which contributes to resist, not cooperate and refuse the treatment. So the non-adherence to treatment can be interpreted as a way for the patient to deny who has the disease and thus prevent exclusion and prejudice that he would suffer.

The socially built stereotype that represents the TB patient as dangerous and a source of contamination, reinforces the attitude of "fear" of nurses, and the essence of care being the proximity to each other, feelings of insecurity and fear of the patient, can weaken the relationship between the nurse and patient, resulting in "non-adherence to treatment by the patient, since the professional also did not adhere to it" [23:177].

In the perspective of the DA device, it is revealed that TB as a symbolic object, for nurses who participated in the study, produces senses and meanings related to memory and historicity of the disease. In this sense, "where the interpretation is, is the relation of language to history to mean," and the words mean from history and language, [17:78]

revealing that the professionals bring their speech words loaded with senses and were marked by the meaning of stigma apprehended by them in their discursive memories.

However it is important to emphasize that there is a risk of illness of catching tuberculosis by nurses, especially those who perform the directly observed treatment, detection of patients, among other actions, since they are the professionals who come into direct contact with the people infected, and this risk increases if the service does not have personal and collective protective conditions, with installed weaknesses in the political or organizational realm [24].

There are myths involving TB. And, according to the respected author Susan Sontag [25], the myth about the disease only cleared up when the appropriate treatment was announced from the discovery of streptomycin and the introduction of isoniazid, respectively in 1944 and 1952. However, the discourse of nurses reveals that the mythology surrounding TB remains affecting patients and health professionals, strengthening the stigma and contributing consequently to the perspective of discriminations and prejudices.

In the Opacity of this discourse, you can see the responsibility given to the patient regarding the therapeutic process. From an ideological point of view, the spoken is not affiliated with a health care practice which involves professional and user. There is a sense of affiliation that evokes the one-sidedness in the perspective of blaming the patient for their lack of commitment regarding the treatment, marked evidence in the statements of nurses [...] have not assumed a commitment in treating themselves adequately [...] (N12); [...] His commitment to the therapy is making it difficult for him to understand importance of getting better [...] (N13).

It is seen in these speeches the erasure of senses, where nurses transfer responsibility for the therapeutic process to TB patients. Senses and meanings forgotten by the subject are observed, making for-

getting an enunciative aspect of the speech [26], which is of semi-conscious character, where the subject favors some forms and "erase" other when selecting certain wordings over others. Thus, the meaning of "commitment" told by nurses, as dependent only of the patient, could be related to the involvement of professional team members along with the patient and the family during the therapeutic percussion.

Another statement shows the patient's resistance in relation to the administration of the medicine unsupervised at home [...] The difficulty I have found so far in these seven years was only one, it was the resistance. And we made the medication, the health worker went there ... and when we went to see the medication, it was moldy because they didn't take it [...] (N5).

It is known that adherence to treatment is related to the patient's knowledge about the disease, of him having responsibility for life and personal care, being aware and having the will to heal. However, in addition, the success of adherence is linked to family support and the link between the patient and the health team [27].

In the nurse's speech (N6): [...] Difficulty is education, his educational level, only the educational level, that is the difficulty, because they have no instruction, they do not understand, then it gets complicated [...] the education of TB patient influences adherence to treatment of the disease. In DA, you can indicate a constitutive silence, where one word deletes other words, and that to say it becomes necessary not to say [17]. In this sense, the erased words could be "there is instruction, understand" to mean that if the patient had instruction, he would understand the importance of adhering to treatment.

The lack of knowledge, according to what was said by nurses, lack of instruction, would lead the patient to not appreciate treatment adherence. There is a relationship between non-adherence to TB treatment and low education, this way, every level

of education achieved increases by 11% the possibility of not abandoning TB treatment [28].

Another web of senses and meanings woven by the speeches of nurses, concerns the difficulties for joining the DOT related to health professionals. In this, the effects of senses attributed to professionals are related, as well as the fear of contagion of the disease, and the transfer of responsibility in patient care to the Community Health Agent (CHA).

While observing discursively the statements of the nurses [...] The irresponsibility of the health agent makes it difficult sometimes (N4) [...] Even the community health agent doesn't know they are doing the treatment. From one thing or another is that we (the team) find out about it. (N10), you can indicate on the wire of these speeches, the transfer of responsibility of DOT to another team professional, in this case, to the CHA, pointed out in failure to adherence, removing from him which is also his competence and responsibility, which is care for patients with TB in DOT.

In the heterogeneity of DA, the subject has a "discursive illusion of being the source of meaning and also of having dominion of what he says, of being the absolute master of all that he states" [29:140]; with this, it is inferred that nurses are positioned affirming the DOT as of the CHA's responsibility when the speech should include the health team and the direct supervision of nurses for the DOT to be successful.

In this context it is important to emphasize the nurse's role in the implementation of TB control actions instituted by the Ministry of Health, through a specific protocol for nursing activities in the service of AB "Directly Observed Treatment (DOT) of tuberculosis in Primary health Care - nursing protocol ", which is " dedicated to the systematization of the work of those professionals who have a fundamental role in ensuring the supervision of all treatment and avoid complications that favor the abandonment ", ensuring a cure for an effective treatment [24:11].

The protocol includes all the control measures for TB, prioritizing organizational aspects of health services for the realization of ODD and organization of nursing process for DOT in health services. Among the activities of the nurse, described in the protocol, there is the nursing consultation for a TB patient, which is divided into five stages, similar to nursing care process: data collection through interview and physical examination; construction of nursing diagnoses for patients of TB, such as unbalanced nutrition, poor knowledge of the treatment, among others [7].

The third stage of nursing consultation is the development of the care plan, with actions and nursing prescriptions to be instituted to TB patient based, for example, strategies for promoting adherence to the treatment regimen, actions to monitor and treat complications that can arise from the disease, among others. The last steps consist of the implementation and evaluation of the proposed actions [7].

However, it is observed in practice that nurses, even when assuming the management of TB treatment actions, are still responsible for actions relating to other areas of APS, resulting in the overlapping of duties for these professionals [26]. Every demand of activities may compromise its best performance in the management of actions TB control, since the care of patients with TB in DOT requires time for daily monitoring, and home visits.

Another web of senses related to the difficulties of adherence refers to the duration of the TB treatment, a fact considered demotivating in the therapeutic process. The nurse (N8) says: [...] there are patients who complain. Now the amount of medication decreased and improved, but the duration of treatment is what they really complain about. Studies on adherence to TB treatment show that the long-time therapeutic process associated with the amount of pills and the illusion of healing by patients after the reduction of symptoms at the

start of treatment, may cause the abandonment of therapy [11].

The supervision is important to identify in advance, situations that can lead to the abandonment of treatment, as it allows the identification of the problem in the beginning, allowing immediate corrective action. [10].

Also regarding the difficulties of adherence to treatment regimen of TB, the unsaid present in the speeches of nurses: they do not like the DOT system so much [...] (E2) and [...] the DOT ends up exposing the patient even more [...] (N12) reveal a production of senses which shows the non-adherence to DOT, indicating that these professionals are unaware of the objectives of this treatment modality in the interdiscourse perspective. The speech of N12 evokes stigma and marks the position of the subject challenged by elements of the discursive memory related to TB.

It is important to note that in his speech (N12) is assertive when announcing that the DOT modality reinforces the prejudice that treatment supervised by staff makes the patient vulnerable to the stigma of TB. In this sense, justifications are found so that the patient does not adhere to this form of treatment.

The DOT should be seen by health professionals as a moment that makes health facilities a place of hosting for the patient. It should permit the creation of bonds, where the patient would feel welcomed and would find a space for solution of doubts and share their needs during the therapeutic process [31].

It is observed that the meanings and senses attributed to the difficulties pointed out by nurses suggest the need for greater understanding of this professional on the meaning of DOT today which seeks to control TB. It is worth noting that the approach, based on the feeling of existing alteration between professional and the patient may respond to the feelings linked to the stigma and prejudice mentioned by subjects in relation to TB patients, as

it would allow a space for the exchange of knowledge, a relationship of trust, which would promote the adherence to the therapeutic process.

Conclusion

When related to other articles developed on the subject of adherence to tuberculosis treatment, the findings in this study corroborate to what has already been discussed. However, in the analyzed discourse, considering the subject-form and the discursive memory, something draws plenty of attention: the fact that the prejudice is not only from the sphere of the patient, but can also be attributed to the healthcare professional.

The transfer of responsibility of treatment to the community health worker, as well as the sense attributed to the DOT as a way to expose the patient, shows that another interpretation is necessary, since the work in the family health strategy should be done in team and the DOT should be meant as an innovative strategy to fight the disease in the current history.

It is necessary that the coordination of TB control in all spheres, prioritize not only qualifications that enable professionals to develop DOT but also that they value actions to combat prejudice, since, as evidenced in this work, stigma impacts adherence to treatment, as much as what it regards on the exposure of the patient who is treated by this therapeutic modality, as well as from the fact of fear of the professional in treating the TB patient through the DOT. It is not only enough for the medication to be available. Innovative measures should be designed and implemented in a way that promotes the discourse of health professionals, following the suggestion of Susan Sontag, less affected from prejudice and more inclined to care to release the patient's disease and the stigma that surrounds him.

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