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Original Article

O VÍNCULO COM O PROFISSIONAL DE SAÚDE NO TRATAMENTO DE TUBERCULOSE: PERCEPÇÃO DOS USUÁRIOS

RELATIONSHIPS WITH THE HEALTH PROFESSIONAL IN THE TREATMENT OF TUBERCULOSIS: PATIENTS' PERCEPTION

EL VÍNCULO CON LOS PROFESIONALES DE LA SALUD EN EL TRATAMIENTO DE LA TUBERCULOSIS: PERCEPCIÓN DE LOS USUARIOS

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RESUMO

Objetivo: analisar, na perspectiva dos usuários, o vínculo com profissionais de saúde que atuam no tratamento de tuberculose, em serviços centralizados e descentralizados de saúde. **Método:** estudo, em que foram entrevistados 89 pacientes com uso do Primary Care Assessment Tool, validado no Brasil, e adaptado para a assistência a TB. Os dados que satisfizeram as pressuposições de independência, homocedasticidade e normalidade, foram submetidos à análise de variância; os demais, ao teste de Kruskall-Wallis. **Resultados:** a maioria dos sujeitos (46, que equivalem a 51,7%) possuía entre 30 a 49 anos e ensino fundamental incompleto (53, ou seja, 59,6%). O enfermeiro foi o profissional mais procurado pelos usuários (46, ou seja, 53,1%); quanto ao indicador tempo para o usuário tirar dúvidas e preocupações, obteve-se a avaliação de regular nos serviços centralizados (média: 3,84, desvio padrão: 1,61) e descentralizados (média: 3,80, desvio padrão: 1,73). **Conclusão:** há necessidade de ampliação do vínculo entre profissionais e pacientes.
Descritores: Tuberculose; Pesquisa sobre serviços de saúde; Relações profissional-paciente; Enfermagem.

ABSTRACT

Objective: to analyze the relationship with health professionals working in the treatment of tuberculosis in centralized and decentralized health services, from the patients' perspective. **Method:** evaluative study, in which we interviewed 89 patients using the Primary Care Assessment Tool, validated in Brazil and adapted for assistance in TB. The data satisfied our assumptions of independence, homoscedasticity and normality and were subjected to variance analysis; the others, to the Kruskal-Wallis test. **Results:** most participants (46, that is 51.7%) were between 30 to 49 years old and 53 had incomplete primary education (59.6%). The nurse was the professional most required by users (46, that is, 53.1%); As for the indicator time for the user to ask questions and concerns, it was evaluated as regular in the centralized (mean 3.84, SD: 1.61) and decentralized (mean 3.80, SD: 1.73) services. **Conclusion:** it is necessary to improve the relationship between professionals and patients.
Descriptors: Tuberculosis; Health services research; Professional-patient relationship; Nursing.

RESUMEN

Objetivo: analizar, desde la perspectiva de los usuarios, el vínculo con los profesionales de la salud que trabajan en el tratamiento de la tuberculosis en servicios centralizados y descentralizados de salud. **Método:** estudio evaluativo, que entrevistó a 89 pacientes utilizando *Primary Care Assessment Tool*, validado y adaptado para la asistencia en la tuberculosis. Los datos que satisficieron las hipótesis de independencia, homocedasticidad y normalidad se sometieron a análisis de varianza; los otros a la prueba de Kruskal-Wallis. **Resultados:** la mayoría de los participantes (46, equivalentes al 51,7%) tenía entre 30 y 49 años y 53 con educación primaria incompleta (59,6%). El enfermero es el profesional más buscado por los usuarios (46 o sea 53,1%); En cuanto al indicador tiempo para que el usuario se saque dudas y preocupaciones, se obtuvo la evaluación de regular en los servicios centralizados (media de 3,84, desvío estándar: 1.61) y descentralizados (media de 3,80, desvío estándar: 1.73). **Conclusión:** hay necesidad de ampliar el vínculo entre los profesionales y los pacientes.
Descriptores: Tuberculosis; Investigación en servicios de salud; Relaciones profesional-paciente; Enfermería.

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INTRODUCTION

Tuberculosis (TB) is a disease that, although known for centuries, still represents a serious public health problem, especially for developing countries[1]. In Brazil, in the period from 2005 to 2014, there were, on average, per year, 70,000 new cases and 4,400 deaths by TB and between 2012 and 2015, 840 drug resistant new cases per year[1].

Given this scenario, the National Tuberculosis Control Program (NTCP) proposed systematized and intensified measures to control TB with the purpose to achieve the international targets set by the Stop-TB strategy, whose objectives run counter to the Global commitment, called the Millennium Development Goals (MDGs), agreed in 2002 by Brazil and 192 UN member countries. This strategy established social, political, economic, cultural and environmental targets to combat HIV/Aids, malaria, TB, among other diseases[2].

About TB, the targets of the MDGs were to reduce by 50% the prevalence and mortality of the disease until 2015, compared to 1990. In addition, the intention was to detect 70% of bacilliferous patients and cure at least 85% of the cases treated[2]. After 2015, the Brazilian Ministry of Health committed to reducing 95% of deaths and 90%, of the disease incidence coefficient until 2035[3].

The actions to achieve the commitments established between the components of the Stop TB Strategy are to expand, improve and strengthen the Directly Observed Treatment Strategy (DOTS), based on five pillars, considered essential for the control of the disease: political commitment, case detection by smear, standardized treatment regimens, Directly Observed Treatment (DOT), regular and uninterrupted supply of standardized medicines and a system of cases registration and reporting[4]. Its implementation will be viable with the support of existing human resources in basic services, especially in the Family Health Strategy (FHS) and Community Health Agents Program (CHAP)[5].

In addition, a fundamental strategy for the treatment of TB is to strengthen the patient-healthcare professional relationship. This bond assumes the existence of a regular source of attention and its use over time and requires the establishment of strong interpersonal ties that reflect mutual cooperation among the people of the community and health care professionals[6].

The relationship with health service users involves affection and respect, which favors autonomy, citizenship and participation during the service provision. From it, the negotiation occurs to identify the needs and encourage the user to conquest autonomy with regard to their health[6], which also expands the health actions effectiveness. The bond assumes the existence of autonomous subjects, both professional and patients. Supported patients can participate actively to overcome their problems, establish decisions and take on their lives[7]. The bond, therefore, is one of the main structural elements in TB care and control, since it pervades accountability, completeness, humanization, among others[8].

The establishment of the patient-healthcare professional bond makes the patient feeling welcomed, finding space to ask questions and express themselves about the therapeutic process. It also involves assistance and clarification of doubts by the professionals, who must understand and give clear answers to the user, when they go to the health service. Furthermore, they should investigate about other health problems, explain the reason they are using the service and about the medicines used for treatment[6].

However, despite some studies show a good relationship between health professionals and patients, some aspects still need to be improved to cover all the individuals who carry out the TB treatment, such as listening to these people problems and spread guidelines on the disease treatment[9-10].

There is no consensus in the literature about whether the decentralization of TB control services promotes the professional-patient bond. A study that evaluated the bond under the perception of the FHS professionals, found that most respondents carried out actions for strengthening this relationship, such as offering information about TB transmission forms, medication schedule and possible adverse reactions, the need to examine contacts and the importance of treatment adherence[11]. Another study, however, demonstrated that there was no difference on the bond establishment between professionals in TB centralized or decentralized services. However, in both types of services they found good performance in the following aspects: talking to the user about other problems beyond TB, providing enough time to talk to and getting answers to their questions and information about the medicine[11-12].

In this sense, home visits are pointed as positive to establish a professional-patient bond, although the fact that TB care services are decentralized, does not necessarily imply the use of this strategy by the health teams[12-13]. On the other hand, the DOT, in centralized services, carried out by

their own staff or the by staff of decentralized health units, constitutes a crucial factor for a satisfactory performance of the professional-patient bond[14-15].

In this context, it is imperative to study the bond in the health services of TB because it exerts a key role in treatment adherence, since it allows a rapprochement between the health professional and the user and gives a main role to the person with TB in this phase. This is because the greater the bond, the more guidance and time for the user to ask questions to professionals and greater access and hosting services. In addition, there is a need to evaluate health services of the health care network that are being re organized, as TB control services, in which they are being incorporated into primary health care. Thus, this study aimed to examine, from the perspective of the users, the relationship with the health professionals involved in the treatment of tuberculosis in centralized and decentralized services in the Northwest of Paraná.

METHOD

It is a cross-sectional study, quantitative in nature, carried out in the framework of the 15th Regional of Health (RH) in Paraná, which is composed of 30 cities with a total population of 712,626 inhabitants and, the headquarters in the city of Maringá-PR[16]. It is worth mentioning that the treatment of TB was decentralized from the 15th RH and started to be performed in the patient's home city since 2008. However, as most of the cities are small, a reference clinic still exists for cases of difficult diagnosis and multidrug-resistant infection, maintained by the Health Intermunicipal Public Consortium in Setentrião Paranaense (CISAMUSEP), based in Maringá.

Of the 30 counties that make up the 15th RH, seven still had centralized reference care ambulatory to the treatment of TB, six of them with a population between 20,000 to 36,000 inhabitants and one with more than 80,000 inhabitants. The other 23 cities had decentralized service in traditional Health Basic Units (HBU) and Family Health Units (FHU). Six of them has population less than 5,000 inhabitants and between 71.5% to 100% (average of 86.6%) is covered by FHS; five, has population between 5,000 to 10,000 inhabitants and between 59.1% to 100% (average of 71.8%) is covered by FHS; two others, with just over 10,000 inhabitants; one do not have FHS team registered and the other has only 32.7% of the population covered by the FHS. One city has 32,209 inhabitants and FHS coverage of 64.2% and Maringá has 362,329 inhabitants and FHS coverage of 60.9%[17].

Data related to TB patients were obtained from the reportable Disease Notifications Information System of (SINAN), with the TB coordination of the 15th RH. The inclusion criteria for the study were: 18 years old or more, having held at least one month of treatment, being able to answer the questionnaire on their own, and as an exclusion criterion, being in prison.

From January to March 2012, 151 cases of tuberculosis were reported at the 15th RH, all in individuals with more than 18 years old. 18 of them were excluded from the study: 12, because the patients were in prison; three because they abandon the treatment and three, by mental illness, such as schizophrenia and Alzheimer's disease registered in the SINAN record, in the item of associated diseases.

The number of individuals included in the study was determined considering prevalence of 50%, confidence level of 90%, and error margin of 5%, resulting in a sample of 89 people. This was set at random by stratified sampling technique in proportion, according to the type of service in which they carried out the treatment of TB (centralized or decentralized). The number of cases chosen in each city can be observed in Table 1. The patients to be studied were drawn using a list of random numbers generated by the Statistica 8.0 program (StatSoft).

Table 1. Frequency of the number of cases drawn in each city to set the sample of the study. Paraná, 2012.

Type of tretment	Number of individuals with tuberculosis	Number of individuals drawn
Centralized	38	25
Astorga	3	3
Colorado	3	2
Mandaguaçu	5	3
Mandaguari	3	1
Nova Esperança	5	2
Paiçandu	4	4
Sarandi	15	10
Descentralized	95	64
Ângulo	-	-
Atalaia	-	-
Doutor Camargo	1	-
Floraí	1	-
Floresta	-	-
Flórida	-	-
Iguaraçu	1	1
Itaguajé	1	-
Itambé	5	4
Ivatuba	1	1
Lobato	-	-
Marialva	3	2
Maringá	68	44
Munhoz de Melo	-	-
Nossa Senhora das Graças	-	-
Ourizona	3	2
Paranacity	4	3
Presidente Castelo Branco	2	2
Santa Fé	1	1
Santa Inês	-	-
Santo Inácio	1	1
São Jorge do Ivaí	1	1
Uniflor	2	1
Total	133	89

The data were collected from April to June 2012, in the patients' homes, after initial telephone contact with the people chosen, in which the objectives of the study were explained, and their participation requested in a scheduled day and time convenient to them. After three attempts of telephone contact or in the absence of it, a home visit was done to request the authorization to conduct the interview. Both by phone and in person, we explained the procedures that would be adopted in the study, the type of desired participation, the free choice to participate or not without any prejudice to the patients' care, and the approximate length of the interview.

For the assessment of TB services, we used indicators built based on the instrument Primary Care Assessment Tool (PCAT), validated in Brazil[18] and adapted to evaluate TB care[19]. The instrument is composed of 108 questions, distributed in eight dimensions. In this study we used variables about clinical and socio-demographic aspects and the professional-patient bond dimension (Tables 2 to 4). We previously requested the instrument authors' authorization to use it, and we obtained a formal

authorization, signed by the main author of the study on the instrument adaptation for TB care.

Each question of the instrument, related to the professional-patient bond, allowed the subject to note the frequency in which the specific situation occurs (whether applied to their individual situation). The answers are presented in a Likert-type scale with a value between zero and five. A value of zero represents the answer "don't know" or "not applicable" and the values from one to five record the degree of preference or agreement with the statements: never, hardly ever, sometimes, almost always and always.

The data was registered into the program Excel 2003 and checked possible misconceptions, such as errors in entry or omission of answers. After that, we carried out the descriptive analysis of data. To do this, it was initially given an average score of each question, which corresponds to the sum of the responses of all patients interviewed divided by total respondents. This score was classified as unsatisfactory (values less than three), regular (values greater than 3 and less than four) and satisfactory (values greater than or equal to four)[15].

To compare the relationship with health professionals in centralized and decentralized services, the data were subjected to analysis of variance, using the F-test. The analysis of variance was applied to questions that satisfied the assumptions of independence, homoscedasticity and normality. Homoscedasticity was checked by the Levene test. For the analyses that violated the criteria for the use of Anova, we opted for non-parametric variance analysis, i.e. the Kruskall-Wallis test. The statistical significance level adopted in all tests was 5%. The statistical analyses were performed on Statistica 8.0 program (Statsoft).

The study followed the guidelines established by resolution 196/96, of the National Health Council, in force at the time, and approved by the Standing Committee on ethics in research with Human Beings of the Ministry of health of Paraná State (opinion no 423/2011).

RESULTS AND DISCUSSION

73 (82%) participants of the study had pulmonary TB, 46 (51.7%) were between the third and sixth month of treatment, 45 (50.6%) were male, 50 (56.2%) married, 46 (51.7%) between 30 and 49 years old, 47 (52.8%) had a family income between one and three minimum wages and 53 (59.6%) incomplete elementary education. About the number of residents in the house, 52 (58.4%) lived with one or two people. Before TB, 70 (78.7%) worked and only 37 (41.6%) did it after diagnosis (Table 2).

Table 2-clinical form, socioeconomic profile of patients affected by tuberculosis in the 15th Regional of Health in Paraná. Paraná, Brazil, 2012.

Variables	Patients in treatment in BHU /FHU		Patients in treatment in the reference clinics		Total	
	N	%	N	%	N	%
Clinical form of tuberculosis						
Pulmonary	50	78,1	23	92,0	73	82,0
Extrapulmonary	14	21,9	2	8,0	16	18,0
Time of drug treatment						
> 1 to 3 months	14	21,9	-	-	14	15,7
> 3 to 6 months	31	48,4	15	60,0	46	51,7
> 6 to 9 months	4	6,3	3	12,0	7	7,9
Concluded	15	23,4	7	28,0	22	24,7
Sex						
Male	30	46,9	15	60,0	45	50,6
Female	34	53,1	10	40,0	44	49,4
Age						
18-29 years old	8	12,5	4	16,0	12	13,5
30-49 years old	35	54,7	11	44,0	46	51,7
50-59 years old	14	21,9	9	36,0	23	25,8
60 years old or more	7	10,9	1	4,0	8	9,0
Marital status						
Single	18	28,1	6	24,0	24	27,0
Married	33	51,6	17	68,0	50	56,2
Separated/divorced	9	14,1	1	4,0	10	11,2
Widower	4	6,3	1	4,0	5	5,6
Worked before the TB						

Yes	48	75,0	22	88,0	70	78,7
No	16	25,0	3	12,0	19	21,3
Continued working after tuberculosis						
Yes	26	40,6	11	44,0	37	41,6
No	38	59,4	14	56,0	52	58,4
Family income						
No income	3	4,7	1	4,0	4	4,5
Up to 1 minimum wage	15	23,4	4	16,0	19	21,3
> 1 up to 3 minimum wages	33	51,6	14	56,0	47	52,8
> 3 up to 5 minimum wages	5	7,8	4	16,0	9	10,1
> 5 minimum wages	8	12,5	2	8,0	10	11,2
Schooling						
No schooling	1	1,6	1	4,0	2	2,2
Incomplete Elementary School	40	62,5	17	68,0	53	59,6
Complete Elementary School	4	6,3	-	-	4	4,5
Incomplete High School	7	10,9	3	12,0	10	11,2
Complete High School	7	10,9	3	12,0	10	11,2
Incomplete Higher Education	1	1,6	1	4,0	2	2,2
Complete Higher Education	4	6,3	-	-	4	4,5
Number of people who live in the house						
1 to 3	34	53,1	18	72,0	52	58,4
4 or more	30	46,9	7	28,0	37	41,6

Source: Research data.

The results show, as well as in other studies[20-21], that TB still affects, in most cases, people socially vulnerable, i.e. those with poor socioeconomic conditions, with low education and low income[20-21].

As for age, the young adults are the most affected by the disease, i.e. those in productive age[22]. However, the infection by the disease prevent many from working and the consequent low-income levels, both individual and familiar, per capita, restricts individual and social freedom of the subject, making deficient and exhausting all their environment, generating diseases[21].

The social vulnerability of patients with TB also favors treatment abandon[20]. Bonds between health professionals and the individual in treatment can cause an increase in therapeutic adherence. Therefore, this dimension is crucial in the process of TB treatment.

Among the professionals who provided care in the health services, the users mentioned doctors, nurses, nursing assistants/technicians and Community Health Agents (CHA) (Table 3). These were mentioned only by patients who underwent treatment in the HBU/FHU, since the patients who underwent treatment in clinics did not have contact with CHAs.

Table 3- Users' perception about care during TB treatment and about the professionals they looked for when they had different health problems or needs. 15th Regional of Health in Paraná. Parana, Brazil, 2012.

Indicators		Health care professional who takes care of the patient well			Healthcare professional demanded because of various health problems or needs		
		Always/almost always	Sometimes	Hardly ever/never	Always/almost always	Sometimes	Hardly ever/never
Basic Health Unit /Family Health Unit							
Doctor (n=62)	N (%)*	55 (88,7)	6 (9,7)	1 (1,6)	19 (30,6)	4 (6,5)	39 (62,9)
Nurse (n=63)	N (%)*	54 (85,7)	3 (4,7)	6 (9,5)	37 (58,7)	4 (6,4)	22 (34,9)
Assistant or Nursing technician (n=57)	N (%)*	50 (87,7	3 (5,3)	4 (7,0)	8 (14,0)	-	49 (86,0)
Community Health Agent	N (%)*	33 (91,7)	2 (5,5)	1 (2,8)	6 (16,7)	2 (5,5)	28 (77,8)

(n=36)							
Clinic of Reference							
Doctor (n=25)	N (%)*	19 (76,0)	3 (12,0)	3 (12,0)	5 (20,0)	5 (20,0)	15 (60,0)
Nurse (N=23)	N (%)*	21 (91,3)	-	2 (8,7)	8 (34,8)	4 (17,4)	11 (47,8)
Assistant or Nursing technician (N=22)	N (%)*	22 (100,0)	-	-	11 (50,0)	4 (18,2)	7 (31,8)
Total							
Doctor (N=87)	N (%)*	74 (85,0)	9 (10,3)	4 (5,6)	23 (26,4)	10 (11,5)	54 (62,1)
Nurse (N= 86)	N (%)*	75 (87,2)	3 (3,5)	8 (9,3)	46 (53,5)	8 (9,3)	32 (37,2)
Assistant or Nursing technician (N=79)	N (%)*	72 (91,1)	3 (3,8)	4 (5,1)	19 (24,0)	4 (5,1)	56 (70,9)
Community Health Agent (N=36)	N (%)*	33 (91,7)	2 (5,5)	1(2,8)	6 (16,7)	2 (5,5)	28 (77,8)

Source: research data.
* Absolute and relative frequency, excluding "don't know" or "not responded by not having access to that kind of professional."

Patients assisted in both types of services showed to have greater bonds with the nurses, because about half (53.5%) (table 3) of them reported that they demanded the nurses always or nearly always in both types of services, when they had different problems or needs.

A study conducted in São Paulo-SP on the professional-patient bond also demonstrated that the nurse is the professional reference for patients in TB treatment, in case of difficulties[23]. On the other hand, this fact diverges from evidences in a study in Ribeirão Preto-SP, in which the vast majority of patients in TB treatment preferred the doctor, when they had a problem[14].

The fact that nurses are more demanded by patients may be related to the implantation of a host system in health units, during which non-medical professionals use all their potential to assist and solve the problems of the population that use health services[23].

In addition, it is necessary to consider that the nurse guides and organizes the demands of the population and that the nursing staff are often more accessible and close to the patient, because in most of cases they give the first assistance, besides they have a major work load in the same unit of health. However, nursing professionals still need to be more prepared to deal with the other's subjectivity and to establish a satisfactory interaction with the user of the health system. It is believed that one of the conditions for this situation is a too fragmented and specific training in nursing courses[24]. Another difficult factor is the lack of investment by the health units in the professional qualification of their employees[6].

Table 4 shows that, in both types of services, the indicators evaluated presented similar performance, except the assistance received by the health team, which was considered satisfactory in the HBU/FHU and regular in the reference clinics, with significant statistical difference.

The indicators "Time for the user to ask questions and concerns" and "explanation of the medicines used for the tuberculosis treatment" had regular indexes and the "search for other health problems" was unsatisfactory. The other indicators were satisfactory.

Table 4- average value, standard deviation and variance analysis of indicators related to the professional-patient of tuberculosis bond according to the type of service on the 15th Regional of Health in Paraná. Parana, Brazil, 2012.

Indicators	Individuals who performed the treatment in HBU/FHU (N=64)		Individuals who performed the treatment in reference clinics (N=25)		
	Average	Standard Deviation	Average	Standard Deviation	Value of p
The same professional was searched when the patient goes to the health service	4,33	1,37	4,58	1,01	0,4323
Doubts about the treatment clarified by the same professionals who perform the service	4,28	1,41	4,44	0,91	0,6060
Health professionals understand the users' questions	4,37	1,09	4,66	0,65	0,1522
Clear answers to questions	4,43	1,14	4,50	1,04	0,8098
Time for the user to ask questions or concerns	3,84	1,61	3,80	1,73	0,9705
Search for other health problems	2,71	1,86	2,52	1,75	0,6403
Explanation of medicines used for tuberculosis treatment	3,80	1,66	3,44	1,75	0,3577
Research on all medicines used by the user	4,22	1,31	3,84	1,49	0,2394
Note attributed to the assistance received by the health team	4,28	0,96	3,60	1,55	0,0485*

* Statistically significant. Source: research data.

The results showed that both in the HBU/FHU as in the reference clinics users are assisted, in most cases, by the same professionals, who according to them, understand and answer their doubts clearly, which confirms the results found in other studies[7,23]. The fact that patients are assisted by the same professionals assumes the existence of a closer relationship between them, which allows the patients to recognize these professionals as a reference for their health care[6].

Also, the fact that the patient has a reference when looking for care favors its longitude, resulting in extended care, since the professional has best conditions to assess the social, psychological and family context of the patient and, therefore, minimize the risk of quitting the treatment, performing necessary interventions early, either to prevent or reverse the cases of abandonment[14].

It is worth noting that the stigmatizing character of tuberculosis and unfavorable social conditions of most patients require involvement and commitment of the professionals with this user during treatment, because the impact caused by the disease in people's lives is still very strong and can interfere with various dimensions of the human being: physical, social, psychological, spiritual and economic[25].

In view of the integral care to the individual, it is essential a more sensitive health professional, who listens to others, know what they think, with a position that is not distant and impersonal. Knowing the reality and the context of the user' life is crucial, since the concept of health involves quality of life and that this is determined, inter alia, by the biological, psychological and social well-being. Thus, strengthening bonds between users, family and community with the team can be considered as a therapeutic resource and as one of the most appropriate means to practice a quality health care[25].

However, in this study, indicators such as "give time for the user to ask questions or concerns" and "provide explanations about the medicines used for tuberculosis treatment" were assessed just as regular, which indicates they need to be improved. Likewise, it also points out as weak ,the assessment on the existence of other health problems, considered unsatisfactory in both health services; the research on the use of other drugs, was considered satisfactory in the HBU/FHU, but regular in the reference clinics. These findings differ from those found in studies conducted in the State of São Paulo, in which these indicators have always been evaluated as satisfactory[14,23]. This reaffirms that the professionals need to improve the bond in the care of patients with TB, in the framework of the 15th RS.

In this way, studies show that the DOT is a tool that fosters the professional-patient bond, resulting in a less fragmented and reductionist approach to individuals[14]. It should be noted that the DOT is not only a strategy that guarantees an effective intake of medicines but also allows a rapprochement between the healthcare provider and the person with TB, given the daily coexistence that enables the patient

to share their difficulties, have their questions carefully listened and answered[13]. It also enables the professional awareness of the other's suffering, the recognition of the patients' needs and less bureaucratic intervention in the living space of the individual/family, sharing commitments, and helping in the subjects' emancipation, making them feel co-responsible for the treatment[13,26].

In addition, when there is a close relationship with the patient's life and context, the health professional can have a look beyond the disease and meet other needs of the patient. That's why in front of an urgent need or a new problem, the patient looks for the same professional to assist them and the professional will have better conditions to implement health actions in the service[6].

We emphasize that, in the specific case of tuberculosis, this approach, in addition to other aspects, has clinical importance considering the drugs used in the therapeutic scheme can interact with several other medications such as birth control pills, medicines for HIV and heart diseases, asthma, kidney and liver insufficiency or diabetes[27].

Given this, and taking into account that social aspects like living in the street and make use of illicit drugs hinder the treatment of TB, it is essential the implementation of an individual care plan that considers the complexity and long treatment time. In this context, the use of the DOT enables the health team to give special attention to subjective aspects in the context of the territory where people live, work and develop their health-disease process, and the clinical context, in the case of patients with comorbidities[4].

As to the users' satisfaction with the care provided by health teams, despite elements that interfere substantially in the relationship were pointed out, it was found that most of the patients who were treated in the reference outpatient clinics, evaluated as satisfactory the assistance by the teams in the HBU/FHU. On the other hand, this concept was assessed as regular by users who performed the treatment in the reference clinics. This fact may be reflecting the lowest average on this service, although the difference is small in some fundamental aspects of the dimension *bond*, such as the research on other health problems and use of other medications, or even a deficiency in the explanation about the medicines used for the tuberculosis treatment.

The approach of these aspects reflects the humanization, respect and commitment of the professional towards the user, which makes the patients feel they are well taken care of. In addition, the user satisfaction with the health service promotes the bond with the team. However, the workload of the professionals in this area, associated with the hegemonic and fragmented health model, turns out to prioritize clinical care dimension. A study in Bayeux-PB, emphasized that the responsibility to develop different programs on HBU and the accumulation of management and care functions causes an excess of work, with the consequent lack of time to plan and execute the DOTS that, combined with the lack of humans and materials resources, may difficult the health team's involvement with TB control actions[28].

FINAL CONSIDERATIONS

The results of this study demonstrated that, referring to people with TB care, the users perceived the assistance by health professionals as well, and in times of need, the professionals who most the patient looked for were the nursing staff. In this regard, with this population profile, it is crucial that these professionals are prepared to solve the problems and/or make the necessary referrals, considering their social and clinical particularities.

For this, it is necessary the coordination with other institutions, since the needs that come to nursing professionals may be related both to health and social aspects, which will require full and humanized care.

The indicators related to the fact that the aspect related to whether the same professionals take care and provide clarification to the users was better assessed; however, there is a need to improve communication between professionals and users, since the former do not provide enough time, don't clarify doubts and do not investigate about other health problems satisfactorily.

In this context, it is necessary to extend the bonds between health professionals and users, mainly in the health units, as a strategy to enhance treatment adherence, provide patient well-being and contribute to the improvement of the organization and the health services performance. This, certainly, will benefit the therapeutic process, constituting an element of protection against the disease determinants mechanisms.

The limits of the study relate to TB control services evaluation being carried out in several cities, each of them embedded in a different context and with their own peculiarities. However, grouping the

cities in HBU/FHU and reference clinics is an important feature of these services, in view of the Ministry of health recommendation to decentralize this type of assistance and the need for evaluating the services after this measure.

When data was collected, DOT had not yet been implemented within the 15th RS in Paraná; however, the health teams were trained to implement it in July 2012. TB care service reorganization through DOT is required to have a closer follow up of the patient and, over time, the working process of nursing and multidisciplinary team will be more sensitive to the health and social needs of the patient and the possible treatment abandonment.

More studies on the bond in the health services, in which this strategy was used in the treatment of TB, must be carried out, because it is possible that daily appointments between professionals and users favor the strengthening of their relationship.

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