

Short-course therapy for tuberculosis: a discourse analysis

Terapia de curta duração da tuberculose: uma análise discursiva

Terapia de corta duración de la tuberculosis: un análisis discursivo

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ABSTRACT

Objective: to analyze the meanings produced by nursing professionals in the directly observed treatment (DOT) for tuberculosis (TB) in the city of São Paulo. **Method:** this is a qualitative study, conducted in March and April 2014 through semi-directed interviews with nine nurses. The empirical material produced was analyzed according to the theoretical and methodological support of the Discourse Analysis of French matrix. **Results:** results have emerged as three discursive blocks: conditions for the production of tuberculosis control practices; production conditions facilitating the treatment of tuberculosis; and production conditions hindering the treatment of tuberculosis. **Conclusion:** these professionals' words produce different meanings, which suggest that the practices of nursing professionals allow the patient to search for a cure, which is reinforced by incentives of a social nature, but permeated by the vicissitudes that are circumscribed in the ill person's everyday production conditions.

Descriptors: Tuberculosis; Directly Observed Therapy; Medication Adherence; Nursing Team; Public Health Practice.

RESUMO

Objetivo: analisar os sentidos produzidos pelos profissionais de enfermagem sobre o tratamento diretamente observado (TDO) para tuberculose (TB) em município do estado de São Paulo. **Método:** trata-se de estudo qualitativo, desenvolvido em março e abril de 2014, por meio de entrevista semidirigida, com nove profissionais de enfermagem. O material empírico produzido foi analisado conforme o aporte teórico-metodológico de Análise de Discurso de matriz francesa. **Resultados:** emergiram como resultados três blocos discursivos: Condições de produção das práticas de controle da tuberculose; Condições de produção que facilitam o tratamento da tuberculose; Condições de produção que dificultam o tratamento da tuberculose. **Conclusão:** os dizeres desses profissionais produzem diversos sentidos, os quais sugerem que as práticas dos profissionais de Enfermagem possibilitam ao doente a busca pela cura, reforçada por incentivos de caráter social, não obstante, permeadas por vicissitudes circunscritas nas condições de produção do cotidiano da pessoa adoecida.

Descritores: Tuberculose; Terapia Diretamente Observada; Adesão à medicação; Equipe de Enfermagem; Prática de Saúde Pública.

RESUMEN

Objetivo: analizar los sentidos producidos por profesionales de enfermería acerca del tratamiento por observación directa (TDO) para tuberculosis (TB) en municipio del estado de São Paulo. **Método:** estudio cualitativo desarrollado en marzo y abril de 2014, mediante entrevistas semidirigidas con nueve profesionales de enfermería. El material empírico generado fue analizado conforme el aporte teórico-metodológico del Análisis del Discurso de matriz francesa. **Resultados:** surgieron como resultados tres bloques discursivos: condiciones de producción de las prácticas de control de la tuberculosis; Condiciones de producción que facilitan el tratamiento de la tuberculosis; Condiciones de producción que dificultan el tratamiento de la tuberculosis. **Conclusión:** los dichos de los profesionales determinan diversos sentidos, los cuales sugieren que las prácticas de

profesionales de Enfermería le brindan al enfermo la búsqueda de la cura, reforzada con incentivos de carácter social; aunque permeadas por vicisitudes circunscriptas a las condiciones de producción del cotidiano de la persona enferma.

Descripciones: Tuberculosos; Terapia por Observación Directa; Cumplimiento de la Medicación; Grupo de Enfermería; Práctica de Salud Pública.

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INTRODUCTION

One of factors contributing to the global reduction of tuberculosis (TB) cases and deaths in recent years was the implementation of the Directly Observed Treatment Short-Course (DOTS) strategy, instituted in 1993 by the World Health Organization (WHO)⁽¹⁾. It is important to mention that the improvement in compliance to TB treatment has been one of the keys to controlling the disease⁽²⁾.

The Directly Observed Treatment (DOT) of TB is one of the components of the DOTS strategy that involves a health-care professional adequately trained to observe the TB patient's drug intake⁽²⁻³⁾. Studies show that DOT increases the rate of compliance, reduces the recurrence of the disease, and prevents the development of multidrug-resistant tuberculosis (MDR-TB)^(1-2,4).

In Brazil, DOT has been performed for more than 15 years⁽⁵⁾. A study conducted in Brazil⁽⁶⁾ shows that, from the DOT, it was possible to establish relationships of reception, connection, and accountability for the patient, which are an appropriate time for valuing what the ill person has to say, as well as social communication and empathy, allowing the broadening of therapeutic focus beyond medical diagnosis and treatment.

Over the years, nursing has assumed a prominent role in the implementation of DOT, valuing the historicity linking the work of nurses to prevention and control, and these widely recognized professionals as educators, health agents, and team leaders⁽⁵⁾.

Despite the relevance of the theme, through a literature review conducted in the Latin American and Caribbean Health Sciences (LILACS), PubMed, and the Cumulative Index to Nursing and Allied Health Literature (CINAHL) databases, the lack of national and international studies focused on the practice of nursing professionals in relation to DOT was evidenced. In general, over the past decade, studies have aimed for the analysis of TB control actions (not specifically DOT) and the evaluation of health services⁽⁷⁾.

A study conducted in Brazil on the perception of nurses working in the Family Health Strategy and performing DOT revealed an involvement of this professional category, which developed a differentiated care practice. In addition, another study contributed to this theme, allowing the comprehension of factors that hinder the functioning of the Program for Tuberculosis Control (PCT) in the daily work of the health teams of family health care. Both studies demonstrated a greater focus on structural and organizational deficiencies in the health service, which ultimately exert a great influence on daily work^(6,8).

In this way, it is necessary to conduct studies, the results of which contribute to the understanding of the performance of

nursing professionals with DOT. It is important to investigate, through the speeches of nursing professionals of high school level and undergraduate level, how DOT is accomplished in order to identify the strengths and weaknesses in the monitoring process of the person with TB, to improve the activities, and consequently to improve care.

Therefore, this study aimed to analyze the meanings produced by the speeches of the nursing professionals about their daily work with the Directly Observed Treatment for tuberculosis.

METHOD

Ethical aspects

This study was approved by the Ethics Committee in Research of the Nursing School of Ribeirão Preto of the University of São Paulo. The right of anonymity and privacy of the respondents is assured.

Type of study

This is a qualitative study of an exploratory type using the theoretical and methodological framework of the Discourse Analysis (DA) of the French matrix.

Theoretical and methodological reference

DA is based on historical materialism, psychoanalysis, and linguistics⁽⁹⁾. The historical materialism focuses on the explanation of historical phenomena, including the ideology that manifests itself in the discourse as a meaning effect among the speakers. Psychoanalysis explains the subjectivity and the individual's relationship with the symbolic, and linguistics explains the syntactical mechanisms and enunciation process⁽⁹⁻¹⁰⁾.

In view of the lessons taught by DA, to understand the reference and data analysis, it is essential to mobilize basic concepts, such as: ideology; the individual; production conditions; and discursive formation⁽⁹⁻¹⁰⁾.

Ideology is understood, from the perspective of DA, as the social representation, a worldview that challenges the non-individual in the individual. The individual is meant to be the position taken by the enunciator throughout the discourse as an effect of meaning. Thus, the words to be analyzed in this DA perspective will be taken as those from individuals who occupy discursive places in their relation of language with history, not from individualities⁽⁹⁻¹⁰⁾.

Therefore, DA takes into account the production conditions, understood as the restricted situation at the time of the interview, and the broad one (socio-historical situation), allowing to identify the different meanings in the discursive formations in which they are incorporated⁽¹⁰⁾. Discursive formation

is understood as what determines what can and should be said from a given ideological position, in a given situation⁽¹⁰⁾.

Study scenario

The research was developed in the city of Ribeirão Preto, in four reference ambulatories for the treatment of TB. The choice of these places is justified because they are institutions that, at the time of data collection, had centered care, providing secondary level service with specialized teams, basically composed of nursing assistants and technicians, nurses and doctors. Thus, among the actions taken to control the disease, the diagnosis of cases, notification, follow-up of notifiers, the search for respiratory symptoms, and DOT are highlighted.

Data source

Data were collected from primary sources. Nine nursing professionals participated in the study (six of high school level and three of undergraduate level); they work in TB control, and most of them (six) are female, aged 28-57 years. Regarding the level of education, there was a predominance of complete high school (five) and four professionals had completed higher education. The inclusion criteria were: to work in services providing activities for TB control for more than six months, and to be exercising their function during the data collection period.

Data collection and organization

For data collection, interviews were conducted in a private place, defined by the participants themselves, between the months of March and April 2014. Each interview lasted 10 minutes on average, being conducted by the main investigator and recorded with a digital recorder with the participants' authorization via the Free and Informed Consent Form (ICF). The semidirected script was composed of the following guiding questions: Talk a little about your daily practice with the actions related to DOT for TB; what actions do you highlight that facilitated the practice of DOT? During your work on the TB control program, did you experience any kind of difficulty related to the supply of DOT?

For data organization, we used the following code: S representing the individual, followed by the initial letter of the profession (E = Nurse, TE = Nursing Technician, and AE = Nursing Assistant), arranged in numerical order according to the order of the interviews.

Data analysis

The results were analyzed from the perspective of DA according to the following steps: 1. Passage from the linguistic surface to the discursive object: it is the first treatment constituting the empirical material to be analyzed, being marked by the accuracy in the transcription process, and operationalization of analysis through successive readings and re-readings of the material, producing the discursive formations that dominate the discursive practice in analysis⁽⁹⁾. 2. Passage from the discursive object to the discursive process, which consists of discursive formations and conforms to the ideological formation. At this stage, the identification of signifiers/discursive

sequences, and the constitution of discursive processes responsible for the effects of meaning produced in the empirical material and symbolic take place⁽⁹⁾. 3. Discursive process (ideological formation): this step consists of the interpretations given the discursive formations, the production conditions, and the existing ideology in the individual⁽⁹⁾. The fragments are distributed in three discursive blocks: Conditions for the production of tuberculosis control practices; production conditions that facilitate the treatment of tuberculosis; and production conditions that hinder the treatment of tuberculosis.

RESULTS

Analysis of the discourses of healthcare professionals allowed the emergence of the discursive blocks below which, by means of discursive formations, revealed the practices of the nursing staff regarding DOT, and the difficulties and the facilities found in the course of their actions.

Production conditions of tuberculosis control practices

Discursive sayings in this block bring evidential paradigms of a real and socio-historical context regarding DOT. Thus, it signals that the healthcare professionals' positions as individuals fall into discursive formations of health care and community health, in which the search, notification, supervision, pursue, guiding, conversation, and explanation are understood as closely connected to the everyday practice of TB control. The words below explain the involvement of the nursing staff to attend the person with TB, in an attempt to get the patient through conversations and directions:

Our search with the patient is daily, so today he took it, tomorrow I'm back there, and tomorrow I have to look somewhere else, we will look for it, [...] then I make contact with my peer and I monitor him, until the peer can cover me there. (SAE2)

[...] so we explain everything, we talk, hmm ... we guide if they say something. "Oh I'm sick, I'm vomiting." We bring him, talk to the doctor, talk, you know? [...] We try to do everything for him [...] be able to take it calmly. (SAE3)

The following words indicate an excess of activities carried out by the professional nurse, which causes a distancing of this professional from the care practices, intensifying bureaucratic activities, placing the professional in a position to perform the activities of the administrative area:

As a nurse so I am notified by employees, [...] making active search, with evidence of tuberculosis and we get all the search process, right? We give the guidelines, ask for X-ray, the search for sputum. Then, once the diagnosis is confirmed, notification is made by the doctor and this goes to the surveillance department [...]. (SE1)

I do not stay in the ambulatory all the time; I am a nurse of the clinic as a whole. Sometimes I follow the ambulatory, and when there are students I do; I go with them to do the DOT, as supervisor. (SE2)

Also in this discursive block, the following excerpts enunciate the importance of home visits when implementing DOT to provide care for the person with TB at home. This procedure is seen by professionals as one that is able to extend and integrate care, especially to the patients in their specificities. The practice of follow-up and monitoring of the person affected by TB is also highlighted, taking place through supervision:

[...] We make home visits, follow the patients who are treated at UETDI (Special Unit for Treatment of Infectious Diseases). (SE3)

[...] You have to see the patient taking it, you have to see because it is a long-term treatment and the patient gives up. [...] You have to be concerned about the other tests; it is not only the visit itself and the medication, there is the collection of sputum [...]. You have to talk, ask the patient to come to the doctor. (STE1)

This visit we make at home is better, because there we're able to see the patient's living conditions; it is possible to see the real situation. Sometimes I had patients whose hygiene and food conditions were poor, we could provide [...] treatment. (STE2)

Production conditions that facilitate the treatment of tuberculosis

The individuals' positions when speaking place them in a discursive formation that focuses on basic shopping basket and transportation vouchers as a facility for adherence to TB treatment, as can be seen in the excerpts below:

Does the patient have any benefits? A liter of milk; there are patients who, due to their financial conditions, wait just for this, you know? There are patients who wait until Friday to get milk [laughs]. (SAE1)

For the patient to go to the health unit, undergo exams, they always need these things, so they are offered the transportation ticket too, right? [...]. (SAE2)

We have a good weapon, which is the basic shopping basket, right? So, ahmm ... we kind of link one thing to the other, right? (SAE3)

The relationship between the professional and the patient, the organizational structure, the availability of vehicles, drivers, and medication are also elements perceived by professionals as facilitators for the treatment of TB, as stated in the words below:

[...] What better facilitates practice is the good relationship with the patient, okay? (SAE2)

We have a good structure, we have a driver, only for us, you know? [...] There is no lack of medication ... you know, like that. (SAE3)

The fact that we have the pharmacy, have this ... this direct communication with the pharmacist, who also understands

this importance, ease in the sense that we have these specialized services, an employee who is scheduled daily to go on these visits, right? [...] The facility to collect these tests and have the availability to take them in the afternoon by the driver, directly to the lab; sometimes we take the container to collect material at the patient's home. Then the patient does not have to come to unit, everything to make it easier, right? (SE1)

Production conditions that hinder the treatment of tuberculosis

In this discursive block several discursive formations emerge, including the use of alcohol and drugs, violence and fear engendered by the production conditions in which the person with TB is; the vulnerability and culpability of the person with TB; and the lack of professionals in the services that implement disease control measures.

Alcoholism, drug use, and the social context of the TB patient are presented as elements that hinder treatment, as evidenced in the following excerpts:

We have patients who have alcohol abuse problems, are drug addicted, then each one has a system; then, there is this individuality. [...] Some are resistant [...] we will give medicine and sometimes they don't want to take it because they want to drink, including some who take the medicine and drink, right? (SAE1)

Sometimes when we got there, when the patient saw the van, we could see him picking up the cup of pinga, putting it under the table, we pretended we didn't see that, right? Because if I told him he would say: "No; then after a while I drink," then he would not drink. (SAE3)

Our difficulty is related to [...] very high ... to the use of narcotics, of drugs ... illegal drugs. Besides being a prostitution area, right? (SAE2)

Traffickers say: "we don't want you to come every day, if you come [...] we will shoot." We insist on some, right? [...] Like I told you, we have arrived at the drug den, at the drug den to give a medication, it depends on each region, in the slum of [name of the slum], for example [...] We arrive there, there are always the owners of the area and they usually go with us themselves; they say, "Oh, who's going to treat?" (SAE1)

In the excerpts below it is possible to note that professionals refer to the patients' vulnerability and focus on the difficulties of the treatment process:

Some people are resistant. Some nasty comments? Yes, there is. Both from those working in the area, ah, but I go there. [...] Patient is easy-living, I will give the medicine and sometimes the patient is not there, doesn't wait for you, right? (SAE1)

You see... difficulty ... I think the major difficulty is related to patients, right? (SE1)

It is a question of culture, of a class, of a social class that only seeks the doctor when [they] feel something; so, all that is preventive for them is irrelevant, right? (SAE2)

[...] *Keep the patient fasting. [...] They are very vulnerable patients with drugs and other such things and live running from this question, so ... It's a bit difficult, sometimes they run away from home, have to find them elsewhere.* (STE1)

The lack of professionals in the services that provide disease control actions is set out through the excerpt below that, in the imagination of the healthcare professional, to improve the quality of care to the patient of TB, there should be one additional professional to assist in the DOT of that unit where he/she works:

I think what is most lacking is professional [...] ... there is a little number. At least here [...] just we two is not enough. There should be another one. (SAE3)

DISCUSSION

In the first discursive block "production conditions of TB control practices," signifiers "search", "is daily", "will look for," and "will monitor," in the context of production where they have been set out, indicate that professional individuals meet the requirements of the rules of the National Program for Tuberculosis Control (PNCT). It is emphasized that these sayings are part of interdiscourse, as has already been said, because WHO has already made these recommendations for TB control practices. A study conducted in the state of Paraíba showed the involvement of healthcare professionals in the treatment of TB performing the same practice as outlined by the individuals in this study⁽¹¹⁾.

In the discursive sequence "tomorrow you have to look for them somewhere else," on the one hand it produces the meaning that the healthcare professional *is subjected* to the standards of the Ministry of Health (MS). On the other hand, it states the instability of a person affected by the disease in terms of staying in the same place of access to carry out DOT, not *being subjected* to the operating mode of the supervision set by the healthcare service because, in a way, the patient's position can be understood as a complaint about an authoritarian practice.

The actions of "talking" and "guiding" evoke a discursive memory of key elements that constitute a humanized care⁽¹¹⁾. Here, a contradictory discourse is noted because, despite presenting some rigidity to the rules presented by the PNCT, the act of talking emerges as a key aspect in the care, either of technical or ludic content, implying communication, interaction, gesturing, and cogitation. Hence its importance for nursing, as the art and science of care⁽¹²⁾.

Continuing with the analysis, the discursive sequences "we bring him, talk to doctor", "we try to do everything for him" instigate the thought that there is a relationship of power between the individuals who are nursing professionals and the patient. Thus, the power comes from the relationship between people and refers to everyday relationships that may involve, although not necessarily, the influence of one towards the other⁽¹³⁾. In this context, however, the act of "doing everything" in the professional imagery suggests its sensitivity to meet the needs of the individual affected by the disease, while limiting the autonomy of the patient in making decisions.

In SE1 and SE2's words, the discursive sequences "I'm notified", "we start the whole process," "makes the guidelines", "orders an X-ray", "search for sputum," "notification is made by the physician," and "this is going to the surveillance department" suggest that the nurses have been busier in the administrative and managerial area than in care itself, causing a distancing of this professional from care. This situation leads to the thought that, somehow, it overloads the nurse and influences TB patients' noncompliance. The aspect of subjectivity of the ill person is something to be considered during the course of DOT so as to value not just the technical and regulatory aspects, because good quality interaction and communication are identified as relevant for the TB patient to be compliant to the therapeutic regimen^(5,14).

It is clear that, in the production conditions to which a nurse is submitted, there is a naturalized sense of the nurse as a manager, as reinforced by the discursive sequences that follow: "I do not stay in the ambulatory all the time", "sometimes I monitor it." The signifiers "I don't stay all the time" state the nurse's workload through the numerous activities in their daily professional practice, which somehow prevents them from getting directly involved in the DOT, which seems to be confirmed by the signifier "sometimes." However, it is important to signal that the figure of the nurse as a qualified professional in caring and management is essential to the effectiveness of TB control actions⁽¹¹⁾.

Healthcare professionals' (SE3, STE1, STE2) sayings are part of the same discursive field of practices. In DA, the confrontation of different registered positions in certain discursive formations are understood as discursive fields that somehow relate to each other⁽¹⁵⁾. In this context, it is observed that these fields unfold in two discursive formations, one emphasizing the practice of home visits, and the other TB patients' monitoring and follow up.

The linguistic-discursive sequences "we make home visits" and "we monitor the patients" mobilize one evidential paradigm to comply with the standards proposed by WHO that are related to TB treatment. In this regard, we note that the position of the healthcare professional falls into an ideological field of normativity of PNCT, with a character of imposition, by stating the following signifiers: "to see the patient taking", "to be concerned with the other tests", "we have the sputum collection," and "ask the patient to come to see the doctor." In these production conditions, these signifiers suggest an institutional power presentation with which the professional is invested. It is important to highlight that the institutional history file of normativity plays an important role in the power of the healthcare professional.

The actions of visiting the TB patients at home, learning about the conditions in which they live, and providing treatment, in the imagination of the health care professional, are the best ways to control TB. It is stressed that the actions present in the discourse of professional nurses have already been identified, and are widely discussed in the literature that deals with DOT as a TB treatment modality, which has showed little about the expansion of the search to make adjustments or look at other ways to offer the treatment, thus revealing the crystallization of these actions in the imagination and everyday actions of those who perform it⁽¹⁶⁾.

Regarding the block of “production conditions that facilitate the treatment of TB,” it is possible to observe, in the first period of the first discursive sequence of this block, the question mark “does it have any benefit?” In these production conditions, this linguistic mark (?) not only suggests the question, but also the poor benefit that is offered to these individuals, such as a basic shopping basket. The numerical quantitative “one liter of milk” seems to confirm the insignificance of the benefit, observed by the healthcare professional. It is important to highlight that the benefit plays a counterpart role of the health service for compliance to treatment, and this may be related to the way that this service has been trying to help the TB patients in their unfavorable financial conditions, with the aim of having them access the health service and complete the prescribed treatment. In this context, the action of waiting “just for this” produces the meaning that the individual affected by the disease has no choice but to wait for what is usually offered. On the other hand, the adoption of incentives of a social nature, such as the provision of transportation vouchers and the basic shopping basket, is able to raise the rates of treatment compliance, which is seen by many authors as potentiating the treatment process⁽¹⁷⁾.

Proceeding with the gesture of interpretation, another important aspect that emerges and is inherent to potentialities is the transportation vouchers. “They are offered the transportation ticket too.” The signifier “too” leads us to think of it as an additional benefit beyond the basic shopping basket. In this case, it produces the meaning that people with the disease who benefit from transportation vouchers and a basic shopping basket have minimum conditions of survival. This suggests that the disease process of TB in populations/individuals urges the need for better coordination among different sectors of society, given the inadequacy of minimum living conditions that could lead the individuals, by themselves, to make decisions about their lives. This insufficiency or material need determines a *status quo* for these patients^(11,18).

The position of the individual enunciating the basic shopping basket presents a metaphor, understood in DA as the semantic phenomenon produced by a contextual substitution⁽⁹⁾ that is presented by the signifiers “a good weapon.” In this context, the weapon, whose function is to threaten, suggests a coercive action performed by nursing professionals when proposing the basic shopping basket as a way to keep the TB patient in treatment, removing from these individuals their autonomous status, placing them as individuals that are subject to care⁽¹⁹⁾. Importantly, in the event patients have no other sources of income, since they are at the margin of the economic production process of society, they feel *subjected* to the conditions that are offered⁽¹⁸⁾.

Human relations, understood as a set of actions and attitudes developed by contacts among people and groups⁽²⁰⁾, have been recorded as an important aspect related to the potentialities for treatment compliance. The signifiers “good relationship with the patient” produce a meaning that the satisfactory relationship and mutual recognition between the patient and the healthcare professional has helped in the treatment process. In this context, the link between the healthcare

professionals and the health service user promotes compliance to treatment, since it results from positive attitudes between the two sides⁽¹¹⁾.

The discursive sequences “good structure”, “we have a driver”, “we have the pharmacy”, “direct communication with the pharmacist”, “collect the tests” suggest that the health institution is organized in order to meet the needs of the person with TB. However, on the other hand, it produces the meaning that the institution is only fulfilling the precepts of DOT, reinforcing it as a practice already rooted in daily life, and little liable for adjustments or modifications. However, although it was emphasized by the professional view that the service has this structure, it suggests that the guarantee of treatment compliance transcends the issue of the structure of services.

Regarding the discourse block “production conditions that hinder the treatment of TB,” the signifiers “alcoholism” and “drug addict” suggest that those in treatment are also involved in the use of alcohol and drugs, which can result in weakness in the process of understanding the importance of treatment, impairing the healthcare professionals’ actions. Moreover, the same signifiers indicate that the subjectivity of those affected by the disease is invaded by existing circumstances: social and economic marginalization. In this context, attitudes and decision-making are *subjected* by the production conditions, determining not only what can be said, but also what governs behaviors.

The use of alcohol and drugs has interfered in patient care and in the activities of health services, and has generated delays in disease search, diagnosis, and delays in beginning treatment, leading to a need to raise the awareness of healthcare professionals about these issues, by proposing and conducting motivating strategies, in order to facilitate compliance with TB treatment⁽²¹⁾.

In the words of health professionals, it is observed that the issue of the use of alcohol and drugs is inserted in the daily life of healthcare teams, because it is a problem that has received emphasis due to aggravating factors for TB patients⁽²²⁾ and consequently to treatment.

The discursive sequences “does not want to take it because he wants to drink”, “some take it and drink” produce meanings that there is difficulty in this group in adhering to treatment, which requires the mobilization of strategic actions and plans that include education and advice focused on this group. Moreover, the situation leads us to think of the need for full care, with the presence of a multidisciplinary team. In view of densifying the analysis, the signifiers “take” and “drink” are highlighted, as they present a cognitive antagonism toward taking a medication that implies the recognition of being sick, and drinking alcohol, which means the continuation of daily practice. This not only causes alienation to the healthcare professional, but also creates the antithesis in the patients themselves. That is, they are identified with treatment and, at the same time, counter-identify it. Under these conditions, as it has been described in the text, there is a lack of knowledge on the part of people affected by TB of the real consequences of keeping the consumption of alcohol and treatment concomitant. This is aside from the absence of actions that should be carried out by the professional nursing

team, which are directly linked to TB control, including guidance on the exposure to risk factors that influence treatment, such as alcohol⁽²³⁾.

In the discursive sequences, "I saw him picking up the cup of *pinga*, putting it under the table", "we pretended we didn't see that", there is an action of complicity between the TB patient and the healthcare professional, which is demonstrated by pretending not to see the practice of hiding the glass under the table, and the attitude of hiding. In this context, in the TB individuals' imagination, they are not being observed. The action to see them hiding the glass and pretending not to see suggests the concern of the professional in wanting to see TB patients taking the medication, which reflects the fear of TB-MDR development, and treatment abandonment, if they do not do that. The escape from the regulations proposed by PNCT, and the autonomy that the healthcare professionals think they have to make a decision without consulting the health team are notorious in the signifiers "pretended not to see." It is also noted that there is a recognition by the professional that the individual with TB is an alcoholic and needs further treatment of the disease that affects the patient, in this case, TB. This situation shows the need to reflect on a multiprofessional assistance, focused on the biological, psychological, and social aspects. This would have the goal of overcoming the "blinding" of the health professional giving the medication, even knowing this condition (alcoholism) and the little reflection about the consequences of this practice for the treatment and for the lives of those who are receiving care⁽²¹⁾.

The issue of drug use is a problem for the treatment of TB; at these production conditions, it is enhanced by prostitution. In the statement of the respondent, there is a "beyond" linguistic mark that suggests an additional in this context, something which adds a component that tends to worsen the patient's condition, as it can be observed by the discursive sequence "prostitution area," revealing that it is an environment where drug circulation appears to be facilitated.

Given the vulnerability presented by these patients, the intervention should be brief and presented through counseling techniques, in all TB services, from diagnosis to the management of the treatment and monitoring of patients, in order to reduce possible damage posed by alcohol use, especially during the treatment, that is, in a manner articulated to therapeutic, preventive, and educational practices^(21,23).

In the treatment process as a relationship between the person affected by TB and healthcare professionals, there is the reaction of the individual with TB that can cause fear in the professional, and the recognition of the presence of the people in charge in drug trafficking zones, with whom they have to talk to facilitate access to, and performance of, the treatment. The discursive language sequences "we don't want you to come every day, if you come [...] [we] will shoot" suggest a threat to the healthcare professional, meaning an attempt to reject the power of service that offers treatment. However, the control over the territorial space, in brief, the control over the social tissue that lives in these places, causes health services to work with the individual control of the patient, and with traffickers over the control of territorial space. Thus, in these

production conditions, monitoring and control in trafficking zones produce effects of meaning related to repression and discipline over the body of the person affected by TB⁽²⁴⁾.

In this context, the individual belonging to the group of traffickers thinks he is dangerous, at a social level, and able to impose his wishes. His threat is a form of imposition not to be obliged to adhere to treatment; thus, "to shoot" would inhibit healthcare professionals' mobilization to meet the needs of the individual to receive treatment.

In the discursive sequence "we have arrived at the drug den, at the drug den to give a medication," there is an indication that the healthcare professionals, within their activities, enter into risk situations. This can be a difficulty for effecting the actions taken by the PCT team, as usually the internal rules of the "den" are not socially designed, and therefore stop the implementation and proper performance of TB control actions that, in this case in particular, are the treatment. As can be seen in the discursive sequence "there are the owners," there are people in charge there that should be contacted in order to allow entrance. This whole situation results in difficulties portrayed in the fact that these consist of places of difficult access, in which people who are undergoing treatment are at greater risk of abandoning it, given the intense situation of social violence that creates the vulnerability.

Already focusing on the difficulties related to the performance of DOT, it is observed that professionals imagine the TB patient as being responsible for the low compliance to treatment. The discursive sequences "the patient is easy-living" and "the major difficulty is related to patients," on the one hand suggest a value judgment by the professional, as if the noncompliance to treatment was only an individual prerogative, not determined by the broader conditions that involve the living conditions of these patients. On the other hand, they suggest that the person with TB does not accept the rules presented by the healthcare service, such as waiting for the professional who brings the drug, prompting them to think that the person does not prioritize treatment. Thus, the lack of prioritization denotes a lack of knowledge of the disease, the difficulty that the person with TB has regarding compliance with the rules, and the socio-historical circumstances surrounding it. It is noteworthy that the same signifier ("the patient is easy-living") suggests the health system's inability to understand the specificity of each individual, and to respond adequately to their demands and needs. The lack of inclusion of health service users in their diversity can cause distancing from the service⁽²⁵⁾. It is necessary that health professionals are sensitive and incorporate the particular characteristics of the population groups into their practice, relating living conditions to the possibility of disease and/or worsening of some diseases, and search for ways to understand and live the illness by certain populations of vulnerable people.

Culture as a set of values, beliefs, and attitudes⁽²⁶⁾ is understood by health professionals as something that influences the behavior of people with TB, as it is made present in the discursive sequences "it is a question of culture", "a social class that identifies itself in the biomedical model and only seeks the health service when they feel something." In this context, the

signifiers “culture”, “social class”, “who only seeks the physician” produce meanings that the social class cited by the healthcare professional has a low educational level, and difficulty in understanding health-related problems, only having awareness of the need to visit the doctor after the onset and worsening of a health problem, prompting the thought that this group, when free from the symptoms, will understand that it is the end of treatment, indicating a difficulty in proceeding with DOT⁽²⁷⁾.

The action of keeping the person affected by TB on treatment involves changing behaviors, this being the most complex action that permeates the work of healthcare professionals, since that behavior is not influenced solely by the current disease, in this case, TB, but by a set of beliefs, values, and attitudes. It is understood here that compliance and continuity of treatment, for some, also requires a behavioral change, which can be extremely difficult when treatment is not associated with the diagnosis of the disease, or the physical signs and symptoms that were previously associated with the disease⁽²⁸⁾.

Another meaning produced by the signifier (“the patient is easy-living”) is related to the antagonism of the patient-professional relationship, since the signifier “easy-living,” as set out by the professional, declares a culpability that the professional assigns to the patients, demonstrating the lack of a link between the professional and the TB patient, thus bringing a relaxation in this relationship, a greater possibility of non-compliance, and therefore of abandonment of treatment. A study performed in the city of Campo Grande (state of Paraíba) highlighted the satisfactory performance regarding the effectiveness of treatment from the link between professional and patient in services that develop TB control actions⁽²⁹⁾, revealing itself as an indispensable element in disease control.

The difficulties of “keeping the patients fasting” and their vulnerability and escape situations have been an obstacle both for effective treatment and for the organization and management of health services, as it is well demonstrated by the discursive sequences “they run away” and “find somewhere else.” These sequences suggest the lack of awareness by the person affected by TB of the need to adhere to treatment. Instead, “find somewhere else” suggests an effort by the professional to look for the one that is on treatment, and offer and supervise the drug intake, but also reveals the excessive control from health services of the TB patient. Accordingly, the escape itself can be understood by the lack of connection that is established with the patient. These disparate situations end up bringing the need to conduct more educational activities for the group of people on treatment, and continuing education activities for professionals who make up the multidisciplinary team.

The lack of professionals was highlighted as another problem in the disease treatment process, as it is made present by

the sequences: “I think what is most lacking is professional [...] ... there is a small number. At least here [...] just we two is not enough. There should be another one.” In the discursive sequences mentioned, it is observed that the individual that is interviewed is part of a discursive formation that understands the scarcity of professionals targeted for the treatment as a difficulty in operation and management of treatment. The number “two” and the adjective of quantity “small” suggests not only the shortage of professionals, but also a plaintive speech based on the daily experience of these “two” professionals. In this context, in the individual’s imagination, adding another professional would result in the improvement of TB care, as set out in the following discursive sequence: “There should be another one.” The lack of healthcare professionals has been described by WHO as a major challenge for the treatment of TB in high disease burden countries⁽³⁰⁾.

One possible limitation of this study would be the interviews with professionals of the nursing team of only one city, which had a specific context and characteristics. However, this study is not intended to generalize results, but to understand the daily work of nurses with DOT, which can help to understand these actions in different contexts. Thus, by analyzing the meanings produced by the discourses of nursing professionals on the DOT, it was possible to identify measures for the improvement of activities in order to ensure efficient and quality care to the TB patient.

FINAL CONSIDERATIONS

The sayings of these professionals produce many meanings that suggest that the practices of nursing professionals enable the patient to search for a cure, reinforced by incentives of social character, but permeated by the vicissitudes circumscribed in the everyday production conditions of the ill person.

Therefore, there is a need to create programs for these users with an engaging and inclusive design, in order to provide integration between the multidisciplinary team and the patients, to meet these specifications, thus allowing the health care proposals to make sense to that ill person, no longer seen merely as a therapeutic intervention object, but as a person being treated as an individual with an opinion who is able to negotiate, taking into account that the production conditions interfere strongly with compliance and the consequent result of this therapeutic process.

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