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Original Article

Tuberculosis control: decentralization, local planning and management specificities[1]

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The goal was to analyze, according to the perception of health managers, the practices that guide tuberculosis control actions in cities in the metropolitan region of João Pessoa – PB, Brazil. This qualitative study involved eight professionals in management functions. Testimonies were collected through semi-structured interviews between May and June 2009 and organized through content analysis. Despite the acknowledged benefits of tuberculosis control action decentralization, local planning indicates the predominance of a bureaucratic model that is restricted to negotiation and supplies. Local programming is centered on the coordinator, which shows a command line and vertical management that lead to the fragmentation of the work process. Management action should follow an innovative and transformative route that surpasses bureaucratic barriers and faces the biggest challenge it is proposed: to balance professional interrelations with a view to improving health work performance.

Descriptors: Tuberculosis; Health Management; Primary Health Care.

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Controle da tuberculose: descentralização, planejamento local e especificidades gerenciais

Buscou-se analisar, segundo a percepção dos gestores de saúde, as práticas que norteiam as ações de controle da tuberculose, em municípios da região metropolitana de João Pessoa, PB. Trata-se de estudo qualitativo que envolveu oito profissionais que exerciam cargos de gestão. Os depoimentos foram coletados por meio de entrevista semiestruturada, entre maio e julho de 2009, e organizados mediante análise de conteúdo. Embora se reconheça os benefícios da descentralização das ações de controle da tuberculose, o planejamento local sinaliza a predominância de modelo burocrático restrito à negociação e provisão de insumos. A programação local centra-se na figura do coordenador, retratando uma linha de comando e gestão vertical que induzem à fragmentação do processo de trabalho. A tarefa de gerenciar deve trilhar caminho inovador e transformador que ultrapasse as barreiras burocráticas e alcance o maior desafio que lhe é imposto: equilibrar as inter-relações profissionais no intuito de aperfeiçoar o desempenho do trabalho em saúde.

Descritores: Tuberculose; Gestão em Saúde; Atenção Primária à Saúde.

Control de la tuberculosis: descentralización, planificación local y especificidades administrativas

Se buscó analizar, según la percepción de los gestores de salud, las prácticas que orientan las acciones de control de la tuberculosis en municipios de la región metropolitana de Joao Pesoa, estado de Paraíba. Se trata de un estudio cualitativo que envolvió ocho profesionales que ejercían cargos de gestión. Las declaraciones fueron recolectadas por medio de entrevistas semiestructuradas, entre mayo y julio de 2009, y organizadas mediante análisis de contenido. A pesar de que se reconozcan los beneficios de la descentralización de las acciones de control de la tuberculosis, la planificación local señala la predominancia del modelo burocrático restricto a negociación y suministro de insumos. La programación local se centra en la figura del coordinador, retratando una línea de comando y gestión vertical que induce a la fragmentación del proceso de trabajo. La tarea de administrar debe explorar un camino innovador y transformador, que ultrapase las barreras burocráticas y alcance el mayor desafío que le es impuesto: equilibrar las interrelaciones profesionales con la finalidad de perfeccionar el desempeño del trabajo en salud.

Descriptores: Tuberculosis; Gestión en Salud; Atención Primaria de Salud.

Introduction

In the contemporary context, the decentralization of tuberculosis (TB) control actions to the Primary Health Care (PHC) context raises the discussion about the extent to which organizational designs and practice arrangements translate users' needs and take the singularities of the territory and health service access into account.

Tuberculosis figures among the six priorities in the Pact for Life, through which managers, under the guidelines of solidary and cooperative regionalization as the structuring axis of the decentralization process, should make efforts to reach 85% of cure for new TB cases in all priority cities[1]. The fact is that this target is not being achieved and that managers continue facing challenges that distance them more from reaching the commitments agreed upon.

It is presupposed that, to reach goals and honor agreements, the organization of TB control actions in the local sphere should be associated with coordinated work, whose practice is potentially based on the

relations that involve people, technology and resources. Thus, managers should have the skills to mediate, maintain and transform these relations in function of the population's needs. Hence, coordination stands out as a determinant instrument in this process, whose effects will be directly related with the ability to provide and articulate information and knowledge, organizational, political and financial resources in function of time and concretely established strategic and operational priorities[2].

At operating level, the organization of the TB care network requires compliance with a set of standards (laboratory network available for diagnostic tests, medication supplies, supervised treatment offering, data entry and analysis), as well as the reordering of practices at the level of individual/collective care as well as work flow control and ordering, in the articulation of the care network, in technological adequacy and in team equipment[3]. These adjustments are based on the management capacity to order efforts coming from different parts of the system, to control processes and performance, to assess end products and results to correct detected deviations.

In priority cities for TB control, despite the existence of operational guidelines in function of the Agreements for Life, in Defense of the Unified Health System (SUS) and Management System, it is observed that local peculiarities challenge municipal managers, expose their weaknesses as the persons responsible for population health and show how specificities constitute management distanced from what is thought necessary for operational changes in the SUS, mainly highlighting decentralization and action planning.

In the context of two priority cities for TB control in greater João Pessoa-PB, and considering management as a necessary instrument for the reorganization of health services, the goal of this investigation was to analyze, according to the managers' perception, the practices guiding TB control actions in these cities.

The study is based on the concept that health management "is the art or science of identifying resources needed to put in practice certain goals, mobilization itself to achieve them and to adequately combine their use through human action and certain work processes, according to dimensions that qualify the achievement of these goals or objectives"[4].

Method

This study is part of the project called "*Assessment of organizational and performance dimensions of family health teams in tuberculosis control in two cities in the metropolitan region of Paraíba"*, approved by MS/CNPq/ FAPESQ- TC 078/07.

The qualitative approach was chosen, using semistructured interviews as an information collection instrument. The guiding questions focused on the insertion of TB in the municipal health context, stakeholders and administrative-management/financial/ operational strengths and weaknesses.

Interviews were held in May and June 2009, involving eight professionals in management function in the cities under analysis, including the Tuberculosis Control Program, PHC, Health Surveillance, Epidemiological Surveillance Coordinators and Health Secretaries. After they agreed to collaborate with the research, they were asked to complete the Informed Consent Term to establish their agreement in writing. Interviews were recorded and later transcribed.

The total number of managers to be interviewed was not set *a priori* as, in qualitative research, data collection continues until sufficient convergences have been found to configure the study phenomenon.

Testimonies were analyzed through content analysis, a set of communication analysis techniques that serve to obtain, using systematic and objective procedures to describe the contents of reports, the indicators that permit deducting knowledge on the conditions in which these messages were produced and received[5].

The analysis comprised three moments: pre-analysis, exploration of the material and result treatment. In this type of analysis, to compose the recording and context units, semantic excerpts are used that originate analytic categories, considered as an assertion regarding a topic, a phrase, compound or summarized phrase, under whose influence a large group of individual statements can be covered[5].

Approval for the project this research resulted from was obtained from the Institutional Review Board at *Centro de Ciências da Saúde* (CEP/CCS) of *Universidade Federal da Paraíba*-UFPB on 08/29/07, under protocol No 1248. In compliance with the orientations inherence in National Health Council resolution No 196/96[6], on research involving human beings, secrecy of participants' identity was guaranteed, establishing a code for managers (M1, M2...) followed by the letter "C" to distinguish the cities (C1, C2).

The analysis of the testimonies revealed the central core of meaning - "Tuberculosis in the municipal health context: decentralization, local planning and management specificities".

Results

Tuberculosis in the municipal health context: decentralization, local planning and management specificities

The inclusion of TB among health priorities in the Pact for Life and as a strategic PHC area to intensify actions and activities across the Brazilian territory[1] requires the overcoming of the traditional model and reorientation of policies and practices. Managers acknowledge the decentralization of TB control actions to the local sphere as a benefit for users.

I think that decentralization was very good, very effective. First because you remove it from a central level, of Referral, so that a wider range opens up, enhancing equity in action. It is a gain for all stakeholders involved, professionals and mainly TB patients (M3/C1); *Decentralization was a great advance, right? Now users, their access to health services has improved a lot. It was also good because of that issue of case monitoring, every day. For the city it was marvelous too, because you don't have to move that specific patient to the Referral Unit Clementino anymore* (M7/C2).

Although the contents disclose the acknowledged importance of health action decentralization, dislocating decision power to the local level imprints competences and skills on managers with a view to adequate action planning. Considering targets and agreements defined for TB control, managers' testimonies mark political commitment to action planning in the municipal health context, although restricted to negotiation and provision of supplies for diagnoses and educative campaigns.

Regarding planning, there is the whole work of calculating, based on the population, the coverage area, number of sputum smears, respiratory symptomatics, in short, all of that is done to plan annually set targets (M3/C1)*; Every year, we do health, action planning, and present it to the Municipal Health Council for approval. Then, in this planning, we raise issues regarding all material needed for diagnostic tests, for events we organize like World Tuberculosis Day, that's the way, you know?* (M8/C2). *Planning is done every year, prioritizing program needs, such as laboratory tests for example, how much more or less we will have to perform… an annual analysis is done and, based on that, monthly analysis* (M1/C1).

The declarations reveal that TB control action planning is limited to the rationalization and adequacy of resource use. They refer to the idea that the subjects consider management performance from a technical-bureaucratic viewpoint, as opposed to the idea of Strategic Planning[7]. This situation seems to be further aggravated when management responsibility is dislocated to the coordinator of the Municipal Tuberculosis Control Program (TCP).

Regarding planning, in fact, I can't really answer you properly about those things, I'm gonna let the coordinator of the TB Program tell you that, right? Because that's not my role, it goes beyond, you see? (M6/C2). *That is something more specific that, even, for me to go deeper, as I have a more macro perspective, that is more the Program coordination's part, right?* (M5/C1).

The lack of knowledge the manager shows compromises his political power, conceived as the ability to trigger mobilization, which in turn depends on knowledge deriving from his practical experience, on feelings these experiences aroused and on scientific knowledge[8]. The situation is aggravated by the fact that the testimonies picture an organization model in which unavoidable departmentalization sets a line of command and vertical management that induces a fragmentation of the work process[9].

What is bad here is the following, there is no integration among sanitary, epidemiological and health surveillance, nor with primary health care. It's all very separated and it shouldn't be like that, because that hampers work (M3/C1).

To achieve changes in a given local reality, it is fundamental to develop the ability to coordinate available, sectoral and extra-sectoral resources, as well as to invest in competency building for the emancipation of non-alienated work relations. It is noteworthy, however, that this conformation of the contemporary management role, whose logic is based on the joint construction of the goal, on the negotiation of individual projects and on the formulation of collective projects, in practice, reveals contradictions and interruptions.

On the one hand, as mentioned, TB control action planning in the cities under analysis is constituted in a fragmented way, that is, the stakeholders in management functions "do not talk mutually" and, on the other, who executes does not participate in planning. This process is aggravated in view of health professionals' turnover.

The city changes professionals like you change clothes (M1/C1). *The change in managers in the city represents a great difficulty, as it hampers the evolution of work a lot, right? After I got here the health secretary has already changed thrice and that contributes a lot for things not to go ahead as they should* (M3/C1). The main difficulty we face in terms of human resources is due to turnover, and also due to the profile, you know*? That hampers the evolution of work* (M8/C2).

Although the Brazilian Constitution recommends holding public service exams, in most cases, contracts for management functions result from indications by

politicians and/or ideological/religious groups, which politically sustain the people in power[10]. Hiring Family Health teams through non-governmental organizations contributes to enhance the precariousness of health work, generally characterized by inadequate bonds and informal, temporary contracts.

Inadequate forms of hiring health workers end up inducing staff turnover and imply a loss of strategic employees, generating a facture of rupture and, consequently, impairing organizational efficiency and TB case monitoring.

We know that the team is fundamental for patients to accept and terminate treatment, but the problem is that, in the Family Health Program, staff turnover is very high (M4/C1). *When you invested in that professional, you trained, prepared and lose him, that is a loss for the city, a loss for users he was already monitoring* (M7/C2). *The staff who was here before was trained, you know? We have tried, but we see that, now, not everyone is 100% prepared to treat the disease* (M5/C).

Another aspect that is highlighted as a limit is related to Tuberculosis Control Program managers' double function. *What is bad is that there is one single coordinator to do everything for two programs… you end up not having the distinguished look to the disease itself, right? You cannot have a program with a person who is coordinating other programs. I think that a program like the one for tuberculosis needs a specific person to prioritize control actions more* (M3/C1). *It is difficult to do things when you are coordinating two programs, you know? That hampers my work so much* (M6/C2).

Statements again translate the fractioning of work, in which managers are responsible for parts, revealing a certain "logic in which one person orders and the others merely obey; each worker develops his work according to the extent to which he conquered autonomy and self-government". Paradoxically, workers have been "appointed as potential subjects of change and reformulation of current health practices and should be valued as such"[10].

Another issue that stands out among TCP managers refers to the funding policy to put in practice TB control actions. As resources are centralized at the central level, TCP managers have no autonomy to determine their use.

It's not like STD/AIDS, which gets resources correctly, you know? What they always say is that there is no money for tuberculosis. The things we get come through epidemiological surveillance. In fact there are no specific funds, right? There are very few resources (M1/C1). *Unfortunately, financial resources are still few. If it were better, you could do better, more effective work. All managers face difficulties in terms of resources. It [the resource] is that insignificant that you can't have a better structure for TB patients. That is concerning, but what can we do about it?* (M2/C1)

The probable success of the TCP is based on five pillars, and one of them is exactly political commitment, which aims for the sustainability of disease control actions, mainly through the Directly Observed Treatment (DOTS) strategy. The term sustainability is considered the competency to guarantee the continuation of TB control actions by providing support in terms of material and human resources[11].

Anyway, most cities' low technical and financial capacity contributes to make it impossible to expand certain services. Insufficient public resources, associated with social vulnerabilities and regional economic disparities, demand constant negotiations with municipal health managers, so that Ministry of Health funding can be converted to enhance TCP actions.

When the city legitimizes commitment to TB, not only can financial resources be allocated but, also, incentives can be made available for benefits like basic food packages and transportation aids, with a view to seeing to some needs of patients under treatment[9].

I have always fought for a basic food package. I think that, if there were one, he [patient] would think twice before dropping out of treatment. It would hold them longer, right? (M1/C). *Our city does not have more effective incentives, which would be the distribution of basic food packages. That would not solve the problem, but it would be a good palliative measure. It would make patients not drop out of treatment, because TB patients are hungry and want to eat, right?* (M2/C1). *Before, the city used to provide aid and that contributed to treatment. It was a basic food package. In fact there wasn't that much, but it helped. But they stopped, they never bought them anymore. They want to distribute that again, but they need resources, it's difficult* (M7/C2).

The latter fragment shows how the lack of incentives/benefits contributes to the discontinuity of treatment, a fact that reduces political sustainability and actions aimed to reach goals, mainly to reach 85% cure rates. It is known that resources enhance therapeutic adherence. The centralization and irregular availability of resources will definitely provoke patients' little willingness to collaborate with treatment, generating ruptures in the planning process and in the practice of surveillance activities.

Discussion

TB control action planning in the research context is limited to a bureaucratic model, without any intent on planning towards qualifying actions, on rethinking what

would be fundamental for a TB patient. Nor do subjects associate planning with "a rationalization process of human actions that consists in defining proposals and constructing their feasibility with a view to problem solving and compliance with individual and collective needs"[12].

TB control actions, in the light of the expanded health concept, demand that systems and service management "strongly considers intersectoriality, a systemic and expanded view of an individual or a group's needs"[4]. Managers are expected to know the premises of the planning process and a broad view of local reality (infrastructure, human resources, logistics), so that the goals, priorities and tools needed to compose/prepare health teams can be defined, mainly for teams working in Family Health Units. Disarticulated activities contribute to jeopardize the success of health practices and policies and show that management work is distanced from goals and priorities.

In this perspective, management is also acknowledged as "the ability to articulate different existing projects, to deal with different groups, interests and realities, and the ability to agree on some goals, through the construction of affirmative consensuses"[4].

In the research context, it should be taken into account that one of the neuralgic issues is related to the inability to achieve articulation among stakeholders in management functions, who are responsible for sectors that would be fundamental to strategically organize TB control actions in operational terms. Besides adequate knowledge on the organization, that is, on what is formally defined, the management function demands knowledge on the "informal" aspects, which determine the organizational climate. That explains the importance of seeing the management role not as an individual attribute, but as a relational phenomenon[13].

In this understanding, management performance goes beyond planning, organization, control and coordination responsibilities. To put in practice changes in the health system, the need is defended to "reinforce movements that aim to redefine health professionals' role", as well as to recover the will of individuals, group and collectiveness so as to compose a critical mass apt to construct new projects"[14].

The macro work processes need to be redesigned, mainly regarding the understanding that management competences be expanded[15] and capable of "triggering, in the group of workers, a process of reflecting on and reviewing their practice that moves towards adherence and commitment to a health care production process, instead of compliance with fragmented tasks, centered on the development of isolated procedures"[16].

It should be observed, however, that temporary contracts and job instability can limit the ability to keep up the processes that were started. Managers and professionals' turnover in PHC services has been appointed as an obstacle to the organization of TB care, as it interferes in problem-solving ability and impedes the maintenance of qualified teams, sensitized and ready to deliver effective patient care[17].

Another noteworthy point is related to the management competence to continuously allocate financial resources to guarantee the provision of incentives (basic food package/transportation aid). It is highlighted that the establishment of TB control actions was based on a policy of incentives, defined as an induced care mode, in which financial transfers to cities is obligatory conditioned by the disclosure of positive results, such as completely cured TB patients reinsertion in society[18].

The two-way correlation between TB and poverty is beyond doubt. Knowing this relation is a determinant step to break this vicious cycle[19]. Providing incentives contributes to strengthen the bonds between health professionals and users, as professionals start to acknowledge patients comprehensively, holistically, while patients, in turn, start to value professionals' health actions[11].

Thus, it is suggested that, by using humanized practices that attend to patients' individual needs beyond the disease, valuing their singularities and articulating with other sectors, the principle of care comprehensiveness can be experienced[20].

Hence, the concept of comprehensiveness obligatorily refers to that of service integration through care networks, acknowledge stakeholders and organizations' interdependence, in view of the finding that none of them has all the resources and competences needed to solve the health problems of a population in its different life cycles. Therefore, it becomes fundamental to develop cooperation and coordination mechanisms characteristic of efficient management that is responsible for collective resources, responding to individual health needs at the local and regional level[21].

Final considerations

In the cities under analysis, it is observed that there is no evidence of planning to permit actions aimed at minimizing problems related to coping with

TB, so as to contribute to the achievement of goals and established agreements. Management acts are based on normative discourse (important, but not founding) and adapt themselves to the federated entity, exempting the management process from planning from the Situational Strategic Planning perspective. The forms of appropriation and action standard are based on a discourse protected by technical/operational rationality and on intervention proposals exclusively deriving from the design of a certain "should be", without first apprehending in depth what happens in reality or without talking about practice based on guiding concepts of collective health management.

The findings reveal the absence of participatory planning and lack of articulation among managers. Local programming centers on the figure of the TCP coordinator and pictures a line of command and vertical management that leads to a fragmentation of the work process. Coordinators' function accumulation and health professionals' turnover weaken and interrupt initiatives towards bonding between workers and users, enhancing obstacles to the efficacy of municipal health management performance.

In line with the Brazilian Primary Health Care Policy, managers should promote qualification processes centered on Permanent Health Education, offering health workers conditions to reflect on their practice and transform it in function of the needs of citizens seeking the health services. The efficacy and sustainability of actions to fight against TB imperatively demand the creation of a new platform and the inclusion of new stakeholders.

Changing health services' practices does not only imply rationalization through action planning and control, but the involvement and commitment of organizational members (health workers, users) and their goals. The management task should follow an innovative and transformative route, which goes beyond bureaucratic barriers and reaches the main challenge it is faced with: to balance the professional inter-relations, with a view improving healthcare performance, so as to redefine indicators that epidemiologically express TB and reveal SUS action in the context of primary health care.

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