



PERCEPTION OF NURSES: FOCUS ON THE FAMILY AND COMMUNITY ORIENTATION IN TUBERCULOSIS ACTIONS¹

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ABSTRACT

Objective: To evaluate the attributes of primary care, focus on the family and guidance for the community in tuberculosis control, on the perception of nurses. **Methods:** it is a descriptive, survey-type study, carried out cross-sectionally using the quantitative approach. The data collection occurred through interviews with the version for health professionals of the form "Primary Care Assessment Tool" (PCATool), whose response category varies according to the Likert scale. The data were analyzed using descriptive statistics. **Results:** 43 nurses were interviewed. From the answers, the average score was 4.30 (almost always) and 2.62 (sometimes) for the focus on family and community orientation dimension, respectively. The evaluation of the dimensions identified that the actions are centered on the patient, superficially covering the family and even less frequently the community. **Conclusion:** Sensitization of professionals in relation to these aspects is essential since through these dimensions, it is possible to contribute to the control of the disease as a public health problem.

Keywords: Nurses. Family. Health education. Tuberculosis.

INTRODUCTION

The Health Care Network (HCN) was implemented to structure the Unified Health System (Sistema Único de Saúde- SUS)^(1,2), for achieving comprehensiveness, one of its principles. In this sense, it is essential that Primary Health Care (PHC) is, at least, territorialized and with its population registered, so that this level of care coordinates care and orders the network with the establishment of flows⁽²⁾.

Among its aspects, PHC encompasses derivative attributes, which include a focus on the family and orientation towards the community. Who, in turn, recognize that the needs pervade the individual, in which the family is the subject of care, demanding greater interaction between professionals with this unit

and the knowledge of its social determinants of health⁽³⁾.

Due to its low technology and high complexity, PHC is responsible for resolving approximately 85% of the community's problems, including tuberculosis (TB) control actions, as recommended by the Ministry of Health. However, access difficulties are perceived⁽⁴⁾, which have a delay in diagnosis and are reflected in the high number of diagnoses in other services, such as referral hospitals⁽⁵⁾, the absence of the user's link with PHC and unfavorable support for epidemiological indicators and operational⁽⁶⁾.

In 2017, Brazil had 69,569 new TB cases and 4,534 deaths, which generated coefficients of incidence and mortality equal to 33.5 and 2.2 per 100,000 inhabitants, respectively, in addition to a low cure rate (71.4%) and a high dropout rate

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(10.8%), when compared to the WHO goals of at least 85% and at most 5%, in due order^(7,8).

In view of the nurse's performance in relation to the Family Health Strategy (FHS), analyzing the assistance to people with TB from the perspective of derivative aspects represents the importance of disease control, since these attributes are considered inter-elements related and fundamental for the development of a resolute and quality PHC⁽⁹⁾.

Supported by legislation (Law No. 7,498/1986), the practice of nursing since consultation, prescription of nursing care, medications established in public health programs and in routine approved by health and education institutions, as well as participation in planning, execution and evaluation, aiming at the well-being of the population.

It is necessary to overcome the borders of health units, surpassing the routines established in the service. As well as a system that chooses to monitor the space/family/community in which the illness occurs, and not only focusing on the individual⁽¹⁰⁾. For this, it is important that professionals know and act on family dynamics, recognizing the relationship, resources and communication between members, since they constitute more than an affective bond, forming a support network in the health-disease process⁽¹¹⁾.

The inclusion of the person with TB in the elaboration of the care plan and their participation in the planning, as well as the respect and encouragement of the autonomy to perform the Directly Observed Treatment (DOT), participation of the population in discussions on the subject and use of community resources by professionals, to support adherence to this method, they are nursing practices that strengthen democracy⁽¹²⁾.

When these actions are not performed by professionals, they go against democratic principles, since the user starts to play a secondary role in the centrality of treatment, which reduces the possibility that he will exercise his autonomy regarding the decision making he deems more proper. These factors are aggravated in the northern region of the country⁽¹²⁾, where was place of study.

That said, the study is justified in the understanding that nurses are sensitive to the

need for changes in TB control actions and that nursing practices need to be flexible and adaptable, as health care is not isolated from the social space, therefore, the participation of the person, family and community is fundamental⁽¹²⁾.

Therefore, this study aimed to assess the attributes of primary care, focus on the family and guidance for the community, on TB control, on the perception of nurses.

METHODS

This is a descriptive, survey-type study, carried out cross-sectionally using the quantitative approach, developed in Porto Velho. The capital of the state of Rondônia has the attention to decentralized TB for PHC, considered the gateway and the first contact for the Respiratory Symptomatic (RS)⁽¹⁾, in addition to being responsible for the clinical evaluation and request for diagnostic tests, care management that it involves treatment, including monthly monitoring and control, DOT, evaluation of contacts for investigation of Latent TB Infection (LITB) and referral of the patient to referral services, when necessary.

For the organization of this flow, the municipality has 19 health units in the urban area, being 17 FHU and two UBS. These units have 60 health teams, covering 46.15% of the population in 2019.

The study population consisted of nurses working in PHC in the urban area of Porto Velho-RO, based on the proportional sharing carried out in the project entitled "Organizational dimensions and performance of health services for the management of care for patients with tuberculosis in Porto Velho-RO", of which this study is part. The choice of the professional category was due to the well-known importance of the nurse's performance in PHC, especially in the attention to chronic conditions such as TB.

As inclusion criteria, we considered the professionals who have followed up at least one TB case and who have been working for at least 12 months in the unit where they were interviewed. And as exclusion criteria, those who were on leave and/or vacation during the period of data collection.

In view of the population of professionals in

these units, the sample number was estimated using the finite population formula. Thus, at least 26 nurses should be interviewed. 74 nurses work in the health units in the municipality, of which 43 participated in the study and 29 did not compose the sample, of which 13 due to the criteria defined and previously presented (nine were on vacation and four on leave) and 16 for other reasons, such as: were not found or were not available in three or more attempts. Two nurses refused to participate in the research, one for lack of interest and the other for not having obtained research feedback previously.

It should be noted that the nurses interviewed were from 36 Family Health Teams (eSF) and seven Primary Care Teams (eAB). The

professionals had an average function of 12.55 years (sd = \pm 6.72 years), with a minimum of one and a maximum of 33 years.

The data were collected between May 2018 and February 2019, using the Primary Care Assessment Tool (PCATool)⁽³⁾, validated for Brazil⁽¹³⁾ and adapted for TB in three versions: TB patients, health professionals and managers⁽¹⁴⁾.

To achieve the objective of this study, only the dimensions of focus on the family and orientation to the community were considered, the version for health professionals, which are represented on the form by the letters "H" and "I", and includes eight and five variables, respectively (Chart 1).

Chart 1. Dimensions and variables selected for the study.

DIMENSION	VARIABLES	
FOCUS ON THE FAMILY	Living conditions of people living with the person with TB and/or their family (job, housing, basic sanitation) during consultations	H1
	Professionals' knowledge of people living with the person with TB and/or their family	H2
	Professionals requesting information about illnesses of people living with the person with TB and/or their family during consultations.	H3
	Questioning TB patients if the people who live with him and/or his family show symptoms of the disease by the professionals	H4
	Professionals' questioning TB patients if the people who live with him and/or his family show symptoms of the disease	H5
	Professionals talk to people living with the person with TB and/or their family about the disease	H6
	Professionals talk to people living with the person with TB and/or their family about the treatment of the disease	H7
	Professionals talk to people living with the person with TB and/or their family about other health problems	H8
COMMUNITY ORIENTATION	Request of sputum examination and/or X-ray and/or PPD for people who work and/or study with TB patients by health professionals	I1
	Advertising/campaigns/educational work to inform the community about TB by professionals	I2
	Development of health professional actions with churches and neighborhood associations to identify respiratory symptoms	I3
	Request for the participation of a community representative to discuss the TB problem by professionals	I4
	Search of respiratory symptoms in the community by professionals	I5

In each question, the professionals had five possible answers, according to the Likert scale: *never*, *almost never*, *sometimes*, *almost always* or *always*, which are classified by means of a variation from one to five, one being the worst performance and five the best performance⁽¹⁴⁾.

The collected data were stored in Microsoft Excel and analyzed using descriptive statistics in Statsoft's Statistic 13.0 software. An average score was determined for each variable that corresponds to the sum of all categories of

responses divided by the total number of participants. In a complementary way, the average score of the dimension listed for this study was defined, which corresponds to the sum of all the average scores of the variables divided by the total of variables⁽¹⁴⁾.

According to the Likert scale of the instrument's response, the following parameters were adopted to categorize the average scores obtained: *never* (1.00-1.50), *almost never* (1.51-

2.50), *sometimes* (2, 51-3.50), *almost always* (3.51-4.50) and *always* (4.51-5.00).

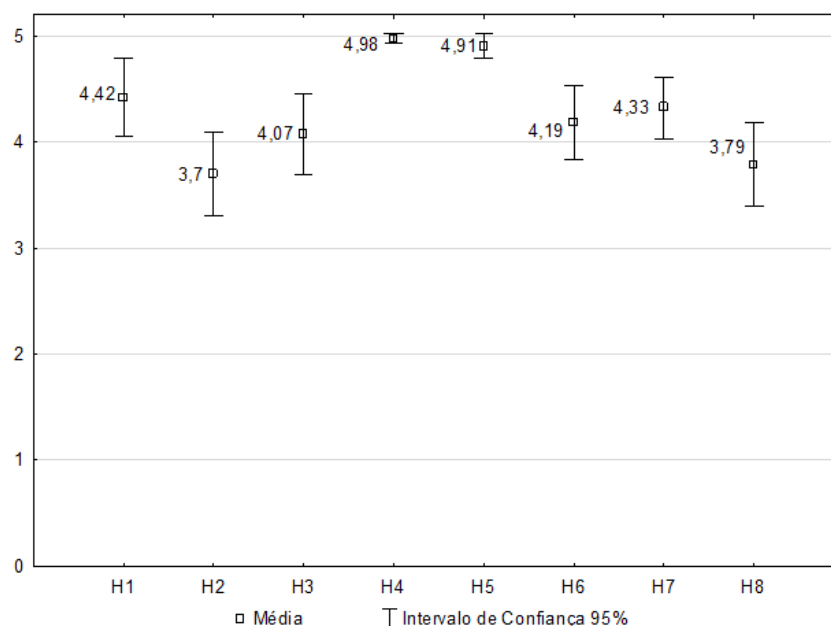
In compliance with the recommendations of resolution 466/12 of the National Health Council, the matrix project entitled “Organizational dimensions and performance of health services for the management of care for tuberculosis patients in Porto Velho-RO” was approved by the Ethics Committee in Research (CEP) of the Federal University of Rondônia Foundation (UNIR), according to opinion number 2.585.934 CEP/UNIR.

The interviews took place after authorization by the Municipal Health Secretariat (SEMUSA) and the signature of the Informed Consent Form (ICF) by the nurse, in the health unit where he worked and in a place that protected his privacy.

RESULTS

Regarding the focus on the family dimension (average of the general score = 4.30 - *almost always*), nurses reported that PHC health professionals always ask TB patients if the people who live with him and/or his family show symptoms of the disease, as well as request diagnostic tests (sputum, X-ray and/or PPD) for people living with the patient. In addition, they *almost always* ask about living conditions, know the people who live with the person with TB and or their family, ask for information about illnesses and talk to the family about the disease, treatment and other health problems (Figure 1).

Figure 1. Graphical representation of the mean and confidence interval of the scores of the focus on the family dimension, obtained by PHC nurses in Porto Velho-RO, from May 2018 to February 2019.



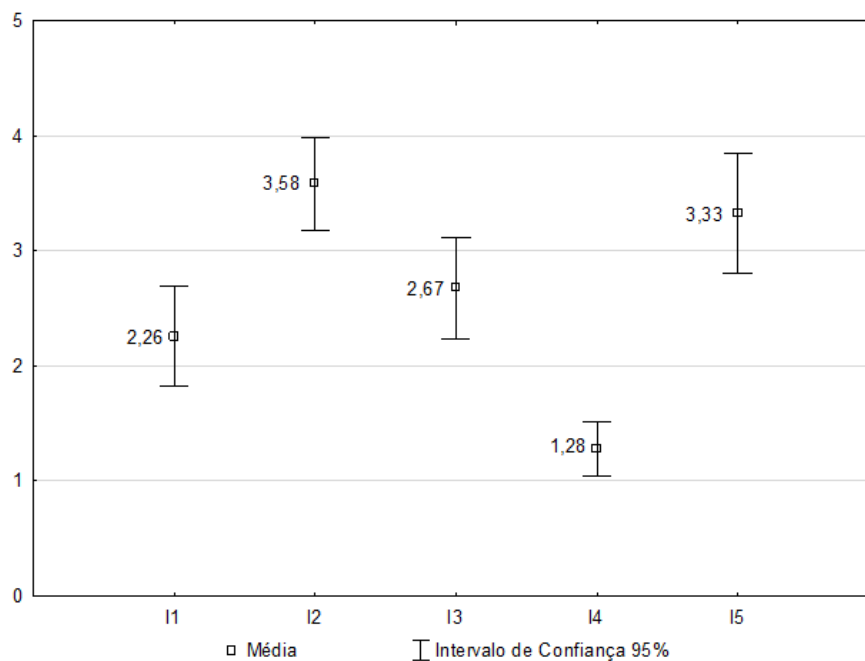
Subtitle: H1 - living conditions of people living with the TB patient and/or their family (job, housing, basic sanitation) during consultations; H2 - knowledge of the professionals who live with the TB patient and/or their family; H3 - request for information about illnesses of people who live with the TB patient and/ or their family by professionals during consultations; H4 - asking TB patients if the people who live with him and/or his family show symptoms of the disease by the professionals; H5 - request for sputum examination and/or X-ray and/or PPD for people living with the TB patient and/or his family by health professionals; H6 - talk to people who live with the TB patient and/or his family about the disease by the professionals; H7 - talk to people living with the TB patient and/or his family about the treatment of the disease by the professionals; H8 - talk to people who live with the TB patient and/or his family about other health problems by the professionals.

In the dimension of orientation to the community (average of the general score = 2.62 - *sometimes*), nurses reported that PHC health professionals *almost always* carry out advertisements/campaigns/educational work to inform the community about TB. *Sometimes*

they develop health actions with churches and neighborhood associations to identify RS and conduct an active search in the community. Still, they *almost never* request diagnostic tests (sputum, X-ray and/or PPD) for people who work and/or study with TB patients, and *never*

ask for the participation of a community representative to discuss the TB problem (Figure 2).

Figure 2. Graphical representation of the mean and confidence interval of the scores for the community orientation dimension, obtained by PHC nurses in Porto Velho-RO, from May 2018 to February 2019.



Subtitle: I1 - sputum and/or X-ray and/or PPD examination request for people who work and/or study with TB patients by health professionals; I2 - carrying out advertisements/campaigns/educational work to inform the community about TB by professionals; I3 - development of health actions with churches and neighborhood associations to identify respiratory symptoms by professionals; I4 - request for the participation of a community representative to discuss the TB problem by professionals; I5 - search for respiratory symptoms in the community by professionals.

DISCUSSION

The core of PHC is promotion and prevention with a focus on teamwork, which should not be alien to TB control actions, but inserted in the management of the disease in such services, even in the role of the nurse in this context, mainly in case of management⁽¹⁵⁾.

Despite the nurses' assertion that professionals always question TB patients regarding the presence of respiratory symptoms in their family members, this questioning does not guarantee that users are able to identify the symptoms of the disease to elucidate the cases. As well, it does not release the professionals' responsibility to investigate and monitor both the individual and the family⁽¹⁶⁾.

The request (*always*) for diagnostic tests for people living with TB patients is opposed to the data revealed by underreporting the evaluation of contacts at SINAN. This is because only the

request for exams does not guarantee the assessment of the contacts, considering that these people may not perform or receive the results of these exams, either due to the low understanding of their importance or the barriers to access health services, impairing surveillance the appearance of signs and symptoms among family members and contacts⁽¹⁷⁾.

The need for nurses' knowledge about family dynamics is emphasized, recognizing the interaction, resources and communication between members⁽¹¹⁾, which *almost always* happen. Even so, inquiring about the living conditions of people living with TB patients, such as employment, housing, comorbidities, basic sanitation and other social determinants of health, should occur more frequently associated with home visits, in order to attend to PHC attributes, especially comprehensiveness and longitudinality, for the exercise of health responsibility in the defined territory⁽²⁾.

In another study, a significant association was observed between the incidence of TB and socioeconomic indicators, that is, the precarious housing conditions and health infrastructure directly interfere in the increase in the number of TB cases⁽¹⁸⁾.

In Porto Velho, the ESF's geographical organization makes it difficult for professionals to approach the territory and collect information, since the same unit includes from one to six ESFs, a quantity that meets the four teams proposed by the National Primary Care Policy (*Política Nacional de Atenção Básica*- PNAB). In addition, some teams have populations so wide that they show the distance from the recommended parameter, and the inadequacy of the characteristics of the territory, which ensured the quality of care⁽¹⁹⁾.

There is evidence of weakness in the formation and strengthening of bonds, development of promotion and prevention actions, DOT, RS screening, health education and monitoring of chronic conditions, such as TB. Like, the tenuous surveillance of the space in which the illness occurs, limiting the focus on the individual and, at times, on the family. Not considering the community as a social unit, in which the patient is inserted and should be known and considered⁽¹⁹⁾.

The articulation of the health service with the community for the management of TB is related to the presence and performance, also, of the Community Health Agent (CHA) in the team. The scores obtained allow us to infer, with what was observed in other studies, a limited capacity for articulation and partnerships between health units and community organizations for disease control and a lack of local health commissions/community leaders to assist patients with TB, family members and community^(19,20).

Nurses recognize that PHC health professionals *almost always* carry out advertisements/campaigns/educational work to inform the community about TB. Although, in the municipality, it was noticeable that these activities happen in a punctual way, during campaigns, when there is greater awareness among professionals, which attributes a momentary impact on TB control actions⁽¹⁰⁾, not

perpetuating throughout the year in planning and execution of activities by the teams.

Another point to consider is the lack of physical structure in health units for the development of educational activities. In this sense, intensifying the performance of activities that happen (*sometimes*) in community spaces, such as churches, schools and neighborhood associations, presents itself as an effective form of dialogue, access and co-responsibility⁽¹⁰⁾.

In addition to having appropriate physical space, educational activities about TB require professional training^(10,21). From this point of view, even with the investment of the TB Control Program (TCP), there is no guarantee that the professional is qualified⁽¹⁰⁾, since it depends on the approach used and reframing on the issues addressed in order to overcome the logic of distribution of pamphlets and lectures, with a view to achieving healing^(10,22).

Health education activities increase the screening of contacts, and through this evaluation, the family of the professional can be approached, which favors their inclusion in the treatment, in addition to reducing the stigma of the disease^(10,16). Such activities are also a fundamental action to fight TB as they influence the adoption of measures relevant to therapy, such as the continuity of taking medication and maintaining monitoring at the health unit⁽¹⁷⁾.

Operating in the family-focused and community-oriented dimensions requires overcoming the physical limits of health facilities. Regarding external actions, it is observed that home visits still do not constitute a timely tool for FHS work since it occurs only for bedridden users and/or who have special needs, often through the Health Service. Multidisciplinary Home Care (MHC) or the area covered by the ESF, even though many professionals refer to "population outside the area" or "uncovered area"⁽²⁰⁾.

In this perspective, it is necessary to pay attention to 53.85% of the geographic space not covered by the ESF in Porto Velho, since the PNAB advocates the duty of health responsibility for the reference territory. However, it allows for the existence of other arrangement of adscription, according to vulnerabilities, risks and community dynamics,

allowing the reduction of this percentage, according to the specificities of the territory⁽²⁾.

The nurses also reported that the PHC health professionals *sometimes* develop an active search for RS, but suggest that it is an activity of exclusive responsibility of the CHA. It is noteworthy that TB is a communicable disease and, therefore, the administrative division of the coverage area is not confined⁽¹⁹⁾, in addition to being configured as the assignment of all team members⁽²⁰⁾.

The active search for RS requires knowledge about the disease, such as signs and symptoms, mode of transmission and guidance on sputum collection. However, a lower offer of training for CHA compared to nurses can impact the effectiveness of such actions. Considering the managerial, organizational and educational character of the profession, the nurse's role as an articulator of permanent health education and the significant advances observed from the professional's individual effort are highlighted⁽²⁰⁾.

The fact that PHC health professionals *almost never* request diagnostic tests for people who work and/or study with patients may be related to the stigma surrounding TB and the difficulty of contact, based mainly on the lack of knowledge about the forms of transmission. In some cases, patients are even afraid to adhere to the DOT for fear of being recognized as sick by the community⁽²³⁾. It is up to the professional, educational actions as a way of intervention in these places, for the reinsertion of the person in the social spaces where he/she frequented before the illness⁽²⁰⁾.

The participation of community representatives (never considered) is essential to discuss the TB problem, based on one of the organizational principles of SUS made available in organic laws 8.080 and 8.142/1990. It is essential to recognize that effective responses in health services depend on social interactions, but despite the participation of the community, collaborate with the construction, implementation, inspection and evaluation of

public policies^(16,19), according to the nurses interviewed, such actions do not happen, reflecting in distancing popular participation and weakening mobilizations in co-responsibility and improving strategies for TB control⁽¹⁹⁾.

CONCLUSION

The assessment of the attributes of PHC, regarding the dimensions of focus on the family and orientation to the community, occurs when health actions go through the family, social, cultural and economic context in which the individual is inserted. In the studied scenario, they are shown to be insufficient, for presenting specific educational actions, exclusive responsibility of the CHA for the active search for RS, clinical evaluation of the disabled community and absence of social participation in coping with the disease, leading to less community guidance on TB.

It is essential that there is awareness of professionals in relation to these aspects, associated with the need to cover their epidemiological view, considering that the attention is still focused on the patient, with limited preventive actions. These dimensions can contribute to achieving disease control as a public health problem, since they strengthen the model of health promotion, early diagnosis and treatment adherence.

Given this, the decentralization of TB control actions for PHC requires reorganization and strengthening of this level of care through the articulation between PCT, SEMUSA, coordination of the Department of Primary Care and social service. Bearing in mind that the illness caused by *M. tuberculosis* is complex and, therefore, requires intersectoral cooperation for effective actions for the individual, family and community, aimed at controlling the disease.

The study is limited for not evaluating all the actors, including managers and users, involved in the performance of the dimensions and that could corroborate with their respective perceptions.

PERCEPÇÃO DE ENFERMEIROS: ENFOQUE NA FAMÍLIA E ORIENTAÇÃO PARA A COMUNIDADE NAS AÇÕES DE TUBERCULOSE

RESUMO

Objetivo: avaliar os atributos da Atenção Primária à Saúde “enfoque na família” e “orientação para a comunidade” no controle da tuberculose, na percepção de enfermeiros. **Métodos:** estudo descritivo, do tipo inquérito, realizado de forma transversal a partir da abordagem quantitativa. A coleta de dados ocorreu por meio de entrevistas com a versão para profissionais de saúde do formulário *Primary Care Assessment Tool* (PCATool), Brasil, cuja categoria de resposta varia segundo a escala Likert. Os dados foram analisados por meio de estatística descritiva. **Resultados:** foram entrevistados 43 enfermeiros. A partir das respostas, obteve-se média do escore geral igual a 4,30 (*quase sempre*) e 2,62 (*às vezes*) para as dimensões “enfoque na família” e “orientação para a comunidade”, respectivamente. A avaliação das dimensões identificou que as ações são centradas no doente, abrangendo superficialmente a família e, em menor frequência, a comunidade. **Conclusão:** é essencial a sensibilização dos profissionais em relação a esses aspectos, já que, por meio dessas dimensões, pode-se contribuir com o controle da doença enquanto problema de saúde pública.

Palavras-chave: Enfermeiros. Família. Educação em Saúde. Tuberculose.

PERCEPCIÓN DE ENFERMEROS: ENFOQUE EN LA FAMILIA Y ORIENTACIÓN PARA LA COMUNIDAD EN LAS ACCIONES DE TUBERCULOSIS

RESUMEN

Objetivo: evaluar los atributos de la atención primaria, enfoque en la familia y orientación para la comunidad, en el control de la tuberculosis, en la percepción de enfermeros. **Métodos:** estudio descriptivo, del tipo investigación, realizado de forma transversal a partir del abordaje cuantitativo. La recolección de datos ocurrió por medio de entrevistas con la versión para profesionales de salud del formulario “*Primary Care Assessment Tool*” (PCATool), cuya categoría de respuesta difiere según la escala *Likert*. Los datos fueron analizados por medio de estadística descriptiva. **Resultados:** fueron entrevistados 43 enfermeros. A partir de las respuestas se obtuvo un promedio de puntuación general igual a 4,30 (*casi siempre*) y 2,62 (*a veces*) para la dimensión enfoque en la familia y orientación para la comunidad, respectivamente. La evaluación de las dimensiones identificó que las acciones son centradas en el enfermo, comprendiendo superficialmente a la familia y aun en menor frecuencia a la comunidad. **Conclusión:** es esencial la sensibilización de los profesionales respecto a esos aspectos, dado que por medio de estas dimensiones se puede contribuir con el control de la enfermedad como problema de salud pública.

Palabras clave: Enfermeros. Familia. Educación para la salud. Tuberculosis.

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