

# Why do tuberculosis patients look for urgency and emergency unities for diagnosis: a study on social representation

*Por que os pacientes de tuberculose procuram as unidades de urgência e emergência para serem diagnosticados: um estudo de representação social*

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**ABSTRACT:** *Objective:* To understand the social representations of patients and professionals working in the field of tuberculosis, on the reasons for seeking diagnosis and treatment in the emergency room and not in the primary health care units called *Unidades Básicas de Saúde* (UBS) or in the health program *Programa de Saúde da Família* near their residence. *Methods:* The survey was conducted in the health services in the municipalities of São Paulo and Guarulhos, Brazil, in hospitals and UBS. We interviewed 20 patients and 20 employees of these units, using the Collective Subject Discourse methodology to analyze their statements. The question presented to the users was: “Why did you seek the urgent emergency hospital and not the UBS to see if you had tuberculosis?” For professionals it was asked: “Why do you think the patient seeks diagnosis in the hospital and not in the UBS?” *Results:* As a result, two categories were found: (A) the cultural patterns; and (B) faults of the basic network. *Conclusion:* Analysis of the two explanatory dimensions show that the actions triggered by the health services should take into account the cultural patterns present in the social imaginary of the population; the health staff should receive training on specific knowledge of tuberculosis; there is a necessity of hiring human resources for the UBS and more inputs for programming.

**Keywords:** Social representation. Tuberculosis. Health services. Primary health care. Organizational culture. Health Personnel.

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**RESUMO:** *Objetivo:* Conhecer as representações sociais de pacientes e profissionais que atuam na área de tuberculose sobre os motivos da busca de diagnóstico e tratamento nas unidades de urgência e emergência e não nas Unidades Básicas de Saúde (UBS) e no Programa de Saúde da Família próximos à sua residência. *Métodos:* A pesquisa foi realizada nos serviços de saúde dos municípios de Guarulhos e São Paulo, em unidades hospitalares e UBS. Foram entrevistados 20 pacientes e 20 funcionários dessas unidades e para a análise dos depoimentos foi utilizada a metodologia do Discurso do Sujeito Coletivo. A pergunta apresentada aos usuários foi “Por que o Sr.(a) procurou a urgência/emergência do hospital e não a UBS para saber se tinha tuberculose?” Aos profissionais foi perguntado “Por que você acha que o paciente busca diagnóstico no pronto-socorro/hospital e não na UBS?”. *Resultado:* Como resultado encontramos duas grandes categorias explicativas: (A) Padrões culturais e (B) Falhas da rede básica. *Conclusão:* A análise das duas vertentes explicativas mostra que as ações desencadeadas pelos serviços de saúde devem levar em conta os padrões culturais presentes no imaginário social da população; que as equipes de saúde devem receber treinamento sobre conhecimentos específicos da tuberculose; que há necessidade de contratação de recursos humanos para as unidades básicas de saúde e mais insumos destinados à programação. **Palavras-chave:** Representação social. Tuberculose. Serviços de saúde. Atenção primária à saúde. Cultura organizacional. Profissionais de Saúde.

## INTRODUCTION

Tuberculosis (TB) is a serious social, economic and public health issue. Eight million new cases of TB are estimated every year all over the world. More than two million annual deaths are caused by TB, which kills more young people and adults than any other infectious disease<sup>1</sup>. This disease affects developing countries the most, where 95% of the cases occur due to its strong social and economic components<sup>1</sup>. People with low income living in dense urban communities, with poor housing and large families, have higher chances of getting infected, sick and die of TB<sup>2</sup>. In developed countries, TB is considered to be a re-emerging public health issue<sup>3</sup>.

With the appearance of the acquired immunodeficiency syndrome (AIDS), in 1981, a growing number of notified cases of TB has been observed among people who are infected by the human immunodeficiency virus (HIV), both in developed and developing countries. The association of both conditions constitutes a serious public health issue, which leads to higher rates of morbidity and mortality caused by TB in many countries<sup>2,4</sup>. The international goals established by the World Health Organization (WHO), which are followed by the Brazilian government, involve discovering 70% of estimated TB cases and curing at least 85%, so that it is possible to control the disease<sup>5</sup>.

In 2011, Brazil notified 69,245 cases, with an incidence coefficient of 36 cases per 100 thousand inhabitants; in the last 10 years, this incidence reduced 15.9%<sup>6</sup>. The State of São Paulo also presented declining rates in the past 10 years, of 20.2%, comparing the years 2000 and 2010. However, in 2009, when this study took place, 15,785 new cases were diagnosed, with incidence rate of 37.9 per 100 thousand inhabitants; in 2011, 16,565 new cases were discovered, with a 39.8 rate. The State of São Paulo has the highest absolute number of TB cases, therefore, controlling it should be a priority<sup>7</sup>.

The diagnosis of TB cases in major urban centers usually takes place in urgency and emergency rooms, due to several factors. According to data from the State Secretariat of Health in São Paulo, through the System of Notification and Follow-Up of Tuberculosis Cases in the State (TBWEB), the proportion of cases diagnosed in urgency and emergency services in 2009, year of the study, was of 26.1%, in Guarulhos, and 24.3%, in the capital. According to Long et al.<sup>8</sup>, emergencies are widely used by TB patients of all urban regions in the world to diagnose the disease.

The active search for TB cases is a public health activity addressed to identifying people who transmit TB (bacilliferous patients), and this is the best measure to reduce the transmission of the disease<sup>2</sup>. This activity should be permanently performed through identifying and immediately examining people who have been coughing for more than three weeks — respiratory symptomatics (RS) — and look for assistance in health services (appointments, examinations, vaccines, patches, hospitalizations etc.). Therefore, it is necessary that health professionals think and know that the disease exists, and that persistent cough can be TB. The Basic Health Units (UBS) do not perform an active search in their routine because of operational difficulties and priority in execution<sup>9</sup>. A study conducted by the Division of Tuberculosis in the State of São Paulo (CVE) and by the Secretariat of Health in Guarulhos showed that the male population at reproductive age is the one that least seeks for assistance in UBS. This is exactly the population that is mostly affected by TB.

Because of the exposed reasons, we chose to conduct an analysis to know the social representations of patients and professionals who work in the field of TB with regard to the reasons to search for the diagnosis and treatment in urgency and emergency units, instead of the UBS and the Family Health Program (PSF) close to where they live.

## METHODS

The research was conducted in hospitals and UBS, with the objective of interviewing health professional and patients with TB. Two hospitals from the Unified Health System (SUS) in the cities of São Paulo and Guarulhos were selected, which had performed diagnosis and treatment of TB in the research period. Also, the study included two UBS in the city of São Paulo and one in Guarulhos, close to the hospitals in which diagnoses were conducted. In total, 40 interviews were conducted, 20 in each city. Twenty patients were interviewed (10 in each city), aged more than 15 years old, who

were diagnosed with TB in the study hospitals. Interviews were also conducted with 20 health professionals (10 in each city). Inclusion criteria were that they had completed high school or higher education, worked in the UBS or in the PSF in which the patients undergo the supervised treatment, and worked in the field of TB by providing supervised assistance to diagnosed patients.

The interviews of the patients were conducted in the unit and/or home visit, until the number predicted per city was reached in 2008 and in the first semester of 2009. Professionals were interviewed in their workplace. This study was based on a convenience sample, since it is mostly qualitative. The study was approved by the Ethics Committee of the Health Institute of the State Secretariat of Health of São Paulo, Protocol n. 22/07. All of the interviewees signed the informed consent form, ensuring the guidelines of Resolution 196/96, from the National Health Council of the Ministry of Health.

Concerning the profile of the interviewed patients, out of the 20 patients, 12 were male and 8 were female. Out of these, 4 were less than 30 years old, 11 were aged between 30 and 49 incomplete years old, 4 were 49 years old or more, and 1 did not give this information. With regard to schooling, 12 had completed elementary school, 6 had completed high school, and 2 did not provide this information. As to race, eight were white, three were mulattos, six were black and three did not provide this information. With regard to marital status, eight were married, seven were single, two were separated, two were living together with a partner, and one did not provide this information. As to the number of children, two reported having none, three had one child, eight had two children, six had three children or more, and one did not provide this information.

With regard to the profile of the interviewed professionals, out of the 20 interviewed professionals, 2 were male and 18 were female. As to age, 1 was less than 30 years old, 17 were aged between 30 and 49 incomplete years old, 2 were 49 years old or more. In relation to schooling, one had completed elementary school, nine had completed high school, five had completed higher education, four had postgraduate courses, and one of them had a master's degree. Regarding position, three community agents were interviewed, as well as eight professionals with a high school degree and nine professionals with higher education. Considering the time of work experience, one of them declared having less than 1 year; 13 of them, from 1 to 10 years; and 6 of them, more than 10 years. In this article, we conducted a comparative study among professionals and patients who answered the following questions:

- PATIENT FORM: *Why did you look for an urgency/emergency service (hospital) and not the UBS to check if you had tuberculosis?*
- UBS/PSF EMPLOYEES FORM: *Why do you think the patient seeks for a diagnosis in the emergency room/hospital instead of the UBS?*

The Discourse of the Collective Subject (DCS) was used to analyze and process the declarations of patients and employees. The discourse strategy aims at clarifying a specific social representation, as well as the group of representations that leads to an imaginary data.

DCS consists of a non-mathematical or metalinguistic way of representing (and producing) the line of thought of a group, in a strict manner, and this is conducted with a series of operations about the declarations. These operations lead to discourse-synthesis, DCSs that gather responses from different individuals with similar discourses. It is possible to observe that DCSs are emitted in the first person singular, with the explicit objective of letting the reader feel that the speech refers to a single person. This strategy intends to show the basic mechanism of how social representations work as socially shared ideological schemes, however, experienced by individual and personal opinions. In studies with DCS, the line of thought is collected by individual interviews with open questions, which allows thoughts, such as discourse behavior and the individually internalized social fact, to be expressed. By using the software *Qualiquantisoft*<sup>11,12</sup>, it was possible to work with selected and relatively large samples of individuals and, thanks to the record embedded in the software, we could segment or filter the results by the record variables.

## RESULTS

Before we present the results, it is worth to observe that, in order to facilitate comprehension and allow a wider view of the results, we gathered the categories and their corresponding DCSs into goals or supracategories. Metacategories of answers we defined for this question were: cultural patterns and flaws in the basic network.

### CULTURAL PATTERNS OF SEARCH FOR SERVICES

A large group of explanations for the search of hospitals to diagnose TB is associated with cultural patterns that are present in the population that uses health services.

#### **Pattern 1: prejudice/fear of being identified**

Prejudice and fear are some of the reasons revealed by the interviewed professionals to explain the search for urgency and emergency services to the detriment of UBS, once the latter could be closer to the residence of the users. Therefore, according to professionals, even when patients know the UBS, they prefer to look for emergency services so they cannot be recognized.

Before presenting the several DCSs, it is worth to point out that these representations were obtained from several declarations, presented in the first person singular as if it were the discourse of a single person. Now, let's take a look at the DCS of professionals corresponding to this category:

Due to its stigma, the disease ends up leading the patients to look for a hospital that may even be distant from their houses. Sometimes, they cross the city, so they cannot be identified, and many times they can begin the treatment in this place, so they cannot be identified inside the unit; especially if they have been living in the region for a long time and might even know the employees of that unit. We conduct active searches in the houses, in the visiting routines, and the patient is approached when presenting with cough. They resist to it, some of them are afraid, the word "tuberculosis" scares them, and when we talk about the sputum examination, even if they know what it is, they are afraid to talk about it, they become resistant to it.

We can find this idea of the professional in the discourse of the interviewed patients, as in the following example.

I go to the hospital because there nobody can tell what I have. In the unit, they will know, the lady is always at my house, the neighbors will see it, so they will know I have this disease.

## **Pattern 2: look for assistance after the disease is severe**

The idea that health services should only be reached when people are feeling bad is very popular. Before that, people usually self-medicate or use home remedies to relieve the discomfort they are feeling. According to the DCS of health professionals:

They (the patients) go when they are feeling bad, because most of them wait until they are feeling bad, and then, when they already have respiratory insufficiency, and sometimes a lot of pain, they go straight to the hospital. The hospital ends up suspecting tuberculosis and requests an x-ray, or a BK test, and then refers the patients for us to treat (UBS). Sometimes, they try to heal at home, they think it could be pneumonia, or the flu, and when they feel this way, when they cannot stand it anymore, they go to the emergency room to have a quick response about what is going on. There are those patients that, even if the community agent goes to their houses to search for symptoms and tells them to go to the unit, for the sputum examination, they do not go because they think it is nothing, or they believe it is caused by smoking, or the flu. So, when they get really sick, with constant fever, they rush into the hospital because they need to at the time. So, when the situation becomes more severe, the patients look for help because they cannot stand the cough, the fever, so they go straight to the hospital, where they received the diagnosis and go back to the UBS, to continue the treatment.

The DCS of the patients confirms this statement from the professionals:

I only went there because I felt really bad. So, I thought it was nothing, because I am like that, you know, I never go to the doctor. But my family insisted on it, so I went. I didn't know I had tuberculosis, I had no symptoms of tuberculosis. The only thing that concerned me was a little pain I felt, as if someone

had turned on the radio volume and the volume remained loud all the time. I didn't know I had it, I lied down and my back hurt, but I thought I had the flu. Then I took some tea, some medicine. It took me a long time to look for help, so it accumulated and I got bad, worse, I don't know. It got worse and, when I realized it, I was vomiting blood. Then I got worse and came here.

When asked about whether or not the patients with TB knew the UBS, the explanation of the professionals was that, even though they know about the UBS, they only search for care at the late stage of the disease.

They know it (the UBS), but many people come here when they are already feeling bad. Most of them know the unit, know about tuberculosis, so when they feel bad, even with high fever, spitting blood, they go to the hospital. Usually, these patients have had the symptoms for a while. Yesterday we received a patient who had had symptoms for two years. How many people this person might have contaminated, right?

The search for the UBS is late, despite the fact that it should be their first destination at the onset of symptoms. So, the user searches for care only when there is already an emergency. The discourse of the professionals is corroborated by the discourse of the users. The next DCS shows that, even with advanced symptoms, the reference is "*I was forced to go to the hospital*".

I felt so bad that I didn't want to go to the hospital, I wanted to stay at home. I didn't want to see anyone, couldn't walk. So the urgency of the hospital was because of my conditions, I woke up in the morning with high fever, coughing and with a strong pain on my chest. I couldn't breathe because of the cough, and felt a strong pain in the chest, in this region, right here, so that is why I went to the emergency room. My daughter called the ambulance, so they took me to the hospital and I was hospitalized. But I was forced to go to the hospital.

### **Pattern 3: men do not seek for medical care**

Another behavioral pattern of the users mentioned by the professionals concerns the fact that men are not used to attending health units. The following DCS shows that, according to professionals, women go to the UBS more frequently than men. Men only search for medical care when the disease reaches its late stage. That would explain the higher number of male patients diagnosed in hospitals with TB.

Men are not used to attending the health unit. They wait until they are feeling very sick to go to one, and, in that case, they go straight to the hospital because they are feeling too sick. I think men are not as careful as women, I can tell that, so they only look for help when they feel bad. Men are resistant to look for a basic unit, and also to take care of their own health, so they are usually diagnosed in hospitals, and are hospitalized, so afterwards they are diagnosed to treat TB.

When asked about whether or not the patient knew the UBS, many professionals answered that men know about the UBS, but do not go there because they believe that men do not get sick, they do not believe in prevention and do not think they have to care for their health, as we can notice in the following DCS.

It is cultural; men do not look for the UBS. This would require more communication, beginning in school and involving the media, recommending that men should start attending the basic unit, because they also get sick. They even know about it because their wives and neighbors talk about it, or because their children have been there. So it is not that they don't know about it, but it is not part of their culture. So I believe there is the culture of the man, who never gets sick, who never needs care, who waits until the situation becomes severe in order to get help.

#### **Pattern 4: immediacy (UBS takes longer than the hospital)**

Immediacy, that is, seeing the doctor quickly, receiving quick diagnosis and medication, is another cultural pattern that leads many users to emergency services, claiming that assistance in the UBS takes longer. The DCS of the professionals below demonstrates this explanation.

I think it is the immediacy thing, they go to the hospital and think they will go home with the medicine. Nowadays, I think it is mostly because, "I have to solve this problem right now", and they think that, in the health unit, it is not going to happen because it takes longer.

The perception that the emergency service solves everything more quickly than the UBS can be observed in the following DCS of the users.

Because the hospital was closer, and they give asthma injections, so, when we go to the unit they are afraid to apply the injection, and my asthma is very severe, I think I even had a cardiac arrest that day, and here they give the correct medicine. So, I usually come to the hospital instead of the unit. Oh! Also because the UBS takes longer, and there are no experts there, only in this hospital, so I had to come here, to the hospital and look for the emergency room. Also, I did it for my mother, because she insisted on it. I was in pain, so she felt better because I came to the hospital.

#### **Pattern 5: not considering prevention**

Another explanation given by the professionals to search for emergency services instead of the UBS is that our culture did not absorb the concept of health prevention.

Actually, I think this is Brazilian culture, there is no health prevention. So, the patient begins to present with symptoms, goes to the emergency room once, twice, three times until the diagnosis of tuberculosis



is established. Then, the hospital refers this patient to the UBS. They only look for outpatient services when a hospital recommends it, and that is general, not only for the tuberculosis program.

### **Pattern 6: routine is to look for a hospital, not the UBS**

Another pattern that consists of searching for emergency services instead of the UBS has also been pointed out by professionals, according to the following DCS.

I think that, usually, these patients are not followed-up here. These patients that come here usually go to their hospital of preference. It is very rare to see a patient with tuberculosis with a medical record here in the unit, who has been seen by a doctor here. Usually, the patient comes from the hospital, skipping this outpatient routine.

This pattern is also pointed out by the users:

No, I went straight to the hospital; I went straight to the emergency room. I prefer to do it because, in the hospital, they care for everything, emergencies or not, and that is how I found out I had tuberculosis.

## **FLAWS IN THE BASIC NETWORK**

The flaws in the system addressed to UBS users were mentioned by the interviewed professionals in detail. They consider that such flaws encourage people to go to the emergency rooms. These flaws involve diagnosis, lack of professionals, lack of assistance and problems in the active search of RS.

Flaws in diagnosis: professionals report difficulties to diagnose TB, and many of them take it for pneumonia or the flu, according to the following DCS:

The complaints of the patients are not deeply investigated, and sometimes they have already been to the UBS, however, nobody suspected of tuberculosis because of the symptoms, which can be mistaken for the flu. They always consider pneumonia, even in the hospital they take it for pneumonia. That is why it takes them a long time to come to the UBS, to be examined here and then be diagnosed with tuberculosis. Sometimes it takes months. Sometimes, the patients see the doctor, complain about something, which is not specific about the respiratory symptom, so not all of the professionals think about TB. So they take it as a persistent cold, or the flu. So, after many attempts at the unit, TB is not suspected, so they go to a hospital and identify it.

The interviewed patients also referred flawed diagnoses:

I went by the unit, passed by the doctor, and they told me I had nothing. They gave me a syrup and dipyrone to reduce the fever. That is what happened. So, as I told you, at first nobody diagnosed tuberculosis, the diagnosis was of pneumonia; pneumonia with water in the lungs. So, the treatment was focused on curing pneumonia. After the first treatment, when they checked what they had done, they referred me to a unit so I could be examined, to see if I really had pneumonia or hidden tuberculosis.

**Lack of specialists:** Another flaw in the health system reported both by professionals and users is the lack of specialists in the basic network to care for TB patients.

“I think the lack of a doctors leads the patient to seek for another unit”. (DCS – professionals)

“I came here in the unit and there were no doctors that day, no doctors for my problem”. (DCS users).

**Lack of reception:** the lack of reception for the user who seeks for a health unit was reported both by professionals and users, as observed in the following DCSs.

Professionals: “Some even go to a UBS, but they end up going straight to the reception desk in order to see a doctor, but since there is no strategy to welcome them, to try and find out why they are looking for a doctor, the staff just says there are no vacancies, and no openings, so the patients prefer to go to the ER”.

Users: “It was hard for me to go there, because I had spent almost one year without going, and then I went back about three times; they told me there was no vacancy, that I needed an opening to be seen by a doctor. Then, afterwards, I came again, but the unit had no structure for me to be hospitalized, to undergo some other procedure. Also, I went on a Saturday, and the UBS does not work on Saturday”.

**Flaw in the active search for respiratory symptomatics:** the flawed active search for RS is another reason pointed out by professionals for patients to be diagnosed late in the hospitals.

Nowadays this matter of active search in the units has improved, but it still needs to get better, because the person comes, nobody listens, and sometimes they leave and go to the emergency room, so they are diagnosed there. Sometimes the staff in the units do not consider tuberculosis, they don't ask, for example, how long the person has been coughing, and you don't need to be a doctor to ask that question, anyone in the health field could do it and ask for a BK test. Besides, the active search does not reach these places men attend to, so it is difficult to do an early diagnosis, usually they are hospitalized too late, with a compromised lung and everything.

**Lack of publicity:** professionals also mention the flawed communication and education regarding health, once there should be campaigns addressed to segments that involve higher risks for the disease.

Prevention is one of the factors. Disclosure needs to reach these people, these men, wherever they are. It usually doesn't reach, for instance, bars, clubs, soccer fields associations, places where they hang out.

This statement is also present in the discourse of the patients, who claim not to know where to go and end up not receiving proper assistance.

“Besides, I wasn’t well informed about where to go, I looked for the best place someone recommended to me, and I also went to the General.”

## DISCUSSION

Facing the matter about the “reasons to search for diagnosis and treatment in urgency and emergency units, instead of UBS/PSF close to their houses”, the analysis of social representations of users and professionals, which were reconstituted by the DCS technique, leads us to two explanations.

The first one is connected to cultural patterns. A study conducted by Langdon and Wiik<sup>13</sup> indicates that the line of thought and organization of a social group to maintain health and deal with episodes of sickness is not dissociated from the view of the world and general experience about the other sociocultural aspects and dimensions. The cultural patterns to look for services reflect this view of the world, according to the sociocultural context of the social representations of TB patients and health professionals.

Among the cultural patterns found in this study, prejudice and fear are present, since participants are afraid of being recognized as TB patients. In a study conducted in Ribeirão Preto, São Paulo, Oliveira et al.<sup>14</sup> observed that 38% of the TB patients searched for health care away from their houses. According to the authors, this happens because patients seek for care in hospitals or emergency rooms, and also because there is the stigma and shame of the disease, which is empowered by the association of tuberculosis with HIV in the past few years.

According to estimations from the Brazilian Network of Tuberculosis Research, in major cities of the South and Southeast regions, about 20 to 42% of the TB cases are notified in hospital units<sup>15</sup>.

Among the cultural patterns involving the search for services, the representations indicate the fact that, in the studied group, generally, patients only seek for health services when they have severe symptoms, so prevention is not part of this culture. Other studies found similar results. Mostly, the diagnosis conducted in hospitals corresponds to more severe cases of the disease, when patients have had symptoms for longer, which can increase mortality rates<sup>14,16-18</sup>.

On the other hand, representations also point out that men do not care for health or look for health services as much as women. This behavioral pattern was also found in a study conducted by Queiroz<sup>19</sup>, in a health district of the city of São Paulo, in which 90.91% of the interviewed men were diagnosed with TB in hospitals. The higher rate of hospital diagnosis for men involves sociocultural patterns of the culture of disease, that is, health services are only used in extreme

cases. Also, after the first symptom, men take longer to seek for health care than women; since they attend the UBS more often, women know more about the disease than men, which can collaborate with early diagnosis. On the other hand, the lack of knowledge and the fact that TB symptoms are mistaken for other respiratory diseases may lead to late diagnosis<sup>19</sup>.

By interviewing health professionals, Machin et al.<sup>20</sup> observed that professionals recognize the fact that men attend health services less frequently, as well as the perception that “men do not get sick”. Besides, in the social imaginary it was possible to observe that women need to take care of themselves, while men hardly care for prevention or first symptoms, by using their working hours as an obstacle, since UBS is not open all the time; on the contrary, even if women have a paying job, this argument is no justification. The time of the women is also dedicated to health care.

The immediacy culture can also be part of cultural patterns, that is, everyone wants to be seen by the doctor rapidly, and have an efficient solution to their health problems, and the UBS does not respond to that expectation. On the other hand, interviewees recognize it is part of the routine of people to search for urgency and emergency units directly, instead of going to the UBS.

A study about emergency rooms in ItapetERICA da Serra, in São Paulo, noticed a high proportion of people who search for the hospital, but could have been assisted by primary care, in their own evaluation. The search for hospital care was mainly owed to the desire for immediate medical care, aspiration for technological resources and sensation of resoluteness in the emergency room, because there they would be medicated immediately

The immediate search for health care cannot be dissociated from cultural patterns that involve health and are connected to the negligence of users with regard to health services; there is still the idea that the basic network offers little resoluteness. Inverting this meaning is still a major challenge for integral and continuous care in primary care<sup>21</sup>. The strategy of the Directly Observed Treatment, short-course (DOTS), officially proposed by WHO in 1993<sup>22</sup>, proposed integrality in primary care. The continuous adaptation of health sectors to assist patients reflects the effort of the Ministry of Health to achieve better quality in basic health networks. Some studies indicate good results from this strategy. A multicenter research conducted in cities from the Southeast and Northeast regions observed that patients assisted by DOTS were satisfied with regard to care and distribution of medications<sup>23</sup>. In spite of that result, advances are necessary to overcome the challenge of the perception of low resoluteness in primary care. According to Monroe et al.<sup>24</sup>, it is important to invest more in the organization of primary care, which involves technical management support, adequate use of resources and professional qualification. The non-prevention culture may reflect a fragmented model of health care, which values treatments and curative actions, but lack the incorporation of principles involving health promotion<sup>14,25</sup>.

The second group of explanations leads us to problems related to services, which involve flawed diagnoses, deficient reception of patients who attend these services, unexperienced doctors when it comes to diagnosing TB in the UBS, flaws in the active search for RS and deficiencies in the processes of education and communication. The relative deficiency concerning the awareness of TB from health professionals, the lack of investments in health policies and the difficulties for patients to access these services and examinations may contribute with the difficulties to conduct a diagnosis. A study performed in the city of Nova Iguaçu, Rio de Janeiro, found that 39% of the patients attended three appointments in the UBS before being diagnosed with TB, and that the time between the first contact of the patient with the system and the beginning of the treatment was of three weeks, which is considered to be long<sup>17</sup>.

The search for primary and secondary health care services may be a result of the qualitative and quantitative lack of human resources in primary care services<sup>14</sup>. A study conducted in Niterói, Rio de Janeiro, found an association between the socioeconomic level and the longer time to reach a diagnosis; the indication was that patients with lower socioeconomic level had more difficulties to access services and waited longer to be assisted in primary care<sup>17</sup>. A study conducted by Scatena et al.<sup>26</sup> showed that the organization of TB care did not improve the access to diagnosis. The findings in this study may indicate that the fact that patients are assisted in hospitals and outpatient clinics is associated with the perception that, in these services, assistance is faster than in the UBS.

## CONCLUSION

The investigation showed that, in order to solve the discussed issue, it is necessary to overcome the traditional organization of the basic network of services, which implies that actions should consider the cultural patterns that are present in the social imaginary of their target population.

It is important to train health teams concerning specific characteristics of TB; hiring human resources for UBS; and supporting inputs addressed to programming.

But, besides that, some things should be considered:

- How to end the tendency of the user who searches for care in urgency and emergency units, directly?
- How to make men understand that health treatments should be included in their routine?
- How to insert health promotion and disease prevention in the mentality of the population?
- How to deal with the existing prejudice against TB?
- How to deal with the immediacy from the post-modern world?

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