



Care Technologies for Facing the Interruption of Tuberculosis Treatment

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Abstract

Technological interventions of high material and knowledge density did not prevent tuberculosis from continuing as a public health problem worldwide. In Brazil, treatments for the disease have a high rate of interruption. This article discusses central issues capable of ensuring that treatments are completed without interruption, interrupting the chain of transmission, and decreasing mortality from tuberculosis. A set of care technology tools is presented to understand the causes of treatment interruptions and produce care strategies to face them, through the incorporation of high relational density technologies, which build shared therapeutic projects. The strategies proposed in this article admit that events in relational processes and dialog city have occurred, so that the user-citizen person disappears from the relationship with the health teams, which needs to be reversed.

Keywords: Tuberculosis; Outcome and Process Assessment Health Care; Health Policy

Introduction

The economic impact resulting from the Covid 19 pandemic, added to the impact caused by conflicts and climate change, are promoting an increase in poverty and, thus, an increase in the incidence of tuberculosis [1]. Over the centuries, the course of tuberculosis has been impacted by the combination of economic and social advances and actions in the field of health, which have reduced morbidity and mortality from the disease. Examples of these actions are the construction of a field of knowledge for the management

of the disease and its prevention, the discovery of effective drugs for the treatment and developments in diagnostic methods, such as rapid molecular tests. However, the interventions provided have not been able to advance beyond a given level and have not allowed reaching the goal of 85% cure, recommended by the World Health Organization. Therefore, tuberculosis persists as a serious health problem on an international scale [2].

The world scenario led the World Health Assembly to approve, in 2014, the Strategy to End Tuberculosis, with

the objective of ending the global epidemic of the disease. The goals defined for the period 2016-2035 are: to reduce the incidence coefficient to less than 10 cases per 100 thousand inhabitants; and reduce the number of deaths from tuberculosis by 95% [1]. The End Tuberculosis Strategy brings “integrated, patient-centred care and prevention; build policies and support systems, with an emphasis on social protection for vulnerable populations; and intensification of research and innovation [3,4]. The achievement of the foreseen goals is linked to the implementation of public policies that improve people’s living conditions, since the disease has a strong social determination and the poorest are the most affected. In the field of health system actions, early identification of cases, prompt initiation of treatment and closure due to cure are essential. The interruption of treatment is part of the menu of treatment failures and is among the main concerns for the control of the disease, as it maintains the chain of transmission, increases mortality, and promotes the development of drug-resistant forms. In Brazil, in 2019, 12% of new pulmonary cases confirmed by laboratory criteria interrupted treatment, a proportion more than twice as high as the WHO acceptable in relation to this indicator: less than or equal to 5% [5]. In the same period, in the state of Rio de Janeiro, the percentage reached 16.9%.

In view of the results obtained with care practices for users-citizens sick with tuberculosis, issues related to care technologies become relevant. According to Gonçalves RBM [6] and MERHY EE, et al. [7], health work is built with the use of material and immaterial technologies. Merhy EE [8] uses the term “techno-assistance model” to understand the technological configurations of care, which are operated in the field of the health work process, and which are expressed as ways of generating assistance through concreteness as “technology of care” operated by three types of distinct natures, which at the same time act in the constitution of technological arrangements for the production of health care: light, light-hard and hard technologies. This article seeks to stress the mistakes of the techno-assistance model in the responses to tuberculosis illnesses, presenting the construction of a territorial base centred on light technologies to produce high-density and relational complexity care, which have been little used. Thus, we seek to highlight the potential of relational care for the creation of living networks of existence and the possibilities to reconfigure the model of coping with the care of people with tuberculosis [9].

The Micro political Plan in the Production of Health Care

The field of care technologies becomes a privileged place to face the interruptions of tuberculosis treatment, because through it is possible for professionals to see themselves in the act of caring and can, thus, place themselves in analytical

processes about their modes of care face the situation they live [10]. However, the deep crisis of the paradigm that structured the current way of working is marked, among other things, by the predominance of intervention modalities centred on hard technologies, based on a structured knowledge reduced to the production of procedures. This way of operating work, a permanent producer of the death of light technologies, inscribed in its clinical processes, systematically generates a user-worker relationship marked by a process of alienation, lack of responsibility, costly and occasionally decisive [11].

In this way of operating in the health field, the interruption of tuberculosis treatment is related to arrangements that are not fully committed to the importance of the life of the other, demanding the expansion of reflections on the power of relational care to reduce the interruption of tuberculosis treatment. In this sense, with each interruption of treatment, it is imperative to know the care technologies offered to users-citizens with tuberculosis, the way they are operated by the health teams and the reactions and feelings they trigger in the user-citizen who receive them. The expression “interruption of treatment” is being used instead of “abandonment of treatment”, recognizing that the user-citizen person is not primarily responsible for the unfavourable outcome of the treatment. Such a vision demands the implementation of a health care practice methodology that affects all those involved. The bet is that the teams will be better able to think of adequate solutions, in a shared way with the different actors. The greater their proximity and their knowledge of the problems faced by the living in the territory, their needs, demands and potential, the greater the possibility of expanding the field of care itself.

It is noteworthy that the knowledge mentioned here does not only deal with what professionals acquire in their professionalization, but with a unique production that occurs in act, in the encounter, the result of a symmetrical intersection between these actors and the unconditional adherence to the life of the other. as ethics. It also stems from the real possibility of forming a bond, allowing the production of shared community care projects, therefore, with more meaning for those people’s lives. This is because there is the power to build care technologies in their various dimensions, greatly expanding the benefit that the use of light relational technologies opens in the construction of bonds, accountability and horizontal sharing in the production of care for the self and the other [12].

Perspective of the Health Professional Relationship x User-Citizen

Health work, which is always carried out through the encounter between worker and user, is centred on live work in action, which consumes dead work in order to produce care

(MERHY & FEUERWERKER, 2016) [10]. In the care practices in force in health services, there is a strongly bureaucratic character, disciplining workers and limiting their creative capacity. The standardized protocols, the logic of production by procedures/services and the agenda oriented towards national programs are examples of the capture of the living work by the dead. However, the instituting nature of live work in action, as a micro political field holds the potential to generate lines of flight, where the creative capacity of its agents is expressed [11,13,14]

These lines of flight with different meanings can lead to caregiving movements-when the worker perceives the imprisonment of protocols or norms as an obstacle to the actions necessary to meet the needs of user-citizens. Or the opposite, lines of flight that can serve to produce an automatic action of complaint-conduct, when the worker is expected to be open to the singularity of cases and an orientation towards integrity [15]. Applying the definition mentioned above by the authors to the management of tuberculosis in Primary Care, lines of escape can be useful to professionals who are faced with the monitoring of homeless people, drug users, or people living with HIV/AIDS, for example, and who see the need to design a care plan outside the protocol rules in order to guarantee a complete treatment, and discharge due to cure. This is where the processes of subjectivation take place. Life is now no longer limited to biological processes and includes intelligence, affection, cooperation, desire. It is precisely this detachment from the biological plan that makes life gain unexpected amplitude, as Pelbart says, being redefined as the power to affect and be affected [16].

Repetition cannot be seen as *déjà vu*, as a generalization. It is important to create areas of visibility for the lines of flight under permanent construction in the field of management. It is necessary to rehearse, experiment, until something new is constituted. Then to undo it [17]. For that, some work strategies are used. Teams, support, and matrix support are new devices that can be very powerful to work on permanent education, integrity and to produce new meanings for care, for the clinic and for general training within the health graduation [18]. Thus, it is in the territory of light technologies that structured knowledge about the body of organs can be presented as an offer and not as an imposition of a lifestyle or the only valid explanation for discomfort and suffering. They can even be the tool to deal with the difference in the production of life and not as a shell that imprisons us in repetition [19-22].

Using the analogy, inspired by the text "Valises Technological", from 2010, written by Merhy EE [17], we will explain the use of care technologies in the treatment of tuberculosis and its relationship with the interruption of treatment.

- Hand valise (hard technology): Where it carries high-density palpable material technologies. Example: rapid molecular test for tuberculosis, diagnostic imaging, drugs, equipment for physical examination, equipment for recording information [23-26].
- Head bag (soft-hard technology): All the clinical and epidemiological knowledge that we hold as knowledge and that allows us, in the face of the other's life history, to think that such a situation can lead to the diagnosis of tuberculosis. The growth of the suitcase in the worker's head increases according to the learning he acquires in the world of work.
- Encounter/relational valise (light technology): Encounter-to-care relationship. When the encounter with the other occurs, the practice of welcoming, considering that the other is to be known; conversation, the ability to speak, to listen. Getting to know each other's way of life [27,28].

The impoverishment of the Encounter/Relational Suitcase can destroy the other Suitcases. For the successful use of care technologies in the treatment of tuberculosis, health professionals need to use them in an integrated way, aiming at the continuity and conclusion of the treatment. The failure of health professionals in the composition of the meeting/relational suitcase, acting in more protocol and bureaucratic ways, forgetting that the meeting has to be an event between pairs and not one to another, makes the problems persist and accentuate in the field of tuberculosis which leads to an increase in treatment interruption [18,29-31]. Relational care has several possible dimensions, one of which is interventions guided by the social history of the disease. It is therefore necessary to build care networks that unfold in a multiplicity of technologies based on the territories of people's lives and work, using tools capable of effectively interfering, with the ability to welcome, dialogue and share actions [12].

Final Considerations

The theme of "treatment abandonment" of tuberculosis has been used in a reassuring way for the current care model, which assumes that the network is working. Seen in this way, it appears that the teams master the monitoring of those they care for, being able to identify very precisely what is happening to the other. It is not usual to consider that the user-citizen has separated him from the team because he does not feel cared for by it and that the care technologies, on the scene, are producing and shaping an expulsion of the user from the context of care itself [32-35]. The notion of treatment interruption occurs when the paradigm of biomedicine is changed to the care of the micropolitics of live work in action, where relational technologies are which are central in the process. Success in coping with interruption will

increase when technological incorporations are created in the tuberculosis care process, which balance the technological arrangements of care for the territory of soft technologies as a place to govern. Monitoring with medications and treatments is important, but to impact treatment outcomes, it is necessary to generate new experiences of welcoming and valuing the other's knowledge about their own existence.

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