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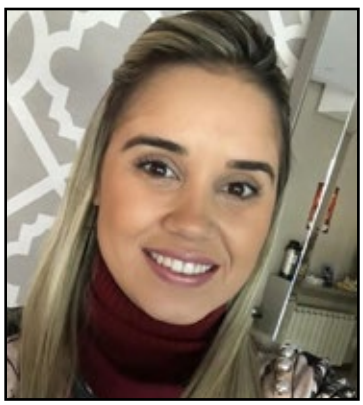

Individual and Social Vulnerability in Adherence to Tuberculosis Treatment: a Descriptive Study

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ABSTRACT

Aim: to verify aspects of individual and social vulnerability related to the diagnosis and to the potential adherence to tuberculosis treatment. **Method:** descriptive, cross-sectional study with 39 patients with tuberculosis under treatment in a municipality in the Brazilian Northeast in 2015. **Results:** lower potential for adherence was evidenced by unfavorable answers to the questions: impact of tuberculosis on work and conception about the causality of the health-disease process. Diagnosis established over a period of more than 30 days, lack of support for treatment at work, negative reaction to diagnosis, negative impact on life and lack of family support were aspects that could increase vulnerability to non-adherence. **Discussion:** the success of the treatment depends on the complexity of each case, taking into account the family, professional and social environments. The intersectoriality of actions aims to find facilitators in the resolution of this problem.

Descriptors: Health Vulnerability; Patient Compliance; Therapeutics; Tuberculosis.

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INTRODUCTION

The aspects of individual vulnerability are determined by cognitive, behavioral and social conditions, and aspects of social vulnerability integrate the characteristics of social space, current social norms, institutional norms, gender relations and inequities. It is necessary to interpret these aspects for the correct understanding of adherence to the treatment of diseases[1].

Considering tuberculosis, its directly observed treatment (DOT) aims to strengthen the adherence process, preventing the appearance of drug resistant strains of mycobacteria, reducing cases of abandonment and increasing the probability of cure[2].

In this context, markers created to detect early aspects of vulnerability in adherence to the treatment of tuberculosis patients by means of scores, with a strong potential for monitoring adherence in Primary Health Care (PHC), can improve the surveillance of people suffering with the disease[3].

OBJECTIVE

To verify aspects of individual and social vulnerability related to the diagnosis and to the potential adherence to tuberculosis treatment.

METHOD

This is a descriptive study, cross-sectional multicenter research study approved and financed by Universal Edict MCT/CNPq No. 14/2013. It was performed with 39 patients with tuberculosis undergoing treatment for at least 30 days, in the city of Campina Grande, Paraíba, in 2015. Foram incluídos como participantes da pesquisa casos diagnosticados no período de setembro de 2014 a fevereiro de 2015. Os dados foram coletados em março de 2015.

Twenty markers were selected as units of analysis, selected for expressing individual and social vulnerability elements to adherence to tuberculosis treatment. The markers are related to the dimensions contained in the instrument of data collection (validated for application in the PHC)[3]: social conditions, vulnerable contexts, health-disease process, and treatment.

For each marker there are three possibilities for responses referring to scores 1, 2 or 3. The lower scores indicate lower potential for adherence to treatment, while the higher ones express greater potential for adherence.

Descriptive analyzes (absolute, relative frequencies and boxplot graphs) were performed to visualize the data dispersion and factorial analysis of multiple correspondence to show similarities between the data.

This study was approved by the Research Ethics Committee of the Nursing School of the University of São Paulo (USP), under protocol number 912.511.

RESULTS

The markers that were most related to scores 1, indicating lower potential for adherence, were: impact of tuberculosis on work, conception on the causality of the health-disease process and work (employment status). On the other hand, markers that were most strongly related to scores 3 (which had a greater potential for adherence) were: drug use, life (housing situation) and difficulties in treatment in relation to the evolution of the disease.

Then, the factorial analysis of multiple correspondence privileged two dimensions (dimensions 1 and 2). The location of the variable "time for diagnosis" in the two dimensions allowed us

to observe that the best adherence conditions were associated with factorial quadrant 4 (when the diagnosis was made in a timely manner and had support for the continuity of treatment by co-workers).

DISCUSSION

The probability of adherence to treatment is higher, especially when the patient has some employment status, receives encouragement and support from family members and it has no negative impact on his or her life. The occurrence of such implications in the life and work of patients may provide delayed diagnosis, with a lower potential for adherence to treatment.

Therefore, once adherence to tuberculosis treatment is interfered by elements of individual and social vulnerability present in the environment in which the patient is inserted, it is possible to signal signs of non-adherence and, consequently, to stimulate the adoption of measures directed at the specific public, trying to prevent abandonment.

CONCLUSION

The use of the instrument was important to highlight markers with low vulnerability potential to adherence to tuberculosis treatment, identifying which ones require intervention. Therefore, its use in PHC is recommended for the monitoring of adherence to tuberculosis treatment because it can work in advance to the process of non-adherence of the treatment, allowing interference on it and favoring adherence to therapy.

The better the living and working conditions (individual and social vulnerabilities), the earlier the diagnosis can be made, the greater the chances of a more positive repercussion occurring, representing more favorable factors for adherence to therapy. Therefore, intersectoriality can reorient actions in resolving this problem.

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