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Quality Perspectives in Tuberculosis Control Programs Evaluation

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Abstract

This paper consists of a theoretical analysis on program evaluation, focusing on the Brazilian National Tuberculosis Control Program, which has been implemented in 1998. It is a conceptual construction that discusses the need, during the evaluative process, to take into consideration the distinct dimensions relating to quality of care, which are central to the Brazilian proposal. Comprehensiveness and humanization of care and their distinct dimensions should be covered, due some symbolic aspects involved in tuberculosis care, in dialogue with professional training. Finally, some theoretical contributions towards the design of evaluative studies are presented, thus showing the qualitative approach as a methodological resource that is inherent to analysis of the multiple dimensions present in this program.

Keywords: Evaluation; Qualitative research; Health services; Health policy; Public health; Tuberculosis

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Introduction

The Brazilian National Tuberculosis Control Program (Programa Nacional de Controle da Tuberculose, PNCT) was implemented in 1998 as an instrument for enabling universal access to tuberculosis control actions. Its aim was particularly to restructure the fight against tuberculosis in this country, through integrating surveillance, control and prevention actions [1].

The National Program for Tuberculosis Control (NTCP) is integrated into the health services network and it is developed by means of a program unified in the federal, state and municipal levels. The guidelines of the NTCP include the establishment of norms by the Ministry of Health including a set of actions: acquisition and supply of medications, ensuring from the distribution free of drugs and other supplies needed to preventive and injury control actions; referrals for laboratory tests and treatment; coordination of the information system; support for states and municipalities; and intersectoral linkups [2,3]. This allows universal access of the population to their actions. The international targets set by World Health Organization (WHO) and agreed by the Brazilian government consists to find 70% of the estimated TB cases, correctly handle 100% of them and cure 85% of them.

Among the countries that are responsible for about 80% of tuberculosis cases worldwide, according to the WHO, Brazil is

ranked 14th despite the advances in surveillance [4,5]. Every year, in Brazil, 110,000 new cases are notified and 6,000 deaths due to the disease are observed [4]. The control of HIV/Tuberculosis (TB) co-infection remains an additional challenge for public health [6-9].

The NTCP needs to be put into operation in conjunction with the Family Health Program, which is a strategy that has been implemented to reorientate the healthcare model in Brazil. This implies placing value on comprehensive and continuous actions for health promotion and recovery and for disease prevention among individuals and families, based on an expanded notion of healthcare [10].

This linkage, which aims to improve adherence to treatment and decrease the abandonment of treatment [4,11], corresponds to placing the NTCP at all levels of healthcare, especially primary care. This position relates to the need, in putting it into operation, to incorporate the principles inherent to this system: universality, equality, comprehensiveness, humanization and resolvability, among others. The literature points out the humanization of health practices with the family and their social space becomes the framework of this new coping strategy, which will surely be a success factor for the objectives to be achieved. In order to understand these important aspects of TB epidemics it is necessary to perform qualitative studies.

Evaluation of the Qualitative and Qualitative Evaluation: Conceptual Demarcation

The evaluation of health policies and programs can be defined as “a set of systematic procedures that aim to give visibility to what is done by reference to what can be done and/or is desired, with regard to the interest in, effectiveness, operational capability and quality of actions, technologies, services or healthcare programs” [12].

It is common to talk about evaluating (or evaluation) while forgetting that this term allows a wide range of senses that are often antagonistic. Uchimura and Bosi drew attention to what they defined ‘polysemy of quality’. They emphasized that intrinsic multidimensionality is a condition inherent to quality, taken to be the passage of quality between the domains of objectivity and subjectivity; while extrinsic multidimensionality is taken to be the capacity for quality to vary and differ according to the positions or interests of groups or social players [13].

Recognition of the extrinsic multidimensionality of quality converges with the fourth-generation characteristics (fourth-generation evaluation) reported by Guba and Lincoln. This points towards the need for negotiation and consensus among the different social players [14].

Within the field of healthcare program evaluation, many authors have pointed out the difficulty in conceptualizing quality [15]. The difficulty that persists in recognizing its polysemy is also perceptible. This results in weakening the concept, since certain meanings and consequently, certain dimensions are preponderant in the evaluative models most used. In other words, the paradigm that guides the evaluation of the quality of healthcare programs and consequently the quality within the scope of tuberculosis control focuses excessively, if not exclusively, on the objective dimensions of quality, i.e. the ones that can be quantified [13]. This results in exclusion of the subjective, symbolic dimension, i.e. the human dimension, thus compromising the evaluation of the processes that compose a program or action [15]. The literature shows the importance of symbolic and cultural dimensions for the success of a policy, especially the stigmatization [16].

Ayres recognized the polysemy of quality and developed a classification proposal (for the evaluation of programs and services) that we have taken to be a perfected version of formulations that have been constructed based on evaluative possibilities [12,13]. In summary, it consists of recognizing two types of evaluation. One of them, called normative evaluation, is aimed at verifying the “technical success” [13,17] of healthcare actions, which includes the products of healthcare work. This type is generally limited to quantification, because it is used to evaluate formal elements of an intervention. It can be accepted as fitting perfectly with what is called evaluation of the formal quality.

The other, called formative evaluation, goes beyond the objective dimension of quality, turning to judgment of the “practical success” [12] of a healthcare action. In other words, it is aimed at the subjective dimension of quality and has a formulation analogous to the concept of qualitative evaluation [15].

It is worth noting that evaluation studies with traditional outlines, focusing on analysis of the efficacy and/or efficiency of a given

program, would be appropriate for analyzing or measuring the technical success of the program, i.e. its formal and therefore objective quality. On the other hand, evaluation studies that are aimed towards the subjective dimension of quality and take in the factors of experiences, emotions and feelings, would be appropriate for analyzing the effectiveness of a healthcare program [18,19].

In more specific terms, the NTCP evaluation can benefit by implementing the qualitative evaluation approach because it allows to better understand some process such as: the access to and the quality of health services; user’s satisfaction of health professional practice; the attitudes and beliefs of patients and relatives, including stigmatization; the humanization in health care, among others dimensions that lead to treatment default and mortality. However, regarding the studies methodology, predominance of quantitative studies was still observed [20], focusing on costs, epidemiology factors or quantitative aspects of quality, without considering the symbolic dimension [21-23]. Despite this hegemony, we can find studies oriented by the qualitative approach. A meta-synthesis study developed by Noyes and Popay [24] is helpful to demonstrate broadly some central contributions of this approach to Brazilian NTCP evaluation. Their study reiterates the importance of considering “socio-economic circumstances [...] explanatory models and knowledge systems in relation to tuberculosis and its treatment; the experience of stigma and public discourses around tuberculosis; sanctions, incentives and support, and the social organization and social relationships of care”, among others aspects.

The comparative analysis of both methods clearly shows we need not only to measure outcomes or prevalence of TB, but also to indicate how to overlap the set of obstacles linked to subjectivity, and how to ensure, in the health service’s practice, some principles like humanization, according the stakeholders voices. It is a central challenge not only for the NCTP in Brazil, but most Public Health problems across the world.

Final Considerations

As we have sought to point out, talking about evaluating healthcare programs and services touches on a complex situation: an objective and symbolic network that is far from simple as a context for reflection and practice.

Concerning evaluations of control programs direct to diseases like tuberculosis, following the example of the PNCT, we can see a great task ahead of us. This implies recognizing and considering the centrality of the symbolic processes and the perspectives of the players involved, especially the users. In particular, this includes what healthcare quality and disease etiology means for them. Therefore, there is the requirement to give value to social players’ perceptions, taking these perceptions as expressions of experiences materialized within relationships established through a given program. This represents an indispensable tool for managing the health system and consequently a policy and its programs, services and actions.

In summary, qualitative evaluation is the type of evaluation that necessarily focuses on the dimensions that escape from

numerical indicators and expressions, since it is aimed at the subjective production that permeates practices within the field of healthcare; in this case, a program.

Finally, we emphasize that talking about humanization and comprehensiveness and in order to incorporate them as

principles within the field of evaluation implies including the players involved in healthcare actions and their subjective demands, values, feelings and desires. Without these, we would be dealing with other concepts of quality that are far from the principle-centered model that guides the purpose of the National Tuberculosis Control Program in Brazil.

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