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Research Article

Political Commitment in the Transfer of Tuberculosis Policy: From the Discursive to the Production of Meanings

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Abstract

Objective: To analyze the effects of meaning on the political commitment of the Mozambican Government in the transfer of the policy for the control of tuberculosis from the perspective of health professionals.

Method: This is a qualitative study that uses the theoretical methodological framework of Discourse Analysis. Fifteen health professional subjects with more than one year of experience in the tuberculosis control program were interviewed. This study is approved by the National Bioethics for Health Committee and authorized by the Minister of Health of Mozambique.

Results: Three discursive blocks emerged: 1) the political commitment of the Government of Mozambique to adhere to the tuberculosis control policy; 2) evidence of lack of commitment in the transfer of policy for tuberculosis control; and 3) the subjects' imaginary and the challenges in relation to political commitment and the implementation of the policy for tuberculosis control.

Conclusion: Political commitment to policy transfer is complex and requires increased government funding, human resources, adequate infrastructure, coverage of health services and uninterrupted supply of medicines and other hospital supplies.

Keywords: *World Health Organization (WHO); Directly Observed Treatment of Tuberculosis (DOTS); Policy Transfer (TP); Political Commitment (PC)*

Introduction

The World Health Organization (WHO) implemented the Directly Observed Treatment of Tuberculosis (DOTS) strategy in the 1990s, which was transferred to countries, states and local contexts worldwide [1]. This significant movement of transferring a policy from one place to another is what is called Policy Transfer (TP) [2]. For effective TP and the maintenance and expansion of any public health policy, political commitment (PC) stands out as a cornerstone, especially in countries with less financial and human resources [3]. Likewise, the CP in a certain way reinforces the guarantee of the right to health as the right to life [4]. In this sense, the PC in TP for the control of tuberculosis (TB) is related to the capacity of a government to make available to its health system the financial and human resources, knowledge and information, the laboratory network for carrying out the exams, the medicines to patients uninterrupted, constant training of health professionals in PD matters for TB control, as well as the creation of coverage conditions and access to health services for the entire population, especially those affected by TB [1,5].

The Mozambican government's PC in relation to the fight against TB started before the TB Control Strategy was developed and recommended by WHO, when two years after the country's independence in 1975, Mozambique identified TB as a public health problem and created the National Tuberculosis Control Program (PNCT) [6]. In this context, the Mozambican government requested technical assistance from the organization International Union Against TB and Lung Disease (IUATLD), launching a strategy to control TB integrated into the National Health System [7]. However, this technical support, despite being based on Directly Observed Treatment (DOT), in the initial two months of treatment, did not mean the implementation of DOT in the whole country was just a pilot experience.

The implementation of the registration of TB cases systematically began in 1984 with the expansion of the PNCT [6] and from 1993 Mozambique began to appear on the list of the 22 countries most affected by the disease, according to the WHO classification [7].

In 2000, the DOTS strategy was implemented in all districts of the country [6], even so, the country came to declare TB control as a National emergency in 2006, due to the proportions that the disease gained until that year [8]. It should be noted that in all these years, the CP of the government of Mozambique consisted of accepting the TB control policy, diagnosing and treating patients, providing medicine and financing the PNCT and training human resources.

The budget allocated to the PNCT ranged from 4.3% in 2014 to 5.6% in 2017 of the total amount ($ 199,877,369 in 2014 and 244,621,345 in 2017) allocated to all Public Health Programs in Mozambique, to quote: National Tuberculosis Control Program, Maternal and Child Health Programs, Vaccination, Malaria, Nutrition, Noncommunicable Diseases, Mental Health, Adolescent Health, Health Promotion, School Health, Epidemiology, Neglected Tropical Diseases and Preventive Medicine. However, this budget is not enough to control the disease that is estimated to affect around 160,000 people a year in Mozambique, of which less than 50% are detected and treated [6,9,10].

Regarding the diagnosis of TB, although there are several methods (clinical examination, chest X-ray, evidence of tuberculin reaction, culture, among others), Mozambique, a country with few financial resources, chose to choose bacilloscopy using the Ziehl-Nellsen method as the recommended technique for the PNCT, with a view to diagnosis in various parts of the country, mainly in rural areas [11]. Furthermore, this method detects most bacilliferous cases, evaluates the success or failure of treatment, in addition to being a simple, fast and low cost method [11].

With regard to human resources, despite the government making an effort to increase the number of health professionals, Mozambique still continues to have critical problems with health professionals, specifically doctors, whose person-doctor ratio is from one (01) doctor to more 30 thousand people, well below what is recommended [10].

In view of the above, it appears that despite the political commitment of the Mozambican government to control TB since the 1970s, this has not been sufficient since the cases of the disease continue to increase making the country one of the most affected population proportion.

In 2016, the annual number of incident TB cases, in relation to population size, varied widely across countries as a whole, from less than 10 per 100,000 inhabitants in most high-income countries, to 150 to 300 in most of the 30 countries with a high TB load and over 500 in some countries such as the Democratic People's Republic of Korea, Lesotho, the Philippines, South Africa and Mozambique, a country with an estimated 27 million inhabitants in 2017 [10].

In this context, despite the importance of the PC and the country's effort to diagnose and treat the disease, this evidence indicates that the Republic of Mozambique still presents difficulties in the government's commitment to TB control actions, a situation that weakens and reinforces the denial of the disease. right to health and appropriate coverage of health services. These barriers are characterized by a deficiency of human resources, whether in quality and/or quantity, insufficient sanitary infrastructure and laboratories, and reduced government funding regarding actions to combat TB, making it difficult to control the disease [3,12,13]. Thus, in order for TP to be effective for TB control, based on ideas, objectives, policies and knowledge, it is important that the government engages in the search for solutions, expanding DOTS in all communities [1,12,14-16]. This implies an increase in the detection and notification of cases of the disease by the health services; the TDO; regular availability of medicines; the systematic registration of cases and the government's commitment to implementing TB policy as a priority [3].

Through a bibliographic survey in the databases Pubmed, Latin American and Caribbean Literature, and Africa Medicus Index, few articles were found on the CP [5,17]. One of them published in Brazil, discusses the implementation of the DOTS Strategy in TB control, focusing on PC and the involvement of managers in the program [5]. Another study carried out in South Africa focuses on TP in the introduction of a new diagnosis, which somehow requires some PC from those who transfer [17]. No studies were found in the databases researched about PC specifically in TP for TB control, through the discourse of health professionals and managers both in Mozambique and in other countries. In this sense, the relevance of this study consists of adding knowledge to the literature on the political commitment linked to the transfer of the policy for the control of TB, focusing on the actors that execute it at the local level. In this way, the objective of the research is to analyze the effects of meaning on the political commitment of the Mozambican government in TP to control TB from the perspective of health professionals.

Method

It is an exploratory-qualitative study using the theoretical methodological framework of Discourse Analysis (AD) of French matrix. AD understands the discourse as effects of meanings among the interlocutors, while the materialization of ideology [18,19]. In this way, the subjects when they position themselves in their sayings are inscribed in certain discursive formations, what in a given ideological formation, that is, from a given position determines what can and should be said [4,18-20]. In this context, it appears that the meanings do not exist in themselves, but are determined by the ideological positions adopted by the subjects when uttering the words [13].

The study was carried out in Mozambique in 2014, from May to August, at the Central (Ministry of Health), provincial (Nampula Provincial Directorate) and District levels, in the districts of Mecubúri, Meconta, Mogovola, Monapo, Muecate, Murrupula Nampula -Rapale and Ribaué. Health services in Mozambique are divided into four levels of care: primary level - composed of health posts and centers, comprising the respective health areas; the secondary level consisting of rural, district and general hospitals; the tertiary level - organized in provincial hospitals; and finally the quaternary level - composed of specialized hospitals [21]. Health posts and health centers are the first level of contact for patients, and the other levels are for reference.

Fifteen health professionals who occupied the positions of managers, doctors, nursing professionals and technicians participated in the study and were considered inclusion criteria for being and acting in the PNCT for over a year; be active at the time of the interview, and accept to be part of the research. For data collection, a consensus was established between the professional and the researcher to schedule the date, place and time of the interview.

The interview script was guided by the following questions: (i) talk about your experience about the government's PC in TB TB, (ii) how has the government's commitment in TB therapy TP been? (iii) what are the lessons learned and the challenges faced by health professionals in TB TB? All interviews were audio-recorded and lasted between 18 and 55 minutes.

For the analysis of the data, three steps were followed, namely: the passage from linguistic surface to object of discourse - consisted of repeated depth readings that provide the understanding of the symbolic material and the identification of fragments that were constituted in discursive blocks and respective discursive sequences.

The second stage, the transition from the discourse object to the discursive process - consisted of identifying the discursive and/or significant sequences to be analyzed and capturing the meanings produced. In this stage, it was identified the discursive formations in which the enunciated words are inscribed.

The third stage, the passage of the discursive process itself (ideological formation) - consisted of mobilizing the theoretical framework of the theme under study and mobilizing the theoretical assumptions of DA, interpreting the discursive sequences and the signifiers previously identified in the clippings.

At the end of each clipping, the subjects were indicated with the letter S, followed by the number of the interview and the position occupied by the interviewed subject: GC (Central Manager), GP (Provincial Manager), GPE (Manager - Nursing Professional), M (Doctor) and TM (Medical Technician). It is noteworthy that the participants were informed about the research objectives and their right to abandon the interview, at any time, if they so wished. All interviews were conducted after signing the Free and Informed Consent Form (ICF).

It should be noted that this study is approved by the National Committee for Bioethics for Health in Mozambique under protocol number 87/CNBS/2014 and registered with the same committee under number 03/CNBS/2014, in accordance with the requirements of the Declaration of Helsinki and also approved by His Excellency Minister of Health of Mozambique with note number 731/GMS/002/2014.

Results

Three discursive blocks emerged that constituted the analysis corpora: The CP of the Government of Mozambique in adhering to the TB control policy; Indications of lack of commitment in the TP for TB control; Imaginary of the subjects and the challenges in relation to the PC and the implementation of the TB control policy. Of these discursive blocks, sayings that focus on PC and others that point out the lack of PC and the circulating challenges in the ideological imaginary of health professionals about TP were notable.

The CP of the Government of Mozambique in adhering to the policy for the control of TB as a determined socio-historical event is presented in the speech of the S11GPE through the following excerpt: (...) the short-term regime (...) we started in the 90s here at least in my district (S11GPE).

From the outline that follows the subject position in its statement, it signals the Government of Mozambique's adherence to the WHO global policy for TB control.

"Stop TBPatnership": (…) TB was declared a national emergency in 2006, so, since that time (...) the Mozambican Government has adhered to most of the policies that were established by WHO (...). Thus, Mozambique adhered to STOP TB Patnership and all documents and standards (S1GC).

Between the lines of the excerpt below, the presence of statements that emphasize the political commitment of the government of Mozambique in terms of financing is notorious: (...) the government has already committed itself to increasing TB financing in recent years, it has already accepted it. (...) one of the prerequisites for continued financing by the global fund (...). So, currently, the government has already committed to contribute 5% of all funding that is allocated in Mozambique (...) (S1GC).

The indications of lack of PC in the TP for TB control are (d) stated by the subject health professionals through the discursive sequences that follow, in which there is the report of the involvement of health professionals with low academic training and insufficient same for the coverage of health services, described as obstacles in the TP process for TB control: Most of our human resources in the TB district are basic nurses (elementary nurses) (...) (S1GC).

If I have few human resources for a range of patients, there begins to be a kind of failure there, so human resources must be guaranteed. So if I guarantee the human resources, then the effectiveness can also pay me a lot. So one of the weaknesses at the moment is this demand, (...), of patients who exist against the human resources factor (S10M).

In the cut-out below, the long distances to access the laboratory network are indicated as an indication of lack of commitment and as a difficulty in the TP to control TB in primary care services, as can be seen in the following cut-out: (...) the laboratory network is not the one desired, the province has 57 laboratories that perform sputum smears, which means that the situation of long distances that patients travel to make the diagnosis persists (S2GP).

The lack of contractual activities (partnerships, norms, guidelines, understandings and coordination) between the government and the healers, and the traditional beliefs existing among the population that base the circulating meanings on the symbolization of the disease and in the treatment process constitute interfaces that challenge the government's CP: Chronic cough always has a traditional explanation that must be resolved in the healer. Activities have been carried out to train healers, but unfortunately, the healers who usually follow the recommendations (government recommendations) are the healers enrolled in the Association of Traditional Doctors of Mozambique and it is perhaps 1/5 of the total healers we we have (...) (S1GC).

The long distances between the patient's home and the health unit and the lack of community agents in these places are described as obstacles in the TP of Directly Observed Treatment of TB: (...) most inhabitants live (...) more than 8 km from the nearest health unit, making it difficult to cover this distance and make direct observation of treatment with assiduity. (...) the main constraint has been the difficulty of finding volunteers (Community Health Agents - ACS) in (...) areas that are more than 8 km from the health unit (S1GC).

The Imaginary of the subjects and the challenges in relation to the PC in the implementation of the TB therapy policy is represented by the circulating meanings that focus on the real history of TP: need to strengthen the health system and the community health system, improvement of the capacity to management, and the existence of representatives of PNCT managers in health units.

One of the most important lessons we are learning from the strategy: it is not easy to implement, so we need to strengthen our health system. For years, we will not be able to cover the whole country in terms of health infrastructure, so we need to strengthen the community health system. (...) improve the management capacity of district supervisors, also improving incentives (S1GC).

For the effectiveness of TP, in the subject's imagination, it is necessary to have professionals who work in the control of TB in all health units: If we could have focal points (people who represent the PNCT in health centers where TB treatment is not yet taking place) in all existing health units in the district, or if we could do some kind of training to ensure that the patient who is in the health unit or distant from the headquarters health center to be assisted there (S10M).

In the professional's imagination, the geography of the residents' location and TB itself, as a disease that constitutes a serious public problem, are described as a challenge: TB is a challenge for the government ... because ... we are here, but there are areas that we have not reached. It is a great challenge (...) (S8TM).

Discussion

The corpora that constitutes the symbolic material for analysis, in its general computation, is permeated by the circulating senses that suggest that the PC, in the scenario under study, is still insufficient. In this context, from the first discursive block, it is noteworthy to say that they point to the beginning of the CP as an event that is inscribed in a story: "we started in the 90's". This discursive sequence encourages us to think that Mozambique adhered to the policy of directly observed TB therapy, shortly after its approval and recommendation by the WHO in 1993. However, it is noteworthy that Mozambique had been applying DOT since the 1980s in a program pilot carried out in the Mozambican capital [16].

The words: TB was declared an emergency in 2006 bring with it an indicative paradigm that instigates to consider, that only in that year, after the worsening of the disease in the country, did the government adhere to the policy: since that time (...) the Mozambican Government most policies adhered (...). These statements (d) state, on the one hand, that TB TB in the country, even though it dates back to the 1980s [13], its application was not yet effective as certain WHO standards were not yet followed.

From the discursive sequences, Mozambique adhered to STOP TB Patnership and all the documents and all the norms, there is a subject position affected by the ideology and challenged by the interdiscourse, enrolling in a discursive formation that emphasizes the poli-

tical aspect of the TP emanated by WHO as important in TB control. The specific goals established in the End TB Strategy include a 90% reduction in TB deaths and an 80% reduction in TB incidence (new cases per year) by 2030, compared to 2015. Achieving these goals requires provision of care and TB prevention in the broader context of universal health coverage, multisectoral action to address the social and economic determinants, as well as the consequences of TB and technological advances by 2025 in this regard, so that the incidence falls more rapidly than rates achieved historically [10]. In this context, it can be inferred that in order to achieve the TB reduction target, the CP of each government in countries whose TB is a public health problem such as Mozambique is important.

Significants adhering to all regulations prompt us to think about the existence of the country's will to control the disease. The discursive sequence the government has already committed makes sense of a commitment at TP. The PC becomes important because it helps to promote national and international partnerships, which must be combined with long-term strategic action plans, developed by national TB control programs [12]. The same signifiers, in their unspoken, suggest that there are difficulties in the government's commitment to TB TB before 2006.

The discursive sequence, one of the prerequisites for the continuation of the financing (...) is that the government increases its financing (...), (d) enunciates a condition that, indirectly, suggests the country's obligation, which receives funding, in adhering to the established standards. Furthermore, the same sequence encourages us to think that TP in Mozambique is copy-coercive, that is, TB control policies are mandatory and copied from global policies. However, it is emphasized that this coercibility is necessary in compliance with the rules for the reduction of TB [14,17]. From this perspective, it can be seen that countries like Mozambique, where per capita income is low, the CP is fundamental to support the global structural and financial changes, necessary for the improvement, availability, distribution and motivation of professionals [2].

From the symbolic material exposed in the clippings of the second discursive block, it is observed that the subject positions inscribed in them (d) enunciate the components that indicate the lack of PC with the supply of health professionals with greater preparation: most of them (...) is a basic nurse; if I have little human resources (...). It is noteworthy that the term basic nurse, in the context in which the discourse was produced, is a professional who does not yet have a secondary level, but who has completed the basic technical level of nursing that corresponds to the 10th year of schooling. These sayings (d) also state the numerical insufficiency of professionals to care for the person with TB. The lack of human resources is a challenge for countries in sub-Saharan Africa and mainly in Mozambique [21], given that they are key actors in the TP for TB control [14,15].

Laboratories and their equipment are a fundamental part of the TB treatment policy, however, their deficiency may indicate the lack of PC and the fragility of PT, a situation that makes it difficult to treat and reduce TB cases. The existence of 57 laboratories is insufficient to meet the population demand in health facilities. The significant long distances (...), instigate to think that several patients live far from a hospital or health center, a situation that can negatively interfere in TB control PD and consequently in the treatment of this disease. The discourse sequence of chronic cough always has a traditional explanation that (...) instigates to think that cultural beliefs have influenced the way of thinking about the disease. In these conditions of production, these beliefs produce a symbology of what TB is and how it is cured. This situation instigates to think about the State's need to legislate and guide this group of traditional medicine practitioners and integrate them into the health system [4].

The discursive sequence but unfortunately (...) maybe 1/5 of the total of healers we have here in Mozambique (...), (d) states, on the one hand, the lack of control and or coordination between the healers and the government through health services. Furthermore, (d) it states the insufficiency of health services and the lack of their capacity to inspire confidence in the population, which suggests the need for the National Health Service to rethink the policies for health education and health surveillance adopted, because a well-coordinated health surveillance needs to inspire confidence for the population regarding the use of health services [12].

The last discursive block produces learning and meanings that mean for the subjects and, that impel for reflection of new actions: (...) we need to strengthen our health system. The signifiers fortify the system (d) state the weakness that is registered in the area of management, supervision in the health system. The same words prompt us to think about the existence of a fragility in the health system characterized by a lack of qualified professionals and adequate infrastructure, medicines and mainly financing: the government has to be more involved (...). This discursive sequence encourages us to think about the need to change the attitude of managers and the need for government involvement in TB control [3,12]. In linguistic marks, polysemy seems to be a challenge, that is, what we have in it is displacement, rupture of processes of meaning, playing a mistake [19] and producing meanings of a multidimensional challenge: difficulty in transferring politics, and to control TB [12].

From the analyzed symbolic material, it appears that the PC in TP in Mozambique is still insufficient and constitutes a challenge for the government, which impels the government in the need to act on the components that interfere in the PC: provision of health services. quality health and for all, training and hiring more qualified health professionals, increasing and improving laboratory equipment, increasing funding for the TB control program and acting on health determinants: drinking water supply, housing and the environment, sanitation, poverty reduction, among others.

Conclusion

From the conditions of production of this research, it is clear that the PC at TP for TB control is complex and includes improvement in the supply and preparation of human resources, adequate infrastructure, coverage of health services, supplies of medicines and other hospital materials, inclusion of community health services and coordination of all actors in the health sector, including healers, in addition to the design and monitoring of policies that are increasingly favorable and comprehensive to populations, especially the vulnerable.

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