

## Right to Health: Limits and Possibilities of Access to the Treatment of People with Tuberculosis

Fernando Mitano<sup>1\*</sup>, Fátima Popino<sup>1</sup>, Rarianne Carvalho Peruhype<sup>2</sup>, Glauder dos Santos Palha<sup>3</sup>, Aline Aparecida Monroe<sup>4</sup> and Pedro Fredemir Palha<sup>4</sup>

<sup>1</sup>Professor, Lúrio University, Nampula, Mozambique

<sup>2</sup>Professor, Universidade Federal de Pelotas, Brazil

<sup>3</sup>Universidade de São Paulo, Brazil

<sup>4</sup>Professor, Universidade de São Paulo, Brazil

\*Corresponding Author: Fernando Mitano, Professor, Lúrio University, Nampula, Mozambique.

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### Abstract

**Objective:** To analyze the limits and possibilities that interfere in the right to health of people affected by tuberculosis in the municipality of Nampula, Mozambique, Africa.

**Methods:** This is a qualitative study that uses the theoretical and methodological framework of the French Matrix Discourse Analysis.

**Results:** 22 subjects were interviewed who had been on tuberculosis treatment for more than two months. From the symbolic material for analysis, three discursive blocks emerged: "Weaknesses in health services: a denial of the right to health"; "Social determinants and their relationship with the denial of the right to health"; "The family as a support structure for the right to health".

**Final Considerations:** The analyzes show that the right to health has not yet been fully realized in Mozambique, due to weaknesses in the health system and social determinants such as the lack of transportation, food, decent housing and employment for the group affected by the disease, the that impels government action in these areas for the realization of the right to health.

**Keywords:** Right to Health; Public Health; Tuberculosis; Health Policy; Public Health Nursing

### Introduction

The right to health is constituted as a civil, political and social right, and has been difficult to enforce in almost all countries of the world, occurring in an aggravated way in developing countries [1-3]. Addressing the right to health means talking about a set of rules and law whose scope is to promote human health collectively and individually [1]. Furthermore, talking about this right includes talking about access to health services, quality of human and material resources necessary to achieve health, improvement of conditions that aggravate people's risk of acquiring diseases, transparency in the management of the health system beyond the right to consent to treatment and the right to decision [1].

In several countries around the world, the right to health is being called into question, due to: the fragility of health systems that are far from providing a quality service to the entire population; social inequities; lack of transportation food, sanitation, and decent housing; weak financing of the health system, mainly from the National Tuberculosis Control Programs (PNCT) [4-6].

In this context, people affected by neglected diseases such as tuberculosis (TB) are one of the groups of patients whose right to health has been neglected by governments. In some African countries, especially those in sub-Saharan Africa, where Mozambique is located, there is an increasing number of TB cases [6], which indicates the difficulty of these countries in controlling the disease, and in effectively the right to health for affected people.

It is known that around 10 million people are infected with TB and of these 5,000 die daily due to their association with HIV/AIDS [6,7]. However, despite the fact that TB is one of the oldest diseases known to humans, it is one of the 10 that causes the most deaths and one of the 10 most rapidly spreading infectious diseases in the world [4,7], although it is curable when treated correctly [7].

When the World Health Organization (WHO) declared TB as an emergency and advised countries and governments to use directly observed short-term treatment, from the English Directly Observed Treatment Short course (DOTS) [6], Mozambique through the Ministry of Health had already begun to engender actions aimed at reducing disease since the late 1970s and early 1980s, however, with each passing year there is an increase in TB cases in the country. Thus, after about three decades after the WHO declared the disease as an emergency, Mozambique has not yet managed to reduce the number of cases detected per year [5-7].

Currently, in Mozambique, it is estimated that around 162 thousand cases of TB occur each year, making it one of the diseases that causes the most deaths in that country [4,6]. However, the cases notified in the country, for example in 2018, were 92,381, a number that is below the estimated. This situation may be related to the low treatment coverage, which is estimated at 57% [7,8], leaving the destiny of the lack of realization of the right to health to several Mozambicans affected by TB.

In 2015, the The End TB Strategy came into force with the objective of eliminating the global TB epidemic, and one of its principles is the protection and promotion of Human Rights and equity [8]. In this sense, the declaration of the disease as an emergency, and the elaboration of the strategy by the WHO demonstrates the concern of that organ in proposing to the nations the realization of the right to health for people affected by TB and protection of more people who did not contact or did not develop the disease. However, both the declaration and the strategy, alone without actions by governments that contribute to the allocation of the right to health to TB teachers, the disease may still persist.

The people affected by TB in Mozambique are among the most likely to see their right to health violated, due to the low coverage of health services that is estimated at 57%, in a population of about 29 million inhabitants, scarcity of health professionals, poverty, lack of employment, and a high illiteracy rate, estimated at 40% in the Mozambican population [5,6]. These people have more difficulties in accessing the health unit, getting around, eating and having decent housing, conditions that can determine the worsening of the disease and interfere in the enjoyment of the right to health. Full access to these people's right to health requires that countries also act on poverty, air pollution, work and living conditions, social inequalities and equity [4,7], that is, the realization of this right to health depends not only from the will of WHO, but mainly from that of governments and the way health services are structured, distributed and operate.

Despite the importance of this theme, a bibliographic survey was carried out using the Pubmed, LILACS, Scielo, Scopus, and Africa Medicus Index databases, using the Health Sciences Descriptors (DeCs): Right to Health, Public Health, Tuberculosis and Social Inequities, and the Medical Subject Headings (MeSH) descriptors: Right to Health, Tuberculosis, Public Health, and Mozambique were also used and there was a scarcity of studies on the subject both in Mozambique and in other countries. A study carried out in Mozambique on the right to health emphasizes the inconsistency that exists between law and practice on the part of the national health system [2]. The study published in the journal *Health and Human Rights* [9] addresses the right to these benefits of scientific progress that can contribute to rights-based approaches to address multidrug-resistant TB, emphasizing that a better understanding of the right to these benefits can help advance legal and civil society action for health rights [9]. Still, another study carried out in Kenya on this topic addresses the active search for people who abandoned TB treatment as an alternative need based on human rights [10], but none of them discusses the right to health: limits and possibilities of access to services of health for people with TB.

### Target

Analyze the limitations and possibilities that interfere with the right to health of people affected by TB in the municipality of Nampula, Mozambique.

### Methods

#### Ethical aspects

The study was approved by the Institutional Bioethics Committee of Universidade Lúrio and in order to safeguard the anonymity of the study participants, they were identified by the abbreviation of the word subject (Suj.), Followed by subsequent Arabic numerals, according to the order in which the data collection was performed.

#### Theoretical methodological reference and type of study

This is a qualitative exploratory study that uses the French Matrix Discourse Analysis (AD) approach, which is concerned with understanding the language producing meaning through symbolic material (signifiers, statements) [11]. Discursive studies “aim to think the meaning dimensioned in time and space of man’s practices, decentralizing the notion of the subject” [11]. The subject is understood as the positions that individuals take during their speech [12]. And this is understood as the effect of meaning between the speakers [11]. In this sense, every discourse is anchored in a discursive formation, that is, what in a given ideological formation, from a given position, determines what can and should be said. In this context, it can be inferred that words and expressions receive meanings from the discursive formation in which they are produced [11]. Thus, an analysis based on this framework allows us to understand the meanings produced through symbolic material.

#### Methodological procedures

##### Study scenario

The study was carried out in eight health units (Health Centers of 1<sup>o</sup> de Maio, 25 de Setembro, Muhala Expansão, Namicopo, Annex to the Psychiatric Clinic, Napipine, Military Hospital of Nampula and Hospital Geral de Marrere), in the Municipality of Nampula, in Mozambique.

##### Data sources

The study included 22 subjects aged between 18 and 60 years of both sexes who had been under treatment for more than two months, that is, who were in the treatment maintenance phase. These subjects were chosen for convenience. Participants were informed about the objectives of the study and those who accepted it, together with the researcher, scheduled the date and place of the interview.

##### Data collection and organization

The interviews were conducted by the first author in one of the rooms provided by the director of the treatment unit for the sick person between October 2017 and January 2018. The interviews were audio-recorded and had an average duration of 30 minutes, taking place without interruption. The interview covered the following guiding questions: Can you talk about your day-to-day life as a TB patient? What services did you have to obtain the diagnosis? What are the difficulties you have regarding treatment in the hospital?

For the organization of the data, the Atlas TI version 6 software was used. Thus, the reference discursive sequences for analysis were identified, however it should be noted that the Software did not interfere in the choice or analysis of these sequences.

### Data analysis

The data were analyzed based on the theoretical framework of the French Discourse Analysis AD [11], which is based on three steps. In the first, the interviews were transcribed and several readings were made, “passing from the linguistic surface to the discursive object.” In the second step, called the passage from the object of the discourse to the discursive process, the discursive sequences of reference that played an important role in the production of meanings were identified. In this step, the production conditions and discursive formations in which the propositions and signifiers were inscribed were taken into account. Finally, the third step, “ideological formation”, consisted of returning to the discursive sequences that were highlighted for analysis, mobilizing the theoretical framework used in the study to support and qualify the interpretations.

### Results

The symbolic material for the analysis consists of discursive reference sequences carefully chosen because, according to the researchers, meanings circulate that (d) enunciate the difficulty of realizing the right to health for people affected by TB. Three discursive blocks were created for analysis: Health services weaknesses: a denial of the right to health; Social determinants and their relationship with the denial of the right to health; The family as a structure for access to health. All study participants until the date of the interview lived on the outskirts of the city of Nampula, and none of the interviewees had completed high school.

As for the “Fragilities of health services: a denial of the right to health”, it is observed that in this discursive block, the positions of the subjects affected by TB, (d) state the difficulty of health professionals to suggest the examination of TB to the patient in the first consultation, which leads him to seek the same service several times or others, since the treatment suggested the first time did not have the expected effect, as can be seen in the discursive sequences that follow.

(...) I came the first time they prescribed pills for me and it didn't happen. I came back again they prescribed me and it didn't pass, so for the third time I asked to do the saliva test. Still to explain it better, the first time I came I took it I stayed 7 days to medicate: paracetamol and cotrimoxazole, I took it up to 7 days it didn't last I came back again (Subject 1).

To detect that I have tuberculosis I went to several hospitals. I went to a military hospital and went to Hospital Central and then to Hospital Geral de Marrere (Subject 3).

The action of going to the Health Unit several times and receiving inadequate treatment for the disease is pointed out as an experience lived by the sick subjects, as can be seen from the discursive sequences that follow between the lines below. But there can also be an awakening in them about TB from the words of other people or from the words inscribed in pamphlets already existing in the health units as (d) enunciate the patients.

I went to the hospital several times and they said it was a fever and they never found out. So I came to this hospital and I was told it was this disease (Subject 7).

I started coughing and went to the hospital and they always gave me pills and it didn't go away. But there at the hospital I saw that pamphlet that says that 3 weeks of cough is TB. Then I was thinking, is that it? Then my friend advised me saying that it could be tuberculosis, because he had it but he got beaten up in prison (Subject 12).

The lack of materials and medicines contributes to the denial of the right to health to people affected by TB, as can be seen from the linguistic-discursive statements.

So the difficulties were when there were no materials, no syringes, for almost 3 days there was no material and it was up to 13 hours without assistance, so to avoid this I would go to the private pharmacy to buy syringes to receive my medication to be injected the medication (Subject 1).

There is no shortage of medication difficulties, but this already has nothing to do with the medicine, because if the medicine has nothing to do with the person who serves us, it is not to blame, so as I said when I have a syringe problem, I will purchase (Subject 1).

To get here it was hurting my chest, I couldn't breathe, so I came here to the hospital and they gave me pills and the second time they told me to do X-rays and at that moment it was getting worse so they sent me to do X-rays. They sent me here to take the exam (Subject 9).

With regard to the discursive block, Social determinants and their relationship with the denial of the right to health, the circulating discourses that denounce the socioeconomic conditions that interfere in the treatment of the disease and consequently in the denial of the right to health are observed in the symbolic material. In this sense, signifiers are enunciated that indicate the lack of money, food, water, decent housing, long distances between the patient's residence and the health unit, as can be understood from the discursive sequences of this block.

The discursive sequences of subjects 7, 6 and 21 (d) state the lack of food and employment as aggravating elements of the disease and difficulties in the treatment of patients.

When I take the medication I get dizzy, if I don't eat it makes the situation worse, I get sick (Subject 7).

(...) if that day there is no dinner, I sleep without eating. I have no money, we have no money. My husband has no job and I don't work. And I have been very hungry due to the medications (Subject 6).

My problem is lack of food, I don't work, I don't have a job. My husband doesn't have a job either, and we live 7 people at home, we don't have breakfast! (Subject 21).

The lack of water is also one of the problems that interfere in the treatment of the disease. Furthermore, the lack of fees caused by the appearance of TB disease in the patient is pointed out as another aggravating factor.

There is a lack of water in the city. So, in the morning, I have to go and pour water in buckets and after that, take the medication (Subject 6).

Every day I have had great difficulties, I have not received it for six months, because they want a justification role for my service, but I have already delivered it, now I am waiting (Subject 8).

Living far from the health unit, lack of transportation, being subject to precarious activities for their own livelihood, and also precarious housing have been identified as obstacles in the treatment of TB.

My problem is the distance. I live a long way and I have transportation difficulties, because it is difficult (Subject 20).

When I came they asked me and I said I was coughing so they started to suspect TB. In fact, I started to suspect once I made fried foods, worked on the fire and also sold charcoal (Subject 21).

As for the third discursive block, the family as a structure for access to the right to health, the positions subject to people affected by TB (d) state the participation of the family in the process of seeking, diagnosing and treating the disease, as important, which can maximize the access of the sick person to health services and, in a certain way, to the right to health. Family help is important in the treatment of the disease, as can be seen in the following discursive sequences.

My family treats me well. When I ask for something they give it to me, then help me (Subject 6).

I don't know how the procedures were in the first meeting with the health professional because my brother took me to the hospital, I was in bad shape (Subject 7).

In the discursive sequences that follow, the action of the family or of some family member emerges as being important in effecting the treatment: (...) they gave me bottles and I took sputum which I later took to the laboratory. But all of this with the help of my brother (Subject 7).

My mother told us to go to the hospital, first she took me right here, this door here. I did saliva analysis (Subject 9).

My father called me here in Nampula to come and try other resources as well, when I got here I started treating myself and it was from there that they discovered that I had tuberculosis (Subject 18).

My first meeting was witnessed by my children, because they took me to the hospital (Subject 19).

On my first day of meeting with the health professional, I was serious, who spoke to the nurse or doctor were my family members who took me (Subject 20).

The fragments presented are the symbolic material to be analyzed. In them there are statements that produce meanings that mean, allowing to understand the limitations and possibilities that interfere in the right to health.

### Discussion

The results of this study, constituted by the corpora of speeches of the subjects who discursively take positions of patients affected by TB and under treatment, suggest that the subject positions on the one hand (d) enunciate the difficulties of realizing the right to health characterized by the lack of material, medication, unpreparedness of health professionals to suspect TB in people at the first consultation; lack of food and precarious economic conditions; but on the other hand, they enunciate speeches that impel to assume that the family constitutes the supportive nucleus, contributing to the consolidation of the right to health, since it has accompanied patients to health units.

The fragility of health services in Mozambique is one of the obstacles to the realization of the right to health [2]. In this context, in light of the production conditions in which the sick subjects were, at the time of the interview, it appears that their statements bring an indicative paradigm of the denial of the right to health. In this regard, the Constitution of the Republic of Mozambique makes explicit, through Article 85, that "all citizens have the right to medical and health care, under the terms of the law, (...)" [12]. However, it does not specify which principles will be followed for the realization of this right, a situation that contributes to the incongruity of the plasmado (having the right to health) and the practicality of the health system in the Municipality of Nampula, as can be inferred from the symbolic material that profile in the words of the interviewed subjects.

The action of returning to the health unit, going through several hospitals, walking several times to the hospital without an exam to diagnose TB suggests, on the one hand, the lack of preparation of professionals to suspect and suggest a TB test to patients, but on the other hand they leave traces that the health system in Mozambique is still unable to fully satisfy the needs of the diagnosis and treatment of people with TB [4].

The sequences of speeches: they always gave me pills and it didn't pass; I came back again they prescribed me and it didn't pass; to detect it (...) I went to several hospitals (...), they leave traces that impel us to consider, that the statements may indicate not only the lack of

preparation of the professionals, but also other adverse conditions to which the National Health System Health goes through, namely the lack of qualified professionals, their overload, greater demand for health services, lack of medicines and insufficient medical technology, among others [2,6]. In view of the above, it is noted that TB control is more likely to be achieved in a country that faces challenges in the fight against the disease, with a fragile health system and considerable work overload by health personnel if the level of knowledge TB is increased among health professionals who manage a group of TB patients [13].

Furthermore, it is known that strengthening health systems for the early detection of TB and improving the quality of care for this disease, including rapid and accurate diagnosis, early initiation of treatment and regular monitoring are priorities for reduction and control disease [14] and increasing the realization of the right to health.

The detection and rapid treatment is incompatible with the overload of health professionals, which tends to weaken the health system since the service has not been of quality, a situation that makes patients not have access to treatment and consequently the right to Cheers.

The practice of giving medication without the definitive diagnosis of the disease contributes, in a way, to the delay in the detection of the disease and its spread. This situation makes evident the existence of a collective and structuring denial of the right to health [2,14].

From the discursive sequences “time when there were no materials, syringes, for almost 3 days (...)”; “It was up to 13 hours without assistance”, it can be inferred that the subject position is part of discursive formations that point out the limitation of health services in offering decent and uninterrupted treatment to people due to the lack of proper instruments for treatment, as is the case with the syringe mentioned by the subject. This situation mobilizes the patient himself to buy it to carry out his treatment: “so to avoid this, I would go to the private pharmacy to buy syringes to receive my medication”. These signifiers produce plaintive circulating meanings that denounce the way in which health services deny the right to treatment to people with TB, which is characterized by a lack of materials for treatment [13,15].

From the signifiers “there is a lack (...) of medication, but (...) this has nothing to do with the person who attends us, he is not guilty”, it can be inferred that the subject in discourse counter-identifies the behavior of the professional with the Health System in which he works, pointing him as fragile and unable to keep medications uninterrupted [14]. This situation leaves several people without access to medication and treatment, in addition to being able to contribute to the disease’s resistance to treatment and consequently the denial of the right to health.

The social determinants of TB constitute a great affront for the realization of the right to health for patients affected by TB, because they deteriorate the situation of the patient, which is in itself precarious, preventing him from having access to treatment. The social determinants of TB include the lack of decent housing, nudity, housing in places such as slums or without territorial order that facilitates air circulation, lack of public transport, food, employment, drinking water and people’s exposure to inhuman services, alcoholic beverages, and tobacco [15].

The lack of food is described as an obstacle in the treatment of TB, as can be understood from the signifiers that follow “if you don’t eat, the situation will get worse”; “My problem is lack of food”. Food is one of the basic and indispensable needs of man and is still very necessary in sick and undergoing treatment. In this context, the lack of food is described as one of the problems that increases the risk of abandoning treatment and dying. The lack of policies related to food production in developing countries like Mozambique, constitutes a denial of the right to health, since it leads to poor health and aggravates the disease and makes it impossible for people to continue their treatment [10,15].

Another social determinant of TB (d) enunciated by the subject positions is present in the linguistic-discursive marks “I don’t work”; “I don’t have a job”. “My husband has no job”; “I’m out of money”. This lack of jobs and money, in the broad production conditions of the



interviews, has been a concern for the population. In Mozambique, about 47% of the population is unemployed, a situation that makes life difficult for people and especially those sick with TB [2].

Another denial of the right to health is noted in the following signifiers: “I have had great difficulties (...) I do not receive it, because they want a justification role”. In these words, the unspoken is notable, but it is said and silenced in the significant “great difficulties” denouncing not only the lack of salary, but the violation of the right to health by the employer, aggravating the patient’s socioeconomic situation. This aggravation, which can be a factor of treatment abandonment [16].

The linguistic-discursive sequences “I live very far and I have transportation difficulties, because it is difficult” produce meanings that encourage us to realize that in Mozambique and particularly in Nampula the public transport system is precarious and unable to satisfy the population. In view of these determinants, it is important that Mozambican authorities in all sectors mobilize efforts to improve people’s lives by reducing poverty and social inequalities that are a global imperative enshrined in the United Nations’ Sustainable Development goals [17].

In this context, considering that TB is known as socially determined, its control will only be achieved through a multifaceted and holistic response that includes the correct and immediate diagnosis, treatment, employment, nutrition and housing [17,18]. In this sense, acting in this way, the right to health for people affected by TB will be guaranteed.

From the words of the discourse block “The family as a structure for access to the right to health”, the imaginary of the person with TB is understood, understanding the family as important in the process of treating the disease. This participation of the family in the diagnosis and treatment of the person with TB, constitutes a driving factor for their participation in the treatment and strengthens the triangular ties family-hospital-person with TB, ensuring the maintenance of the patient in treatment, which in a certain way This way guarantees the right of access to health services and consequently the right to health. The participation of the family, despite not interfering in the decisions made about the person with TB, in some way, interferes in the compliance with the treatment and in the reduction of the spread of the disease, which requires that both the person with TB and the family know the way transmission, treatment and the care you should take [19].

The signifiers “my brother took me to the hospital, I was in bad shape”; “My family accepts me” are inscribed in discursive formations that recognize the role of the family as important in supporting the sick, contributing to a certain extent in the realization of their right to health. These sayings also produce meanings that lead us to believe that the demand for health services has been late, situations that cause the late treatment of the disease [19,20].

The figures mother, brother, son, become important in the treatment of the disease: “but all this with the help of my brother, it is my mother who told us to go to the hospital”; “In the early days my children witnessed it”. These statements leave traces that although the family is important for the patient’s life and participate in his treatment, his action has been late [21]. The action of going late to the health unit can be an obstacle to the realization of the right to health and also indicates the lack of correct information about the disease in the population.

In the discursive sequences analyzed, several meanings circulate that leave clues to the existence of difficulties in realizing the right to health, in the conditions of production in which the study was carried out, despite the government’s effort to treat people with TB [22].

### Study Limitations

The limitation of the study is the fact that it focuses on the right to health of TB patients undergoing treatment in the maintenance phase, leaving aside those who are undergoing treatment in the intensive phase and those of other neglected diseases.



### Contributions to the Area of Nursing, Public Health and Public Policies

From the symbolic material of the analyzed subjects, it can be seen that there is a weakness in health services, lack of preparation by health professionals, overload of them, in addition to the lack of hospital material and the difficulty of patients to eat properly, situations that contribute to the full lack of effectiveness of the right to health to TB doetes. Thus, these findings are important for the areas of Nursing, Public Health, and Public Policy, because from these findings, strategies for improving health services and the qualification of professionals can be designed, in order to realize the right to health, in addition to leading health professionals to be aware of the lack of realization of the right to health for patients.

The nurse, as one of the main protagonists in TB control actions, can promote coordinated actions that lead to rapid identification of the disease and effective treatment and thus contribute to the realization of the right to health of people with TB.

### Final Considerations

From the analyzed symbolic material, it is observed that the health services of Mozambique still face difficulties in realizing the right to health, especially for people affected by TB. The delay in treatment and the various difficulties, such as lack of transportation, food, lack of medication are aggravating conditions for the denial of the right to health of thousands of people with TB. In this context, for the realization of this right, the competent authorities in the area of health and the government as a whole need to move actions to improve the sectors of education, health, public health, transportation, housing, food, basic sanitation, among other sectors. It can be understood in this way, that the realization of the right to health for people affected by TB implies the mobilization of joint actions by various sectors of the government.

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