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Aspects hindering the quality of tuberculosis care records in primary health care

Aspectos dificultadores da qualidade dos registros inerentes ao cuidado em tuberculose na atenção primária

Aspectos que dificultan la calidad de los registros de atención a la tuberculosis en atención primaria

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ABSTRACT

Objective: To analyze managers' discourses regarding aspects that hinder the quality of records related to tuberculosis care in Primary Health Care.

Method: A qualitative study conducted in a municipality in the state of Paraíba, Brazil. Data were collected through 55 individual interviews between June and September 2023. The collected material was systematized using ATLAS-ti® 23 software. The theoretical-methodological framework of Pecheutian Discourse Analysis was used for the corpus analysis.

Results: The main aspects hindering the quality of records are related to factors inherent to professionals and services: improper completion of forms, insufficient information in medical records, the large number of reports, and difficulties with the electronic record system. Another set of hindering aspects is associated with users, such as: failure to attend health services, treatment abandonment, and lack of recognition of the disease.

Conclusion: It was found that managers recognize the difficulties regarding the quality of records, but do not demonstrate proactivity in addressing them. There is a need for managers to participate in continuing education processes, with the aim of developing and applying specific strategies to improve records related to the care of people with tuberculosis, especially in terms of notification, treatment follow-up, and data completeness.

Descriptors: Tuberculosis; Records; Health Management; Primary Health Care.

RESUMO

Objetivo: Analisar os discursos dos gestores a respeito dos aspectos que dificultam a qualidade dos registros relacionados ao cuidado em tuberculose na Atenção Primária à Saúde.

Método: Estudo qualitativo realizado em um município do estado da Paraíba, Brasil. Os dados foram produzidos por meio de 55 entrevistas individuais no período de junho a setembro de 2023. O material coletado foi sistematizado no software ATLAS-ti® 23. Foi utilizada para a análise do *corpus* a fundamentação teórico-metodológica da Análise do Discurso pecheutiana.

Resultados: Os principais aspectos dificultadores da qualidade dos registros estão relacionados a fatores inerentes aos profissionais e aos serviços: preenchimento da ficha de maneira inadequada, poucas informações no prontuário, o quantitativo de relatórios e as dificuldades com o sistema de registro eletrônico. Outro grupo de aspectos dificultadores está associado aos usuários, como: não comparecimento ao serviço de saúde, abandono do tratamento, e falta de reconhecimento da doença.

Conclusão: Foi verificado que os gestores reconhecem as dificuldades quanto à qualidade dos registros, no entanto não demonstram proatividade para saná-las. Há a necessidade da participação dos gestores por um processo de educação permanente, com o propósito de desenvolver e aplicar estratégias específicas para a melhoria dos registros relativos ao cuidado da pessoa com tuberculose, especialmente nos aspectos de notificação, acompanhamento do tratamento e completude dos dados.

Descritores: Tuberculose; Registros; Gestão em Saúde; Atenção Primária à Saúde.

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RESUMEN

Objetivo: Analizar los discursos de los gestores sobre los aspectos que dificultan la calidad de los registros relacionados con la atención de la tuberculosis en la Atención Primaria de Salud.

Método: Estudio cualitativo realizado en un municipio del estado de Paraíba, Brasil. Los datos se obtuvieron mediante 55 entrevistas individuales realizadas entre junio y septiembre de 2023. El material recopilado se sistematizó en el software ATLAS-ti® 23. Para el análisis del corpus se utilizó la base teórico-metodológica del análisis del discurso de Pecheut.

Resultados: Los principales aspectos que dificultan la calidad de los registros están relacionados con factores inherentes a los profesionales y a los servicios: cumplimentación inadecuada de la ficha, escasa información en el historial clínico, cantidad de informes y dificultades con el sistema de registro electrónico. Otro grupo de aspectos que dificultan la calidad está asociado a los usuarios, como: no acudir al servicio de salud, abandonar el tratamiento y no reconocer la enfermedad.

Conclusión: Se verificó que los gestores reconocen las dificultades en cuanto a la calidad de los registros, pero no muestran proactividad para solucionarlas. Es necesaria la participación de los gestores en un proceso de educación permanente, con el fin de desarrollar y aplicar estrategias específicas para mejorar los registros relativos a la atención de las personas con tuberculosis, especialmente en lo que se refiere a la notificación, el seguimiento del tratamiento y la completitud de los datos.

Descriptores: Tuberculosis; Registros; Gestión Sanitaria; Atención Primaria de Salud.

INTRODUCTION

Tuberculosis (TB) persists as a global public health issue, remaining one of the leading causes of death from an infectious agent. In 2023, approximately 10.8 million people developed TB, and 1.25 million died from the disease worldwide. In 2024,84,308 new cases of TB were reported in Brazil, representing an incidence of 39.7 cases per 100,000 inhabitants. It is imperative to improve and expand control strategies to achieve better outcomes and meet the targets established in the National Plan to End Tuberculosis[1].

Primary Health Care (PHC) provides an essential organizational structure for implementing this control. This organization, combined with decentralized care, allows for the formulation and implementation of actions aimed at ensuring effective care, as well as enhancing active case finding, contact investigation, and clinical follow-up through directly observed treatment (DOT), contributing to the reduction of treatment abandonment rates, resistant cases, and deaths[2,3].

For this process to be effective, the involvement of multiple health services is necessary, which demands the use of instruments that enable communication and integration between them, as well as promoting the continuity of actions and the coordination of care by PHC[4]. The use of information tools aims to manage TB cases, supporting the actions performed by managers and health professionals, ensuring data quality, and assisting in planning and decision-making that can improve care management for people with TB and disease prevention[5,6].

It is crucial for management to assign new dimensions to the role of information and define its importance for professionals working in PHC, since the use of health records, such as medical charts, notification forms, e-SUS, case registries, among others, can contribute to providing quality care to people with TB[7,8].

Considering that records are essential in the care process for TB patients in PHC, it is necessary for the multiprofessional team, including those working in epidemiological surveillance, to correctly complete the records, as these instruments contain information about all care provided to the patient, contributing to the effectiveness of care and efficiency in monitoring actions[8].

Beyond patient identification, test results, and treatment regimens, records should include information on biopsychosocial and spiritual aspects, clinical intercurrences, and guidance regarding medication, disease, and self-care[4].

Collecting patient information within PHC involves a series of factors that may interfere with data analysis and management, such as incorrect information entry in the system or medical chart, workload among professionals and service coordinators, as well as delays in the data collection process due to the presence of numerous bureaucratic protocols and divergence in information. This can negatively affect health planning and action development, hindering better patient care and disease prevention[6].

Therefore, for records to be fully utilized by health professionals, they must be completed correctly, without errors, to present the real clinical situation of the

individual, contributing to the continuity and comprehensiveness of care. The recording of care for people with TB should be complete, as coherence and clarity in writing allow professionals to identify which clinical changes require greater attention[9].

Health records have been the subject of research both in Brazil and internationally, particularly in secondary sources, which have addressed the incompleteness of records of TB care actions/guidelines[9,10], the volume of records generated in TB detection[10], the completeness of TB case records in the Notifiable Diseases Information System (*Sistema de Agravos de Notificação* - SINAN)[11] and the underreporting of TB cases due to incomplete records[12,13].

In this study, records of care for people with TB are understood as systematically collected, observed, and/or detected data, recorded in institutional health documents, with the purpose of producing qualified information that guides and directs care actions at the individual, family, and social levels. This definition is based on the authors' experience in this field.

Therefore, the present study aimed to analyze managers' discourses regarding aspects that hinder the quality of records related to TB care in Primary Health Care.

METHOD

Exploratory research with a qualitative approach, guided by the criteria included in the Consolidated Criteria for Reporting Qualitative Research (COREQ).

The study was developed in the Family Health Units (FHU) and in the five Health Districts (HD) of the municipality of João Pessoa, capital of Paraíba. The PHC service is structured by 211 Family Health Teams (FHT) and 99 Family Health Units (FHU), covering 90% of the municipal territory.

The population selected for the study consisted of professionals working as managers in the HD and PHC services in the municipality, totaling 79 managers, five of whom are in the Epidemiological Surveillance sector and 74 as Health Managers in FHU. The selection of Health Managers was performed by requesting, from each HD, the list of FHU that reported TB cases from 2021 to the first half of 2023. This period was chosen due to the change of the municipal manager, which largely results in the transfer of some professionals, as well as new hires.

It should be noted that, only in João Pessoa, was the term Health Managers adopted to refer to the professionals working in the management and monitoring of each FHU. Since professionals from Epidemiological Surveillance and Health Managers participated in the research, the term "managers" was used throughout the study to refer to these professionals.

Inclusion criteria were: Health Managers and professionals working in Epidemiological Surveillance as TB references in the HD for a minimum period of six months; Health Managers who had TB cases in their unit during their management. Exclusion criteria were professionals who were on vacation, leave, or any other reason preventing them from performing their duties during the empirical data collection period.

Of the 79 individuals eligible to participate in the study, one did not meet the inclusion criteria because they had held the position for less than six months, two were on vacation, five were on leave or could not be identified, and 16 refused to participate in the study, resulting in a sample of 55 interviews. The sample was selected by convenience, and participants were approached personally at their workplace and informed about the purpose of the study.

To prepare the empirical material, the interview technique was adopted, using a semi-structured script composed of open-ended questions, developed in accordance with the research objectives and structured in six discursive questions: 1. As a manager, talk about your experience regarding the care provided to people with tuberculosis; 2. Regarding records of care provided to people with tuberculosis, what do you consider should be recorded?; 3. Considering your experience as a manager, could you talk about the weaknesses found regarding the quality of records?; 4. Mr., how does the quality of these records impact care management and the generation of health information?; 5. Mr., could you describe the difficulties faced in ensuring satisfactory quality of these records?; 6. Based on your experience, how can a manager contribute to improving these records?

The interviews were recorded using a smartphone audio recorder and subsequently fully transcribed, with an average duration of six minutes. They were conducted at locations and times chosen by the participants, all at the workplace, with only the researcher and the interviewee present in the room. A pilot test

was conducted to test, modify, and improve the data collection instrument. The pilot test was conducted in eight randomly selected Family Health Units (FHU). These interviews allowed the authors to reflect on the questions and adjust them for better understanding by the interviewees.

For the transcription of the participants' statements, Google Docs® voice typing and the transcription and captioning software Happy Scribe® were used, resulting in the textual corpus.

The interviews were systematized in the ATLAS-ti® software version 23, using the Pecheutian Discourse Analysis (DA) technique[14].

In the first moment, the aim was to identify the analysis-concept. For the interpretation of the research corpus, the analysis-concept "Difficulties in ensuring the quality of care records for people with TB in PHC" was used. The concept-analysis and the discursive corpus were established through the guiding question "What do managers' discourses reveal regarding the difficulties for the quality of records on the care for people with TB in PHC?", consequently, the meanings attributed by the managers related to the records on the care for people with TB were identified, through meticulous readings and the identification of textual markers, until sample saturation, signaled by the absence of new elements in the discourse, to the point of being concluded.

In the second moment, the analysis was written, articulating the perceptions and elucidation of the theme found by the researcher, along with an explanation of the theoretical-analytical framework.

From this perspective, the aim was to understand the meaning constructed by the managers that supported the analysis report as: interpretation relating to the path of the discourses taken from the corpus and description; the return of the analysis, outlined by the moment in which the content contemplates the feedback provided by the social and which must be returned to the social sphere; allusive to and concerning the appendices and annexes regarding the investigated theme, revealing the role of ideology in its written expression[14]. The following Discursive Blocks emerged: difficulties for the quality of records resulting from factors inherent to professionals/services; difficulties for the quality of records resulting from factors inherent to users.

This research project was reviewed by the Ethics Committee of the Health Sciences Center of the *Universidade Federal da Paraíba* – UFPB, complying with ethical and legal guidelines. Approval was granted on April 25, 2023, under opinion no. 6.020.651 and CAAE no. 68596423.1.0000.5188. Therefore, the study was conducted respecting all ethical criteria applicable to research involving human beings, as per Resolution 466/2012 of the National Health Council, ensuring confidentiality and anonymity of the subjects, which were guaranteed through coding with the letter M, referring to "managers", followed by Arabic numerals according to the order of the interviews M1 to M55.

RESULTS

A total of 55 managers participated in the study, of whom 46 were female, with a mean age of 41 years, ranging from 23 to 69 years. They had diverse educational backgrounds, such as: Nutritionist (12); Physical therapist (14); Administrator (2); Social Worker (8); Psychologist (6); Nurse (3); Dentist (2); Physical Education Professional (2); Lawyer (2); Pharmacist (1); Biologist (1); Speech Therapist (2). Among these professionals, 31 reported having a specialization degree; of these, only 11 were specialists in family health.

The predominant employment relationship was as service providers (51). Regarding time working in management positions, the average was six years, with only four interviewees reporting less than one year of experience.

After the presentation of the theme and the objective of the research, resistance from managers to participate in the study was identified during data collection. They claimed that there were few TB cases in the territory, that they did not have much information about TB records, and that, as this was an attribution of another health team professional, it would be more feasible to conduct the research with nurses, physicians, or pharmacists, since these professionals were responsible for dealing with other issues such as receiving and distributing food baskets for patients, submitting notification forms, medication delays, among others.

The analysis was conducted by identifying two discursive blocks: difficulties in the quality of records resulting from factors inherent to professionals/services; and difficulties in the quality of records resulting from factors inherent to users, as described below.

Difficulties in ensuring the quality of records resulting from factors inherent to professionals/services

The difficulties pointed out by managers, which weakened the quality of care records for people with TB, were associated with professionals who did not complete the forms appropriately, the entry of limited information into medical records by professionals, the volume of reports to be completed, difficulties in using the electronic record system, and the fact that records were completed manually.

> *And I think that many times it comes down to the professional themselves. The professional profile not liking to keep records, and I think that is something that happens a lot in primary care nowadays.* (M18)

> [...] *it will depend on the prescriber, the physician or nurse who is reporting the case, to correctly complete the record.* (M29)

> *I think that some professionals make mistakes in entering the data correctly. They often do not complete the form properly.* (M10)

> *The records are of quality, but what sometimes has a small impact is that we may even receive some guidance, and sometimes the notification ends up missing some information.* (M46)

> *The difficulty some professionals have, especially physicians, since nursing already has a greater habit of completing the medical record more thoroughly and providing more details* [...]. (M52)

> *Look, nowadays health units report that there are many reports to be completed, many spreadsheets. It really is a large demand.* (M50)

> [...] *the routine of primary care is another difficulty as well, with numerous lines of care and diverse demands.* (M1)

> [...] *sometimes there's one or two who have difficulty using the system, but that's happening little by little, right?* (M4)

> *If there were less bureaucracy and a more electronic system. I think paperwork is making things a little difficult. Because by the time they bring it, pick it up, and do all that part. If it were more electronic, I think it would improve our records.* (M39)

Difficulties in ensuring the quality of records resulting from factors inherent to users

Regarding difficulties related to obtaining quality records, managers mentioned that these were associated with people with TB who did not attend health services, who abandoned treatment, who did not recognize themselves as having TB, or who did not adhere to treatment.

> [...] *the difficulty of... having the patient... patient adherence to treatment, because sometimes many don't want to or don't show up when it's time to pick up medication* [...] *this creates weaknesses in the record, right? Not having patient attendance, right? And treatment adherence can lead to this, because there won't be the necessary information, right?* [...] *think it has more to do with the patient not coming in than with the professional not making the record.* (M12)

> *The difficulty encountered is only with the users, because with my professionals, from the experience I've already said, and in the space where I am, I don't have this difficulty.* (M17)

> *No, the difficulty I see is treatment abandonment in relation to the patient. But regarding the team, no. We are well aligned.* (M27)

> *So, there are patients who aren't, it's their fault, they don't want to complete the treatment, so they run away, you know? But, regarding the unit and the records, I think everything is OK.* (M35)

> [...] *I think the difficulty encountered is really on the user's part. Their acceptance, you know?! Having the awareness that they have the disease and that they need treatment and to continue this treatment. Many of them do this treatment, but sometimes they even abandon it.* (M43)

> *It is basically what I have already said, right? This issue of adherence and the patient not showing up, which will generate this overall lack of information.* (M12)

The difficulties are basically these: when we lose contact with the user, when they move away, or when they do not answer the phone [...] *the greatest difficulty is this disappearance of the user, because sometimes it makes it difficult for us to collect this information.* (M44)

The difficulties I encounter are more related to the user's own information, you understand?! For them to tell the truth. And to accept it, because nowadays it's difficult, incredibly, for them to accept that they have the disease and to provide the correct information so that we can monitor and identify the problem, right? [...] The difficulties are more related to the patient themselves, to the user themselves providing correct and truthful information, right?! (M41)

The managers' statements indicate weaknesses in TB care records in PHC, resulting from multiple factors involving both professionals and services, as well as the users themselves. In the first discursive block, workload overload, lack of preparedness or resistance in completing recording instruments, and limitations of information systems, still heavily dependent on manual records, stand out. In the second discursive block, users are highlighted with low treatment adherence, abandonment of follow-up, difficulty in accepting the diagnosis, and the provision of inaccurate information.

DISCUSSION

Part of the follow-up of users with TB involves recording the health actions performed by professionals. This task contributes to communication, continuity of care provided by the multiprofessional team, identification of new problems, and evaluation of the care delivered. However, the records lack detail, since the more complete the records are, the greater their usefulness[15,16].

In the managers' discourse, there is a tendency to undervalue record-keeping as an essential responsibility of PHC professionals. When records are not recognized as a relevant practice, the quality of care provided to users is compromised, and the production of health information is weakened, negatively impacting the organization and implementation of care focused on TB control. Managers remain silent regarding the presentation of strategies to overcome this gap, such as providing guidance and raising team awareness about the importance of correctly completing records, especially regarding TB cases.

The multiprofessional team has a legal and ethical duty to complete patients' medical records. Therefore, neglecting record completeness represents a serious infraction subject to professional regulatory bodies. Studies indicate that records should be completed objectively and clearly, as illegible handwriting, technical jargon, and erasures may compromise understanding of the information, resulting in communication gaps among health teams and leading to deficits in the quality of care[8,17].

A study conducted in Denmark found that healthcare professionals do not recognize records as the primary means of communication, which affects their daily practices and negatively influences health actions performed with users, in addition to not considering records as a tool for decision-making[18].

Although managers' discourses point to weaknesses in record completeness, they do not indicate concrete strategies to address these difficulties, nor do they signal evidence of systematic supervisory actions aimed at monitoring record quality or identifying and correcting weaknesses. Initiatives such as guidance, training, or educational actions aimed at healthcare professionals regarding the relevance of proper record completion are also not mentioned. Considering that the quality of recorded information is fundamental for the clinical follow-up of users with TB, as well as for family guidance and the organization of counter-referral, poor record quality may compromise continuity of care and favor treatment abandonment.

Another point to be highlighted is a contradiction in managers' discourse: while they state that records are of good quality and that they receive guidance on how to complete them, it is common for notifications to present missing information. In addition, there is an attempt to downplay the incompleteness of records using terms such as "a little" and "sometimes."

It was identified that, upon receiving notifications, managers forward them directly to the Surveillance sector of the respective Health Districts without verifying data completeness and consistency. There is silence in the discourse regarding who receives guidance on the correct completion of forms, as well as how this

information is shared with other team members. The strategy adopted to supplement missing data remains unclear, especially whether this action occurs through active case finding.

Complete records are important elements for verifying data quality within information systems and are essential for understanding the health–disease process, monitoring the demographic, temporal, and spatial trends of TB, and supporting decision-making in the development, implementation, and evaluation of strategic actions and public policies. Insufficient data hinder the epidemiological understanding of TB and case follow-up, as records may be misinterpreted due to improper completion of the instruments that are part of TB care[19].

A study conducted in southern Ethiopia on the quality of medical records in public health facilities found that, among the 2,145 records evaluated, only 394 had all the complete data[20]. These findings corroborate the results of the present study, in which managers point out physicians' difficulties in completing TB records, which may be related to the transfer of care strictly directed to nurses in the follow-up of the user with TB.

It is understood that, although the medical professional records TB patient care, the actions that are favorable to the positive treatment outcome, such as creating a bond with the patient, guidance regarding the diagnosis and medication intake, and other care measures, are mostly carried out by the nursing team[21].

It is noteworthy, in this analysis scenario, that the TB follow-up and monitoring records carried out by the nurse expedite and enhance care, optimizing access to the devices for recording and controlling information by the health team. However, it is important to delimit and redirect actions, so that the other members of the team are exempt from their responsibilities regarding TB control activities in PHC services[4].

In the discourses, managers point to difficulties related to the excessive amount of documentation to be completed and the multiple lines of care developed within health units. Despite the number of records required from suspected infections to cure, these reports may reinforce the perception that TB care is centered on only one health professional.

A study conducted on health professionals' perceptions regarding the use of records for TB detection highlighted the need to complete numerous forms to initiate the detection process, resulting in duplication of information. Therefore, data bureaucratization may generate weaknesses in form completion due to the large volume of records, undermining continuity of care for people with TB across different health services[9].

Difficulties related to the proper completion of records may be associated with several factors, such as lack of involvement of health professionals responsible for notification; lack of awareness regarding the importance of the information to be collected, considering this activity merely as a bureaucratic task; lack of knowledge about the flow of information within the system; or even work overload, which leads these professionals to direct their time to actions considered priorities[18].

Although the use of electronic records has proven positive, contributing to improved detection of new TB cases and communication among health services, factors such as lack of computer skills and the failure of some health professionals to complete electronic records were classified as obstacles to the use of the information system[8].

It is understood that, regardless of the type of instrument used, it is essential that professionals and managers receive adequate training for proper record completion and recognize its relevance as a fundamental component of the care process and health management.

In their interdiscourses, managers reproduce the social invisibility surrounding the care for people with TB when, in their statements, they acknowledge the weaknesses in the quality of records completed by health professionals, justified by the high demand for care, low local incidence, and transfer of responsibility in follow-up, while failing to point out strategies implemented and/or planned to address the problem from a management perspective, especially interdisciplinary and multiprofessional care for managing assistance and overcoming difficulties.

The recognition of interprofessional practices with a focus on interdisciplinarity and multiprofessional collaboration can contribute to improvements in management and care for people with TB in PHC services[22].

By assigning responsibility to others — in this case, users — for difficulties related to record quality, managers render invisible preventive care activities, actions

aimed at preventing treatment abandonment, and active case finding, which are professional responsibilities and were not mentioned in their discourses. Managers should monitor the care provided to people with TB and ensure adequate record-keeping, as these records are essential for monitoring the care provided to individuals with TB and for achieving indicators.

In this sense, DOT is fundamental to ensuring adherence to TB therapy, as it places the professional into the social context of the user with TB, strengthens the bond between the health unit, users and family, and allows the identification of factors that may interfere with treatment adherence[23,24].

Although they recognize the existing challenges, managers maintain a passive stance, waiting for the initiative to be taken by the users themselves. No strategies are indicated to bring patients to the unit, nor how the user is informed about the severity of the disease, about the importance of adhering to treatment, even if there are improvements in symptoms.

It is known that non-adherence to treatment is one of the obstacles to cope with TB, and can increase treatment costs, disease transmissibility, mortality, recurrence, and drug-resistant cases. Related to the clinical complexity of TB, there are also aggravating factors such as: alcohol and drug use and immunosuppressive coinfection such as AIDS, or comorbidities such as diabetes mellitus, poor social conditions, among others, which hinder improvement of health conditions and cure, making it necessary for professionals to understand the importance of organizing actions to cope with the disease, prevention, diagnosis and treatment[20,25].

Considering that better treatment outcomes involve multiple sectors and contributing agents, the first step is to facilitate users' access to timely diagnosis and early initiation of treatment. In addition, it is necessary to promote educational actions for people with TB, encouraging autonomy and more active participation in the care process from the moment of diagnosis through discharge[26,27].

Furthermore, incentives can be offered to users to encourage treatment adherence and ensure completion of therapy, such as monthly food baskets, breakfast, and transportation vouchers, given that TB is directly associated with situations of vulnerability[15,16].

In view of the above, the managers signaled in their statements a traditional (hegemonic) management model. Although they agreed that there are obstacles that hinder the quality of records and their relevance to the performance of actions aimed at TB control, the discourses reveal an erasure of the managerial function in planning, monitoring, evaluation, and control of TB-related actions. Thus, responsibility is transferred to others — whether a healthcare professional or the TB user who did not seek health services and/or did not adhere to TB treatment.

The traditional model of care management provided to users occurs in a fragile and fragmented manner, focusing only on procedures, pathologies or body parts, instead of being offered holistically, by a multiprofessional team that recognizes the singularity of each individual[28]. This logic contrasts with the actions carried out in PHC, which are based on prevention and aimed at teamwork and group integration for TB control[4].

A limitation of this study lies in the fact that its results, derived from a qualitative investigation conducted in a single municipality, do not allow for generalization. The applicability of the findings to other contexts depends on their similarity to the investigated setting.

FINAL CONSIDERATIONS

The study identified, based on managers' discourses, that the quality of TB records in PHC is hindered by factors such as the excessive number of instruments to be completed, lack of information, and incomplete records. Managers also attribute weaknesses in record quality to users' behavioral issues, such as failure to attend healthcare services, lack of adherence, and treatment abandonment. This stance shifts responsibility to the health team and to the user with TB. According to the discourse, managers adopt a passive stance in the process, as there are indications of a lack of concrete management actions to address these weaknesses.

It is essential that managers adopt a more active and articulated stance with health teams in the construction and implementation of strategies aimed at improving the quality of records. Such initiative aims to support the organization of actions and services, contributing to the optimization of care for users with

TB and the strengthening of disease control activities. To this end, the continuing education of managers and professionals is essential, ensuring understanding of their responsibilities and of the impact that incomplete records have on the effective performance of care and management functions.

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Data and material availability

Access to the dataset is available upon request from the corresponding author.

Authorship contribution

Adriana Maria da Silva: Conceptualization, Data curation, Formal analysis, Methodology, Writing - original draft.
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Haline Costa dos Santos Guedes: Conceptualization, Data curation, Formal analysis, Methodology, Writing - original draft, Writing - review & editing.
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Anne Jaquelyne Roque Barrêto: Conceptualization, Data curation, Formal analysis, Investigation, Methodology, Validation, Visualization, Writing - original draft, Writing - review & editing.

The authors declare that there is no conflict of interest.

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