

Health and leprosy conferences: sayings and silences about the neglected disease and its stigmas

Conferências de saúde e a hanseníase: ditos e silenciamentos sobre a doença negligenciada e seus estigmas

Kauanne Naysa Alves Pegaiani^a

 <https://orcid.org/0000-0001-7891-5348>
E-mail: kauannepegaiani@hotmail.com

Noeleni de Souza Pinto^a

 <https://orcid.org/0000-0002-0845-9401>
E-mail: noeleni_pinto@hotmail.com

Adriane Pires Batiston^b

 <https://orcid.org/0000-0002-9567-7422>
E-mail: abatiston@gmail.com

Mara Lisiane de Moraes dos Santos^b

 <https://orcid.org/0000-0001-6074-0041>
E-mail: maralisi6@gmail.com

Károl Veigas Cabral^c

 <https://orcid.org/0000-0001-5678-7859>
E-mail: karolveigascabral@gmail.com

Márcio Mariath Belloc^c

 <https://orcid.org/0000-0003-0928-7557>
E-mail: mmbelloc@gmail.com

Alcindo Antônio Ferla^b

 <https://orcid.org/0000-0002-9408-1504>
Email: ferlaalcindo@gmail.com

^a Universidade Federal de Mato Grosso do Sul. Programa de pós-graduação em Saúde da Família. Campo Grande, MS, Brasil.

^b Universidade Federal de Mato Grosso do Sul. Instituto Integrado de Saúde. Campo Grande, MS, Brasil.

^c Universidade Federal do Pará. Programa de pós-graduação em Psicologia. Belém, PA, Brasil.

Abstract

Seen as a serious public health problem in different locations, leprosy is marked by taboos and carried by stigma. It is a neglected disease and made up of several explanations throughout history, which update living marks of the past, including in the implementation of public policies. Health conferences are spaces for society to participate in the definition of policies, aiming to impact the care plan of different illnesses. The objective of this article is to understand the relevance and perspectives pointed to public policies for the care of people affected by leprosy present in the municipal, state, and national stages of the 16th National Health Conference. This is a documentary research based on the final reports and in the wake of the ascending process of the 16th National Health Conference. The results show the lack of visibility of leprosy in the reports of the municipal and state stages of the conference and, in the national stage, the record has a double emphasis: producing visibility about the disease and its context, claiming to update social mobilization around it and permanent education actions aimed at workers.

Keywords: Neglected Disease; Stigma; Community Participation; Public Health Policies.

Correspondence

Kauanne Naysa Alves Pegaiani
Av. Rita Vieira de Andrade, 658, Residencial Bela Vista. Campo Grande,
MS, Brasil. CEP 79052-420

RESUMO

Vista como um sério problema de saúde pública em diferentes localidades, a hanseníase é marcada por tabus e carregada de estigmas. É uma doença negligenciada e constituída por diversas explicações ao longo da história, que atualizam marcas vivas do passado, inclusive na implementação de políticas públicas. As conferências de saúde são espaços de participação da sociedade na definição de políticas, com o objetivo de impactar o plano de cuidado de diferentes enfermidades. O objetivo deste artigo é compreender a relevância e as perspectivas apontadas às políticas públicas para a atenção às pessoas acometidas por hanseníase presentes nas etapas municipal, estadual e nacional da 16ª Conferência Nacional de Saúde. Trata-se de uma pesquisa documental baseada nos relatórios finais e na esteira do processo ascendente da 16ª Conferência Nacional de Saúde. Os resultados demonstram a falta de visibilidade da hanseníase nos relatórios das etapas municipal e estadual da conferência e, na etapa nacional, o registro tem dupla ênfase, produzir visibilidade sobre a doença e seu contexto, reivindicando atualizar a mobilização social em torno dela e ações de educação permanente voltadas aos trabalhadores.

Palavras-chave: Doença negligenciada; Estigma; Participação cidadã; Políticas públicas de saúde.

Introduction

Seen as a serious public health problem in several places, leprosy bears taboos and stigmas. The religious and transcendental explanation of the disease was paradigmatic throughout the Middle Ages and associated with a dogmatic principle that subjected science and life (Inacio; Invernizzi, 2019). The religious explanation in force throughout the medieval period produced most of its stigma. Later, the action of public policies further strengthened it as they centered around isolating and criminalizing carriers and holding society accountable for “denouncing” suspected cases to the police and health authorities.

The religious explanation equated this millennial disease to a divine punishment for humanity’s sinful actions. Families and friends excluded the affected individuals from society, condemning them to compulsory isolation in what were known as “leper colonies.” Other measures to control and treat patients have been incorporated over the years (Baialardi, 2007), including the development of drugs (Baialardi, 2007; Pinto Neto et al., 2000). However, in Brazil, only the expansion of the concept of health in the 1988 Brazilian Constitution and the creation of the Brazilian National Health System (SUS) substantially advanced actions toward the care for this disease within health services.

Although leprosy cases are decreasing, Brazil has failed to reach its elimination target (one case per 10,000 inhabitants) and ranks second in the world ranking of cases. Leprosy is a silent (with an incubation period ranging from two to seven years) and greatly disabling disease. Its first symptoms manifest themselves as lesions such as pigmentary or dyschromic spots, plaques, tubercles, and nodules with altered sensitivity. The disease spreads by untreated multibacillary cases, which spread the infection at the beginning of contamination until the first dose of polychemotherapy (Magalhães; Rojas, 2007). The SUS institutional context defines the access to necessary actions and services as a people’s right, and the guidelines for health policies in each locality are defined by the participation of the population in conferences and health councils. The participation of society is guaranteed in the 1988 Federal Constitution and Federal Law no. 8,080 of 1990.

Social participation in health and public policies in Brazil has a historical milestone in the holding of the eighth National Health Conference (8th CNS), which was fundamental to reform the health system, basing actions and services on a more democratic modeling and integrality of care (Ferla, 2004). Health conferences are spaces that occur periodically so society can participate in the evaluation and definition of health policies. Thus the 16th CNS was carried out in 2019. Its general theme (as with the 8th CNS) was the relation between health and democracy. This association was made visible with the motto of “*Conferência 8ª + 8*” (8th+8 Conference) and the resumption of the fundamental themes of the 8th CNS such as the right to health, the restructuring of the health system and sectorial financing, and the ratification of the course of the Brazilian health reform as per the documents generated during its implementation.

The official documents used in this research include the fixed records in history, those referring to the “achievements produced by man that are shown as indications of his action and that can reveal his ideas, opinions, and ways of acting and living” (Silva et al., 2009, p. 4554; our translation), and a plateau in the construction of consensus and/or negotiation of disagreements on the agenda of health policy that explains both a certain “archaeological” accumulation related to the development of knowledge and practices in health and public policies and a “genealogical” alchemy referring to the exercise of power and the articulations of force between participating segments (Ferla, 2004). This double condition of production of reports is fundamental in the construction of analyses.

This condition is visible in the documents that show the coping with leprosy throughout history. Important initiatives, such as the 2004 National Program for the Elimination of Leprosy, the 2006 Ordinance no. 399 (Pact for Health) of 2006, and the 2009 Ordinance no. 125 (Leprosy Control Actions), are valuable for their technical content, but they also express the relevance the theme has for the different actors while showing their ability in inserting the theme on the agenda of the debates and making leprosy a priority within SUS.

We describe the results of a participation that has been able to impact the aesthetic plan of care and

that can incorporate knowledge beyond biomedicine, involving a greater degree of user participation in the management of their care, in which they can place not only the needs related to the biomedical aspects of the disease but also the other involved aspects, including their support networks (Ferla, 2004).

This study aims to analyze and understand the relevance and perspectives pointed to public policies to care for people affected by leprosy in the municipal, state, and national levels of the 16th National Health Conference.

Methodology

This is a case study on the formulation of policies to control leprosy and care for people and communities affected by it or by the risk of contracting it and its consequences following the ascending process of the 16th CNS. This study is based on the final reports of several Conferences, among them the 16th National Health Conference, the ninth Mato Grosso do Sul State Conference, and the eighth Municipal Conference of Campo Grande - Mato Grosso do Sul. The documents were treated by thematic content analysis with fluctuating reading and empirical categorization. Both what is common in the three reports and what is particular to the municipality was sought. In each situation, this research begun from the local context to discuss broader circumstances (Alves-Mazzotti, 2006). The documentary research is based on materials considered primary sources, which received no analytical treatment. In them, the researcher analyzes the facts without interference, only interpretations (Sá-Silva; Almeida; Guindani, 2009).

The first moment of this research consisted of a documental analysis of the final reports of the municipal, state, and national levels of the 16th National Health Conference. The three reports were initially read, giving rise to a central theme “Democracy and Health: Health as a Right and Consolidation and Financing of SUS” and the following thematic axes: Health as a right; Consolidation of the Brazilian Unified Health System (SUS) principles; and Adequate and sufficient funding for SUS. Soon after the general reading, detailed readings were carried out seeking records on the care services for the disease and/or proposals to organize work in primary care that would

eventually change the care for people with leprosy. Then, the material was surveyed by themes that encompassed the universe of the research, which were subdivided into axes: 1) specific propositions for people living with leprosy, 2) specific propositions about neglected diseases and/or relevant diseases to more vulnerable groups, and 3) general propositions that apply to leprosy and neglected diseases.

Soon after, the material was organized with the aforementioned themes and the most significant excerpts from the analyzed documents were transcribed. The third step was to construct tables with the related data without losing sight of the main contextualization of this study. This organization managed to find the circumstances on the themes to be analyzed and, as observed, the material itself directed the establishment of the themes that would compose the categories of analysis, enabling the mapping of emerging themes and promoting the categorization and the crossing of its key content with the literature. Thus, each axis enabled the construction of three new categories of analysis. It is important to note that thematic categorization fails to precisely depict reality but produces an interpretive rhizome that enables movements of thought and opens new windows to support initiatives by articulating ideas.

The first axis (Specific propositions for people living with leprosy) produced three categories of analysis: a) the invisibility of leprosy in health policies and in the health system, b) leprosy as a disease in its clinical and biological dimensions, and c) leprosy as a stigma.

The second axis (Specific propositions about neglected diseases and/or relevant diseases to more vulnerable groups) produced three more categories of analysis: a) social and sanitary vulnerability as a health system problem, b) the access of vulnerable populations and groups to care networks with specialized and resolute actions, and c) vulnerable populations and groups and territorial primary care actions.

Finally, the third axis (General propositions that apply to leprosy and neglected diseases) organized three other categories: a) the defense of SUS as a modeling of actions and services and as a social achievement, b) the financing of the health system and its threats, and c) the involvement of society as a whole to defend SUS.

For a better visualization of the produced material, tables were constructed summarizing these axes and the most significant fragments of the analyzed documents. This analysis showed fundamental points regarding the reality experienced by people affected by leprosy and construct the thematic categories that make up the analysis of this research.

Results

As mentioned, our analysis of the reports of the levels of the 16th National Health Conference enabled the construction of three axes of analysis. Chart 1 organizes the records about the disease based on a careful reading to locate textual records or initiatives aimed at the care services for people or groups affected by leprosy.

Table 1 – Specific deliberations on leprosy in the levels of the 16th National Health Conference

AXIS	PEOPLE/GROUPS WITH LEPROSY
Municipal Health Conference	Report failed to address the specific reference.
State Health Conference	Report failed to address the specific reference.
National Health Conference	Construction of a policy to make leprosy visible and protect the human rights of people affected by it; promote teaching about leprosy from basic to higher education; expand its coding among SUS procedures; ensure investments in research on the disease; carry out permanent campaigns and health education; and ensure treatment or rehabilitation for SUS users.

Source: own authors based on the analyzed documents

The table shows very few specific records on leprosy, found only in the national level of the 16th National Health Conference. Thus, this study found no specific discussions and records about leprosy in the analyzed conferences. This lack of recognition in Chart 1 highlights how important it is to think about the struggle of people affected by the disease and its relocation in the imagination of the population, including health activists. The construction of the specific axes in these frameworks seeks to give greater visibility and better understanding of the space that people and groups affected by the disease occupy in the formulation of public policies and in the proposal of promotion measures. In the specific case of leprosy, a disease whose history involves the social and sanitary production of stigma and isolation, the records in the final reports of the conferences also explain the secondary place measures to reintegrate people into society occupy in the socio-sanitary agenda.

This finding produced three empirical categories of analysis for this axis: a) the invisibility of leprosy in health policies and systems, b) leprosy as a disease in its clinical and biological dimensions, and c) leprosy as a stigma. This study will address these categories later.

Chart 2 characterizes the second axis of analysis, seeking to find the presence of deliberations to guide public policies on diseases that affect specific

populations that endure neglect and vulnerability in different ways or whether these go unnoticed due to unequally distributed variations.

This axis of analysis shows deliberations in the three levels of the 16th National Health Conference. This study found important variations regarding the detailing of actions and the denomination of specific groups but the sense of neglect of public policies with specific social groups and populations configures a problem in the agenda of health and other public policies, especially by intersectoral health actions. In the three forums, policymakers received the indication of the need for differentiated actions for these populations, groups, and diseases as initiatives to produce equality.

Based on these records, this study produced three empirical categories for this axis of analysis: a) social and sanitary vulnerability as a health system problem, b) the access of vulnerable populations and groups to care networks with specialized and resolute actions, and c) vulnerable populations and groups and territorial primary care actions.

To elaborate Chart 3, this research systematized records on the characteristics of what could be conducted by the principles and guidelines of the SUS and proposals and policies for implementation, universal and free access, pharmaceutical assistance, and influence of the biomedical model.

Table 2 – Specific deliberations of the levels of the 16th National Health Conference on neglected and relevant diseases for the most vulnerable groups

AXIS	SPECIFIC, NEGLECTED, AND VULNERABLE POPULATIONS
Municipal Health Conference	Expand care teams on the streets; assist women with disabilities; implement prevention policy for trans men and lesbians.
State Health Conference	Strengthen the Indigenous health subsystem.
National Health Conference	Public policies aimed at the health of women; immigrants; fishermen; the homeless; of those who live in the countryside, forest, water; LGBTI+, Indigenous, and quilombola people; individuals with rare diseases or liver coagulopathies; men and women; traditional peoples of African origin; extractive settlers; riverine dwellers; and people with disabilities, HIV/AIDS, or co-infected with TB.

Source: own authors based on the analyzed documents

Table 3 – Deliberations of the levels of the 16th National Health Conference with general themes that could be applied to leprosy and neglected diseases

AXIS	GENERAL THEMES
Municipal Health Conference	Unfreezing investment in health (PEC 95); expand the care of specialties and NASF teams; enlarge units of professional psychologists and pharmacists; build and renovate health facilities; comply with the Brazilian Law of Inclusion 13146/15; implement means of transport as needed; create evidence nucleus in partnership with public universities to guide demands and needs; increase supply of essential medicines (REMUNE); expand home care services; set servers for training; grant transportation vouchers to patients in social vulnerability during health care to ensure comprehensive care.
State Health Conference	Repeal PEC 87/2015 and PEC 95/2016; establish a professional manager with higher education in basic health units, guarantee integrality and longitudinality; consolidate SUS principles; maintain territorialized primary health care; update the list of basic pharmacy and high-cost drugs; render health care more humane and welcoming.
National Health Conference	Repeal Constitutional Amendment 95/2016, which froze public investments in health for 20 years until 2036; strengthen and expand primary health care by the PNAB; guarantee access to the rights to a dignified life; expand multiprofessionals in teams; implement and ensure comprehensive health and equality for vulnerable populations; consolidate the care network; structure policies that consider territoriality and regionality for access to health; formulate and implement public policies that promote actions to reduce the risk of diseases; ensure the supply of medicines; guarantee the agility and continuity of services and consultations.

Source: own authors based on the analyzed documents

These deliberations resume the defense of SUS, adequate financing, and of the implementation of policies according to the definitions in the 1988 Federal Constitution and of the ideology within the Brazilian Health Reform Movement and respond to the device of the convocation of the conference, which symbolized its 16th edition with the mark of the “8th + 8,” by recovering the slogan and ideas that founded the formulation of SUS.

These deliberations evidently discuss the guarantee of rights in laws but the effective capacity of public health offers and services to the population remains a gap. Moreover, the struggle for equality and integrality entails reconsidering important aspects of planning, supply and demand, and managing and constructing new knowledge (Cecilio; Kings, 2018).

This axis of analysis gave rise to three empirical categories that are relevant to our research problem: a) the defense of SUS as a modeling of actions and services and as a social achievement, b) the financing of the health system and the threats to it, and c) the involvement of society as a whole under an agenda to defend SUS.

Discussion

Specific propositions for people living with leprosy

As mentioned, the reports of the municipal and state levels of the 16th CNS lack a specific reference to leprosy. At the national level, registration as a motion has a double emphasis: producing visibility about the disease and its context and guaranteeing the human

rights of those who live with it. The invisibility and neglect of people affected by leprosy is explicit in the general context, naturalizing stigmas.

The invisibility of leprosy in health policies and the health system

An important finding is that leprosy was totally or partially invisible in the levels of the 16th CNS. Recognizing this problem corroborates issues such as the recognition of those with leprosy, lack of communication, and difficulties in access and care. If subjects/groups remain unmentioned, they become imperceptible. Therefore, public policies are neither constructed nor receive proper attention, thus perpetuating risks and the illness. Invisibility is, thus, an integral part of the current vicious cycle of leprosy (Martins; Spink, 2020).

It is possible to assume that the invisibility in the debates of the conferences feeds a cycle that produces fragile subjects who are unable of acting and positioning themselves in the world as active beings. This issue must be overcome so that those affected can disseminate their ideas, express their needs, and recognize themselves as rights-holder.

Leprosy as a disease in its clinical and biological dimensions

In the biomedical perspective of health, leprosy is a disease as any other, manifesting signs and symptoms and requiring tests to confirm diagnosis and appropriate treatment until cure, which SUS should make available for free.

Adopting the Family Health Strategy reoriented health priorities, which now focus on the needs of the population in the territory (Leal et al., 2017), a strategic point to incorporate disease control measures. This level of care promotes active searches (routine visits by health teams to people affected by the disease or exposed to great risk), thorough clinical examinations, and treatment to promote recovery, social reintegration, and the restoration of values (Sobrinho et al., 2016).

The teams' lack of guidance or preparation promotes the continuity of the disease, late diagnoses, and thus the evolution to disabilities and deformities (Bordon et al., 2019).

Leprosy as a stigma

In general, the disease is still marked by the lack of knowledge of its cause, cure, and form of contagion from the past. Compulsory isolation and family breakdown reflect the strong stigmatization of the disease (Pinto Neto et al., 2000). The humiliation, embarrassment, fear, and contempt attributed to these people influenced—and still influences—the devaluation of their images in their lives and in public space (Almeida et al., 2018). Stigma is socially and historically constructed and is updated in the reactions of prejudice and even forgetfulness, including reactions to body changes as the disease progresses in the absence of treatment (Bordon et al., 2019). The lack of adequate guidance and the shame patients may feel tend to lead them to a scenario of omission of the disease. In addition to physical distress, work skills decrease and other psychological aspects harm patients. Rather than an individual issue associated with changes in people's bodies, this configures a cultural issue rooted in the imaginary. Confronting leprosy requires prevention, treatment, rehabilitation, and initiatives to break stigma and prejudice. Integrality, as it has been said, includes both good individual and collective clinical practice, seeking to reconfigure social imaginaries (Ferla, 2004).

Specific propositions on neglected diseases and/or those relevant to the most vulnerable groups

Table 2 shows a common concern in the three reports about the production of inclusion and equality policies that, to some extent, contrasts with the invisibility of leprosy as a singular problem in the first axis.

Social and health vulnerability as a problem for the healthcare system

The different conditions of social inequality to which certain groups are subjected influence their well-being given that those who are socially less favored show a greater possibility of falling ill than the more privileged groups. This is because the health scenario is determined by social, economic, cultural, ethnic/racial, psychological, and behavioral issues (Souza; Silva; Smith, 2013).

The production of social vulnerability precedes any disease and is expressed in the difficulty of access and quality deficits of the activity of social policies related to people or groups. Leprosy is doubly associated with this concept, as an increased risk and as a difficulty of access since, despite affecting any person or social class, it occurs more prevalently in poor groups due to unfavorable socioeconomic conditions that facilitate contamination and the spread of the bacillus. Moreover, it is marked by customs that expand its dissemination, hygiene habits, and the late search for care, leading to some degree of disability or deformity of the disease (Lopes; Rangel, 2014).

Recognizing differences and vulnerabilities would enable access to public policies. Thus, insufficient care and the scarcity and weakening of the experienced social protection intensify the vulnerability of these subjects. It is important to recognize them to ensure effective popular participation in decision-making (Adorno, 2011) and break the stigmatizing social imaginary to socially reinsert those affected by the disease and its context.

Access of vulnerable populations and groups to care networks with specialized and resolute actions

Constitutionally guaranteed access to health care is an achievement of social movements. Although the right is guaranteed to all citizens, vulnerable populations/groups still face difficulties in accessing health care, remaining unnoticed by the system (Engstrom; Teixeira, 2016).

The principle of universality rearranged the territory to ensure health care. Thus, its organization in care networks enabled hierarchization and regionalization (Araujo et al., 2017).

The challenges in health are great and include the ability to respond to the problems faced by various population groups since distributing a service fails to ensure the production of good effects (Cecilio; Kings, 2018).

Vulnerable populations and groups and the territorial actions of primary care

To mention the issue of territory regarding health is to understand that space includes the dissemination of news, information, ideas, movement of people, exchange of knowledge, and structured actions, rather

than only referring to geographical characteristics. Therefore, it configures a place that offers advantages for analyses as it seeks to understand the health-disease process beyond its biological aspects, considering the way societies function to build a relation with the territory (Colin; Pelicioni, 2018; Teixeira et al., 2014).

The introduction of the Family Health Strategy expanded the coverage of Primary Health Care since its action seeks to prioritize the promotion, prevention, and recovery of health (Teixeira et al., 2014).

However, the notorious and marked fragmentation of administration, programs, actions, and practices creates obstacles to the care model. These circumstances impose the need to adjust service offerings to the health needs of the population, considering the social and economic contexts in which they are inserted. Thus, it is essential that professionals consider subjects' social determinants, individuality, and vulnerability in developing care strategies (Teixeira et al., 2014; De Oliveira, 2018).

General propositions that apply to leprosy and neglected diseases

The general characteristics in Chart 3 implicitly show the variations of themes such as SUS financing and management, work valorization, health education, participation, social control, service intentionality to reduce social inequities, and professional interest toward patients/families.

Defending SUS as a model of actions, services, and social achievement

The idea of human rights evokes movements that culminated in the achievement of fundamental guarantees to citizens such as popular initiatives and conferences. The defense of SUS includes struggles regarding the provision of health services, regional inequalities, and underfunding (Campos, 2018).

Services show a need to expand multiprofessional teams, reduce bureaucracy in specialty care, and build more humanized and welcoming care. Regarding inequalities, it is necessary to provide measures that guarantee integral health and equality to vulnerable populations, consolidate the care network, and structure policies that consider territoriality and regionality in access to health. Regarding underfunding, we seek to

repeal Constitutional Amendment no. 95/2016, which froze public investments in health for 20 years (Marin; Marchioli; Morackvick, 2013; Fields, 2018).

The financing of the health system and the threats to it

Despite its undeniable advances, SUS faces several obstacles, including funding, which is always insufficient to guarantee universal and quality public health. According to the constitutional resolution, SUS would have to be financed with resources from the social security budget and with the participation of each sphere (municipal, state, and federal), rather than being defined by the percentages each instance should provide (Cislaghi; Teixeira; Souza, 2011).

However, problems include non-compliance by the spheres in the planned linkage and deviations from the purpose of the resources aimed at health. In 2015, Constitutional Amendment no. 86 determined that the minimum federal resources for health would be calculated based on the net current revenue of the Union, starting with 13.2% in 2016 until reaching 15% in 2020 (Menezes; Moretti; Kings, 2019; Bevilacqua; Soares; Santos, 2020). The current barrier refers to repealing Constitutional Amendment no. 95, which froze primary public spending for 20 years (Campos, 2018).

The involvement of society as a whole in an agenda to defend SUS

The idea of society involvement comprises mobilizations that can influence the guarantee of rights and social protection. Merhy (2014, p. 13) points out that each individual presents their singularity, which is ever changing. Subjects are in constant change and in “production.” This action exercises representations of speeches, discourses, and values that can provide greater visibility to SUS (Fernandes; Moreira, 2013; Ferla et al., 2019). Strengthening social participation can advance universalization and equality of access to health as it gives space to several perspectives and voices and socializes and reconciles public health interventions with real social demands (Coelho, 2012).

Final considerations

Regarding the results in this study, it is important to note that the state and national levels of health conferences cumulatively focus on the municipal base of the Brazilian decentralized and ascending health system. Therefore, the deliberations made at the local, state, and federal levels affect the policies of the municipal system. In view of the observed aspects, it is important to point out that the absence of prioritization in conference reports continues to make leprosy a neglected disease. This disease affects vulnerable populations and causes stigmatizing social conditions, limitations, uncertainties, discomfort, and lower self-esteem and self-image.

However, the scarcity of specific propositions regarding leprosy in the reports of the levels of the 16th CNS contrasts with the records on the set of neglected diseases that affect vulnerable population groups more rigorously. By itself, this scarcity points to the need to induce SUS health policies in the three spheres of government toward inclusion and reduction of current inequalities. Moreover, it is necessary to enforce SUS as a policy of inclusion and as a social conquest in clear resistance to recent budget restrictions and reduction of the scope of care and/or access. It is very relevant to continue reflecting on the approach to leprosy as a socially relevant public health problem under an expanded understanding of collective health. SUS cares for individuals with diseases and people’s health and configures an observatory of civilizing processes and a laboratory of inclusion and equality since the production of health involves these dimensions.

Our analysis is limited by its basis on documental analysis that, even in the case of the reports of the Health Conferences, fails to directly represent the daily routine of care. These documents have the formal capacity to focus on the formulation of policies and initiatives. Further studies are needed, especially to monitor the implementation of the formulated guidelines in SUS health plans and strategies at the national, state, and municipal levels.

Our most relevant contribution refers to the invisibility leprosy continues to have in public policies, which is probably associated with its condition as a neglected disease and its current

incidence and prevalence, reaching people and groups in greater vulnerability. This finding suggests the implementation of health education actions to mobilize the culture of society and permanent education in health, promoting and updating actions in workers of public and private health services.

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Authors' contribution

KNA Pegaiani participated in the general organization of this study, analyzed the content of the Conference reports, prepared the tables summarizing the reports, and further developed the findings that were put into dialogue with each other and with the literature; AA Ferla defined and advised the methodology, results, and discussions of this study, and performed the general review of this study; AP Batiston, KV Cabral, MLM dos Santos, and MM Belloc participated in the theoretical construction of this study and the successive revisions that gave it its current configuration; and NS Pinto participated in the theoretical review and harmonization of this study to the standards of this journal.

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