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HEALTH PROFESSIONALS' AND MANAGERS' PERCEPTION OF LEPROSY CARE WITHIN THE FAMILY HEALTH STRATEGY

Percepção dos profissionais de saúde e gestores sobre a atenção em hanseníase na Estratégia Saúde da Família

Percepción de los profesionales sanitarios y gestores sobre la atención de la lepra en la Estrategia Salud de la Familia

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ABSTRACT

Objective: To know health professionals' and managers' perception of leprosy care within the Family Health Strategy. **Methods:** Qualitative research conducted from July to August 2016 using semi-structured interviews with professionals with a higher education degree who work in reference Family Health teams and in the Family Health Support Center (*Núcleo de apoio à Saúde da Família - NASF*), as well as their respective coordinators in the city of Morada Nova, Ceará, Brazil. The data corpus was subjected to content analysis. **Results:** Leprosy care in the municipality is carried out in a centralized way under the responsibility of a single specialist and without the effective participation of the Family Health Strategy (FHS). Interprofessional collaboration does not occur and there are no formal spaces for dialogue and case discussion among the team members. The main challenges reported by the interviewees referred to the centralization of the service, the users' adherence to the prevention and treatment activities carried out, and the lack of support from municipal management. **Conclusion:** This mode of organization of leprosy care impacts on several aspects of the work and care processes, negatively influencing the prevention, the surveillance and the monitoring of leprosy in the municipality, as well as favoring the hegemonic biomedical model and maintaining the critical epidemiological situation of the region. Further studies are required to correlate the mode of organization of leprosy care in the FHS with the epidemiological situation of the territories to foster care changes.

Descriptors: Leprosy; Primary Health Care; Health Services.

RESUMO

Objetivo: *Conhecer a percepção dos profissionais de saúde e gestores sobre a atenção em hanseníase na Estratégia Saúde da Família.* ***Métodos****: Pesquisa de abordagem qualitativa realizada a partir de entrevistas semiestruturadas, no período de julho a agosto de 2016, junto aos profissionais de nível superior que atuam nas equipes de referência em Saúde da Família e Núcleo de apoio à Saúde da Família (NASF), assim como seus respectivos coordenadores na cidade de Morada Nova, Ceará, Brasil. O corpus de dados sofreu análise de conteúdo.* ***Resultados:*** *Evidenciou-se que a atenção em hanseníase no município é realizada de maneira centralizada sob a responsabilidade de um único profissional especialista e sem participação efetiva da Estratégia Saúde da Família (ESF). A colaboração interprofissional não se efetiva e não existem espaços formais para diálogo e discussão de caso entre a equipe. Os principais desafios relatados pelos entrevistados foram com relação à centralização do serviço, à adesão dos usuários às atividades de prevenção e tratamento desenvolvidas, e à falta de apoio da gestão municipal.* ***Conclusão:*** *Identificou-se que esse modo de organização da atenção em hanseníase impacta em vários aspectos do processo de trabalho e cuidado, influenciando de maneira negativa a prevenção, a vigilância e o acompanhamento em hanseníase no município, bem como favorecendo o modelo biomédico hegemônico e mantendo a crítica situação epidemiológica da região. Sugere-se que estudos futuros correlacionem o modo de organização do cuidado em hanseníase na ESF com a situação epidemiológica dos territórios, subsidiando mudanças assistenciais.*

Descritores*: Hanseníase; Atenção Primária à Saúde; Serviços de Saúde.*

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RESUMEN

Objetivo: *Conocer la percepción de los profesionales sanitarios y gestores sobre la atención de la lepra en la Estrategia Salud de la Familia.* ***Métodos:*** *Investigación de abordaje cualitativo realizada a partir de entrevistas semi-estructuradas en el período entre julio y agosto de 2016 con los profesionales de nivel superior que actúan en equipos de referencia en Salud de la Familia y Núcleo de Apoyo a la Salud de la Familia (NASF) así como sus respectivos coordinadores de la ciudad de Morada Nova, Ceará, Brasil. Los datos fueron analizados por el análisis de contenido.* ***Resultados:*** *Se evidenció que la atención de la lepra del municipio se da de manera centralizada bajo la responsabilidad de solamente un profesional especializado y sin la participación efectiva de la Estrategia Salud de la Familia (ESF). No existe la colaboración entre los profesionales y no hay espacios formales para el dialogo y la discusión de caso entre el equipo. Los principales desafíos relatados por los entrevistados fueron respecto la centralización del servicio, la adhesión de los usuarios a las actividades de prevención y tratamiento desarrolladas y la falta de apoyo de parte de la gestión municipal.* ***Conclusión:*** *Se identificó que esa manera de organización de la atención de la lepra causa impacto de varios aspectos del proceso de trabajo y del cuidado influyendo de manera negativa en la prevención, la vigilancia y el seguimiento de la lepra en el municipio así como favorece el modelo biomédico hegemónico para la manutención de la crítica situación epidemiológica de la región. Se sugiere que los estudios futuros relacionen el modo de la organización del cuidado de la lepra en la ESF con la situación epidemiológica de los territorios, subvencionando cambios asistenciales.*

Descriptores: *Lepra; Atención Primaria de Salud; Servicios de Salud.*

INTRODUCTION

Leprosy is an infectious disease caused by the bacterium Mycobacterium leprae, which affects the peripheral nervous system (PNS), causing sensitive and tegumentary changes that can result in important physical disabilities and progress to definitive deformities. Brazil is the second most endemic country in the world, featuring leprosy as an important public health problem[1]. According to the Strategic Management Support Room (*Sala de Apoio à Gestão Estratégica - SAGE*), in 2016, the coefficient of detection of new cases in the general population of Brazil was 9.47/100,000 inhabitants[2]. In 2015, according to the computer division of the Unified Health System (*Sistema* Único *de Saúde - SUS*), 29,257 new cases of leprosy were identified. These numbers indicate the magnitude of the leprosy issue in the country[3].

In 2015, new leprosy cases appeared in 148 (80.5%) municipalities in the state of Ceará, and 34 (18.4%) of these registered more than 10 new cases of the disease. In relation to the spatialization of the detection of new cases, regions with a high detection rate (high, very high and hyperendemic) were observed, concentrating in the south of the state. This scenario evidences the need to expand the primary care network with diagnosis, treatment and rehabilitation service, providing access to users and favoring an early diagnosis of the disease[4].

In Brazil, with the creation of SUS and the adoption of Primary Health Care (PHC) as the axis of care reorganization, the PHC of the Brazilian municipalities, organized from the Family Health Strategy (FHS), is accountable for comprehensive care for the leprosy carriers. The PHC is also in charge of the epidemiological surveillance of the disease, by means of the investigation of household contacts, active search for new cases, and health promotion for the population. Because this is a highly disabling disease, specialized care must be guaranteed whenever necessary, and the FHS is accountable for coordinating care[5,6].

The Leprosy Control Actions *(Ações de Controle na Hanseníase - ACH),* inserted in the Primary Health Care (PHC), are adopted by the World Health Organization (WHO) as a strategy to enhance care response capabilities and reduce the disease and complications that it may cause[7]. For these to be accomplished, multiprofessional integration is necessary, in order to provide care for all the needs produced in the individuals by the disease. In the FHS, the reference teams in Family Health (FHT) have a multiprofessional constitution and articulate with the Family Health Support Centers (*Núcleos de Apoio à Saúde da Família - NASF*), which, composed of professionals from the different professional categories, intends to expand the scope of action of the FHTs[8].

Despite this legal and normative effort to guarantee the effectiveness of care for leprosy patients and the multiprofessional constitution of the FHS, the clinical practice and some studies[9,10] still identify a number of hindrances to the accomplishment of the early diagnosis and timely treatment of the disease, thus favoring the motor and neurological damages caused by the disease. Such delay aggravates the situation and makes sequels a physical and psychological burden for these subjects and their relatives. Faced with this challenge, which is especially reflected in the PHC, the preferential SUS entrance door, a question is posed: how are the PHC services articulated for leprosy care and control?

From the perspective of the field of Community Health, analyzing the dimension of professional practice and management related to leprosy care in the PHC is important in order to evaluate the implementation of this public policy and suggest initiatives necessary for its effectiveness. Undoubtedly, health promotion is one of the inherent aspects of this analysis, considering that, despite the increasing knowledge of clinical control of the disease and the availability of drugs and protocols, a scenario marked by inequities, negligence, and delay in leprosy care is prevailing in Brazil[9,10].

The investigation of this problem in the reality of a small municipality is believed to be relevant for the deepening of the debates on the current scenario of leprosy care and for the proposal of strategies that can overcome the challenges then verified. Moreover, studies on the role of the PHC in leprosy care are relevant, mainly with respect to the local reality of municipalities. On the other hand, the work in the FHS presupposes a team work articulated in a network[11]; in this sense, it is also defined the interest in developing a study that covers the interprofessional perspective of care. Thus, the present study aimed to know the health professionals' and managers' perception of leprosy care within the Family Health Strategy.

METHODS

Exploratory study of qualitative approach[12]. The research was based on the municipality of Morada Nova, Ceará, Brazil. The study was carried out with Family Health Strategy (FHS) professionals with a higher education degree, who worked in the urban area of the municipality, composing the FHTs, and NASF professionals, in addition to the managers of the PHC of the municipality and NASF. The FHS aims to restructure the PHC in accordance with SUS principles and with the support of the NASF, a structure linked to PHC that seeks to expand, improve health care and management in the FHS, prioritizing the construction of care and support networks, providing support to the FHTs and expanding their response capabilities and ability to share and coordinate care[13] .

The participant professionals were contacted by the researchers through the local management of the Basic Health Units (BHUs) and invited to participate in the collection of information. The participants were selected for convenience and the final sample size was determined by theoretical saturation[14]. The study included two PHC and NASF managers and 13 professionals who had been working at the BHU for at least six months and agreed to participate voluntarily. Those who were not working at the BHU during the study period and/or did not fit the inclusion criteria were excluded. No dental surgeon, for example, was included because, for structural reasons of the BHU, this category was not developing its activities in the PHC during the research period. Thus, the sample consisted of 15 participants.

Information collection took place in the period from July to August 2016, through semi-structured interviews that, besides investigating the characterization of the participant professionals with the variables (profession, age, gender, length of professional training, length of time working for the municipality PHC, educational profile), comprised questions that addressed the actions developed by the team for leprosy care and control; the professionals' duties in leprosy care; and the challenges posed to the implementation of actions in the municipality.

The field diary was also used for record of emergent perceptions in the field. The information was analyzed through the Content Analysis technique [11], from the operational stages: data ordering; data classification, and final analysis. From this process, three thematic categories emerged: "The centralization of leprosy care and the reduction in the role of the FHS"; "Multiprofessional team and the (de)integration of care"; and "The challenges to leprosy care: from care to management".

To ensure the anonymity of the participants in the presentation of the results, the letters "M" were used for managers, "NASF" for NASF professionals and "FHT" for reference team members, which were followed by numbers according to the chronological order of the interviews.

The study was approved by the Research Ethics Committee of the Catholic University Center of Quixadá (Opinion no. 1,538,726), initiating the information collection process, considering Resolution 466/12[15].

RESULTS AND DISCUSSION

For presentation and discussion of the results, the data referring to the characterization of the research participants were first systematized. The detailing and discussion of emerging dimensions in each thematic category begins right after that.

Characterization of participants

Of the 15 participants in the survey, two are managers, five are NASF professionals and eight are FHT members. As for the professional categories, physiotherapists, physicians, nurses, social worker, speech therapist, and nutritionist participated. Most were female. The age ranged from 24 to 47 years, with a mean of 33.5 years.

Regarding the time of professional formation, it is noticeable that all the interviewees, except for one manager, have an undergraduate degree in the health area, accumulating at least seven years of academic formation. Of the graduates, only three do not have postgraduate degrees.

A study[16] found that the specialization program in Family Health contributed to increase the notion about PHC and FHS among the workers, thus giving rise to a series of questions and reflections about the work process, and influencing a change and reorientation in everyday practices. In this sense, the importance of Community Health postgraduate programs and Permanent Health Education (PHE) strategies for the improvement and training of PHC workers is emphasized in order to subsidize the implementation of health care practices, especially those that face challenges to their effective implementation, such as leprosy control actions.

It was also verified that the physicians of the FHT visited were belonging to the "Mais Médicos Program" (*Programa Mais Médicos - PMM*). This program is an initiative of the Federal Government, in articulation with states and municipalities, whose objective is to expand and qualify the care for SUS users through the recruitment of physicians to regions of greater social vulnerability[17]. It is believed that, because they belonged to this PMM group, the professionals interviewed had an educational profile more focused on Family and Community Medicine.

The PMM collaborated to improve the access of Brazilians to health services[18]. Thus, the care profile of the physicians participating in the study may have influenced the results, since the program includes actions more intensively directed at guaranteeing the comprehensiveness and the response capabilities of the services, even providing in-service monitoring by a preceptor. Therefore, it is believed that the PMM professionals tend to develop a work that is more in line with the FHS guidelines.

The centralization of leprosy care and the reduction in the role of the FHS

According to the Ministry of Health (MoH), the strategies adopted for elimination of leprosy rely mainly on the early detection and cure of cases under treatment. For this, it is necessary that the PHUs incorporate in their routine the follow-up and control of the disease, decentralizing prevention and treatment actions while enabling a health care closer to the reality of people's lives[19].

Nevertheless, the present study revealed that leprosy care in the municipality of Morada Nova is carried out in a centralized way at the Municipal Health Secretariat, where there is a single physician responsible for the follow-up of all patients representing suspected and/or diagnosed cases of the disease, as can be seen by the following speech:

> *"All patients with leprosy and tuberculosis are monitored by the Municipal Health Secretariat, so they have consultations there with the infectious disease specialist, and the follow-up of the supervised dose occurs directly there" (FHT 01).*

The FHT professionals act supportively in leprosy care, being responsible only for prevention and education about signs and symptoms of the disease; evaluation of household contacts; implementation of procedures for prevention of disabilities and identification of suspected cases from the demand brought to the service. Therefore, the FHT professionals are not granted autonomy to give the final diagnosis at the very BHU, nor to conduct the multi-therapeutic treatment. Any suspected case must follow the flow as previously agreed, being referred to the specialist in charge of the Leprosy Control Program in the municipality. Besides, the treatment usually starts only after some tests, such as the bacilloscopy.

> *"The actions of the health unit, what we basically do, in terms of prevention, are the lectures. The follow-up of these patients under treatment is an issue centralized at the Health Secretariat [...]" (FHT 05).*
>
> *"[...] Then, we immediatly refer to the doctor at the Secretariat. He looks, examines when he thinks that the spot can indeed be leprosy, and the test was negative. They are requiring a biopsy to actually make the diagnosis, otherwise it's done by clinical diagnosis. We only conduct the subsequent follow-ups" (FHT 08).*

Contrary to this reality, the literature on the subject and the leprosy care protocols recommend that the diagnosis and treatment of the disease be essentially based upon dermatoneurological clinical examination, that is, by means of the clinical characteristics, it is already possible to reach the operational classification of the disease and get the treatment initiated immediately after this evaluation. Complementary examinations may be requested as a diagnostic support; initiating the treatment, however, is not conditional on their results[20,21]. Because it is a basic clinical procedure, the actions for leprosy prevention and control, when included among the duties of the FHS, facilitate the decentralization of care actions[22]. Moreover, according to the authors, such integration of leprosy actions into the country's PHC services has been showing good results, such as the improvement of some epidemiological indicators, the reduction in cases diagnosed when physical disabilities are already established, and the reduction in the detection of new cases in individuals younger than 15 years of age, in addition to the lower prevalence of multibacillary cases, and the increase in the magnitude of healing.

Even so, it is observed that the organization of the leprosy care in the city of Morada Nova poses several consequences for the effectiveness and evaluation of the actions developed. As this is a municipality with a considerable territorial extension and with the great concentration of the population in the districts, the displacement to the Health Secretariat, which is located in the urban zone, makes the treatment of the disease more expensive for the patients, rendering them unable to receive follow-up and medication closer to their home, as recommended by the MoH[23]. This geographical barrier can also facilitate the abandonment of treatment and, consequently, favor the activation of the epidemiological chain of transmission.

Another dimension of care hindered by the centralization of the service is the follow-up of the cases by the FHT.

> *"[...] the issue of follow-up by nurses and the physician is complicated because, sometimes, when the result is positive and someone starts being treated here at the Health Secretariat, it takes some time for some teams to have this feedback, sometimes they will get the feedback by the third, forth month of treatment. If (the patient) does not seek the BHU, the nurses will only be able to learn of it after some additional time" (G. 01).*

In result of the centralization, the monitoring of users with leprosy by the FHT becomes more difficult, because, given the counter-referral delay, the evaluation of the contacts, and the prevention of disabilities are carried out late, which sometimes gives rise to the onset of disabilities in these patients, as well as prevents the early detection of the disease in the contacts. According to authors[24] who analyzed the epidemiological situation of leprosy in the microregion of Araçuaí, Minas Gerais, Brazil, the mode of organization of the health services has a significant influence on the epidemiological situation of leprosy. The centralization of diagnosis in the specialized care contributes to maintain the hidden prevalence[24].

The actions aimed at prevention and control of the disease are carried out by the FHT through health education interventions in conjunction with the NASF team, mainly through lectures, educational posters displayed at the BHU and training of the CHWs for the identification of signs and symptoms of the disease. The activities performed by the NASF team in leprosy care are solely prevention activities by means of lectures. However, these actions are only punctually carried out, when there is a municipal attribution for the conduction of specific campaigns, or by request of the FHT. The active search for new cases of the disease is practically not performed by the FHT professionals, as expressed in the report by FHT 08:

> *"Normally, we reach it through the patient's evaluation, when they come for consultations, saying like 'I've got a spot, 'a spot has appeared here', then we make an examination during the spontaneous consultation, [...] For us to make a diagnosis, the patient must come to the unit. How could I go searching for them? Leastways, we provide guidance, training to the CHWs..." (FHT 08).*

The only activity that enables the active search for new cases, in addition to the investigation of the contacts, is the Health at School Program (*Programa Saúde na Escola - PSE*), which is also carried out in partnership with NASF. However, the activities carried out by the PSE cover a small portion of the population of the municipality, the schoolchildren, while leprosy can affect any individual of any age group, being necessary that prevention and active screening reach the entire population. When this is not effective, the chain of disease transmission is sustained [25].

On the other hand, the NASF professionals demonstrated lack of preparedness and lack of knowledge about the scope of activities liable to be carried out in the leprosy care. At the same time, the limitation of the NASF's work process to educational and health promotion actions is a de-characterization of the proposal of matrix support[26, 27]. The NASF's work process should not be limited to preventive measures, but should work in the specialized rearguard of the FHT instead, through specialized health care directly to the user and also by means of pedagogical and technical support[27, 28].

Such disagreement between what has been advocated and what is actua done by the NASF professionals is justified by the educational profile of the professionals composing the NASF team of the municipality, who have, on average, five years of academic training and, moreover, most have not attended any specialization program focused on community health. Since the NASF's proposal is still recent and the interviewees have not undergone any formal process of professional updating, one realizes that it is still necessary to study and improve the NASF strategy and its dimensions of action. Another important aspect that was verified was the lack of knowledge of the leprosy care protocol on the parto f the medical professionals belonging to the PMM.

> *"The diagnosis is always through the examination, [...] we already have the experience and knowledge to make the diagnosis, but we do make the treatment plan without a positive leprosy test, we must have the positive test otherwise the treatment cannot be initiated, do you get it?" (FHT 06).*

As leprosy is not an endemic disease in Cuba, the diagnosis and clinical management of the disease does not constitute the training path of medical undergraduate programs in the country. It is assumed that, in Morada Nova, this factor has contributed to the centralization of leprosy care in the municipality. On the other hand, researchers[29] who sought to identify the impact of the PMM on PHC indicators in the city of Altaneira, Ceará, Brazil, verified, among other factors, a significant increase in the number of medical procedures directed at patients with tuberculosis and leprosy, and reduced referrals. For the authors, this fact seems to reflect the active search actions triggered by these doctors and their teams, causing the number of notification and diagnosis to increase. Therefore, despite the lack of knowledge of the diagnostic criteria of leprosy, it can be overcome through the organization of the work process with a focus on active search and comprehensive care. A quantitative study of the indicators of health status and health production in this municipality would support the confirmation of this hypothesis.

Multiprofessional team and the (de)integration of care

This category addresses the leprosy care with the multifactorial team. Because it is a disease that encompasses several aspects of the patients' life, the MoH indicates that, in order to achieve comprehensive care, the care offered must be conducted by a multiprofessional team[30].

In the work organization of the PHC team in the municipality of Morada Nova, it was observed that each professional category has a specific attribution and there are no formal spaces for dialogue and discussion of cases of leprosy patients among the team. From what was discussed and evidenced in the previous section, leprosy care in the municipality occurs in a centralized way, hampering the accountability of the professionals that make up the FHS in caring for these patients.

> *"They only consist of visiting them, provide them with guidance on the attention for the prevention of disabilities and also, according to the protocol, the specialist follows [the patient]. It's somehow limited, isn't it? Just making the diagnosis, trying to make the diagnosis here, searching, that's it [...]" (FHT 02).*

However, even with the centralization of the diagnosis and drug therapy, there are many other dimensions of care that can be conducted by the FHS multiprofessional team. Leprosy is still considered a stigmatizing disease, so the patients and their families usually develop negative psychological reactions associated with self-shame, fear of death and social withdrawal. Prejudice and ignorance, still very present in society, contribute to the patient's low self-esteem, making it difficult to accept the disease. Care aimed at educational, behavioral, psychic and social aspects of these patients, their families, and the overall society becomes indispensable to the accomplishment of a successful treatment and, after that, for the reintegration of the individual into society[31]. It was observed, however, that this dimension of treatment, in the municipality under study, is not contemplated.

In the organization of the multiprofessional work in leprosy, the participation of the CHWs is also highlighted. These ones most often identify suspected cases during home visits, inform the FHT of the list of contacts, and verify whether the patients are complying with the treatment. Therefore, the importance of training the CHWs stands out as a way of qualifying the leprosy care, guaranteeing, through these professionals' performance, the active search for new cases, early diagnosis and treatment follow-up. Moreover, by expanding the knowledge of the disease, the discussion of health promotion actions is believed to become strengthened.

On the other hand, the professionals of the NASF team in Morada Nova exempt themselves from any responsibility for health prevention, which includes acting to demystify the perception of the disease and the prejudice related to it[32] and its diagnosis, for the patients and their relatives:

> *"I did a home visit to a bedridden patient; one of the relatives I saw had very suspicious-looking spots, I did not get to evaluate, but I just saw that, visually and, talking to the CHW, she told me she had already advised that person about it, to go to the health unit, to look for the doctor or the nurse of the unit, and the person refuses to go" (NASF 01).*

Contrary to this position reported by NASF 01, from the identification of a suspect case and by recognizing the patient's resistance to attending a health unit, it is assumed that the professional integrating a multiprofessional team feel accountable for the case, in addition to taking the situation found to be discussed in a shared way by the whole team.

The matrix support aims to build possibilities for expansion of clinical and health work. This methodology intends to ensure greater effectiveness and efficiency in the health work. However, even with a multiprofessional team focused on matrix support, it was observed that this integration did not occur in such a way to favor the expanded clinical practice in leprosy care in the studied reality[26].

The challenges to leprosy care: from care to management

In this category, when trying to identify the FHS professionals' and managers' opinions on the monitoring and organization of leprosy control actions in the municipality, challenging situations to the accomplishment of the work in the municipality were identified. The main challenging issue reported by the interviewees was the mode of organization adopted by the municipality in leprosy care.

> *"The main challenge, I believe it is to decentralize the program because, sometimes, we get to diagnose a patient here, and it can take some time before the treatment begins, and in the meanwhile he will keep on transmitting the disease, if he is multibacillary, isn't it?" (FHT 05).*

The decentralization of services in leprosy care is still regarded one of the greatest challenges to the effective control of the disease in the municipality and in the country. Even with the publications and recommendations of the MoH defining that leprosy care and control are PHC attributions, there is still a predominance of care centralized in specialized care[33,34].

Another aspect identified as challenging concerns the prevention actions. These challenges range from the acceptance of this type of activity by the population to the management support to the implementation of these interventions.

> *"What I think is... the challenge consists mainly in the non-appreciation on the part of the population participating in the primary care, which often thinks that this is bullshit, that health promotion doesn't work, and also the financial issue. Lack of investment for educational material purchasing, to give lectures, isn't it? [...]" (NASF 02).*
>
> *"[...] And it is also a challenge, as for the management, to have a little more complete support of the management, so as to give a more adequate support in such cases" (FHT 01).*

Through the speech of FHT 01, it is noticed that the population's lack of information collaborates in a significant way to reinforce the patients' non-adherence to the treatment and the control of the contacts. Furthermore, the importance of PHE to these professionals is highlighted as a way to improve professional performance in leprosy[35]. PHE, in addition to broadening

the technical knowledge, can subsidize these workers' performance with the sharing of methodologies and resources that aid in the actions of health promotion and injury prevention.

Given this context, it is also important to reflect on the support of municipal management to the implemantation of such actions by guaranteeing, for example, PHE moments and support with the resources, infrastructure and logistics needed for the accomplishment of the interventions.

On the other hand, the evaluation and monitoring of leprosy actions in the municipality also constitute limiting factors, according to managers of the municipality's PHC. Faced with the centralization of the program, these activities are only carried out when it is necessary to feed the information systems, or when there is some warning regarding the non-accomplishment of the activities by the FHT:

> *"Because it is centralized, the person in charge of running the program along with the physician, she sends me the information on how this figure is, and then we really act when we feed the COAP [Contrato Organizativo de Ação Pública, meaning Organizing Contract for Public Action], which we have to close, then we'll take a look at it, or else when some team is not requesting. The lab warns about the amount of examinations they are requesting and we check it out. When I see that a health unit hasn't done any searching for two, three months, without any requests, we get some feedback with them to know what is happening" (G 01).*

In line with NASF professionals' attitude towards leprosy care, it was also observed that the management, the NASF coordination, is not involved in the accomplishment of activities related to monitoring leprosy control actions and the epidemiological situation in the municipality:

> *"Well, currently, the part related to epidemiology is more up to the coordinator there. Whenever there is any kind of incident, she warns us, because the NASF comes in support, along with the reference BHU of the region, and informs that this incidence has occurred, and we will work together. The most accountable one for that is the coordinator of epidemiology and health surveillance" (G 02).*

Such failure in carrying out the evaluation and monitoring in a more effective way on the part of PHC managers also contributes to new cases of leprosy in the municipality. In 2015, the city of Morada Nova registered a detection rate of 29.16/100,000 inhabitants in the general population [(2)], in spite of the goal proposed by the Pact for Health, in 2006, to reach the level of less than one leprosy case per 10,000 inhabitants in all municipalities[(36)]. The National Leprosy Control Program (*Programa Nacional de Controle da Hanseníase - PNCH*), which aims to reduce the disease burden, relies, among its components, on the implementation of evaluation and monitoring of actions, and has taken the incorporation of this strategy as a priority to elaborate the action plan, since 2007. Thus, evaluation and monitoring are essential tools for managing the Leprosy Control Program[(37)].

When questioned about the impact of the actions carried out by them in the municipality and how they evaluate them, some contradictory interpretations arose. NASF professionals, despite having difficulty explaining the impact posed on leprosy by the work and understanding it only as educational actions, they evaluated the impact and organization of work in a positive way:

> *"[...] I think that, well, it ends up giving people a little more information about what the disease is" (NASF 05).*
>
> *"[...] I think I feel happy about this issue of trying to break this paradigm that leprosy is a seven-headed bug" (NASF 01).*

On the other hand, the FHT professionals, when reflecting on leprosy care in a broader perspective, expressed dissatisfaction with the mode of organization of the work in the municipality and pointed out the negative impact of the actions.

> *"I feel my hands tied. I feel like I'm not doing anything, that's how" (FHT 02).*
>
> *"Well, I see the impact as a negative thing because that's how I told you: we previously diagnose the patient, we know that he has leprosy and we have our hands tied, in a way that we know that it is basically a clinical diagnosis" (FHT 05).*

Such discrepancy in opinions is justified by the fact that NASF professionals are not effectively involved in caring for patients with the disease or their relatives, nor there is a good communication between the professionals who make up the FHS.

Thus, it is perceived that the biomedical model is still present in health issues. This model fragments the individual with a tendency to the vertical and impersonal relationship with the users, associated with the standardization of curative interventions[(38)].In a study carried out in the state of Rio Grande do Sul, from the twenty interviewees, it was observed that the users, when asked about the professionals that compose the health team, partially cited the team, except for the medical professional, which was mentioned by all. This makes clear the participants' lack of knowledge regarding the basic health team. It is also deduced that the understanding of health as a state that corresponds to the absence of disease still persists in the social culture. Thus, the practices performed at the BHU may be associated with the curative medical treatment[(39)].

The present study presented some limitations, such as the delimitation of the research only to the urban area of the municipality and the lack of comprehensiveness of all the professionals working in PHC, especially the dental surgeons and,

above all, the CHWs, who make up the team and are in direct contact with users, being essential in the construction of bonds with users of the services. Such limitations are justified by the temporal conditions of the study, but point out possible designs for future investigations.

FINAL CONSIDERATIONS

It was observed that the organization of leprosy care in the municipality follows a traditional and centralized model of specialized medical care. This model of care, which is not advocated by the MoH, impacts on several aspects of comprehensive care for leprosy, such as non-articulation of services for disease care and control, lack of evaluation and monitoring of actions by the managers, and lack of professional training on the conduction of such activities. These aspects of the work process have a negative influence on leprosy monitoring and care in the municipality.

It can be inferred that professionals and managers have a limited critical and constructive perception of leprosy care in the municipality. There is a focus of the central management on the organization of practices, which is followed with no replies, despite the low effectiveness of care and the reported dissatisfaction. Likewise, professionals and managers do not perceive the planning of leprosy care as the work object of the teams, relegating planning actions exclusively to the central management.

Moreover, the main challenges inherent to the model of leprosy care in the municipality, in the managers' and professionals' perception, translate into the work management and lack of professional qualification. As the management of the work, training and health information is not carried out with the objective of guaranteeing comprehensive care, care remains fragmented and inefficient. Likewise, the non-effectiveness of interprofessional work contributes to keeping clinical care essentially based on the hegemonic biomedical model. It is believed that only through the reorientation of the work process can the leprosy care in the municipality be qualified, facilitating the integration of services and professionals, and reflecting positively on the improvement of the epidemiological indexes of the region.

This study also evidences the need to analyze leprosy care from the perspective of the users of the service. Moreover, further studies may contemplate the correlation between the epidemiological situation of the specific territories and the mode of organization of leprosy care in the FHS of the municipality studied.

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