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ORIGINAL ARTICLE

Stigma of leprosy by community health workers: associated factors

Estigma da hanseníase por agentes comunitários de saúde: fatores associados

Estigma de la lepra entre los agentes comunitarios de salud: factores asociados

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ABSTRACT

Objective: to identify the factors associated with the stigma of leprosy, manifested in guidance regarding the separation of objects in family life, by community health workers in Palmas, Tocantins, Brazil. **Methods:** a quantitative cross-sectional study was carried out in Basic Health Units in Palmas in a population of 301 community health workers (CHWs), using a self-administered questionnaire. **Results:** of the 301 CHWs, 22.92% guided people at home regarding the separation of personal objects, such as cutlery, glasses, plates, towels, bed linen, clothing, and bedroom isolation. Guidance to separate objects for personal use was significantly higher for male CHWs (*PR: 1.89*; *CI: 1.25-2.87*), younger (*PR: 1.90*; *CI: 1.14-3.17*), with less time living in Palmas (*PR: 2.06*; *CI: 1.253.40*), with the location of the Basic Health Units out of the master plan (*PR: 1.75*; *CI: 1.11-2.76*), who had not taken a leprosy course (*PR: 3.03*; *CI: 2.01-4.58*), who had never followed up cases (*PR: 3.82*; *CI: 2.02-7.22*) and who did not have a family member affected by leprosy (*PR: 1.96*; *CI: 1.10-3.47*). **Conclusion:** the high prevalence of CHWs who have leprosy stigma represents a barrier to disease control actions. It was observed that the chances of stigma occurrence were higher in young, male community health agents, without training on leprosy and with a workplace in the peripheral regions of the city. Factors to be considered by the local control program with the adoption of Permanent Health Education. Investments in courses aimed at leprosy can contribute to reducing ignorance about the disease, as cultural aspects and generational beliefs influence the maintenance of concepts and social stigma.

Keywords: *Leprosy. Community Health Workers. Social Stigma.*

RESUMO

Objetivo: identificar os fatores associados ao estigma da hanseníase, manifestado na orientação quanto à separação de objetos no convívio familiar pelos agentes comunitários de saúde de Palmas, Tocantins, Brasil. **Métodos:** estudo transversal do tipo quantitativo realizado nas Unidades Básicas de Saúde de Palmas em uma população de 301 agentes comunitários de saúde, por meio de um questionário autoaplicável. **Resultados:** dos 301 agentes comunitários de saúde, 22,92% orientaram as pessoas no domicílio quanto à separação de objetos de uso pessoal, tais como talheres, copos, pratos, toalhas, roupa de cama, vestimentas e isolamento de dormitório. A orientação para separar objetos de uso pessoal foi significativamente maior para os agentes comunitários de saúde do sexo masculino (RP: 1,89; IC:1,25-2,87), mais jovens (RP: 1,90; IC: 1,14-3,17), com menor tempo de moradia em Palmas (RP: 2,06; IC: 1,253,40), com localização da Unidade Básica de Saúde fora do plano diretor (RP: 1,75; IC: 1,11-2,76), que não fizeram curso em hanseníase (RP: 3,03; IC: 2,01-4,58), que nunca fizeram acompanhamento de casos (RP: 3,82; IC: 2,02-7,22) e que não teve um familiar acometido por hanseníase (RP: 1,96; IC: 1,10-3,47). **Conclusão:** a elevada prevalência de agentes comunitários de saúde que apresentam estigma da hanseníase representa uma barreira nas ações de controle da doença. Observou-se que as chances de ocorrência de estigma foram maiores nos agentes comunitários de saúde jovens, do sexo masculino, sem capacitação sobre hanseníase e com local de trabalho nas regiões periféricas do município. Fatores a serem considerados pelo programa de controle local com a adoção de educação permanente em saúde. Investimentos em cursos direcionados à hanseníase podem contribuir para a redução do desconhecimento acerca da doença, pois os aspectos culturais e de crenças geracionais influenciam na manutenção de conceitos e do estigma social.

Palavras-Chave: *Hanseníase. Agentes Comunitários de Saúde. Estigma Social.*

RESUMEN

Objetivo: identificar los factores asociados al estigma de la lepra, manifestado en la orientación sobre la separación de objetos en la vida familiar, por los agentes comunitarios de salud en Palmas, Tocantins, Brasil. **Métodos:** se trata de um estudio cuantitativo transversal realizado em las Unidades Básicas de Salud de Palmas con una población de 301 agentes comunitarios de salud, utilizando un cuestionario autoadministrado. **Resultados:** de los 301 agentes comunitarios de salud, el 22,92% orientaró a las personas en el domicilio a respecto a la separación de objetos personales, como cubiertos, vasos, platos, toallas, ropa de cama, ropa y aislamiento del dormitorios. La orientación para separar objetos de uso personal fue significativamente mayor para los agentes comunitarios de salud masculinos (RP: 1,89; IC: 1,25-2,87), más jóvenes (RP: 1,90; IC: 1,14-3,17), con menos tiempo viviendo en Palmas (RP: 2,06; IC: 1.253,40), con la ubicación de las Unidades Basicas de Salud fuera del plan maestro (PR: 1,75; IC: 1,11-2,76), que no habían realizado curso de lepra (PR: 3,03; IC: 2,01-4,58), que nunca habían realizado seguimento de casos (PR: 3,82; IC: 2,02-7,22) y que no habian tenido ningún familiar afectado de lepra (PR: 1,96; IC: 1,10-3,47). **Conclusión:** la elevada prevalencia de agentes comunitarios de salud con estigma de lepra representa una barrera para las acciones de control de la enfermedad. Se observó que las posibilidades de estigmatización eran mayores entre los agentes comunitarios de salud que eran jóvenes, hombres, no formados en lepra y que trabajaban en las regiones periféricas del municipio. Factores a ser considerados por el programa de control local con la adopción de la educación sanitária permanente. Inversiónes en cursos sobre lepra puede ayudar a reducir el desconocimiento sobre la enfermedad, ya que aspectos culturales y creencias generacionales influyen en el mantenimiento de conceptos y estigmas sociales.

Palabras clave: *Lepra. Agentes Comunitarios de Salud. Estigma Social.*

INTRODUCTION

Leprosy is a chronic, infectious, neglected, and stigmatizing disease caused by *Mycobacterium leprae*[1]. The disease's stigma is the result of a powerful social process characterized by labeling and stereotypes, leading to loss of status and discrimination[2]. Thus, leprosy's stigma constitutes a barrier to the care of people who seek services for disease prevention, treatment of chronic conditions, or support to maintain a healthy quality of life[3,4].

Such biopsychosocial repercussions of leprosy go back thousands of years due to the serious skin problems and deficiencies resulting from the disease, which terrified people[5]. It was believed that leprosy was caused by a curse or by sin[6]. This belief is widely held to this day. Studies show that different populations perceive leprosy as a disease or divine punishment[5,6].

In this scenario, it is worth mentioning that, associated with the aforementioned factors, there's a persistence of high rates of leprosy at a national level. The state of Tocantins is considered hyperendemic, ranking second in the detection of new cases, with a detection coefficient of 96.44/100,000 inhabitants in 2019. In addition, the capital of Tocantins, Palmas, has the highest rate of detection of new cases among all state capitals in Brazil, with 226.99 cases per 100,000 inhabitants in 2019[7,8].

Considering that stigma is a serious obstacle to diagnosing new cases and continuing treatment, which are the main concerns of disease control programs[5,6,9], many efforts have been made to reduce the burden of stigma associated with leprosy[5]. Alternative terms have been used in Brazilian Portuguese. For instance, instead of "lepra", "hanseníase" is used[10].

However, the lack of knowledge about the disease strengthens the stigma, causing this process of exclusion, with consequent psychological damage to the affected person, making the process of treatment and cure difficult[5].

Although leprosy control actions have been successful in diagnosing new cases in Palmas[8], these interventions have not been aimed at reducing the stigma related to the disease. It is a fact that people affected by leprosy are still stigmatized by health professionals, friends, and neighbors. Thus, Permanent Health Education becomes an instrument of extreme importance for these actions in Primary Health Care (PHC)[11].

Therefore, the importance of community health agents (CHA) as members of the Family Health Team (FHT) in leprosy control actions is evident[12]. This professional is responsible for recording the territory's population, providing guidelines, and representing the link between the community and the team.

In this perspective, the goal of this study is to identify the factors associated with leprosy's stigma, manifested in the guidance regarding the separation of objects in family life, by the CHA of Palmas, Tocantins.

METHODOLOGY

Place of study

The study was developed in the municipality of Palmas, the capital of Tocantins, in the northern region of Brazil. It is the newest municipality in the country and attracts migrants from all regions, especially North, Northeast, and Midwest. These people come in search of new opportunities. The estimated population was 313,349 inhabitants in 2021. It has an area of 2,219 km^2[13].

The Health Care and Surveillance Network (HCSN Palmas) of the Municipal Health Department of Palmas has 87 Family Health Teams (FHTs), 506 CHAs, 15 Family Health Support Centers (FHSC), and 4 Polyclinics for care of specialized clinics. The average coverage of the population by FHTs has reached almost 100% since July 2016. These 87 FHTs are distributed in 8 health territories. Each territory has 3 to 5 Basic Health Units (BHU). There is 1 municipal laboratory, 7 accredited laboratories, and 1 reference center for physiotherapy and rehabilitation.

Type of study and population

This is a quantitative cross-sectional study carried out in Palmas, Tocantins, between 2017 and 2018.

Of the 506 CHA linked to primary care in Palmas, 474 were active in the FHTs and of these, 40 were on vacation during the application period of the self-administered questionnaire and 131 did not attend the invitation. Thus, 301 CHAs (60.5%) linked to the Family Health Strategy (FHS) for more than 6 months and who agreed to participate in the research were included in the study. CHAs with a function deviation, on sick leave, and/or on vacation at the time of data collection were excluded from the study.

The questionnaire was applied after clarifying the purpose of the research and signing the Informed Consent Form (ICF), complying with the norms of the National Health Council (NHC), through Resolution 466/2012.

Data collection

At first, a partnership was established between Instituto Tocantinense Presidente Antônio Carlos de Palmas (ITPAC) and Fundação Escola de Saúde Pública de Palmas (FESP), as the research was developed in response to the needs of the municipal health plan, considering the most prevalent problems in the capital.

After this stage, each BHU was visited individually by the researchers to schedule the data collection, where the project was presented to all BHU managers and FHTs professionals, who invited the CHAs on the team meeting day.

Ten days after the CHAs were invited, researchers came to the BHU, as scheduled, for clarification on the research, application of the TCLE, and subsequent application of the questionnaire to the CHAs of each BHU. Thus, all CHAs who agreed to participate in the research remained in a reserved room, without the researchers' presence, to answer the questions, with an average duration of 20 minutes.

Finally, after all the BHUs were visited to carry out the research, the collected data were analyzed for the permanent education program by FESP and ITPAC Palmas, according to the gaps in the CHAs' knowledge.

Evaluation tool

The database was obtained from a self-administered, multiple-choice questionnaire with 39 questions, prepared by the researchers, standardized and structured to identify gaps in the knowledge of CHAs about leprosy, which can be observed in doubts about diagnosis, transmission, treatment, and monitoring of cases.

Variables selected for this study were gender, age, area of residence, time of residence in the municipality of Palmas, race/skin color, location of the BHU, family income, years of study, length of service as CHA, taking courses in leprosy, duration of the course, follow-up of leprosy cases by the CHA, confidence, and security to follow up cases and history of a family member with leprosy.

The outcome variable of this study was the CHA stigma manifested in the guidance regarding the separation of objects in family life.

Data analysis

At first, a univariate statistical analysis of variables was carried out, to evaluate behavior in terms of the distribution of each variable in the study population. Then, a bivariate analysis was performed using Pearson's chi-square test, and odds ratios (OR) were calculated, with 95% confidence intervals (95% CI). Pearson's test was applied to verify the degree of correlation between explanatory and dependent variables.

Ethical aspects

The study was approved by the Research Ethics Committee (REC) of Centro Universitário Luterano de Palmas, Tocantins (CAAE nº 86581218.5.0000.5516/CEULP/ULBRA, Legal Opinion nº 2.656.443).

RESULTS

A total of 301 CHAs participated in the study. The minimum age of the CHAs was 20 and the maximum was 67 years old, with an average of 42.6 years old. Of the study participants, 153 (50.83%) were married, 25 (8.31%) were divorced, 82 (27.24%) were single, 35 (11.63%) had a stable relationship and 6 (1.99%) were widowed. More than half of the CHAs are from Tocantins (52.82%), and the rest are migrants from other states (47.18%). Of the participating CHAs, the highest percentages were from the following BHUs: 806 South, 712 South, 503 North, 1206 South, and 1004 South.

Among the 301 CHAs who answered the questionnaire, 22.92% advised people at home about the separation of objects in family life, such as cutlery, glasses, plates, towels, bed linen, clothing, and the isolation of the bedroom.

Guidance to separate objects for personal use was significantly higher for male CHAs (*PR: 1.89*; *CI: 1.25-2.87*, *p-value: 0.003*), younger (*PR: 1.90*; *CI: 1.14-3.17*, *p-value: 0.010*), with less time of residence in Palmas (*PR: 2.06*; *CI: 1.25-3.40*, *p-value: 0.007*), with BHU location outside the master plan (*PR: 1.75*; *CI: 1.11-2.76*, *p-value: 0.012*), who have not taken a course in leprosy (*PR: 3.03*; *CI: 2.01-4.58*, *p-value: 0.000*), who have never followed up cases (*PR: 3.82*; *CI: 2.02-7.22*, *p-value: 0.000*), who were not confident to follow leprosy cases (*PR: 2.45*; *CI: 1.65-3.65*, *p-value: 0.000*) and among those who did not have or do have a sick family member (*PR: 1.96*; *CI: 1.10-3.47*, *p-value: 0.013*), as shown in Table 1.

Table 1 – Bivariate analysis of factors associated with leprosy stigma by CHAs in the city of Palmas, Tocantins, Brazil, 2017-2018

Variables	Total	Guides to separate objects of personal use		PR	CI95%	Value of p
		n	n	%		
Gender						
Female	233	44	18.88	1	–	–
Male	68	25	36.76	1.89	1.25-2.87	0.003
Age						
> 45 years	96	18	18.75	1	–	–
35 to 45 years	124	22	17.74	0.94	0.53-1.66	0.847
< 35 years	81	29	35.80	1.90	1.14-3.17	0.010
Area of residence						
Urban	281	63	22.42	1	–	–
Rural	20	6	30.00	1.33	0.66-2.70	0.435

Variables	Total	Guides to separate objects of personal use		PR	CI95%	Value of p
		n	n	%		
Residence time in Palmas						
> 20 years	186	36	19.35	1	–	–
10 to 20	80	19	23.75	1.22	0.75-2.00	0.417
< 10 years	35	14	40.00	2.06	1.25-3.40	0.007
Race/skin color						
White	32	5	15.63	1	–	–
Yellow	10	5	50.00	3.20	1.15-8.83	0.025
Mixed race	214	49	22.90	1.46	0.63-3.40	0.353
Black	45	10	22.22	1.42	0.86-0.73	0.471
BHU Location						
Master plan 163	46	28.22	1	–	–	
Out of the master plan	137	22	16.06	1.75	1.11-2.76	0.012
Family income						
> 3 salaries	67	12	17.91	1	–	–
2 to 3 salaries	72	21	29.17	1.62	0.87-3.04	0.119
< 2 salaries	162	36	22.22	1.24	0.68-2.23	0.465
Years of study						
> 12 years	45	8	17.78	1		
9 to 12 years	98	22	22.45	1.26	0.60-2.61	0.524
Up to 8 years	158	39	24.68	1.38	0.70-2.75	0.332
Length of service as CHA						
> 18 years	21	4	19.05	1	–	–
10 to 18 years	170	31	18.24	0.95	0.37-2.44	0.927
< 10 years	110	34	30.91	1.62	0.64-4.09	0.272
Course in leprosy						
Yes	207	29	14.01	1	–	–
No	94	40	42.55	3.03	2.01-4.58	0.000
Duration of the course in leprosy						
< 2 years	79	15	18.99	1	–	–
> 2 years	128	14	10.94	0.57	0.29-1.12	0.105
Leprosy cases monitored by CHAs						
4 or more cases	100	11	11.0	1	–	–
1 to 3 cases	144	34	23.61	2.14	1.14-4.03	0.012
None	57	24	42.11	3.82	2.02-7.22	0.000

Variables	Total	Guides to separate objects of personal use		PR	CI95%	Value of p
		n	n	%		
Feel safe to follow up on leprosy cases						
Yes	226	38	16.81	1	–	–
No	75	31	41.33	2.45	1.65-3.65	0.000
Having a family member with leprosy						
Yes	88	12	13.64	1	–	–
No	213	57	26.76	1.96	1.10-3.47	0.013

Subtitle: PR = prevalence ratio; CI = confidence intervals

Source: Elaborated by the authors

DISCUSSION

In this study, a statistically significant odds ratio was found for stigma in the group of male CHAs, young, who did not take a course, with a place of work in the periphery, and with no experience in monitoring cases. These are factors to be considered by the local control program with the adoption of a Permanent Health Education program.

There was also a scarcity of studies that addressed the factors related to the stigma of leprosy by CHAs. Research related to the topic encompasses general knowledge about leprosy and mostly uses a qualitative approach, in addition to beliefs and taboos related to it, but without the CHA as a protagonist.

It is a fact that the stigmatization of leprosy by the CHAs represents a public health problem since it produces serious consequences for the people affected, such as suffering, exclusion, and helplessness. In addition, the stigma rooted in the community makes its mitigation difficult, resulting from the diagnosis delay, with definitive consequences in individuals' lives[3,4,14].

Thus, PHC actions become extremely important in leprosy control and stigma reduction, as they allow the community to become aware of important factors, such as clinical status, diagnosis and treatment, and transmission[8,14]. Besides, educational actions must be carried out to prepare the CHA in the territory, and these actions must focus on the knowledge gaps of these professionals, to mitigate discrimination[8,15,16].

Furthermore, the results indicated an odds ratio of 1.89 times more for males to practice the stigma of leprosy.

This can be explained because, in general, self-care and the enhancement of health are not relevant social issues for men and are even a barrier to their inclusion in health actions[17].

There is still a divergence between men and women about health practices, as men are impatient and seek healing practices, while women are more open to knowing about the disease and its entire healing process[17]. Men acquire less knowledge regarding diseases and, consequently, mistakenly advise on health issues due to the low rates of involvement in actions[17,18].

Younger CHAs also had a 1.9 times higher odds ratio for practicing stigma when compared to the older group. This result can be explained by the inexperience and insecurity of the practice of younger CHAs. Corroborating this finding, a study on health practices in patients with tuberculosis demonstrated a significant association between greater knowledge in older professionals[19]. There is also research that points out that more experienced CHAs tend to have more defined concepts about the health-disease process. On the other hand, for the younger and less experienced CHAs with the disease in question, these concepts seem not to be as clear and grounded[20]. Thus, it appears that the older age of the CHA leads to a safer practice, causing the professional to change his/her perception of the disease and stop stigmatizing the patient.

Regarding length of service, the CHAs with less time in the field provided 1.62 times more guidance on separating objects, but there was no significant difference with the group with the longest length of service. This higher percentage of guidance is explained by the experience in the position of CHA, with greater sedimentation of knowledge about leprosy. Similar results were found in another study, relating the CHA’s knowledge about leprosy with longer service time[21]. Thus, it appears that experience can lead to a more up-to-date practice, in addition to enabling a better understanding of the health-disease process.

The fact that CHAs in rural areas have an odds ratio of 1.33 times higher for the practice of stigma in their work may be related to the influence of the environment in which the person resides, considering aspects of sociocultural relations[22]. Another explanation is that CHAs working in rural areas have fewer opportunities to participate in permanent education activities offered by the local control program. These difficulties may be linked to the obstacles of displacement and long distances. In this bias, the literature supports the importance of health education offered in the CHA’s workplace, resulting in advantages in critical reflection and daily practice of the health professional[8].

Parallel to this, there was a significant association with the practice of stigma by the CHAs working in regions outside the city’s master plan, with an odds ratio of 1.75 times higher. Also, for the CHAs who lived in Palmas for less time, this ratio was 2.06 times higher. These results are related and can be explained by the centralization of health education projects in specific locations, neglecting more distant units, as well as territories that are not hyperendemic[8,21].

In this way, the local control program, as well as the FHTs, need to direct efforts toward equitably offering courses and breaking barriers. It is a fact that actions aimed at mitigating the disease collide with centralization and fragmentation of the health system, making it necessary to organize the system and develop permanent education policies disseminated throughout all territories[8].

The study also pointed out a 3.2 times greater odds ratio of stigmatization by the CHAs of yellow race/skin color. This factor can be explained by a color identification deviation in the questionnaire response. Corroborating with the literature, the self-declaration of race/skin color can raise doubts, mainly due to the lack of familiarity with the criteria, influencing the moment of filling[23].

Thus, these CHAs would actually be white, which allows the explanation of the variable by a social bias, since blacks and mixed race, due to suffering from racism in their daily lives, have a more empathetic look at these issues. One study stated that the black population has less access to health services, which directly impacts how these CHAs, who suffer daily from the consequences of exclusion from the health system, carry out their practice[24].

In the analysis of education and income, the results contradict the assumption that these variables have an impact on the level of stigmatization of CHAs with leprosy, given that this association was not significant. Still, no studies were found in the literature that could support these findings. Despite this, we can infer that the salary that professionals receive, and their level of education do not directly influence their availability to take professional development courses and update their practice. Thus, regardless of social class and education level, everyone is susceptible to stigma if they do not update their health education[21].

The CHAs who did not take a leprosy course had an odds ratio of 3.03 times greater for practicing leprosy stigma. It is a fact that these knowledge gaps contribute significantly to the conduct of these professionals towards the affected people, considering that CHAs have the attribution of disclosing adequate information about leprosy, as well as deconstructing the negative image associated with it since distant times of history. The greater the knowledge about leprosy among individuals, the greater the chance of having positive attitudes towards the disease and the affected people[20]. Professional qualification is a potential factor for breaking the idea that the patient poses risks to those who live in the same house, especially when the affected individual follows the treatment properly and in a timely manner[25].

Conducting a course for CHAs on aspects related to the diagnosis, transmission, and treatment of leprosy is essential for disseminating the necessary knowledge to users and reducing stigma[8,25]. It is a fact that leprosy control in primary care depends on the CHA's knowledge about the disease, since these professionals are in direct contact with people in the territory, through home visits[8,15].

Notably, the CHAs who did not follow up on leprosy cases had an odds ratio of 3.82 times more for stigmatization. Thus, it is observed that professional experience promotes a greater understanding of the disease, which may reflect on the behavior of the CHAs. Reinforcing this finding, a survey carried out with CHAs in Belo Horizonte, in 2013, demonstrated that professionals who carried out a greater number of home visits to people with tuberculosis had a better understanding of the disease, through a more humanized practice, when compared to less experienced CHAs[26].

In addition, insecurity in monitoring leprosy cases in the territory led to inadequate guidance on item segregation, with an odds ratio 2.45 times higher. It is a fact that the CHAs who receive permanent education in health have less perception of insecurity when exercising their profession[27]. It is believed that this situation may be related to greater knowledge and experience with health care, confirming the above[8,27]. There was also an odds ratio of 1.96 times greater for stigma practice in the group of CHAs who did not have a sick family member. Corroborating these results, a study carried out in a hyperendemic state for leprosy showed that the support of family members in leprosy treatment contributed to its cure and reduction of stigma[28]. Therefore, monitoring the history of a family member with the disease promotes greater knowledge about it.

Added to this, a systematic review of stigma in health units showed that the reduction of this problem occurred after encouraging community interaction with stigmatized people, being the most effective method in reducing prejudice[4]. This demonstrates that variables related to greater interaction with people affected by leprosy, such as the number of cases followed up and the presence of family members with the disease, are relevant in this research, reaffirming that experience promotes greater knowledge.

The limitations of this study are related to the application of a multiple-choice questionnaire, created, and validated by the researchers. This instrument investigated sociodemographic and work process variables, so the observation did not take place in the CHA's work routine, therefore, the conclusions obtained by this study reflect the professionals' statements about their actions but cannot effectively describe the activities developed in the daily life of health units. On the other hand, the answers to the questions were completed in their entirety and ensured better quality of analysis.

CONCLUSION

The high prevalence of CHAs who have leprosy stigma represents a barrier to disease control actions. This way, the higher prevalence of stigma manifestation in young male CHAs, without proper training on leprosy and with a workplace in the peripheral regions of the municipality are factors to be considered by the local control program, since their identification allows the elaboration of a Permanent Health Education strategy, with emphasis on the stigma caused by leprosy.

CHAs who are unaware of how stigmas manifest and affect people can damage control actions. Therefore, investments in health education, with courses aimed at leprosy, are extremely necessary, they will contribute to reducing the lack of knowledge about the disease, as cultural aspects and generational beliefs influence the maintenance of concepts and social stigma.

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