

## 20 Years of the National Program for the Prevention and Control of Viral Hepatitis: Historical Process and Contributions to Management

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## 20 Years of the National Program for the Prevention and Control of Viral Hepatitis: Historical Process and Contributions to Management

20 Anos do Programa Nacional para a Prevenção e o Controle das Hepatites Virais: Processo Histórico e Contribuições para a Gestão

20 Años del Programa Nacional para la Prevención y Control de las Hepatitis Virales: Proceso Histórico y Aportes a la Gestión

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### Abstract

**Research objective:** to organize historical aspects of the National Program for the Prevention and Control of Viral Hepatitis (PNHV) about management strategies to anally recognize actions to cope with viral hepatitis in the Unified Health System (SUS).

**Theoretical Framework:** reference of the analysis of Health Policies that takes the approach of political content as guidelines, plans and programs, passing through the organization of the health system and its various components that support the legitimacy of the actions proposed by government agents in relation to the PNHV.

**Methodology:** documentary analysis study of sociopolitical and historical context with time frame, since the creation of the PNHV (2002-2021), based on documents of the scope of legal frameworks. The analysis allowed grouping the findings into two sections: the Implementation of the public policy of care for hepatitis: main milestones and analytical assumptions and Strategies to support management in coping with viral hepatitis.

**Results:** there have been advances, especially in the last decade, regarding the extension of vaccination to the population, building guidelines to support the decentralization of care, with attempts to organize a more integrated care network. There is a need to broaden the dialogue on the conduct of management to strengthen guidelines that articulate a health care network respecting the principles of the SUS.

**Originality:** it exposes a production that summarizes important legal milestones and makes it possible to reflect on the management of the SUS in coping with hepatitis, but also presents strategies to management to enhance the PNHV.

**Theoretical and Practical Contributions:** marks a political context of the PNHV's performance and summarizes considerations that can contribute to increase the capillarity of health services in the care network, analyze the organizational model, in addition to scoring the need for investment in qualified professional quantity, that is, aspects that will require strong management action to achieve the goals agreed in the 2030 agenda

**Keywords:** Human viral hepatitis, Health Management, Health services, Comprehensive health care, Unified Health System.

## Resumo

**Objetivo da Pesquisa:** organizar aspectos históricos do Programa Nacional para a Prevenção e o Controle das Hepatites Virais (PNHV) acerca de estratégias de gestão para analiticamente reconhecer ações de enfrentamento das hepatites virais no Sistema Único de Saúde (SUS).

**Enquadramento Teórico:** referencial da análise de Políticas de Saúde que toma a abordagem do conteúdo político enquanto diretrizes, planos e programas, perpassando pela organização do sistema de saúde e seus diversos componentes que sustentam a legitimidade das ações propostas pelos agentes governamentais em relação ao PNHV.

**Metodologia:** estudo de análise documental de contexto sociopolítico e histórico com recorte temporal, desde a criação do PNHV (2002-2021), embasado em documentos do escopo dos marcos legais. A análise permitiu agrupar os achados em duas seções: a Implantação da política pública de atenção às hepatites: principais marcos e pressupostos analíticos e Estratégias para subsidiar a gestão no enfrentamento das hepatites virais.

**Resultados:** constata-se avanços, principalmente na última década, quanto à extensão da vacinação à população, construção de diretrizes para apoiar a descentralização da atenção, com tentativas de organização de uma rede de atenção mais integrada. Há premência de ampliar o diálogo sobre a condução da gestão para fortalecer diretrizes que articulem uma rede de atenção à saúde respeitando os princípios do SUS.

**Originalidade:** expõe-se uma produção que sumariza importantes marcos legais e possibilita refletir sobre a gestão do SUS no enfrentamento das hepatites, mas também apresenta estratégias à gestão para potencializar o PNHV.

**Contribuições Teóricas e Práticas:** marca um contexto político de atuação do PNHV e sumariza considerações que podem contribuir para ampliar a capilaridade de serviços de saúde na rede de atenção, analisar o modelo de organização, além de pontuar a necessidade de investimento no quantitativo profissional qualificado, ou seja, aspectos que requererão forte atuação da gestão para alcance das metas pactuadas na agenda 2030.

**Palavras-chave:** Hepatite Viral Humana, Gestão em Saúde, Serviços de Saúde, Assistência Integral à Saúde, Sistema Único de Saúde.

## Resumen

**Objetivo de la investigación:** organizar aspectos históricos del Programa Nacional de Prevención y Control de las Hepatitis Virales (PNHV) sobre estrategias de manejo para reconocer las acciones para enfrentar la hepatitis viral en el Sistema Único de Salud (SUS).

**Marco teórico:** referencia del análisis de las Políticas de Salud que toma el enfoque de contenido político como directrices, planes y programas, pasando por la organización del sistema de salud y sus diversos componentes que apoyan la legitimidad de las acciones propuestas por los agentes gubernamentales en relación con la PNHV.

**Metodología:** estudio de análisis documental del contexto sociopolítico e histórico con marco temporal, desde la creación del PNHV (2002-2021), basado en documentos del alcance de los marcos legales. El análisis permitió agrupar los hallazgos en dos secciones: la Implementación de la política pública de atención a la hepatitis: principales hitos y supuestos analíticos y Estrategias para apoyar la gestión en el enfrentamiento de la hepatitis viral.

**Resultados:** ha habido avances, especialmente en la última década, en cuanto a la extensión de la vacunación a la población, construyendo directrices para apoyar la descentralización de la atención, con intentos de organizar una red de atención más integrada. Es necesario ampliar el diálogo sobre la conducta de la gestión para fortalecer las directrices que articulan una red de atención de salud respetando los principios del SUS.

**Originalidad:** expone una producción que resume hitos legales importantes y permite reflexionar sobre el manejo del SUS en el enfrentamiento de la hepatitis, pero también presenta estrategias de manejo para mejorar el PNHV.

**Contribuciones teóricas y prácticas:** marca un contexto político del desempeño de la PNHV y resume consideraciones que pueden contribuir para aumentar la capilaridad de los servicios de salud en la red de atención, analizar el modelo organizacional, además de puntuar la necesidad de inversión en cantidad profesional calificada, es decir, aspectos que requerirán una fuerte acción de gestión para alcanzar las metas acordadas en la agenda 2030

**Palabras clave:** Hepatitis viral humana, Gestión en Salud, Servicios de salud, Atención Integral de Salud, Sistema Único de Salud.

## Introduction

Globally, viral hepatitis represents an important public health problem because it is characterized as a chronic and silent disease, diagnosed in most people at an advanced stage. About 257 million people living with chronic infection by the hepatitis B virus and 71 million people with the hepatitis C virus are unaware that they have the infection, and estimates indicate that approximately 57% of cases of liver cirrhosis and 78% of primary liver cancer cases derive from infection with hepatitis B and C viruses (PAHO, 2020). In Brazil, in the period 1999-2020, 254,389 people diagnosed with hepatitis B and 262,815 with hepatitis C were notified (BRASIL, 2021). This epidemiological scenario is relevant and warns the Health Systems (HS) of the need to consider guidelines for the management of hepatitis care, with the incorporation of care and management technologies.

As for the clinical conditions of hepatitis care, there is a vast consolidated scientific production, where, in summary, is possible to highlight socioeconomic issues related to drinking water and sanitation, low vaccination coverage in childhood and the monitoring of cases in a priority target population, such as transmission of hepatitis involving men who have sex with men, injecting drug users, contaminated food and the low investment in studies for vaccination and treatment (Pisano *et al.*, 2021). With regard to the responsibility and commitment of HS concerning the organization of different health care resources in terms of coping with hepatitis, making access to diagnosis more equitable with guaranteed treatment is still a challenge in HS, as well as publicizing the management actions to favor the role of this condition in the health agenda.

One strategy to place viral hepatitis on the HS agenda was to consider them in the Sustainable Development Goals (SDGs) to be achieved by 2030. The World Health Assembly, through the Global Health Sector Strategy, proposed to undertake efforts to reduce new infections by 90% and lower mortality by 65%, and the World Health Organization (WHO) recommended for the period 2016-2021 to increase awareness, encourage advances in treatment, increase diagnostics and other technologies, in addition to strengthening the health equity (WHO, 2016). The Pan American Health Organization (PAHO) proposed an integrated and broad response through equitable access to preventive and clinical care through the capacity to offer laboratory supplies to enable diagnosis, surveillance and safety in blood transfusions and hemodialysis centers (PAHO, 2016a).

Then, there is a set of international guidelines that support actions to combat viral hepatitis, but it is necessary to take a cautious look at the contexts of organization of health services in HS, the morbidity and mortality profile, the supply and use of resources that facilitate or hinder access. In Brazil, since the creation of the National Program for the Prevention and Control of Viral Hepatitis (PNHV, as per its Portuguese acronym) in 2002, guidelines and actions have been recognized in an attempt to organize hepatitis care in the Unified Health System (SUS, as per its Portuguese acronym). Nonetheless, there is an irregular distribution of health services for hepatitis care, which daily confronts the distances between the incorporation of advanced technologies for diagnosis and treatment, running into the inequality of access exposed to issues of socioeconomic heterogeneity, the organization of the care network and fragility in the political guideline in terms of expanding the universalization of access, guaranteeing equity and comprehensiveness in public health care (Gleriano, 2021; Almeida *et al.*, 2019).

In this sense, it is understood the relevance of public policies to establish management and care guidelines that can propose strategies in an orderly way in different health scenarios. This study takes this analysis space to unite efforts, based on the findings of the political guidelines to cope with hepatitis in Brazil, with the reflection that the Brazilian public health system is solely responsible for the care of this problem in the health network. Thus, the repercussion of viral hepatitis in the health scenario, the urgent need to expand the focus of care and the importance of SUS in terms of favoring the organization of care for this condition, in order to avoid/minimize the resulting complications, justify this study, which aimed to analytically organize historical aspects of PNHV about management strategies to cope with viral hepatitis in SUS.

The contribution of this study is highlighted by conceiving an analysis of health policies from the evolution of PNHV, establishing connections with the reference of system management and health services to encourage a dialog focused on coping with hepatitis, as a chance to verify decisions in the face of demands that are technical, social and political, exposing the contribution to the Brazilian public health policy.

## Unified Health System and management: a reference for Health Policy Analysis

By approaching the broader conception of health, based on its different models, from elaboration to decision, implementation and evaluation, attention is drawn to the magnitude that the concept of health gains and, at the same time, exposes the structural fragility of how the guidelines and allocation of resources delimit the rules in the relationship between the State and society. In this space, health management plays an important role in terms of recognizing fragilities and equating strategies to qualify HS.

In HS management, the greater the expansion of the population care coverage group, given the different organizational arrangements to meet the multiple demands of health determinants, the more difficult the coordination, monitoring, evaluation and alignment to financial issues of sustainability. Considering the study focus on management strategies, as well as the multiple and broad aspects of health management, it is pertinent to highlight that this study understands that:

Management does not concern a position or person, but the interactions, relationships and institutional agreements of a set of actors with power to make decisions about health policy agendas, including the formulation of proposals, norms and legislation, prioritization, discussion and strategic operationalization of technical, administrative and political actions (Gleriano, 2021. p.37).

The analysis of public policies enhances the management of a government in the action and/or reflection of its action. Accordingly, they can be understood in the perspective of a cycle, which runs from the moment of awareness of the agenda in the public entity until the specific moment of materialization of the policy. The phases of the public policy cycle, from the agenda, the formulation, the implementation and the evaluation, constitute aid for the methodological organization in studies on public policy analysis, being able to subsidize its evaluation (Batista, Domingos & Vieira, 2021; Trevisan & Bellen, 2008).

In terms of management, the analysis of health policies is not an easy task, which is why theoretical-methodological approaches may be theoretically and conceptually scarce (Baptista, Azevedo & Machado, 2015), a situation with greater strength of evidence in middle- and low-income countries (GILSON *et al.*, 2018). Brazilian scientific knowledge in the field of health policy analysis shows different theoretical and methodological references, recognizing, through the approach, the use of historical institutionalism, the cycle of policies, development throughout the process and a critical approach to strategic thinking (Baptista, Azevedo & Machado, 2015). In Brazil, it is still necessary to focus attention and expand the analytical debate on the conceptions of approaches, theories and models in the analysis of health policies (Vaitsman, Ribeiro & Lobato, 2013).

In the area of health policy research, two central approaches can be distinguished, “Policy Analysis in Health”, which assumes as its central object the analysis of power relationships in health inside and outside institutions, and the “Health Policy Analysis”, which adopts the approach of political content as guidelines, plans and programs, going through the organization of the health system and its various components that sustain it (Teixeira & Silveira, 2016). In this regard, three distinct notions are established: *policy* (plans, guidelines and programs), *politics* (distribution of power and struggles at stake) and *polity* (structural or system dimension, sometimes referred to the State itself, bringing together the set of constitutional norms; political society) (Santos & Teixeira, 2016).

In SUS, political and technical accumulation is shown with emphasis due to its role in the decision-making process regarding the formulation of planning. Thus, the importance of positioning management in studies on health policy should be defended. In order to increase the predictive degree of an analysis that



has SUS management as an object, the selection of stakeholders and their negotiation arenas for the decision-making space are important in the analysis of different aspects that make up the System. The adoption of stakeholder theory (Freeman, 1983) helps to understand the attributes of an evaluation. Three classes are identified, the latent, the expectant or the definitive actors, and the important thing is to verify the analysis of legitimacy, that is, of the actions that are desirable, proper and appropriate according to a socially constructed system, the power, identified as a relationship between social actors in terms of achieving the goals they desire and the urgency that will only be considered based on two conditions: the first when a relationship or complaint is time-sensitive or when this relationship or complaint is important or critical to the stakeholder.

In research on the analysis of health policies and programs, the dynamics of actors in the field of SUS management, technical area, commissioned positions and collegiate management require attention to the stakeholder, which shows the potential to identify legitimacy, power and urgency in terms of guaranteeing doctrinal and organizational principles in the management process (Pimenta et al., 2022; Gleriano 2021). Therefore, analyzing this dynamic field of actors that represents negotiation is pertinent and peculiar at the same time.

In light of the foregoing, it was decided to use the “Health Policy Analysis” to understand the content that expresses the decisions of PNHV and its guidelines, issued by the Brazilian Ministry of Health (MS, as per its Portuguese acronym), the plans and structure of the Program in the process of decentralization of care, going through the organization of the health system and the components that support it. Faced with the analytical categories selected to understand the historical process, the dimensions of *policy*, *politics* and *polity* are taken.

## Method

This is an original documentary analysis study used to enable diversified content analysis (Esperidião, 2018). It uses a qualitative narrative review (Rother, 2007) of pre-analyzed documents (Figure 1), organized and classified in the group of structuring legislation, institutional records written and published by the Brazilian Ministry of Health (MS, as per its Portuguese acronym) and other relevant documents of scientific knowledge produced from the scope of the legal milestones of PNHV, with a time frame (2002-2021).

The sociopolitical and historical context (Sá-Silva, Almeida, & Guindani, 2009) is used for information about the historical context of immunization, the organizational structure of PNHV and the network of testing and treatment services, as well as advances from the guidelines issued in the Clinical Protocols and Therapeutic Guidelines (PCDT, as per its Portuguese acronym) to enunciate the guiding questions: in the perspective of advances and challenges, what is it possible to capture in the time frame of the legal milestones of PNHV? What are the strategies that can contribute to the political analysis in terms of coping with viral hepatitis in the dimension of SUS management?

The text was organized into axes aligned with the scientific literature and built according to the fundamentals of the theme analyzed from the reference that subsidizes the management of health systems and services. The use of the reference for analyzing health policies (Teixeira & Silveira, 2016), the actors and processes, contributed to asking why, for whom and by whom the national policy to cope with hepatitis was developed, identifying the main mobilizing elements and the achieved results (Esperidião, 2018).

The organization of the reflection was presented in two sections: Implementation of the public policy on hepatitis care: main milestones and analytical assumptions and Strategies to support management in terms of coping with viral hepatitis.

It is not intended to present the impact and effects of PNHV, the aspects that are unwanted, even because it would be contradictory to take this boldness only for a documentary analysis study, but to point out elements that are important in the historical process and that represent in the relationships of

legitimacy power and urgency. This is an approach that may support provocations for new field investigations.

## **Implementation of the public policy on viral hepatitis care: main milestones and analytical assumptions**

The organization of this topic follows the presentation of the milestones regarding the historical context of immunization, the political and organizational structure of PNHV and the network of testing and treatment services, as well as the advances from the guidelines issued in PCDT, under the eyes of the plans and guidelines of the Program with what can be obtained from the distribution of power and the struggles around the fight against hepatitis.

Documentation on the history of viral hepatitis in Brazil before the beginning of the XIX century is considered scarce, and the actions to cope with it were based on the sanitary model through vaccination in specific areas of priority populations with susceptibility to hepatitis B (Fonseca, 2010). It is highlighted the action of the Brazilian Ministry of Health as the second country in the world to carry out mass vaccination against the hepatitis B virus in endemic areas (Blumberg, 2006), but it was only with the creation of SUS that the model of care improved, from the field of health surveillance and service networks to the organization of health care (Tofani et al., 2021; Gleriano, 2021).

As a public policy, hepatitis care in SUS has been consolidated since the publication of the ministerial document “Viral Hepatitis: Brazil is attentive in 2002” (Brasil, 2002d), which presents PNHV and invites health professionals to learn about the new structure of care for this condition, opening the publication of manuals and signaling the need for a constant process of discussion, evaluation and revision of the goals envisaged by this Program.

In these twenty years of PNHV, MS has adopted strategies related to the prevention, diagnosis and treatment of hepatitis, which configured the direction of a public health policy. In Figure 1, it is possible to recognize the main historical milestones of this period.

## Legal and documentary milestones, actions and events

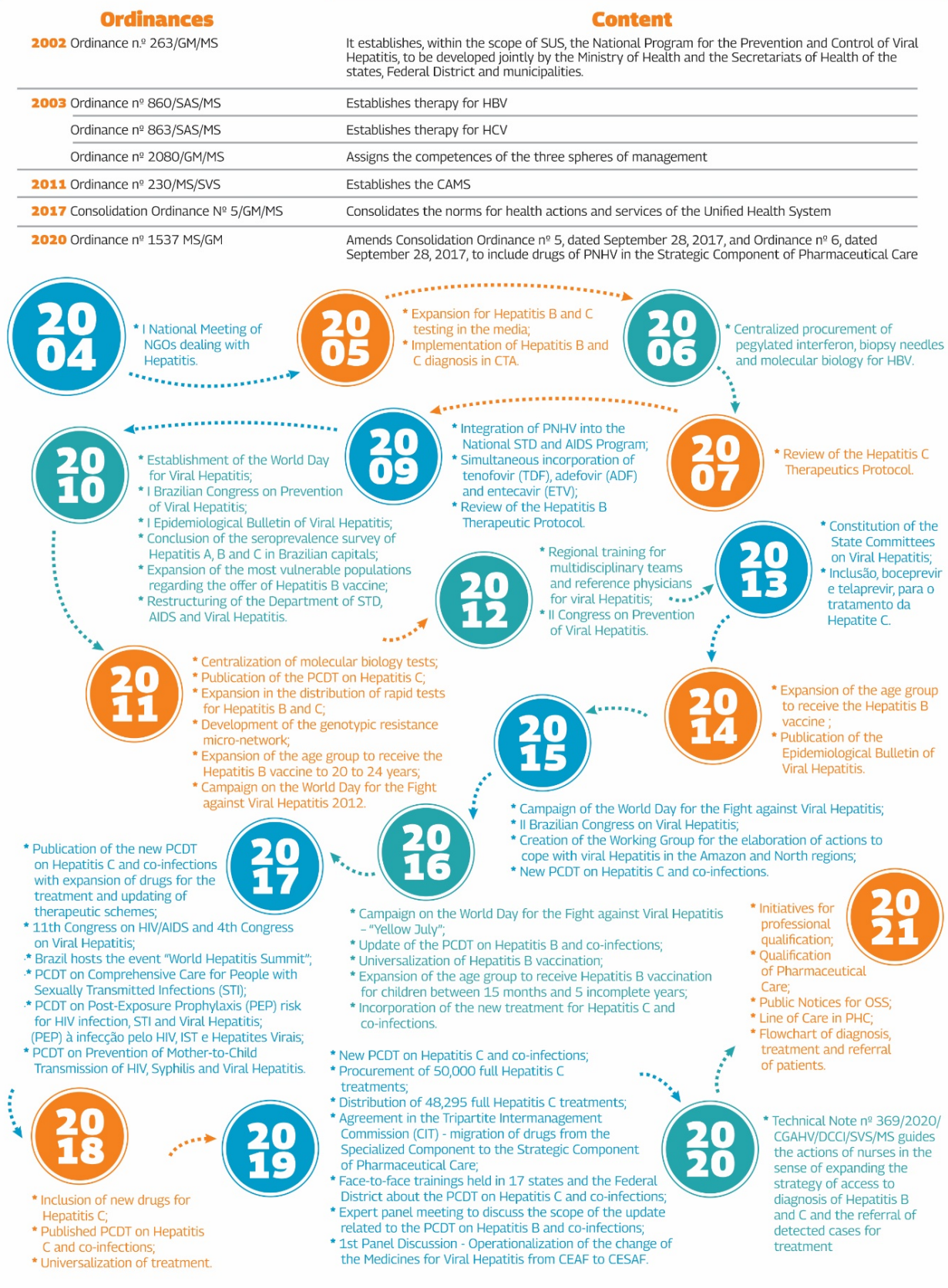


Figure 1: Main milestones of PNHV for the period 2002-2021  
Source: designed by the authors based on Viral hepatitis: history of actions (Brasil, 2019a).



The offer of immunization for the prevention of hepatitis B precedes the creation of PNHV. The hepatitis B vaccine was gradually incorporated into the immunization schedule; in 1989, indicated for children in the west of the state of Amazonas, then gradually with the protagonism of the induction of public health policy promoted by SUS, offered to the other states of the North region of the country; in 1992, recommended for priority groups; in 1993, offered to children aged up to four years in the states of the South and Southeast regions; in 1998, recommended for all children at birth, being incorporated into the National Child Vaccination Schedule (Brasil, 2003a); in 2001, the offer was expanded to the age group of up to 19 years old; in 2011, for people up to 29 years old; as of 2013, it was made available to people up to 49 years old; and, since 2016, it has been aimed at the entire population, regardless of age or conditions of vulnerability (Ximenes *et al.*, 2015). Vaccination against hepatitis A was incorporated into the national schedule, in 2014, for children aged between 15 and 24 months and, in 2017, for children aged from 15 months to 5 years old (Brasil, 2017a).

Globally, it is estimated to have prevented about 310 million cases of hepatitis B between 1990 and 2020, proving its importance in elimination plans in HS (Cooke, *et. al.*, 2019). In SUS, the National Immunization Program (PNI, as per its Portuguese acronym) is a reference for the capillarity of the vaccination offer throughout the national territory, but vaccination coverage for hepatitis is still heterogeneous, both between age groups and by regions of the country (Brito & Souto, 2020).

The first conducted initiatives were relevant in policy and management to create mechanisms for organizing, articulating and integrating actions aimed at preventing and controlling hepatitis. The recognition of hepatitis in the national list of notifiable diseases was through Ordinance GM/MS n° 1.461/1999. The creation of PNHV by Ordinance GM/MS n° 263/2002 (Brasil, 2002a) with emphasis on prevention, surveillance and care, in different health services, defining the expansion of access, the installed capacity of health services and reference centers for treatment based on regulation, monitoring and evaluation. The publication of Ordinances SAS/MS n° 860/2002 and n° 863/2002 and the evaluation report of the Viral Hepatitis Care (Brasil, 2002b) triggered the first steps of public health policy, which guided the PNHV Operational Plan.

In the twenty years of PNHV, it was supervised by fifteen ministers of health and was in the management of different departments. At the time of its creation, the Program was linked to the Secretariat of Health Policies (SPS/MS, as per its Portuguese acronym) in the Department of Primary Care (DAB, as per its Portuguese acronym), having as its coordinator Antônio Toledo Júnior. In 2003, through ministerial restructuring (Brasil, 2003b), started to incorporate the Department of Epidemiological Surveillance (DEVEP, as per its Portuguese acronym), which was part of the Secretariat of Health Surveillance (SVS, as per its Portuguese), remaining in this structure until 2009, with the coordination of the Program headed by Antônio Toledo Júnior (2003), Gerusa Figueiredo (2003-2007), Argemiro D'Oliveira Júnior (2008) and Ricardo Gadelha (2008-2009). In the ministerial restructuring of 2010 (Brasil, 2010a), it became part of the Department of Surveillance, Prevention and Control of STIs, HIV/AIDS and Viral Hepatitis (DIAVH, as per its Portuguese acronym), when the Program was coordinated by Ricardo Gadelha (2010) Jorge Eurico Ribeiro (2011-2013), Elisa Cattapan (2013-2014), Marcelo Naveira (2014-2016) and Gláucio Mosimann Júnior (2017-2018). In the ministerial restructuring of 2019 (Brasil, 2019b), it became part of the Department of Diseases and Chronic Conditions and Sexually Transmitted Infections (DCCI), when the Program was coordinated by Gláucio Mosimann Júnior (2019-2020) and Ana Cristina Garcia Ferreira (2020-2022) (Davidian & Fonseca, 2022; Brasil, 2019a).

Since 2005, the management of PNHV has been responsible for promoting, within the structure of SVS, formalized through Ordinance GM/MS n° 892/2005, a dialog with the Secretariat of Health Care (SAS, as per its Portuguese acronym) and the Secretariat of Science, Technology and Strategic Inputs (SCTIE, as per its Portuguese acronym), responsible for fostering the National Policy on Pharmaceutical Care, even notes that SVS became responsible for the protocols related to PNHV (Davidian & Fonseca, 2022). The change from PN-DST/AIDS to DIAHV internally carried out a demand from organized civil society movements and some subnational managers to formalize strategic agendas in MS that worked with

promotion and prevention, diagnosis, health care, drug logistics, human rights and civil society. The inclusion of PNHV in DCCI was justified to favor a greater focus on hepatitis in the set of chronic communicable diseases, with a greater focus on health surveillance, in addition to a strategy to point out investments in global responses (GHSS, 2022), in the expectation that the illness would take advantage of the AIDS Program budget, through the Global Fund, mainly due to the co-infection (EB134/36). It promoted a discussion of the fear of hepatitis being subordinated to HIV/AIDS and the loss of focus on building an identity capable of giving visibility to the illness, in addition to the fears of managers and social movements of HIV/AIDS in the dissipation of resources (Davidian & Fonseca, 2022). Since the creation of the PNHV, it was decided not to associate it with the work dimension of the HIV/AIDS Program; however, there is evidence that, in the decentralization of actions at the state level, cases are perceived in which the policy has always been in the shadow of HIV/AIDS (Gleriano, 2021).

In 2005, with the creation of the National Commission for Coordination with Social Movements (CAMS, as per its Portuguese acronym), greater dialog between health management and social movements was encouraged, which became, in 2011, a consultative instance in the formulation of policies to cope with the sexually transmitted infections, HIV/AIDS and hepatitis, with strong pressure to respond to legal demands for access to new drug therapies (Cibils, 2022). In interfederative management, as of 2008, the creation of coordination bodies in states and municipalities is intensified, bringing together actions discussed with greater emphasis in the National Council of Health Secretaries (CONASS, as per its Portuguese acronym) and the National Council of Municipal Health Secretaries (CONASEMS, as per its Portuguese acronym) through Ordinance SVS/MS n° 94/2008 (Brasil, 2008b), in addition to macro-regional forums to consolidate a diagnostic update of the main obstacles of PNHV and to approach strategies to align political guidelines (Brasil, 2010b).

In order to understand the dynamics of PNHV in the decision-making chain of management, it will be pertinent to expand qualitative studies with the stakeholders, who occupied and occupies the space of formulation and implementation, but, above all, what are the possible questions that alter decisions within the scope of the negotiation in multi-layering and multi-level decision processes, capable of revealing perspectives and values that contribute to implementation. Accordingly, designing analytical models that look at these actors becomes essential for the matrix of future analysis.

The disclosure of the first edition of the Epidemiological Bulletin on Hepatitis, launched in 2010, contributed to the analysis of the dynamics of this condition in the Health Regions (HR), including to highlight the need to develop population-based prevalence studies (Bepa, 2007), in addition to encouraging training in epidemiological surveillance conducted in partnership with Non-Governmental Organizations (NGOs) (Brasil, 2009), as well as expanding the dissemination of the topic on social media. These developments led to the creation of State Committees on Viral Hepatitis, in the federal entities, which boosted a governance movement with space for regional analysis and implementation of thematic projects from 2013 onwards. It is worth pointing out that the lack of reliable data and underreporting led to the non-publication of epidemiological bulletins in the years 2013 and 2014. The working group for the development of actions to cope with hepatitis in the Amazon and North regions, created in 2015, constitutes a relevant initiative in the sense of giving specificity to the confrontation in a region with peculiar characteristics.

With regard to partnerships, MS and PAHO carried out collaborative projects, configuring a milestone for international goals. An analysis of the Cooperation Term 66 (PAHO, 2020), signed in 2011, showed results of alignment of political and technical strategies to face this problem. In 2017, MS, in partnership with the Center for Disease Analysis (CDA) and PAHO, developed a collaborative epidemiological project for hepatitis B and C, making it possible to identify goals to be achieved with regard to diagnosis and treatment, as well as preparing the Hepatitis C Elimination Plan (Brasil, 2018). Nonetheless, signs of challenges regarding the downward trend in actions have already been pointed out in an analysis of the implementation of this plan (Coutinho, Basto, Fonseca & Shadlen, 2021). Another relevant truth concerns the fact that Brazil hosted the World Hepatitis Summit, an important international event that

brought the country closer to an articulated agenda of joint actions by the WHO and the World Alliance against Hepatitis (WHO, 2017).

The publication of Informative Note nº 55/2019-CGAE/DIAHV/SVS/MS with new criteria for defining cases of hepatitis, in line with the Health Surveillance Guide, promoted a strategy to strengthen and expand information to health services, as well as to highlight the need for surveillance to notify hepatitis in the Notifiable Diseases Information System (SINAN, as per its Portuguese acronym), including the investigation of laboratory test results or rapid tests.

The distribution of services and the availability of offers for testing for hepatitis affect access (Gleriano, 2021, Almeida et. al., 2019). In the creation of PNHV, regarding testing and treatment, initially, it was defined that the competences of the three spheres of management for organizational actions of the State Care Networks were the responsibility of the Secretariats of Health of the states, Federal District and municipalities, as well as the establishment of reference and counter-reference flows, covering the articulation between state managers and possible interstate references (Brasil, 2002a). It was decided to welcome and test for hepatitis at the Testing and Counseling Centers (CTA, as per its Portuguese acronym), a service that already carried out HIV care (Brasil, 2005a), which historically are diagnostic/testing, counseling and referral services. Serological screening and the capillarization of services in regions of the country were initially centralized in the Central Public Health Laboratories (LACEN, as per its Portuguese acronym) of the states (Brasil, 2002a), and it was only in 2010 that it gained emphasis with greater decentralization (Davidian & Fonseca, 2022). Nonetheless, this service, especially in the Legal Amazon, has made little progress in terms of organizing its network capable of subsidizing the principles of the health system, an aspect that also has repercussions on the role of state management in the competence of organizing the network and guaranteeing greater equity in access (Gleriano, 2021; Almeida et. al., 2019).

Treatment was initially centralized, provided more frequently at the state level by outpatient clinics in hospitals and medical offices linked to universities. In order to advance comprehensive care and decentralize referrals, Specialized Care Services (SAE, as per its Portuguese acronym) were organized, which are also responsible for rapid testing, requesting viral load to confirm the diagnosis and treatment of hepatitis (Brasil, 2017b; Brasil, 2008a). With regard to transplants, it is worth underlining that Brazil is a world reference, and SUS is largely responsible for this response. In the period from 2001 to 2019, 24,810 liver transplants were performed, with an upward growth from 2009; however, there is a considerable queue of people waiting for this transplant (Brasil, 2020). Nevertheless, the South and Southeast regions are the ones that most perform this procedure (Soares et al., 2020), a scenario that requires careful analysis for interfederal agreement strategies.

The conformation of the hepatitis care network, especially in the last decade, was influenced by political aspects and management guidelines to expand decentralization, mainly for PHC, as an attempt to reach a larger population contingent (Rocha, Santos, Conz & Silveira, 2016). It is underlined that this articulation is the result of work in SVS in partnership with the Secretariat of Primary Health Care, the Secretariat of Specialized Health Care, the National Health Foundation, the National Health Surveillance Agency and the Secretariat of Science, Technology, Innovation and Strategic Inputs in Health (SCTIE). The publication of technical note nº 369/2020 CGAHV/DCCI/SVS/MS (Brasil, 2020) in partnership with the National Nursing Council (COFEN, as per its Portuguese acronym), about the role of nurses in the diagnosis of hepatitis B and C, represents this effort. The agreement in the Tripartite Intermanagement Commission (CIT, as per its Portuguese acronym) for the migration of drugs from the Specialized Component to the Strategic Component of Pharmaceutical Care, made official by Ordinance MS nº 1.537/2020 MS/GM, promoted remodeling in the dispensation to strengthen the autonomy of federated entities in terms of structuring the administrative and care network in the Bipartite Intermanagement Commissions (CIB, as per its Portuguese acronym) capable of promoting regional reorganization of pharmaceutical care.

Internationally, PHC has been recommended for monitoring patients undergoing treatment for hepatitis (Balkhy, El-Saed & Sanai, 2016), but this expansion of access to treatment requires analysis of the



specificities that this condition requires from professional behavior, a fact that requests of strategic managers regarding people management policy and health team training, as pointed out in the WHO document that issues coping strategies (WHO, 2016). In this sense, it is up to the management to order the existing services, CTA and SAE, with a definition of work organization and care flow from the perspective of following-up/monitoring users, especially those who require greater therapeutic support.

It is important to reflect that the breadth of actions induced by MS, as of 2019, needs to be considered in the planning of local and state management about the peculiarities and heterogeneity of HR, the very organization of the decentralization of management in the federative entities, which is in line with mechanisms to promote training and availability of resources that can guarantee access to health services. In a new perspective of the health policy for PNHV, it should be encouraged an articulation to expand the scope of care actions, in addition to overcoming obstacles arising from the centralized structure, which possibly prevented the desired progression in terms of coping with hepatitis in Brazil. It is necessary to consider that the time, speed and consolidation of changes occur at a different pace in the different contexts of health management.

An opportunity to support the hepatitis care network is to use the existing structure for HIV care, the investment that MS has made in terms of training multidisciplinary teams and reference physicians at the regional level, in addition to the organization of infrastructure to carry out molecular biology tests (Brasil, 2018). Therefore, defining the entry points, the services that coordinate care, as well as who are responsible and their functions, is crucial to organize a robust health services network that can solve hepatitis.

From Technical Note n° 319/2020, which allowed a considerable increase in drug dispensing units, a process of rearranging actions was triggered to expand the decentralization of treatment, preferably closer to the user to be treated. In this regard, the PHC attributions/competences are defined according to the level of complexity of the case, established in PCDT.

The decision on models capable of promoting public policy formulation by means of PNHV has placed Brazil, since the first PCDT, ahead of other countries by choosing to incorporate high-cost medicines into the System (Brasil, 2002c). The PCDT, initially published by ordinances in 2002, 2007 and 2009, later in 2011, the first PCDT for the management of hepatitis B and, in 2013, the PCDT for the treatment of Chronic Viral Hepatitis C, follow a worldwide trend of establishing consensus for conducting the practice of approaching treatment and guiding managers and health professionals in the face of appropriate technologies for therapeutic safety. The PCDT launched in 2019 expands guidelines regarding hepatitis for users undergoing pre-exposure prophylaxis (PrEP) and prevention of vertical transmission, which is in line with the perspective of giving visibility and focus to different priority populations. It is worth underlining that Ordinance SCTIE/MS n° 32/2020 puts on the agenda the decision to incorporate universal testing for hepatitis C in prenatal care in pregnant women, confirming advances in guidelines in a consolidated health care network, considered opportune to organize the access and solvability of care in the health system (Gleriano, 2021).

It is plausible to point out that, despite the relevance of the investment in terms of creating therapeutic guidelines, there are difficulties to follow these recommendations related to the duration of outpatient follow-up in health services, especially in chronic cases (Gleriano, 2021; Pacheco, *et. al.*, 2016). Aspects of regulation and evaluation by the care network manager are mentioned only in the PCTD dated 2019, but do not advance in guidelines for organizing the care network and the necessary integration to strengthen access and adherence to treatment.

Over the 20 years, it is from 2011 onwards that the investment on the part of the Ministry of Health in more specific approaches to patients is strengthened to minimize the serious forms that often culminate in liver transplant. The discussion on Direct-Acting Antiviral (DAA) drugs started through the Joint Technical Note DIAHV/SVS/MS CONITEC SCTIE n° 319/2011, with an important role of the National Commission for the Incorporation of Technologies (CONITEC, as per its Portuguese acronym) by promoting incorporation from the PCDT dated 2013, representing advances in therapeutic effectiveness through cost-minimization analysis for SUS (Brasil, 2017b). The incorporation of DAA in SUS is the result of the support of a considerable participation in the public consultation with



contributions from scientific societies, health professionals, but also from SUS users and their families (Brasil, 2015a).

Recognized by PAHO, SUS stands out among the first health systems in the world to universalize treatment through DAA (PAHO, 2016b), with an important role in terms of mediating negotiations, in the political and economic field, with the pharmaceutical industry on prices and matters of local production through consortiums, which placed Brazil in a political transaction space for reducing the cost of treatment (Fonseca, Shadlen & Bastos, 2019).

Until now, the most relevant milestones in the care of hepatitis have been highlighted, resulting from a process of social construction of public policy. Due to the dynamism and complexity that characterize the approach to this problem, there are certainly advances and setbacks, permeated by power relationships, disputes and interests that undermine health management. It is pointed out that initiatives still have a heterogeneous and differentiated effect in the Health Regions (HR), certainly due to structural limitations of services and professionals, lack of ability to perform tests and confirm diagnosis, availability of drugs and specific therapy, as well as management aspects (Davidian & Fonseca, 2022; Gleriano, 2021; Almeida *et al.*, 2019).

One aspect to be highlighted for the year 2020 concerns the Covid-19 pandemic that devastated HS, affected the work agenda and the follow-up of the planning of care services in the fight against hepatitis (PAHO, 2021; Gleriano, Chaves & Ferreira, 2022). Consequently, the schedule for the achievement of the goals of the 2030 Agenda and the Hepatitis C Elimination Plan will require from health management a strategic positioning beyond what has already been planned.

## Strategies to subsidize management in terms of coping with viral hepatitis

This topic addresses spaces for social mobilization, access, care coordination, regionalization, care and people management as key devices for coping with hepatitis.

From the viewpoint of patients, hepatitis was considered an underprivileged disease by MS, and researchers consider that the relationship between HIV and hepatitis is complicated, since there is a lack of resources and personnel to give the same visibility and protagonism to both evils (Dominguez, 2012; Gleriano, 2021). In this sense, the action of the social movement in defense of the person with hepatitis makes it possible to highlight the importance of the struggle on the part of civil society in terms of raising awareness about the disease and in favor of guaranteeing treatment.

It should be recognized that collegiate management in the scope of SUS conceives the institutionalization of a public policy with the participation of different important stakeholders for decision-making space. Thus, for this space of protagonism of organized civil society, two segments act in defense of patients with hepatitis, the Brazilian Movement to Combat Viral Hepatitis (MBHV, as per its Portuguese acronym) and the Independent Alliance of Support Groups (AIGA, as per its Portuguese acronym), in addition to other organizations that consider themselves independent. These social movements highlight the need to train their members for participatory action with a view to maximizing the power to provoke a positive impact on the cause they advocate (Beloqui, 2018).

It is underlined that national events by NGOs, Networks and Social Movements against AIDS and by the MS itself incorporated viral hepatitis into the agenda from 2004 onwards. It is a possibility of bringing the social segments and health services closer together to compile strategies in health policy, fostering the organization of access, coordination of care, regionalization, management of care and people.

The involvement and participation of social movements can encourage individuals to disseminate information. It is in the community that vulnerable populations are identified, which is why it needs to be an intersectoral work, which can expand the possibility of offering diagnosis, an action that requires extrapolating the care beyond the building installation of the service. There is no comprehensiveness and equity if there is no expansion of access to health needs, and advancing towards universality with territorial responsibility requires management to act on investment, organization and logistics.

The organization of access is a central element for coping with hepatitis. Access goes through the supply and availability of resources at the right time and location, with sufficient quantity, thus guaranteeing the health system a reasonable cost (Sanchez & Ciconelli, 2012). This broad definition makes it possible to reflect on the importance of different variables and locoregional realities that have an impact on access to viral hepatitis care, which is why, even today, remnants of the municipalization process and the political-administrative-care discontinuity plague inequalities in the distribution of services (Gleriano, 2021).

In coordination, the Ministry of Health recognized fragilities in PNHV, such as little attention to priority groups, since prevention actions were directed at the general population, a situation that consumes a significant volume of inputs that could be better directed, in addition to the organization of the service itself, which restricts access by condition of service hours, requirement of pre-test counseling, need for documentation and user identification (Brasil, 2008). These fragilities result from the fragmentation of ministerial guidelines that end up being replicated in the State and Municipal Secretariats of Health, in the different coordination bodies, fragility in regional coordination, which should be strengthened with efficient communication to guarantee comprehensive hepatitis care (Gleriano, 2021).

In order to contribute to care models that simplify the access doors and reduce inequalities in social contrasts, it is recommended to invest in information systems and expand management analyses based on secondary databases that favor the creation of indicators and support the decision-making process (Zimmermann, 2020; Ouma *et al.*, 2018). By considering the multiple dimensions of care management in the organization of the network, it is possible to incorporate the elements of definition of regional needs by defining the population/health region, organizational structure of the service network to guide a model of care capable of enhancing access and consolidate solvability in PNHV.

The regulation of access to health care and the health care system, an important management tool, favors care coordination that recognizes locoregional capabilities, expands regulatory flows and improves agreements in the care network. In addition, it can advance in the sense of bringing the focus of comprehensiveness closer to the care towards viral hepatitis, since each point of care of the health care network (RAS, as per its Portuguese acronym) can exercise the approach to hepatitis, provided that the instrumentalization of professionals and other health care resources are guaranteed by the management.

The WHO presented the strategic line of strengthening preventive and clinical care for hepatitis through equitable access (WHO, 2016). The experience in Europe with microelimination (Papatheodoridis *et al.*, 2018) can help national management to drive the organizational governance arrangement to face adversities. Therefore, it is up to the management to increase the capacity of laboratory inputs, in order to enable the diagnosis in the services (Brasil, 2015b), in addition to training them for surveillance in the health system and increasing safety in the treatment. Systematic review and meta-analysis of the effects of decentralization of testing and treatment showed positive aspects to equate decentralization policy guidelines with a focus on places at risk of social vulnerability (Oru *et al.*, 2021). Ensuring early diagnosis and treatment with DAA reduces the number of patients undergoing liver transplant (Crismale & Ahmad, 2019). Accordingly, the monitoring and evaluation of processes involving the logistics chain of hepatitis care help management in decision-making.

In the region of Latin America and the Caribbean, even with the use of DAA in treatment, access is still incipient and the number of people who use this therapy is still low (PAHO, 2020). A proposal to improve access has been to engage professionals who work in specialized services, as they quickly identify waiting lists for diagnostic consultations and waiting times for treatment (Johannessen & Alexandersen, 2018). Expanding the service network that offer testing and at the same time monitor treatment points, based on testing, can help to achieve comprehensive care. It is a fact that there is a shortage of broad analytical studies on hepatitis care in the scope of SUS, and the available evidence shows organizational fragilities in the articulation of services in their territorial arrangement (Gleriano, 2021; Almeida *et al.*, 2019).

In SUS, the organization and operation of health services need to be reviewed to expand access possibilities, promote alliances and mobilize political resources around the WHO goals. For this reason, studies on regional dynamism for a deeper understanding of the structure of the health network,

encompassing its main elements: operational structure, population and care model, may show different approaches to favor access towards hepatitis care.

The path suggested to understand the dynamics of care from a regional perspective seeks to make it more efficient/effective and, also, to avoid running the risk of expanding services without effectively guaranteeing timely access. Furthermore, it is necessary to consider that this work front is subject to the multiple influences of the political and technical dimensions. Nevertheless, the guarantee of services of different technological densities, logistical support and dissemination of information to guide the user in his/her itinerary through the network must be ensured.

The epidemiological characteristics of hepatitis should be included in the discussion on the territory of HR and considered in regional planning, negotiated through the Agreed and Integrated Program (PPI, as per its Portuguese acronym), in the deliberative forums of SUS. It is up to health managers to unite what is supposedly fragmented in the hepatitis care network by adjusting health capacity, which is why the exercise of interfederative governance is essential for defining strategic elements, organization and functioning (Gleriano, 2021). MS should induce the states to recognize the installed capacity to advance in terms of coordination, which should summarize the dynamics of the organization of testing services, from reference to care and treatment up to the highest degree of complexity.

In hepatitis care, part of the interventions take place in decentralized services, but a relevant part of care is also centralized in strategic points. In this scenario, the challenge is to develop an expanded view of the logistics chain to contribute to the planning, schedule of acquisition, storage and strategic distribution, in order to increase the solvability of the diagnosis offer, time of delivery of the results, return rate and clinical referral, in addition to guaranteeing treatment. Even with the decentralization and protagonism of PHC, it is worth pointing out that aspects of diagnostic confirmation and treatment supervision require a trained team. In this perspective, one possibility would be to invest in clinical governance, expanding the management capacity related to coordination and articulation of care for the expansion of actions and services with the proper qualification of professionals (Padilha *et al.*, 2018). For this purpose, important elements to be considered by health management are the use of pillars such as clinical effectiveness, clinical audit, risk management, information usage, education and training, personnel management and patient/public involvement.

The human resources policy for hepatitis, both in terms of sizing regarding the provision and qualification of teams, mainly by the distribution of physicians and their specialties, is a problematic issue in terms of SUS. Few infectologists are focused on hepatitis care, and this situation increases the difficulties of ensuring timely treatment (Marques & Carvalheiro, 2017). Valuing interdisciplinary work in the scope of SUS, in order to improve communication channels and the expanded conception of health with an emphasis on comprehensiveness, will be a strategy to overcome great challenges of fragmentation of care. It is underlined that there is a need to continuously invest in the ministerial articulation of the coordination of PNHV with the Secretariat of Management of Work and Education in Health (SGTES, as per its Portuguese acronym) and training centers to expand qualification and training networks with recognition of the reciprocal relationships between the technical interventions and the interaction of agents.

In SUS, in order to advance towards the goals of the 2030 Agenda and in the agreements with international organizations, investing in the sense of prioritizing the approach to populations and guaranteeing equity in access, starting from the perspective of the dynamics of regional organization of networks, require from the management a broad positioning.

## Final considerations

It is noted that there were significant advances in PNHV driven by international guidelines that recognized hepatitis as a public health problem. In SUS, the Program has a clear advance in terms of guaranteeing treatment and expanding the guidelines for testing, but the positioning of management in the organization of the care network is emerging to ensure that, in regional governance, the System can be connected, thus reducing the fragmentation of care and the locoregional inequalities caused by

technological concentration. It should be underlined that the ways in which the federated entities organized to implement PNHV configures its logic as a care network, often in the shadow of other illnesses with greater epidemiological repercussions or a source of funding.

In the two decades of PNHV, the capacity of organizing services to compose a solid care network, which promotes access mainly to assist priority population groups, is still a challenge. It will be necessary to invest in studies with analysis of the micro-organizational level and the mechanisms of responsive governance in the State apparatus, in order to recognize the disputes in hierarchical control and the processes of agreement, competition and decision-making protagonism in these environments, as well as the position of specialists in the advocacy capable of elaborating decisions through the translation of knowledge.

Investing in a plan to cope with hepatitis C is a powerful strategy; however, the policy cannot be restricted without considering other types of hepatitis. Attention to treatment requires components that are intrinsic to the development of the field of technology and the leading role of the industrial complex involving innovation in health, which is why it is pertinent to include it in the SCTIE agenda. It should be underlined that, in the negotiations of all the presented elements, the political arena that involves HS and the interests, values and objectives interact in social relationships and management dynamics. Thus, recognizing the power and capacity of all actors is essential for the confrontation of hepatitis.

Establishing regional governance will be crucial to overcome the centrality of the organization of care in HR. It is about emphasizing the production of care based on the needs of users, as a possible proposal to qualify care.

From the reflections prepared in this study, it is possible to act on several fronts of analysis, where the use of evaluation becomes important to reiterate ways for management to expand its responsibility in the care towards viral hepatitis.



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