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PREVENTION ACTIONS AND TREATMENT OF MALIGNANT NEOPLASMS OF CERVICAL CANCER IN FAMILY HEALTH STRATEGY[1]

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ABSTRACT
This study examines the perceptions of women affected by malignant neoplasm of the cervix and nurses regarding prevention services and treatment. We interviewed women service users and nurses who work in the Family Health Strategy (FHS) of a medium-sized city in the state of Santa Catarina (SC). For different subjects, instruments were developed to collect semi-structured data. The interviews were analyzed according to its theme. Among the results obtained in interviews with women, were reported to delay in responding to their needs and the need to improve the quality of services and care to female demands. Interviews with nurses revealed that the planning done by the teams are weak and do not consider the needs of women, so it is urgent the reorganization of services. It was evidenced the gap between what nurses do and realize in the work process and the factors influencing women in choosing (or not) for the service.

Keywords: Family Health. Neoplasms of the Cervix. Women's Health. Politics of Health.

INTRODUCTION

Health is a fundamental right of every citizen, citizenship is directly related to the exercise of rights and duties. Throughout history, the rights have been secured thanks to the demands of civil society, especially social movements and health workers. In the Unified Health System (SUS), the particular female part of a list of actions of the National Policy for Integral Attention to Women's Health (PNAISM) which aims to promote the improvement of living conditions and health of women by ensuring rights and the expansion of access to resources and services of promotion, prevention, treatment and recovery[(1)].

The comprehensive care to women's health involves several senses, among which thinking biological, social and subjective dimensions, establishing the daily care practices that permit horizontal overcome fragmentation still present in the work processes of the professionals and in the organization of health services. Simply, we can say that these are acts constructed with women, involving complex systemic issues and their context in seeking care for multiple health needs, expanding the autonomy to life[(2)].

The scope of the organization of health services, the National Policy (PNAB) presents the Family Health Strategy (FHS) as the model for the reorganization of primary care and the professionals who work in the ESF as responsible individuals, families and communities in its catchment area. One of the prevention acts developed for specific attention to women's health in the FHS is to perform the Pap smear of the cervix, a practical exam at a low cost[(3)]. Among the possible changes to be detected by this test, it is a malignant neoplasm of the cervix, which affects adult women in a progressive incidence from 30 years to reach the peak in the age group 45-50 years. It was expected approximately 17,540 new cases per year in Brazil in 2012, with an estimated risk of 17 cases per 100,000 women[(4)]. In Chapecó, in 2010, it was detected 32 cases of malignant

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neoplasm of the cervix and recorded two deaths from this cause [1]. The Pap smear testing of the cervix, also known as a Pap smear or Pap test, also detects cell changes early and on time for intervention. According to the National Cancer Institute (INCA), when a malignant neoplasm of the cervix is detected early, the chances of cure are 100%[4]. However, deaths from this cause continue to occur, which justifies the need for studies that seek to understand the reasons why these women do not have access to the exam on time and evaluate the quality of health services offered to women.

The main form of prevention is the use of condoms in all sexual relations, and the vaccine that protects against oncogenic subtypes 16 and 18 human papillomavirus (HPV)[4,5] which is an important ally, but there is still controversy regarding the effectiveness of this action in certain age groups and / or people who have had unprotected sex.

The aim of this study was to analyze the perceptions of women affected by malignant neoplasm of the cervix and nurses regarding prevention services and treatment offered to these women in the FHS in Chapecó. We emphasize that the Family Municipality Units are called Family Health Centers (CSFs).

METHODOLOGY

The methodology was to develop a descriptive and qualitative study. In total, 13 individuals were interviewed, seven women users of public health services and six nurses who work in these services. The study was conducted in Chapecó belonging to macro-Far West of Santa Catarina, which has a population of 183 561 inhabitants, with a coverage of approximately 70% of the family health strategy distributed in 25 Family Health Centers.

Among the 32 women registered in the Information System for Cervical Cancer (SISCOLO) Ministry of Health (MOH) in 2010, only 14 were followed up by teams of family health team or the Women's Clinic, but only seven were reached by telephone, from which all agreed to participate.

Regarding the nurses, coordinators of the CSFs of the catchment area in which resided the service users were invited to take part in the study, since they articulate information related to the administration and direct care of the population, play the role of immediate supervisors in multidisciplinary team and therefore have a direct influence on team decisions. The invitation to participate in the study was conducted by telephone, at which the objectives of the research were exposed. All agreed to participate.

The interviews were scheduled with the women for September 2011 and, with the nurses, for December 2011. In the first meeting face to face, the term of free and informed consent was presented to participants and signed by them, being shielded the identity of the respondents and the possibility to withdraw from the research at any time.

The collection / construction of primary data was conducted through semi-structured interviews - recorded (with an average duration of 40 minutes), transcribed and analyzed. The construction of the interview scripts was performed from issues related to the assumptions of public health policies, specifically the BANP of PNAISM and Notebook Primary n. 13 - Control of Cancers of the Cervix and breast cancer. The interview guide for women and nurses had 42 and 24 questions, respectively.

The analysis technique used was the thematic content. The notion of theme is linked to the statement of the issue and involves a series of relationships that can be graphically presented by a word, a phrase, an abstract[6]. It consists of discovering the meaning units that make up a communication in which the presence or absence mean something to the object being analyzed.

The information obtained through the application of the two survey instruments were subjected to fluctuating readings with further vertical and horizontal deepening[6]. The first consisted of the initial reading step for impregnating the interviews, favoring the in-depth reading of each of the reports. This procedure enabled synthesis of each statement highlighting the central ideas in the light of the

theoretical framework guided the construction of the core themes identified from the interviews. Then began the horizontal reading of the interviews, which established relations between statements, highlighting elements that indicate repeating events, as well as those out of the standard[6].

This study was approved by the Committee Opinion Embodied Research Ethics CEP / Unochapecó as log n. 027/11.

RESULTS AND DISCUSSION

Perception of women

This is the characterization of the seven women affected by malignant neoplasm of the cervix who were interviewed: age between 26 and 52 years, five of them reside with mates and just one does not have children, among those with children, the number of these varied from six, and age at first pregnancy was between 15 and 29, one of the women has six children, had their first sexual intercourse at age 16, it was reported a miscarriage regarding the woman with five living children, she had her first relationship sex at age 14 and never attended school.

In the analysis of the interviews with the women, we identified perceptions of two main types of health facilities: the public (ESF - the subject of this study), and the Women's Network Against Cancer (RFCC), an NGO that develops specific health actions to combat cancer in women, which provided that all could take this service as a reference for the performance of such tests of the cervix and care on the suspicion of malignancy, although there was bringing these services. Besides the reduction of time, it was explicit appreciation of confidence in the quality of service and the good reception accorded by professionals. Given this scenario, we selected core themes relating to perceptions of these women about preventive services and treatment of malignant neoplasm of the cervix, appointing the following categories, in which are discussed.

The slow response to the needs of users

Waiting time is an indicator which is not compatible with the pressure opinion of a malignancy disease like the cervix. The wait seems to be no problem for some actions such as seeking a contraceptive method, but when women are faced with the risk, the suspicion or the pain tolerance is no longer compatible with the expected, ie when there is a perception that the problem can be severe, there is a search for factors that enable the reduction of the time. In this case, users of the city in the study chose the service that, in their perceptions, offered resoluteness in the shortest time:

> I got the result here [ESF] it was changed then they scheduled me, like it was May I guess [...] they had me scheduled for December, so I know I was worried because I did it all year and never had any bad results and I found too much time for me to wait. So I took my sister and I went there on Women's Network. When I got there, I said " I want to do my preventative", but I was not told that I had done here and had given [changed]. So I did, it was changed, so kind or two months I had done all the tests that they ask a lot of tests and everything and I operated there in the Women's Network. [...]. (M4)

> I think it took about 20 days to get the results, after I took the test. I came to schedule it [to display the result], but she [CSF receptionist] said that there was no available day [consultation with the nurse], the head nurse said. I was supposed to come back another day. Hence even she said to me, ‘call here and you may find the nurse’ [...]. And there was a day that I called and she was not in, right. Hence now this week I came because it was no scheduled, so I got there, again. (M2)

The lack of clear streams and adequate regulation may give banks the arrangements that although facilitate access for some users, as reported by the interviewee below, can be one of the factors that hinder access to many other users, putting in level of inequality people with similar priorities.

> For you to get an appointment in the FHS {nearest}you have to go at four o'clock in the morning and stay there in front of the ESF, and

> then since it was so hard I went to the other CSF {}, I got there, it was much easier, I arrived six hours, I knew, I was sure I would be scheduled. [...] Dr. said: "no prediction of your surgery, you will have to wait in line ... and it may not take long, otherwise... ", even when he told me what I had ... I got scared, I said you can say if it is anything serious, he says: " it can take a turn, don't take too long", but he put me in line I did not know when I would be scheduled, right? One thing: if I did not get through a colleague of mine there, I was hoping perhaps far to do the surgery. (M3)

Likewise, inattention and / or lack of accountability with the comprehensive care can increase the time of access to effective treatment, worsening the prognosis:

> I came up to the woman, she didn't see it was three, she just scheduled one. It is necessary to have seven days between each session. She then scheduled it, she said she'd be busy and that I should come back in a month. We were in august in the first time, she set the date to September, late September. I had a meeting with the doctor, he said that the exam was incorrect. It took them a month to find out it was incorrect and then from September it went to November. [...] (M6)

Health professionals have a responsibility to advise women about the importance of performing the Pap smear of the cervix, regardless of risk factors and age[7], and also to continue the treatments / necessary care in the health[8]. To put it in another way, the team at FHS, provided caregiver of a territory, assumes responsibility for coordinating health care, bond and continuity, comprehensiveness, humanization and fairness of these women, as establishing the policy of Primary Care[1]. Perhaps the weakness of implementation of these elements, some of which are presented in the interviews that were transcribed, explain the delay / difficulty in accessing the needs of users, which causes them to seek other places to carry out the treatments, the situation pointed out by other authors[9].

The subjective element that accompanies women like feeling that something bad can happen, strengthens the pilgrimage more convincing responses[10], but can be minimized by good connection and confidence in the services they attend.

Quality of services and care of female demands

Besides reducing the waiting time, one also perceives the search for quality services and procedures and / or expression of the lack of them:

> I had already taken the exam a couple of days ago in the health center, but since it was taking long to arrive and I was feeling well, I decided to take it at the women's network, which is faster, but the preventive I took in the health center showed anything but the second one I took did, in a gap of about 20 days. I had already talked to nurse at the time, and she said it might have been during collection. I have no problem with trainees, but you know, it was them the ones who collected it. (M7)

The embarrassment of women regarding exposure and manipulation of their body, especially when by male professionals, is also cause for resistance to the service:

> They'd complain too because there were a lot of female trainees here during preventive, and this would scatter woman, the same happens to male trainees. We know this is regular procedure since they are studying, but the problem is that not only it is a guy, there is normally a group of them. Some women don't care, but specially the young girls. [...] he was kind, I don't know, I just think men aren't too delicate for this kind of job. (M6)

In the dialogue with the researcher, the interviewee reports the "mismatch" of information received from health professionals:

> The doctor said that if I had came at the time to go through the treatment, I wouldn't have to go through surgery. [...] This result I took to the nurse, she took a look. [...] The nurse said I was ok. [...] she was the one who said I was ok, and she also said that I should come back in three months time. The exam was taken in that very same health center. (M3)

For some women, the duration of symptoms beacon still searching for services:

> I rarely come to the doctor's, I just started because I had to take the preventive and also because I was in pain, I knew something wasn't right, we don't look for a doctor if we aren't in pain, right? We are lazy. **And some time ago I didn't feel ok going there, I was overweight, felt embarrassed.** Nowadays I'm ok, but I know some women who don't go due to this. (M5)

The perception that the procedures must involve promotion and health prevention can be identified between the lines of women's testimonies:

> I believe that there's a lack of knowledge on behalf of women regarding the illness [...] we shouldn't face these kind of problems with such a bad look, such a pessimist look. **Since we are talking about public health for poor people there should be more campaigns to enlighten them on certain issues.** There are a lot of reasons that take women aback when they have to go there. They should make it (the campaign) in an organized way. (M6)

The relationships and how to accommodate the women demands are also mentioned as key elements for the care of women:

> I hadn't had much contact with this health center, more with the women's network. **I'm not sure if they are more sympathetic or careful, it's just that we are talking about women, you know?** In this kind of job, we're they deal with intimacy and the body, they must be kind and nice, to make you more comfortable. (M6)

Accommodate female demands decode means very unique and complex issues related to the dynamics of life, perceptions, culture, which far transcends the procedure itself if a Pap test, underscoring the need for quality in professional-users, the links, the technique itself, plus all the care in the dialogue between professionals and services.

The testimonials detailing singularities that often are not perceived as relevant by the professionals - the case of the embarrassment of exposing the body in front of a male professional[11]. It is noteworthy that the shame felt by women interferes consubstantially, for not performing the Pap smear of the cervix and the demand for health services only at the time of worsening of signs and symptoms [12].

Women give clear clues that services need to qualify, both in the sense of professionals conception about the disease process, seeking to overcome fragmented and reductionist visions, and in the work process itself, qualifying practices and flows in services and in care networks.

Perception of nurses

The six nurses interviewed completed graduation for more than three years (between three and 16 years), working in the public health system between two and 12 years in the ESF between one and five years. All have one to three courses of specialization in health and four attended specialization focusing on FHS.

In the analysis of interviews with nurses, it was highlighted the actions that are being developed in the CSFs, the concern with the low demand of women to perform the collection of cytological examination of the cervix and the problems existing in the process of work, being identified thematic units that follow.

Planning of prevention and treatment actions of malignant neoplasm of the cervix developed in ESF

The health planning is a key tool to reduce uncertainty and make the necessary changes and / or possible before certain health situations, requiring analysis of the health needs of the population and the various possibilities for solving problems. In this direction, the broad participation of health actors, including users understood, is central to the qualification of the situation analysis and the development of strategies to achieve the goals proposed.

Among the six nurses interviewed, five said they are planning actions on women's health in teams. However, this social practice appears in the statements more like a work schedule of what exactly a thorough analysis of the problems:

> There's a schedule for the care of women's health. [...] Also in this planning which is more like a problem assessment [...], during the first days it kind worked out. They (nursing technicians and auxiliaries) ask, but then it start

> to become routine and they don't ask anymore. [...]. (E1)

The professionals interviewed mentioned that team meetings occur in technical discussions on the actions to be taken, but that such discussions seem to lack looks that reflect the basis on which the actions are to be implemented, approaching the complex reality experienced by users (their needs) of the offers available. The dialogue between the different subjects allows addressing the diverse perspectives of meeting the needs of women and services and enhances the understanding about the live and be healthy that people construct from their experiences and the relationships they establish in society[2].

The participation of all staff and the public in planning, although it is a precondition for the construction of the SUS, does not occur in most of the teams they belong to the nurses interviewed. Some health teams perform disjointed actions, ad hoc and based on knowledge of each team member[7]. When different actors do not participate in the discussion of the situation found, comprising, deepening and prioritizing problems on the actions to be taken, they do not feel empowered to transform the problem situation, which jeopardizes the result of the actions developed.

The work process requires conducting monitoring and evaluation of actions in a team as well as participation in local health planning. According to reports, the evaluation of actions in women's health that have been conducted by the teams are weak:

> [...] we did this assessment in July where we realized that it was a little down, not July, sorry, August, during the collection of data. [...]. (E1)

> We always assess! Always...We don't let too much time pass. In the next week (after the campaign) we sit down and talk it over. (E2)

When planning is not carried out with the support of tools that support the process, the evaluation of actions ends up being summed to total attendances and empirical observations of the team, leaving aside the use of health indicators that facilitate the understanding of the situation of population in that area[1].

The use of indicators was reported by nurses as something difficult to be used, by ignorance about the calculation method, the lack of updated information in the Information System of Primary Care (SIAB) or even by different age group between the SIAB and denominator of indicator, which complicates the calculation.

Nurses reported that, seeking to increase the number of women who have had Pap smears of the cervix, teams organize program actions as the setting of a day of the week for the health care of women, for example, campaigns that happen on Saturdays, information dissemination existing groups in CSF and the "pact" of appointments of women to the staff.

> [...] in this campaign we did it too, apart from waiting for them to come, we also did a scheduling because we had experience from the last campaign, which was also a little number of people. We came in three nurses and did only about thirty preventives, even though we had down a lot of invitations... (E4)

Among the commitments that women assume, it is the requirement to hold an annual Pap smear of the cervix in order to continue receiving the scholarship program with family and / or the receipt of contraceptive. Therefore, some nurses impose to users a condition not established in the programs of the Ministry of Health, thereby exerting control over women's bodies. Procedures such move away from the purpose of the planning that provides seizure of distinct realities, effective participation, solidarity and independent of those involved.

People seek rather than being reduced to a number or an illness, seek care in health services[2].

Planning is something that requires constant monitoring and evaluation and flexibility for any changes throughout the process. However, despite the testimony of nurses demonstrate concern with seeking greater adherence of women to prevention and treatment of cancers of the cervix, it is clear

that the practices of these professionals are not placed under review remained predominantly strategies to expand the schedule of visits.

Limits in the organization of services

For nurses, the delay between sample collection and receipt of the result because the users dissatisfaction and loss of opportunity for timely treatment, with a limit on the organization of services.

> [...] yes, some results were up to 90 days. (E6)

> On average up to 40 days. I also think this is a problem, this is a problem for us because some women decide to take the exam at the women's network, since it is closer to their homes, and also because results are in about a week. For us, it takes like 40 days. In the beginning of last year, it took like up to 60 days. For example this HPV, it's from September, 09/17, it got in today (12/01) it took two months and a half to arrive. It's too long, I particularly think so. It should be faster. (E1)

When the test results arrive, the nurses make reading and prioritize cases that show changes, in particular the most serious. The professionals cite the support of community health agent[7] and electronic medical records as facilitators at finding such women - despite carrying the exams, many women do not return to the CSF to fetch the result, not all teams perform active pursuit of these users, it should be routine practice in services and a concern of all ESF[7,13,15].

In interviews, nurses reported that women with the Pap smear results cervical change are addressed in the CSFs or forwarded to the referral service, but did not mention the guidance to others, such as to safe practices. This procedure should be strengthened guidance on delivery of results in order to reduce the risk of HPV infection and other sexually transmitted diseases (STDs)[14].

On aspects related to materials for collection, are also mentioned concerns, but the actions have indicated improvements:

> Today we want that point of the commission to revise the material; the dischargeable speckles are something that got much better. (E1)

It is noteworthy that, despite the recognition of the limits, especially too much time waiting for the receipt of the screening, the nurses seem to have no such problems under their governance. One must ask if organized actions of management, encompassing care and management, professionals and users could not change that.

FINAL CONSIDERATIONS

The aim of this study was to analyze the perceptions of women affected by malignant neoplasm of the cervix and nurses regarding prevention services and treatment offered to these women by family health teams.

There is a mismatch between what nurses perceive and do (actions and strategies) in the process of work in relation to the prevention and treatment of cancer of the cervix and the factors that influence women to choose (or not) the services: women say they do not use such services by understanding them ineffective (difficult access, delay in results, dissatisfaction in welcoming and quality) and professionals seeking to increase coverage through programmatic actions, in particular increasing the agenda, "pacts" and "secondary benefits".

Health professionals and managers need to advance the understanding of the meaning that care is for women, improving the relationship between listening and users in order to increase access and provide more quality services, promoting integrity management and health care.

AÇÕES DE PREVENÇÃO E TRATAMENTO DA NEOPLASIA MALIGNA DO COLO DO ÚTERO NA ESTRATÉGIA DE SAÚDE DA FAMÍLIA

RESUMO

Este estudo analisa as percepções de mulheres acometidas pela neoplasia maligna do colo do útero e de enfermeiras sobre os serviços de prevenção e tratamento. Foram entrevistadas mulheres usuárias dos serviços e enfermeiras que atuam nas Estratégias de Saúde da Família (ESF) de um município de médio

porte do estado de Santa Catarina (SC). Para os diferentes sujeitos, foram elaborados instrumentos de coleta de dados semiestruturados. As entrevistas foram analisadas na modalidade temática. Entre os resultados obtidos nas entrevistas com as mulheres, foram relatadas a demora nas respostas às suas necessidades e a necessidade de melhoria na qualidade dos serviços e no acolhimento às demandas femininas. As entrevistas com as enfermeiras revelaram que o planejamento feito pelas equipes é incipiente e não considera as necessidades das mulheres, por isso se faz urgente a reorganização dos serviços. Ficou evidenciado o descompasso entre o que as enfermeiras fazem e percebem no processo de trabalho e os fatores que influenciam as mulheres na escolha (ou não) pelo serviço.

Palavras-chave: Saúde da Família. Neoplasias do Colo do Útero. Saúde da Mulher. Política de Saúde.

ACCIONES DE PREVENCIÓN Y TRATAMIENTO DE LA NEOPLASIA MALIGNA DEL CUELLO DEL ÚTERO EN LA ESTRATEGIA DE SALUD DE LA FAMILIA

RESUMEN

Este estudio analiza las percepciones de mujeres acometidas por la neoplasia maligna del cuello del útero y de enfermeras sobre los servicios de prevención y tratamiento. Fueron entrevistadas mujeres usuarias de los servicios y enfermeras que actúan en las Estrategias de Salud de la Familia (ESF) de un municipio de tamaño mediano del estado de Santa Catarina (SC). Para los diferentes sujetos, fueron elaborados instrumentos de recolección de datos semiestructurados. Las entrevistas fueron analizadas en la modalidad temática. Entre los resultados obtenidos en las entrevistas con las mujeres, fueron relatados el retraso en las respuestas a sus necesidades y la necesidad de mejoría en la calidad de los servicios y en el acogimiento a las demandas femeninas. Las entrevistas con las enfermeras revelaron que la planificación hecha por los equipos es incipiente y no considera las necesidades de las mujeres, por esto se hace urgente la reorganización de los servicios. Quedó evidenciado el desorden entre lo que las enfermeras hacen y perciben en el proceso de trabajo y los factores que influyen a las mujeres en la elección (o no) por el servicio.

Palabras clave: Salud de la Familia. Neoplasias del Cuello del Útero. Salud de la Mujer. Política de Salud.

REFERENCES

1. Metelski FK. Percepções de mulheres e de enfermeiras sobre os serviços de prevenção e tratamento da neoplasia maligna no colo do útero. 2012. [dissertação]. Chapecó (SC): Universidade Comunitária Regional de Chapecó; 2012.

2. Soares MC, Mishima SM, Meincke SMK. A integralidade da atenção às mulheres com câncer de colo uterino. Cienc Cuid Saude. 2009; 8 (suplem.):62-69. [citado 2013 ago 12]. Disponível em: http://periodicos.uem.br/ojs/index.php/CiencCuidSaude/article/view/9719/5532.

3. Matão MEL, Miranda DM, Campos PHF, Machado AF, Ornelas ER. Percepção de mulheres acerca do exame colpocitológico. R. Enf. Cent. O. Min. 2011 jan/mar; 1(1):47-58. [citado 2013 ago 12]. Disponível em: http://www.seer.ufsj.edu.br/index.php/recom/article/view/24/90.

4. Brasil. Instituto Nacional de Câncer. Programa Nacional de Controle do Câncer do Colo do Útero. [on-line]. 2011 [citado 2012 fev]. Disponível em: http://www2.inca.gov.br/wps/wcm/connect/acoes_programas/site/home/nobrasil/programa_nacional_controle_cancer_colo_utero/conceito_magnitude.

5. Borba PC, Teixeira JC, Roteli-Martins CM, Carvalho NS, Naud PSV, Neves NA. O que falta na luta contra o câncer de colo uterino? Diagn Tratamento. 2010; 15(4):198-202. [citado 2013 ago]. Disponível em: http://files.bvs.br/upload/S/1413-9979/2010/v15n4/a1750.pdf.

6. Minayo MCS. O desafio do conhecimento: pesquisa qualitativa em saúde. 12. ed. São Paulo: Hucitec, 2010.

7. Oliveira ISB, Panabianco MS, Pimentel AV, Nascimento LC, Gozzo TO. Ações das equipes de saúde da família na prevenção e controle do câncer do colo do útero. Cienc Cuid Saude. 2010 abr-jun.; 9(2):220-227. [citado 2013 ago]. Disponível em: http://periodicos.uem.br/ojs/index.php/CiencCuidSaude/article/view/11133/6070.

8. Costa CO, Costa CFS, Vaaghetti HH. Acolhimento no processo de trabalho da enfermagem: estratégia para adesão ao controle do câncer do colo uterino. Rev Baiana Saúde Pública Miolo. 2011 mar.; 34(3):706-717. [citado 2013 ago 23]. Disponível em: http://files.bvs.br/upload/S/0100-0233/2010/v34n3/a1870.pdf.

9. Nascimento MI, Monteiro GTR. Características de acesso ao preventivo de câncer de colo do útero: três etapas metodológicas da adaptação do instrumento de coleta de informação. Cad. Saúde Pública, Rio de Janeiro. 2010 jun.; 26(6):1096-1108. [citado 2013 ago]. Disponível em: http://www.scielo.br/pdf/csp/v26n6/04.pdf.

10. Salci MA, Marcon SS. Itinerário percorrido pelas mulheres na descoberta do câncer. Esc Anna Nery Rev Enferm. 2009 jul-set.; 13 (3): 558-66. [citado 2013 ago]. Disponível em: http://www.scielo.br/pdf/ean/v14n3/v14n3a26.pdf.

11. Cestari MEW, Zago MMF. A atuação da enfermagem na prevenção do câncer na mulher: questões culturais e de gênero. Cienc Cuid Saude 2012; 11(suplem.):176-182. [citado 2013 ago 20].

Disponível em: http://periodicos.uem.br/ojs/index.php/CiencCuidSaude/article/view/17073/pdf.

12. Ferreira MLSM. Motivos que influenciam a não-realização do exame de papanicolaou segundo a percepção de mulheres. Esc Anna Nery. 2009 abr-jun.; 13 (2):378-384 [citado 2013 ago 20]. Disponível em: http://www.scielo.br/pdf/ean/v13n2/v13n2a20.pdf.

13. Carvalho MCMP, Queiroz ABA. Lesões precursoras do câncer cervicouterino: evolução histórica e subsídios para consulta de enfermagem ginecológica. Esc Anna Nery. 2010 jul-set.; 14(3):617-624. [citado 2013 ago]. Disponível em: http://www.scielo.br/pdf/ean/v14n3/v14n3a26.pdf.

14. Pasin RR, Sisson MC. Avaliação do programa de controle do câncer de colo uterino: percepção de portadoras de papilomavirus. Cienc Cuid Saude. 2010 jul-set.; 9(3):440-447. [citado 2013 ago]. Disponível em: http://www.periodicos.uem.br/ojs/index.php/CiencCuidSaude/article/view/12556/6649.

15. Vale DBAP, Morais SS, Pimenta AL, Zeferino LC. Avaliação do rastreamento do câncer do colo do útero na Estratégia Saúde da Família no Município de Amparo, São Paulo, Brasil. Cad. Saúde Pública, Rio de Janeiro. 2010 fev.; 26(2):383-390. [citado 2013 jul]. Disponível em: http://www.scielo.br/pdf/csp/v26n2/17.pdf.

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