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THE USE OF WOMEN'S HEALTH RECORD IN CERVICAL CANCER PREVENTION

USO DO PROTOCOLO DE SAÚDE DA MULHER NA PREVENÇÃO DO CÂNCER DE COLO DO ÚTERO

EL USO DEL PROTOCOLO DE SALUD DE LA MUJER EN LA PREVENCIÓN DEL CÁNCER CERVICAL

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Objetivo: analisar o uso do protocolo de saúde da mulher na prevenção do câncer de colo do útero por enfermeiros na Atenção Básica. Método: estudo de caso, exploratório, de abordagem qualitativa. Os participantes foram enfermeiros da Estratégia Saúde da Família. Utilizou-se como técnica de coleta de dados a entrevista semiestruturada, analisada pela Análise de Conteúdo do tipo categorial temática. Resultados: o enfermeiro realiza o acolhimento limitado à queixa da mulher motivada por demanda espontânea e apresenta autonomia para a realização do citopatológico, embora nem todos realizem avaliação do resultado desse exame. Conclusão: a análise do uso do protocolo de saúde da mulher permitiu constatar-se uma discrepância entre as ações realizadas por enfermeiros na Atenção Básica, que ora estavam de acordo com o Protocolo de Atenção Básica, ora divergiam de suas normativas.

Descritores: Atenção Primária à Saúde. Saúde da Mulher. Câncer de Colo do Útero. Prevenção Primária. Protocolos Clínicos.

Objective: analyzing the use of the women's health record in the prevention of cervical cancer by nurses in Primary Care. Method: this is an exploratory case study of a qualitative approach. The participants were nurses of the Family Health Strategy. The data collection technique used was the semi-structured interview, analyzed by Content Analysis of the thematic categorical type. Results: the nurse performs the reception limited to the complaint of women motivated by spontaneous demand and has autonomy to perform the cytopathological examination, although not all perform the evaluation of the result of this examination. Conclusion: the analysis of the use of the women's health record allowed a discrepancy to be found between the actions performed by nurses in Primary Care, which were sometimes in accordance with the Primary Care Record, sometimes diverging from its norms.

Descriptors: Primary Health Care. Women's Health. Cervical Cancer. Primary Prevention. Clinical Records.

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Objetivo: analizar el uso del protocolo de salud de la mujer en la prevención del cáncer cervical por parte de las enfermeras de Atención Primaria. Método: se trata de un estudio de caso exploratorio con enfoque cualitativo. Los participantes fueron enfermeras de la Estrategia de Salud de la Familia. La técnica de recogida de datos utilizada fue la entrevista semiestructurada, analizada mediante Análisis de Contenido de tipo categórico temático. Resultados: el enfermero realiza el acolchado limitado a la piel de la mujer motivado por la demanda espontánea y se muestra autónomo para la realización del citopatológico, aunque no todos realizan la evaluación del resultado de este examen. Conclusión: el análisis del uso del protocolo de salud de la mujer permitió constatar una discrepancia entre las acciones realizadas por los enfermeros en la Atención Básica, que a veces estaban de acuerdo con el Protocolo de Atención Básica, y a veces divergían de sus normativas.

Descriptores: Atención Primaria de Salud. Salud de la Mujer. Cáncer de Cuello de Útero. Prevención Primaria. Protocolos Clínicos.

Introduction

Cervical cancer is the second most common type of cancer among Brazilian women, but it is easily detected through the collection of material for the preventive cytopathological exam, with priority given to women aged 25 to 59 years old and sexually active. The interval between exams should be three years, after negative results in two consecutive annual exams[1].

In Brazil, in 2020, 16,710 new cases of cervical cancer were estimated, with an approximate risk of 15.38 cases per 100,000 women. In 2019, this neoplasm was responsible for 6,596 deaths, representing an adjusted mortality rate of 5.33/100,000 women, according to data made available by the National Cancer Institute[2].

The main risk factor associated with the high rate of development of cervical cancer is infection with the Human Papillomavirus (HPV), especially subtypes 16 and 18, which are responsible for 70% of cervical cancers. In addition, factors such as unprotected sexual activity, immunosuppression, smoking, multiparity, inadequate diet, use of oral contraceptive pills for a long period of time (more than five years), multiple sexual partners, early initiation of sexual activity, and age over 30 can influence the development of HPV infection and progression to precursor lesions or cancer[3].

Primary prevention of cervical cancer begins with the provision of vaccination against HPV, guidance on condom use, and combating smoking. These conducts do not reduce the need for following through cytopathological examination, with a focus on early detection of precancerous lesions. Thus, it is important to actively search for women within the target population and with overdue tests, follow up on cases with abnormal results (referral to referral services, specialist or more complex examination) and health education[3].

For the operationalization of these actions, the Ministry of Health has been producing technical materials that aim to guide the work process in Primary Health Care. These materials are the Primary Care Notebooks, which were released in 2006 and 2013. The most recent material aimed at enhancing the performance of health teams is the document "Primary Care Records: Women's Health", published in 2016[4]. This publication has national coverage and includes the following guidelines: attention to the most common problems/complaints in women's health, attention to women in low-risk prenatal care, puerperium and promotion of breastfeeding, reproductive planning, cervical cancer prevention, breast cancer prevention, attention to women in the climacteric period, and attention to women in situations of sexual and/or domestic/intrafamily violence[4].

In the context of cervical cancer prevention, the nurse performs several activities, being responsible for conducting the nursing consultation and collection of material for cytopathological examination. In addition, the nurse provides guidance on preventive measures, manages the provision of material resources, refers suspicious results, and performs several educational activities with the health team and the community[5].

It becomes noticeable that the activity that nurses perform in the Family Health Strategy (FHS) is of total importance not only for the development of practices based on records, which can be defined for all nursing activities at all levels of care[6], but also for the performance of the team in which they are inserted in the health services.

Based on the above, this research had the following guiding questions: Do nurses of the Family Health Strategy (FHS) in the municipality of Campina Grande (PB) know and use the Primary Care Record to guide their actions on women's health regarding the prevention of cervical cancer? What are the possible facilities and difficulties in the use of records in the nurses' work process?

This article aims to analyze the use of the women's health record in the prevention of cervical cancer by nurses in Primary Care.

Method

This is a case study, exploratory, qualitative approach, guided by the COREQ tool. The research setting was the FHS of the city of Campina Grande (PB).

Nurses who met the following inclusion criteria participated in the study: working in the FHS of the city, since they perform cervical cancer following. As exclusion criteria, it was considered only not to be exercising the care function in the Family Health teams.

For the sample, 5 nurses from each health district were randomly selected, totaling 40 participants. During data collection, one participant was lost due to unavailability to participate in the research. Thus, the new total included 39 nurses.

Data were collected between May and June 2017, at the place where the nurse worked, at a time he/she deemed possible. In addition to the interview with semi-structured questions, we used a data collection instrument consisting of two parts: the first, with questions regarding the characterization of the subjects; and the second, with questions related to the research objective. The construction of the data collection instrument was based on the Primary Care Record –Women's Health 2016, published by the Ministry of Health[4].

For the validation of the research instrument, a pilot test was conducted with a nurse, aiming to assess possible interpretation biases during the questioning, as well as to identify if the formulated questions met the research objective.

The interviews were recorded on a double-entry digital recorder. The interviewees signed a consent form for voice recording. The recording of the interviews was transcribed in full and constituted the corpus that was subjected to analysis. To ensure anonymity, the participants were identified by the acronym NUR followed by the order number of the interviews.

The content analysis was of the thematic categorical type, which is organized in three phases: pre-analysis, with floating reading of the material; exploration of the material, which consists of coding and decomposition according to the previously listed categories; and treatment of the results as units of analysis, the fragments of the interviewed subjects' speeches based on inferences and interpretations[7].

The present study is part of the research entitled "Knowledge and Use of Women's Health Records by Primary Health Care Nurses", in which the knowledge and use of records by these professionals are analyzed, in its eight dimensions mentioned. The research record was approved by the Research Ethics Committee of the Universidade Estadual da Paraíba, under Opinion nº 1881700, Certificate of Ethical Appraisal Presentation (CAAE) n. 602782163.0000.5187.

Results

The research sample consisted of 39 nurses of the FHS distributed in the 8 districts of the city of Campina Grande (PB). Most were female (94.9%), aged 25 to 39 (46.2%) and married (74.0%).

Regarding the time of graduation, 35.9% of the interviewed nurses had graduated more than a decade ago. Regarding postgraduate

studies, more than 92% of the interviewees had the title of specialist. Of these, nine nurses held more than two specializations, with the highest percentile (63.6%) being specialists in Public Health/Family/Community Health.

Regarding training, 97.4% of the interviewees had some training in Women's Health and 92.3% completed at least two training courses. Thus, 76.9% were trained in Cervical Cancer Prevention, and 36.0% completed it less than five years ago.

Qualified listening reception

Among the nurses interviewed, some informed that they received the women who sought the service and based their complaints on them, as can be seen in the following statements:

> *If she has a complaint. If you're doing it for the routine or if she has any complaints, and then she's going to come with a complaint of pelvic pain, pain to urinate, discharge, bleeding. And then, depending on her complaint, I continue* [...] (Nur. 7).

> *I try to see why she came to that appointment, what was her complaint at the time.* (Nur. 15).

Evaluation global of the woman

When caring for women who will undergo cytological exams, the interviewed nurses referred to a comprehensive approach, as the following statement reveals:

> *First, we make a full consultation. So, I'm going to see the general state of the woman's health, I'm going to ask the questions that are pertinent, if she has any complaints, and, of the complaints, I'm going to see if they're related to the genitourinary system, in the gynecological part of it. We'll all see there. And you're going to fill out that file that has all story.* (Nur. 28).

In the present study, other nurses reported limiting themselves to the current complaint and to performing the collection of material for cytological examination:

> *Look... I don't like to get into her intimacy and ask how many people she's ever had a relationship with or anything like that. So, I'm trying to assess what her complaint is, the value of her blood pressure. And when it's been a long time since she's had routine tests, I take the opportunity to request.* (Nur. 1).

They stated that they performed a syndromic approach, for the users who were identified some alteration at the time of cytological collection, as seen below:

> *Yes. Depending on the changes, right? If it's one, leucorrhea, something that can be solved right here, we'll see. If you have medication, we'll take care of it. Depending on the clinic, we already use the record* [...] (Nur. 18).

> *Yes. I consult the COREN* [Conselho Regional de Enfermagem] *manual and prescribe the medication, depending on the patient's complaints and the findings at the time of cytological collection.* (Nur. 3).

> *Pregnant women, women who are in climacteric or menopause and those who have had hysterectomy.* (Nur. 1).

> *Yes. I know it's the pregnant women with menopause and the ones who removed the uterus. You also have those with HIV, because you must take the test more often.* (Nur. 5).

Care plan in the prevention of cervical cancer

The participants stated that they had autonomy to perform the return consultation, as revealed in the following statements:

> *Usually, the return consultation is made with the doctor or else, it is... As we receive the result previously, we evaluate. If it is a simpler examination, a simpler result, within the record of the Ministry, that we can solve, the nurse solves as well.* (Nur. 18).

> *Yes. After they do the cytological, I ask them, when they have with the result schedule the appointment, to go through me or the doctor.* (Nur. 20).

Regarding the referral of users to reference services, some of the interviewees said that they were referring the users to colposcopy after the cytological result, as shown in the statements:

> *Referral for colposcopy can only be made after birth of the cytological result. As it is the doctor who analyzes the results, it is usually she who makes the referral.* (Nur. 5).

> *When the result, the result we get from the lab, he already suggests colposcopy, understand? And when it does not come with this suggestion, I see the parameter that we follow right, and then if it is NIC II, we can ask for colposcopy.* (Nur. 33).

However, other nurses reported referral of these users for colposcopy by identifying visible alterations during cytological collection, as corroborated by the statements:

> *I'll forward it. Just when she has an injury to her cervix, which I identified at the time of cytological or if she comes with any other alteration in her cytological examination, which suggest the collection of colposcopies, the most detailed examination.* (Nur. 12).

[...] *however, when we identify a situation, visibly, that draws attention, we ask to make this careful evaluation, even so*. (Nur. 14).

Regarding the performance of educational actions with the users, to encourage them to perform preventive tests, some nurses reported performing these actions in the waiting room, in groups or through lectures, as the statements explain:

Yes. Whenever possible, the team carries out health education through the waiting room. (Nur. 1).

We usually do it in conjunction with the NASF [Extended Family Health Center] *staff, with students who come to intern and with our unit. So, we always try to perform moments in the waiting room or invite the users to a lecture*. (Nur. 5).

Ease of care and/or difficulties encountered in the implementation of prevention actions in Cervical Cancer

Among the facilities found, the spontaneous search for the examination and the link with the service were identified, as observed in the statements:

Good. Here in my unit, specifically, I have no difficulty. I have an assiduous demand, which seeks the service, regardless of disclosure or not. She seeks the service [...] *And I have a faithful demand* [...] (Nur. 26).

The ease is that they have a large bond already. Most of them already have a bond with me, and then many of them already feel comfortable because of this bond that has already been formed [...] *they already feel more comfortable taking the exam*. (Nur. 30).

The low participation of users to the examination and the lack of active search were highlighted by other nurses as difficulties encountered in this process, as shown in the following statements:

The only difficulty, which I think is the millennial [laughs] is the non-adhering to women. Many times, we catch a woman over 10 years old, who did not come to do the cytological [...] *So... but the biggest difficulty is that... It is the same culture, that they have not yet* [...] *feel much still, the taboo, about cytological*. (Nur. 15).

There's still the fear of coming to the exam, of shame. So that's one thing that there are still many people who don't seek the service. That's still a barrier for us. As a nurse, I try to guide these people and then, usually, when she does not want to do in the unit, because she is seeing that professional, I try to talk and sensitize the woman to take care of her health. (Nur. 24).

Difficulty due to lack of updating, professional training, was also listed as observed in the speech:

I think we should be more up to date, because, as I was saying, we haven't had training in a long time. As medicine grows every day, we stay behind. I think there must be something we don't even know, and we stop acting. (Nur. 11).

Discussion

Among the record's highlights, qualified listening is fundamental for the service's resoluteness, because this listening facilitates the service and the forwarding of the demands presented by the user[8].

It is considered important that the nurse, when approaching the woman during the cytological examination, act in a different way, ensuring the necessary conditions so that she can talk about the disease and learn how to prevent it. Respect for her intimacy and privacy should also be guaranteed[9].

By taking the humanistic nursing perspective as a reference, nurses provide care aimed at promoting women's health, based on knowledge about their bodies and sexuality, through an open and empathetic conversation[10].

However, the construction of a bond between the user and the professional is compromised when the approach is limited and implies a quick and mechanical service, disregarding the relational process[11], as in cases reported by some nurses. According to them, when users seek the basic health unit for cytopathological tests, only the current complaint, collection of cervicovaginal material and request for routine tests are taken into consideration. The non-approach to the intimacy of women by nurses reinforces the search for cytology based on a complaint dissociated from the preventive nature of following. In this sense, there is a need for emphasis on listening and dialogue since the affective bond is essential for the promotion of sexual and reproductive health[10].

Sexual and reproductive health is considered one of the priority axes of primary health care and of the guidelines of the National Policy of Integral Assistance to Women's Health. The constitution of this field refers to autonomy, safety, and freedom to make decisions about the ways of expressing and living sexuality,

without risk of disease and discrimination. To this end, it must ensure clinical care in prenatal, birth, and puerperium, educational activities, care for sexually transmitted infections (STI) and other reproductive tract disorders, referral and guidance on infertility treatment, care in cases of abortion provided by law, among others[12].

Addressing the sexual and reproductive health of women in a comprehensive way can foster preventive measures for cervical cancer, by enabling the mitigation of some risk factors, such as unprotected sexual activity, multiple sexual partners and HPV infection. However, the predominance of the focus of the approach on sexuality, reproduction, cervical cancer following, selective reproductive planning for some contraceptives, the restricted approach to vulnerabilities, among others, becomes a challenge for the effectiveness of the care provided by family health teams focused on sexual and reproductive health[13].

According to the record, the nurse can perform a syndromic approach – identification of signs and symptoms for timely treatment follow-up – during the collection of the cytopathological exam, in the presence of abnormal vaginal secretion or friable cervix and, regardless of this approach, continue the following routine. In case of abnormalities, such as bleeding outside the menstrual period or suspicious lesions, the user should be referred for specialized evaluation. In cases such as Naboth cyst, which does not require intervention, the nurse should only observe[4]. Thus, the syndromic approach of professional performance is considered relevant, as it enables early treatment and prevents complications from STIs, to intercept transmission[14].

The record[4:178] states that they need referral or specialist services evaluation, and therefore should be referred, the cases of:

> Suspected lesion on specular examination; Result of a colpocytological with ASC-H; LIE or SIL high-grade or *carcinoma in situ;* result of two consecutive colpocytological with ASC-US; LIE OR SIL low-grade; [...] Results of neck biopsy with: invasive neoplasia (squamous cell carcinoma/ adenocarcinoma); microinvasive carcinoma; severe cervical dysplasia, LIE high-grade (CIN 2/3); Result of colpocytology with: malignant cells or invasive carcinoma; AGC (atypical glandular cells of indeterminate significance).

The nurses, in their speeches, showed concern about the timely diagnosis and treatment for women who presented alterations in the cytological exam. This concern is consistent with research on the importance of these interventions. The reduction in incidence, as well as mortality due to cervical cancer, does not depend only on the high rate of cytology coverage, but it is also necessary adequate expertise for the collection of the exam, less time-consuming results and appropriate treatment in a timely manner[15].

Also, in the global evaluation of the woman who undergoes the colpocytological exam, the complaint should be evaluated at the time of the exam and treated when necessary. It is also important to check for the presence of other diseases, such as STIs, and to prescribe medications[4]. Professionals do not fully assume the role of prescribers in any area of care, despite what is regulated by the law of professional practice of the category. This is since these nurses do not feel qualified for this assignment[16-17].

Among the women who are in special situations for the collection of cytological exams are the immunosuppressed – women infected with HIV, or who have undergone solid organ transplantation, cancer treatment, and chronic use of corticosteroids –, who should be checked after the beginning of sexual activity, in the first year, with semi-annual intervals. If the results are normal, annual following should be continued. HIV-positive women with CD4 less than 200 cells/mm^3 should correct their levels and have following every six months. For the group of women with no history of sexual activity, there is no indication for following[1].

Regarding the care plan in cervical cancer prevention, the attributions are the responsibility of both nurses and doctors, as well as the multiprofessional team. This plan involves the scheduling of return visits, referral to reference services, post-examination follow-up, stimulation of primary prevention actions, health surveillance and health education[1,4].

The record gives freedom to nurses to make referrals (either to gynecology/colposcopy or oncology) of cases that need evaluation

in reference services, according to criteria agreed upon by municipal, state and/or federal management, following recommendations for each case[4]. Moreover, it also deals with the nurse's autonomy when evaluating the cytology results. However, it is necessary to reflect whether nurses, when they fail to attend, are not also failing to ensure attributes of Primary Health Care, such as accessibility and completeness of care.

As seen, the result of cytology also allows the diagnosis of cervical cancer. However, it can occur late, when it is related to factors such as: professionals not trained in oncologic care, health units unable to receive the demand of these users and the lack of care flows established by municipal and state managers at various points in the health care network[18-19]. These flows should ensure the management of care thought fully, requiring numerous health services[20], because there is no integrality without the transversality of the system.

Nursing professionals, when performing educational activities during consultations, in the waiting room, and in groups, should emphasize the aspects related to cervical cancer prevention and control and not only the complaints presented by women, to make it possible to intensify preventive measures[21].

As a form of health education, the record talks about the issue of individual and collective guidance about the exam and its importance, also addressing risk factors such as smoking, HPV infection, and age. Other topics to be addressed in the educational activity are safe sex, the periodicity of the exams, and the guidelines that precede the collection of cytological material[4].

In this study, the main facilities regarding the implementation of preventive actions for cervical cancer, cited by the nurses, were the spontaneous search for the cytopathological exam and the establishment of a link with the community.

Although the research participants mentioned the search for cytology as a facility for cervical cancer prevention, it is recommended to pay attention to the excessive spontaneous demand and the irregular supply of the test, since this reflects the focus on the current complaint and deficiency in early following. Thus, the need to know the population attached to the basic health unit is emphasized, to support the completeness of care and the active search for women who meet the criteria of the target audience for cytology (women aged between 25 and 64 and who have had sexual activity)[13].

In the FHS, the bond is characterized by the interpersonal relationship between the health professional and the user, allowing better adherence to health care and greater understanding of the vulnerabilities of the local community through qualified listening and mutual respect. When this bond is established, the user places trust in the nurse's practice, expanding health actions and stimulating preventive and self-care practices[22].

As for the difficulties reported by the study participants, the low adherence of users, lack of active search and scarcity of training for professionals stand out. The low adherence of users and the lack of active search reveal problems related to the organization of care flows, such as delays in scheduling and returning test results, factors that hinder the establishment of an early intervention[23].

The problems related to the resolutivity of the service network that interfere with the quality of care, such as the absence of communication tools between levels and disorganization of the work process of family health teams, generate distrust of the service by the user and impair the coordination of care, an essential attribute of the FHS, the priority gateway of the public health system[23].

Other obstacles are also pointed out, such as the lack of electronic medical records in family health units and specialty centers, lack of intersection between the various points of the network and limited use of clinical records. These obstacles were identified in a study that dealt with care management in southern Bahia and revealed that they hindered the contact between generalists and specialists, leaving the communication up to the user[24].

Difficulties were also found by nurses in an integrative review study on the role of this professional in cervical cancer prevention, such as excessive workload, limited availability of materials and supplies for the exam, delay in returning results to the health unit and poor infrastructure of Health Units. Other difficulties are related to women's feelings of fear and shame in performing the exam, besides the prejudice of partners[25].

Finally, regarding professional qualification and training, an aspect also reported by study participants, it is necessary to promote continuing education actions, in the context of the FHS, to fill knowledge gaps and attitudes of health professionals, providing subsidies to combine theory and practice[4].

The limitation of this study refers to the fact that the research was directed only to nurses of the Family Health Strategy of a municipality, restricting the reality analyzed. However, it is estimated that the record on the use of the women's health record in the prevention of cervical cancer by nurses can identify possible weaknesses on this topic and guide actions to improve the health care offered in Primary Care.

Conclusion

The analysis of the use of the women's health record in the prevention of cervical cancer by nurses in Primary Care allowed us to verify that most of the professionals interviewed used this record to subsidize and guide their conduct related to the prevention and early detection of cervical and breast cancer.

The look at each dimension of the record highlighted important details that can improve the quality of women's health care. In the hosting with qualified listening, it was observed that the nurse performed it, limiting himself to women's complaints motivated by spontaneous demand.

In the Global Assessment of Women, it was observed that most nurses performed a comprehensive consultation, not restricting themselves to the simple collection of the cytological exam. Regarding the intervention in cases of alterations present in the cytological exam, they already performed the syndromic approach – depending on the type of alteration –, but after the collection. Others ratified that they only took some action when they received the results, to possibly contrast the macroscopic and microscopic observations and establish the best conduct for the user.

In the Plan of Care in the prevention of cervical cancer, all nurses reported having autonomy to perform the exam, however, not all of them evaluated the results of this exam. The referral of users to referral services happened, but there was no counter-reference service.

In the dimension Facilities and difficulties in cervical cancer prevention actions, it was observed that there were facilities regarding spontaneous search and bonding. As difficulties pointed out, many were related to the low adherence of users to the exam and lack of active search. The study showed that nurses needed to collaborate in the active search for women who had never had the cytological exam or who had not done it for more than three years, as well as to carry out educational activities to show them that it was a simple, but important exam.

Considering what was examined in the nurses' statements, a discrepancy was found between the actions performed, which were sometimes in accordance with the Primary Care Record, sometimes diverging from its norms. Thus, this research revealed fragility in cervical cancer prevention, especially regarding the performance of cytopathological exams by nurses in Primary Care.

Collaborations:

1 – conception, design, analysis and interpretation of data: Joyce Carolyne Ribeiro de Holanda, Wezila Gonçalves do Nascimento and Claudia Santos Martiniano Sousa;

2 – writing of the article and relevant critical review of the intellectual content: Joyce Carolyne Ribeiro de Holanda and Maria Helloysa Herculano Pereira de Oliveira de Araújo;

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