

Pap smear: profile of women and assisted quality assessment and access to the service

Exame citopatológico de câncer de colo do útero: acesso e qualidade no atendimento

Citología vaginal de cáncer cervical: acceso y calidad en llamada

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ABSTRACT

Objective: To know the access and the quality to the Papanicolaou from the users' perspective and the coverage of the tests performed. **Methods:** Exploratory research with a qualitative approach was used to collect data on the semi-structured interview with 30 women and for the secondary data, SISCOLO. **Results:** The participants were mostly between 35 and 44 years of age, started sexual life before age 19 and 30% had inadequate knowledge about the exam. The analysis of thematic content resulted in three categories: access/knowledge; Feelings, ethics and confidentiality/information; and assessment of care provided by the nurse. **Conclusion:** Long wait times and lack of confidentiality in results (92%) are difficult to access. The main lesions were those of low grade and among women aged 25 to 29 years. Therefore, the screening for cervical cancer was shown to be ineffective, unequal and with low coverage.

Descriptors: Papanicolaou test, Access to health services, Quality management, Assistance.

RESUMO

Objetivo: Conhecer o acesso e a qualidade ao Papanicolaou a partir do olhar das usuárias e da cobertura dos exames realizados. **Método:** Pesquisa exploratória com abordagem qualitativa. Utilizou-se, para coleta de dados, a entrevista semiestruturada com 30 mulheres e, para os dados secundários, o SISCOLO. **Resultados:** As participantes, em sua maioria, tinham entre 35 a 44 anos, iniciado vida sexual antes dos 19 anos e 30% apresentavam conhecimento inadequado sobre o exame. A análise de conteúdo temática resultou em três categorias: acesso/conhecimento; sentimentos, ética e confidencialidade/informação; acolhimento e avaliação da assistência prestada pela enfermeira.

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Conclusão: O longo tempo de espera e a falta de confidencialidade nos resultados (92%) são elementos dificultadores do acesso. As principais lesões foram as de baixo grau entre as mulheres com 25 a 29 anos. Portanto, o rastreamento para o câncer de colo do útero mostrou-se pouco efetivo, desigual e com baixa cobertura.

Descritores: Teste de Papanicolaou, Acesso aos serviços de saúde, Gestão da qualidade, Assistência.

RESUMEN

Objetivo: Conocer el acceso y la calidad al Papanicolaou a partir de la mirada de las usuarias y de la cobertura de los exámenes realizados.

Métodos: Investigación exploratoria con abordaje cualitativo se utilizó para recolección de datos la entrevista semiestructurada con 30 mujeres y para los datos secundarios, el SISCOLO. **Resultados:** Las participantes en su mayoría tenían entre 35 a 44 años, iniciado vida sexual antes de los 19 años y 30% presentaban conocimiento inadecuado sobre el examen. El análisis de contenido temático resultó en tres categorías: acceso/conocimiento; Sentimientos, ética y confidencialidad/información; La acogida y la evaluación de la asistencia prestada por la enfermera.

Conclusión: El largo tiempo de espera y la falta de confidencialidad en los resultados (92%) son elementos dificultadores del acceso. Las principales lesiones fueron las de bajo grado y entre las mujeres de 25 a 29 años. Por lo tanto, el rastreo para el cáncer de cuello de útero se mostró poco efectivo, desigual y con baja cobertura.

Descriptores: Prueba de Papanicolaou, Acceso a los servicios de salud, Gestión de la calidad, Asistencia.

INTRODUCTION

Cervical cancer is a major global health issue. Yet, it has a higher incidence in underdeveloped countries. Mortality rates are more alarming due to the influence of factors commonly present in the female population of developing countries, such as difficult access to the screening service, partially offered control, low income and low level of schooling. In Brazil, only in 2016, it is expected that 16,340 new cases and the third cause of mortality, excluding non-melanoma skin cancer.¹

Latin America, part of Asia, the Caribbean, and Africa have recorded the highest rates of this disease.² Brazil, according to estimates of high incidence in the Midwest and Northeast, is in the second position, with rates of 20.72/100 thousand and 19.49/100 thousand cases, respectively.³ The control of cervical cancer is still a challenge for the Northeast region, only in *Bahia* State were registered/identified 1,120 new cases in 100 thousand inhabitants in 2014.⁴

The main risk factor for developing cervical cancer is persistent infection with human papillomavirus (HPV-especially type 16 and type 18); nevertheless, other factors such as smoking, multiparity, sexual multiparity and the use of oral contraceptives help precipitate the onset of the disease.⁵ Cervical cancer begins with a pre-invasive, slowly evolving lesion, so that mild HPV or Degree I Cervical Intraepithelial Neoplasm (CIN I) dysplasia takes approximately three years to progress to carcinoma in situ, whereas moderate (CIN II) and severe (CIN III) cervical intraepithelial neoplasms take less than two years.⁶

If the precursor lesion is treated, it has a 100% chance of cure.⁵ In order to achieve 80% coverage in the last three

years and the reduction of the incidence rates of this cancer, the effectiveness of the cervical cancer screening program is essential, added to the treatment in the initial stages, so that there may be.⁶

In Brazil, this type of screening has been performed through the Papanicolaou test, which was inserted as a routine procedure of the gynecological consultation from the 1940s, with women in the age group from 25 to 64 years old as the priority group.⁷ The carcinoma has a maximum incidence in the age group from 45 to 49 years old, the strategy adopted for early detection through the cytopathological exam.⁷

The technique is widely accepted and feasible. It is a low-cost, painless and easy-to-execute method, and can be performed on an outpatient basis in Basic Health Units (BHU). In this way, it is considered by the National Cancer Institute and the Health Ministry (HM) as a method of screening for high reliability and efficacy.⁶

In addition to the collection of the examination for the preventive screening and control of cervical cancer performed at the BHU, there is also, guidance and follow up, evaluation of the quality of the collection, as well as the evaluation of the coverage of examinations performed by area. Nonetheless, two aspects are essential in consolidating the reduction of the high rates of this malignant neoplasm, the users' access and quality of the Papanicolaou test.

It is worth mentioning that the nurse as a component of the multidisciplinary team working at the BHU, has the technical competence and duties to perform the Papanicolaou test as a fundamental strategy for injury reduction, according to the proposal recommended by the HM, thus promoting the detection to improve the women's life quality.

The theme was chosen in view of the possibility of deepening the problems addressed by nursing students in the field of practice, due to the lack of work related to the subject in the region in question, and to enable visualization of the indicators of this disease and proposition of effective actions. Given the aforesaid, this study started with the following guiding question: what is the profile of the women who underwent the Papanicolaou test, and how does occur the welcoming at the BHU? The study's goal is to understand about the users' access and the quality of the Papanicolaou test provided to them by taking the users' perspective and also using data regarding the exams performed.

METHODS

It is an exploratory research with a quantitative approach, which uses the content analysis and descriptive statistics. Content analysis has been widely used in nursing research since it reveals the universe of meanings, beliefs, values, and attitudes of individuals in relation to care.⁸

The initial reading was the first activity and consisted in establishing contact with the documents in order to know them, and once transcribed interviews undergo a deepening to define the categories in the pre-analysis,

with the systematization of the initial ideas, then the categorization according to the speeches of the participants guided by the adopted issues of the instrument, for the discussion was sought theoretical basis and later grouping of the analysis.⁸

The study included thirty women among the 230 who underwent examination in the year prior to data collection, within the age group from 15 to 59 years old; the obtained sample and the number of participants was the difficulty in locating the users of the service by the incompleteness of records in BHU. The temporal range comprised the years 2010 to 2013 and for determining the sample was considered the weekly average of exams performed at the chosen unit.

It should be noted that the women were randomly selected among those who fit the inclusion criteria, who were: to be resident in the area of coverage of the chosen BHU; having undergone the examination at the BHU - verified through registration in medical records of the unit and consent by means of signing the Informed Free and Informed Consent Term.

The data were collected in the year 2014, at the participants' home, through a guide applied through a semi-structured interview. The data collection instrument consisted of 17 questions, with open and closed questions, including socio-demographic, behavioral variables related to the subject, gynecological, preventive care for cervical cancer, evaluation of access to health services and evaluation of the quality of care provided.

This work was carried out in a municipality of the Northern Macroregion of Bahia State, Brazil. The health unit where the data collection took place was one of the BHU located in the urban zone, which covers a population of six districts of the municipality. This was chosen because it has a relatively high female population (between 10 and 15% of the women in the city), it is located in a peripheral district, low income and with a care service for the prevention of cervical cancer implanted more than three years ago.

During the sample selection, the following problems were found: the data collection coincided with the period in which the BHU underwent a restructuring and thus, during this period, the women were referred to other municipal units for the examination. Moreover, the BHU did not have all the records, medical records and books of this period analyzed, consequently established as a new criterion for inclusion the verbal affirmation of the users who had previously performed the Papanicolaou test in the unit.

The statements were recorded in digital media equipment (Mp3) in order to obtain total reliability, registered with the letter "E" and with a number for each deponent (1-2-3... 30), and to preserve the anonymity of the deponents was used the alphanumeric system for the identification of the reports. During the interviews, the records were subject only to the answers provided by the women, a situation that is subject to memory bias, especially in those with lower levels of education, which implies information misuse.

After the transcription of each testimony, a floating reading was carried out, which enabled the perception of the relevant structures as well as the central ideas for understanding the subjective phenomena present in the participants' reports, in order to identify the manifest content.

Subsequently, the answers were grouped by a question of the interview script for a better visualization and interpretation of the deponents' reports, then the essential structures were examined, organized into three thematic categories: access/knowledge; feelings, ethics and confidentiality/information; welcoming and assessment of care provided by the nurse. Next, it was sought to relate them to the findings in the literature consulted, highlighting the relevant points for understanding the meanings expressed in the Thematic Units.

The provisions regulated by the Resolution No. 466/2012 for human research were complied.⁹ After submission, the work was then approved by the Research Ethics Committee from the *Universidade do Estado da Bahia*, under the *Certificado de Apresentação para Apreciação Ética (CAAE)* [Certificate of Presentation for Ethical Appraisal] No. 31300014.7.0000.0057.

RESULTS

Among the 30 women interviewed, the predominance was those being from 35 to 44 years old, race/skin color brown/black, with monthly income less than a Minimum Wage (MW), complete or incomplete High School. There is a preponderance of women in the intermediate age group, among those proposed by the HM, who live either with or without a partner, with a low level of schooling and residents in the neighborhood (73.3%) where BHU is based. The data that characterize them are shown in **Table 1**.

Table 1 - The characteristics of the users assisted by the BHU. *Senhor do Bonfim, BA, Brazil, 2015.* (n=30)

Age Group	15-24	25-34	35-44	45-54	>55
	3	3	12	10	2
Race/skin color	Black	Brown		White	
	6	15		9	
Income	No income	Less than 1 MW	Up to 1 MW	More than 1 MW	
	4	13	10	3	
Schooling	Illiterate	Incomplete Elementary School	Incomplete High School	Complete High School	
	2	13	1	14	
Sexual initiation time	Before 19 years old			After 19 years old	
	19			11	
Marital status	Single	Common-law marriage		Married	
	11	8		11	
Sexual partner	Just 1	Up to 2		3 or more	
	19	4		7	
Papanicolaou current result	Negative	Inflammation		CIN I	Unknown
	14	7		3	6

Source: Authors' data (2015).

Table 1 also shows a sexual initiation before reaching 19 years old, though, with a single sex partner reported in life (63.3%) followed by three or more sexual partners in life (23.3%). The geographic location of their residences combined with the low purchasing power reflects the poverty and social exclusion that these women may be subjected.

The municipality performed 4 thousand tests per year on average, but in 2013 this number was less than 50% of what had been performed, only 1,934 exams. Data are described in **Table 2**.

Table 2 - Absolute number, the percentage of exams and age group of women assisted by the BHU studied between the years 2010 to 2013. *Senhor do Bonfim, BA, Brazil, 2015.*

YEAR	Total at the municipality	Total at the unit	Exams at the unit (%)	Altered exams	Altered exams (%)	Age Group
2010	4,187	509	12.15%	8	1.57%	40-44
2011	4,358	491	11.26%	2	0.40%	35-39
2012	4,116	230	5.58%	1	0.43%	25-29
2013	1,934	-	-	-	-	-

Source: *SISCOLO/DATASUS* (2015).¹⁰

The data registered in the *Sistema de Informação do Câncer de Colo do Útero (SISCOLO)*, for the total number of examinations performed in the city, according to **Table 3**, in relation to the changes detected in the examinations was 1.57%, 0.40% and 0.43 %% between 2010 and 2012, respectively. It should be noted that the year with the most changes in exams was that of 2010, it is worth mentioning the year of 2012 where the number of exams was lower, dropped by around 50%, and the age group with the highest concentration was from 25 to 29 years old.

Table 3 - Number of exams altered and registered in the *SISCOLO* between the years 2010 to 2013, *Senhor do Bonfim, BA, Brazil, 2015.*

YEAR	Unspecified Scaly	Unspecified Glandular	Intraepithelial low degree	Intraepithelial high degree (microinvasion)	Adenocarcinoma <i>in situ</i>
2010	1	1	4	1	1
2011	2	0	0	0	0
2012	0	0	1	0	0
2013	-	-	-	-	-

Source: *SISCOLO/DATASUS* (2015).

Herein, the data obtained through the interviews were grouped into three thematic categories, previously defined in the collection instrument, for their relationship with the questions formulated: access/knowledge; feelings, ethics and confidentiality/information; welcoming and assessment of the care provided by the nurse.

DISCUSSION

The socio-demographic profile directly implies in the opportunities of accessing goods and services offered in the health care field, where Latin America has one of the worst incidence rates for cervical cancer, an index similar to that found in *Roraima* state, where it was estimated that a large portion of the female population had never performed preventive cytological exams, especially those found in the exclusion profile.²

Other characteristics to be highlighted are as follows: age group from 45 to 54 years old (33.3%), black skin color (20%) and low income. Adding the information without income and receiving up to a minimum wage reached the percentage of 46.6% of women. In a survey of the impact of this disease in the north of the country, data showed an average age of 49.2 years, a high fertility rate (5.5 pregnancies on average), early sexual initiation (average of 13.8 years old), and an average of 4.2 sexual partners during the lifetime, the age range of the first cytological examination was 32 years, there was low schooling and the average family income of these female patients was 0.5 minimum wages per capita, corroborating with the incidence of women in this age group with income below a minimum wage and low level of schooling found in this study.²

In another study that also proposed to draw the profile of the women who performed the test, but with women from the urban area of southern Brazil, the average age for screening was between 20 and 39 years old, white, married or living in common-law marriage, having nine or more years of study and performing paid work,¹¹ a reality quite different from that found in this study.

As for the findings resulting from the analysis of the blades, the cancer precursor lesions were concentrated in the age group from 40 to 60 years old, confirming that the changes in the tests have a maximum incidence in this age range, in women who started life sex before the age of 19 years old and reported more than one sexual partner in life. The prevalence of cervical changes affecting cervical cancer control is related to precocity and sexual promiscuity, illiteracy, precarious basic sanitation and low level of education, women who have sexually transmitted infections with discharge are more susceptible to the onset of cancer, especially among those in situations of greater precariousness and low income.¹²

We call attention to the results found by also pointing out a relationship between the presence of epithelial cell alteration and lower education to complete primary education, data that compose the profile of patients with cervical cancer in *Roraima* (brown woman, unemployed, single, with low educational level, low socio-economic level, living in housing without basic sanitation, beginning of early sexual activity, who does not have regular Papanicolaou tests or has never done one).²

All injuries should be considered significant and deserve due treatment. The importance of the gynecological preventive exam is due to the ample capacity to prevent and to minimize the damages caused by this, the conduct adopted in the CIN I is to repeat the examination with 6 months, in the CIN II

and III is see-and-treat, diagnosis followed by treatment to prevent the progression of invasive carcinoma.

The results related to the evaluation of access to the service obtained 47% in the good and the good statements and 36% in the regular ones. Regarding the quality of care, 56% said that they were good and good and 34% said they were regular. The evaluation of the participants is quite satisfactory; nonetheless, it was observed that the worst evaluations for access and quality of care (bad/really bad) were evaluated by women with incomplete elementary education and monthly income lower than a minimum wage, so it may infer the size of the impact of social inequalities in the use of preventive health services.

In the sample studied, 12 women (40%) reported not having a gynecological preventive exam annually, and only 9 (30%) had adequate knowledge about the test, they knew that the purpose of the test was for cancer prevention.

The interviews with regard to access/knowledge are described in the category 1.

Category 1: access/knowledge

When questioned about the annual achievement of the exam and what brought them to the health unit, a group of participants answered that access to the unit is easy, they know the importance of the exam and believe in cancer prevention, according to the following speech:

Yes. Because it is necessary, for women's health, to be prevented. Because of diseases as they are today, there are diseases that have no symptoms. I always did there [BHU] (E9).

In opposition, another group exposed the difficulty of access, inadequate knowledge, and pointed out barriers to the Papanicolaou test such as fear, shame, lack of time, lack of knowledge, fear of discovering something, among others:

No. I only did it once, because I was afraid, I thought it would hurt, but it does not hurt, it was out of fear. I did in other place (E17).

Issues related to the quality of care such as dissatisfaction with accessibility, clinical assistance to the user, long waiting time, right to information, dignity and courtesy revealed the obstacles that led to the failure to perform the Papanicolaou test annually. An obstacle to access was identified with low flexibility in the scheduling of consultations, an element that contributed to the distance of women from the health unit and not to the Papanicolaou test. Factor that added to the knowledge and inadequate practice and the obstacles to not performing the exam reflect the low coverage of the Papanicolaou test found in the study.

There are different studies, such as Silva's study in a city from the *São Paulo* State, that indicate the same reality observed, points to the low flexibility in scheduling appointments, emphasizing the excessive bureaucratization of services as a disincentive to the process.¹³ A study carried out in the Northeast region shows that there is difficulty

in accessing and that the scheduling of consultations is the greatest obstacle found for the use of services.¹⁴

It is important to listen to complaints and suggestions from users who find barriers to accessing health care services. The analysis of this category has revealed difficulties in access, and that not all women are welcomed into the service in the same way, when taking into account the geographical, economic and organizational aspects.

Category 2: feelings, ethics and confidentiality/ information

It is observed a high satisfaction with the quality of care, especially in the dimensions of the right and confidentiality of the information and clinical assistance offered to the user.¹⁵ Herein, the participants reported moments of satisfaction and others of dissatisfaction, being possible to perceive satisfaction, in relation to the time of the examination, related to the dimensions of quality of care, such as absence of pain and/or interurrences in the procedure, restriction of people in the care room, satisfaction with clinical care and comfort.

On the other hand, they noted as unpleasant feelings the embarrassment due to the presence of people in the exam room or when they were performed by trainees, besides the inadequate management and pain during the material collection.

No, just her [nurse]. My privacy was preserved because I only had the nurse around (E21).

At the time I received the result of my preventive with CIN II and III, the person that called me up was in a room with six to eight trainees, I stood up and she gave me the result. At that moment my privacy was not preserved in any way. Actually, I felt embarrassed in front of all those people (E28).

The care with the technical and ethical issues when carrying out the examination reinforce the positive aspects found. In the study carried out in municipalities in Ceará State, it points to the professional-patient relationship as a determinant for user satisfaction and quality of the Family Health Program, relational aspects such as professional clarity, reception, trust and respect.⁷ Regarding the Papanicolaou test, it was evident that when referring to the care quality, one should also be concerned with the use of the techniques in a correct and painless way.

On the other hand, neglect of technical and ethical issues reveals a lack of commitment to the quality of care provided at the time of the examination with the presence of people in the room, lack of women's preparation, non-confidentiality, discomfort, indignity, and courtesy.

The women showed a certain discredit in the service offered by the health unit studied, pointing from the long waiting time for the test result (92%) to the low confidentiality of the results and the denial of the right to information.

The result will take from forty-five to sixty days. It does not take less than sixty days at all. Even having a problem. It comes with a clip (E28).

Primary care does not correspond as the first site for the discovery of cervical cancer, which raises the difficulties for accurate and rapid diagnosis.¹⁶ Revealing that access to timely diagnosis is a crucial point for credibility in the service, which is not a reality for the participants of this study.

Category 3: welcoming and assessment of the care provided by the nurse

In the routine established in the unit the women are initially attended by a nurse and in some situations referred to a physician. The service is structured in the perspective of spontaneous demand, in other words, the cancer screening is aimed at women who look for the service, such an organizational model, results in inequalities in access and inadequate use of resources making it difficult to get accurate and fast referral for treatment and/or management.¹⁷

When informed about the negative result for cervical cancer, a significant number of participants draw attention to the quality of the information, because minimizing and/or misunderstanding about the results makes it difficult to follow up both prevention and treatment of the different results found.

Looks like it is some inflammation. She just prescribed an ointment and said it was not too much trouble (E20).

It is imperative to understand the complexity of cervical cancer control, which goes beyond collection, such as periodic appointments, STD control, access to HPV diagnosis, adequate follow-up for abnormal exams, quick and easy access to services, flexibility to mark and reschedule queries and speed of service.⁵

Corroborating, another author reveals the flaws in the nursing work process, such as the active search of these women for treatment in a human and integrated way, emphasizing that cancer patients start treatment late, implying physical, emotional and social aspects.¹⁶

Based on the women's viewpoint, it was possible to perceive satisfaction with the clinical assistance of the nurse, highlighting elements such as patience, listening to health problems, care at the moment of consultation, respect, trust, bonding and the right to information. On the other hand, the dissatisfaction was related to technical questions and quality of the exam, partial information, lack of management/preparation and the woman's preparation for the examination.

She [the nurse] treated me well, I would indicate. I liked it, it was good! But she's not there anymore, they keep replacing the professionals, we cannot even remember their names (E21).

The high satisfaction related to the work of nursing professionals with confidentiality and right to information

has already been reported by other authors.¹⁵ There is also a need for the ability to deal with the characteristics of each woman, such as age, hormonal influences, pregnancy, presence of inflammatory changes and previous therapy, depend on specific and still fragile training in Family Health Strategy.¹⁸

The aforementioned author also points out that the conditions of material collection, fixation on the blade, transport, processing, and analysis of the blade are factors related to the process of cellular atypia detection that deserves the full interest of the team and managers.¹⁸

For the quality of care to be fulfilled in the BHU, it is necessary to meet certain requirements such as the type of care provided, the involvement and preparation of the team, sufficient material, and human resources, and the impacts that this type of care can cause in people's lives and community.¹⁵

The elaboration of projects for health and service education might minimize inequalities in access and strengthen humanization in the care provided, especially if the reception is carried out by all staff, since it enables the formation of the bond that is established as a function of elements facilitators of the access, among them the form of organization of the service and the professional competence of the team, starting the relationship established with the time of use of the service.

It is known that in order to reduce incidence and mortality in underdeveloped countries, the practice of Papanicolaou test is attributed through programs that guarantee access to and quality of care provided to women.¹⁹ The population of women in the age group from 15 to 59 years old totals 19,283 in the municipality of *Senhor do Bonfim*,²⁰ therefore it has a coverage of about 65.6% for this age group, the data show that the municipality has been disregarding what is recommended by the Health Ministry, the goal established by the WHO is at least 80% of the population from 25 to 59 years old.⁵

The unit studied performed more than 10% of the total of examinations made in the municipality. In 2012 reached only 5.58%, the following year, being closed for restructuring, no examination was either performed or registered as coming from the unit. Regarding the age group, this is concentrated year-by-year in different bands, sometimes in the upper limit (women from 40 to 44 years old), sometimes in the lower limit (women from 25 to 29 years old).

In the period studied, there was a decrease in the number of exams performed in the population of women residing in the five districts served by the health unit, the percentage shows a low coverage, discontinuity in attendance and an increase in the percentage of altered exams. Study of the cytological alterations performed in Northern *Paraná* from 2001 to 2006, of the 6,356 oncotic cytology tests, 65 (1.02%) of the women presented cellular alterations, the low coverage per year of cancer prevention exams and that there was a higher frequency in the change in CIN I and CIN II,⁴ which was also found in this study, where most cases corresponded to preinvasive lesions.

The low detection of cellular changes in the studied municipality does not represent an indicator of quality. Precursor lesions (CIN I, II and III) of uterine cancer were concentrated in women from 40 to 60 years old. It can be

affirmed that the coverage of cervical cancer preventive exams in 2010-2013, reaching only 65.6%, was very distant from that recommended by the Health Ministry, and that the BHU contributed, in the study coverage, 12.15%, 11.26% and 5.58%, respectively.

The search for and performance of the Papanicolaou test is still focused on younger women who seek service more often. In this study, the women's speech show that some actions can improve access, for example: the service has to be scheduled in advance and with alternate hours of operation; semi-annual campaigns to increase supply; educational actions and active search in the age groups recommended by the screening program with the purpose of identifying and capturing women who do not perform the Papanicolaou test.

Regarding the medical records that were not located and/or presented fields not filled in, in the basic unit, it is necessary to consider, for the legal and ethical aspect both for the patient and for the health professionals, that it is impossible to use data without being consistent, correct and complete.

This research has as much coverage as the participants regarding the context of their production. Nevertheless, when carried out in a single municipality, it does not allow generalizations regarding the topic addressed, in addition to not having accessed some information contained in the medical records of the BHU and in the *SISCOLO* information system due to its unavailability. Notwithstanding, the results are significant for the analysis of access and quality of the offer in basic care and may be used in theoretical comparisons related to the theme.

Considering the findings, the authors draw attention to the responsibility of health professionals who work in the health care of women, since the problem is not limited to the deficiency of technologies or health policies.

FINAL CONSIDERATIONS

Through this research was possible to highlight the population profile, which is mainly comprised by women: residing in the BHU headquarters region, within the age group from 35 to 44 years old, with less than one minimum wage in monthly income, married and/or single, and with incomplete elementary school and high school.

It was discovered that the precursor lesions (CIN I, II and III) of uterine cancer were concentrated in women between 40 and 60 years old, then not differing from other studies. It is possible to affirm that the coverage of preventive exams of cervical cancer from 2010-2013, by reaching only 65.6%, was very far from the one recommended by the Health Ministry and that the unit contributed, over the studied period, in decreasing order to cover exams, 12.15%, 11.26% and 5.58%, respectively.

The access to the Papanicolaou test, second the women's viewpoint, presents limitations due to the delay in attendance and low-resolution capacity. The conditions mentioned by the users often lead them not to return to the unit, so that it becomes essential that the unit starts seeking for new possibilities of organization of the service that responds to the needs presented, with extension to the network of health

services in the municipality, adapting the proposal of the single health system and the national policy of women's health.

Despite the satisfaction with the clinical performance of the nurse practitioner, there are still obstacles in the organization of the studied unit as an absence of welcoming and scheduling mechanisms that directly influence the access to the exam.

Hence, it is concluded that the actions developed have not been sufficient to improve the health care of women and do not directly influence the reduction of the carcinoma rates, since its prevention is based on access to the examination and the knowledge about its importance. It is crucial that the management and the health professionals can become attentive towards the improvements in the attention of the cervical cancer, then minimizing the health aggravations toward the most vulnerable population.

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