

Breast cancer: essential attributes of Primary Health Care in a border region

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ABSTRACT

Introduction: Breast cancer in Brazil is considered a public health problem, as it represents one of the main causes of death in female population. **Objective:** To analyze the presence of essential attributes of Primary Health Care in border region in the context of care for women with breast cancer. **Methods:** This is a qualitative research based on the Complexity Paradigm, held in Foz do Iguaçu, Paraná. In-depth interviews were conducted with 13 women diagnosed with breast cancer. Thematic analysis was chosen as a technique to analyze the material produced. **Results:** The following categories emerged: *Barriers to access services for women with breast cancer; (De)constructing the bond: women, professionals and health services; Fragmented care, focused on the biological: interference for comprehensiveness; and (Dis)coordination of care for women with breast cancer within the public health system.* **Conclusion:** The essential attributes of Primary Health Care were not present in their entirety for care for women with breast cancer, as difficulties in accessing primary care services, weaknesses in the construction and strengthening of bonds due to discontinuity of care were reported, attributed to the incipient coordination within the public health system. It points to the need to implement care strategies, with behavioral, functional and structural changes in health services at the border.

Keywords: breast neoplasms; Primary Health Care; border health.

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INTRODUCTION

Breast cancer is a public health problem and is the leading cause of cancer death among the Brazilian female population¹. In Brazil, the estimate for each year of the triennium 2020-2022 was 66,280 new cases of the disease².

In 2015, the Brazilian Ministry of Health edited the guidelines for Early Detection of Breast Cancer, based on scientific evidence, constituting a fundamental step towards the consolidation of practice³.

Primary Health Care (PHC) services are essential in actions to combat breast cancer, as they are considered the main model of care, the preferred gateway to the Brazilian Unified Health System SUS (*Sistema Único de Saúde*)⁴.

This ability to solve problems guided by PHC encompasses the follow-up of essential attributes of care⁵. The first contact implies accessing services for the problem or health monitoring. Longitudinality contemplates the provision of care on a regular basis, over time, in an environment of reciprocity between users, families and health teams. Comprehensiveness consists of services that meet the needs of the enrolled population,

accountability for other points of care. Coordination involves the ability to ensure continuity of care within the Health Care Networks RAS (*Redes de Atenção à Saúde*)⁵.

In this way, it is through essential attributes that PHC will be able to meet the needs of women with breast cancer, especially in environments of greater vulnerability such as border regions.

On the triple border of Paraguay, Argentina and Brazil, understanding the free movement of people brings challenges to the health system, requiring specific policies for these regions, considering the right to universal health care. However, this demand for health services can lead to system overload, and consequently, to (lack of) attention to complex demands⁶, such as breast cancer, considering the failures to promote health and prevent diseases, added to the inefficiency in urgent and emergency care^{7,8}.

From this, the guiding question is presented: How is the problem-solving of the health problem of women with breast cancer, from the diagnosis to the beginning of treatment, understanding it from the focus on essential attributes of PHC in the border region?

Thus, the objective was to analyze the presence of essential attributes of PHC in the border region in the context of care for women with breast cancer.

METHODS

Qualitative research based on the Complexity Paradigm⁹, which starts from a concrete experience of the discovery or originality of phenomena, is not limited to the simplified way of thinking and seeks to broaden the horizon of reflection by complex thinking⁹.

Seven principles guide complex thinking, and in this study four were used: Dialogic, Hologrammatic, Recursive and Organizational Circle. The justification for the use of this framework involves the complex nature of breast cancer, based on the analysis of attributes of PHC, especially in regions of greater vulnerability¹⁰.

The population consisted of women, over 18 years old, SUS users, undergoing treatment for breast cancer at the outpatient clinic of an oncology center in Foz do Iguaçu, Paraná, Brazil, after applying the exclusion criteria of having a diagnosis of a mental health problem in the medical record, not speaking Portuguese, not from Foz do Iguaçu and the need for hospitalization during the data search period. The sample resulted in 13 women.

In Foz do Iguaçu, outpatient and hospital care for individuals with breast cancer takes place at an oncology center, which assists SUS users, health insurance plans and private individuals, in western Paraná, as well as in Paraguay and Argentina. The flow of care through SUS for patients in the municipality happens through network referral, called Foz-Saúde, and via Regional Health to the other municipalities, and for health insurance/private patients, service is direct through the referral of the primary care physician.

Data search was carried out between March and June 2018, and the first contact occurred at an oncology center, when a participant sought the service for care, such as a medical appointment, to receive medication, nursing assessment, to perform exams, among others. At this moment, participants were invited to participate in the research, and the objectives were explained and signatures were collected through the Informed Consent Form. Then, a home visit was scheduled to conduct the in-depth interview. At this stage, one of the researchers, who is a nurse with professional experience in women's health, had in her possession a field diary as an additional resource to record the aspects of the environment, as well as the researcher's impressions regarding the repercussions of breast cancer for the research participants.

The interviews, lasting an average of 40 minutes, were audio-recorded and transcribed in full, and, after completion, participants were made available to listen for consent. For three participants, there were family members present, but without their participation.

The analysis of the results occurred through thematic analysis¹¹, which was organized in three phases: pre-analysis of all material, exploration of the collected data and treatment of results and interpretation, which resulted in four thematic categories.

The study was approved by the Research Ethics Committee, under Number 2,483,312, in 2018, and complied with Resolution 466/2012. To ensure anonymity, participants were identified by the letters "PW" (participating woman) and the subsequent number of the interview.

RESULTS

Participants aged between 33 and 68 years old were mostly white, Catholic, with complete high school, married or in a stable union, had their own house, paid work, average income of R\$2,061.50 (about US\$374.32), without government assistance and SUS users. Four categories emerged from the analysis of the results for discussion, described below.

Barriers to accessing care services for women with breast cancer

In search of care, women described barriers to access health services. The geographic barrier was linked to organizational ones, leading to the search for other services and professionals, far from their home, even across the international border, in Paraguay, using sometimes inadequate means to access the health system and obtain care.

"I think I went twice [health center], because they refer me to another place. From this place they forwarded it to another place" (PW3).

“There is no gynecologist in the unit. I went to a physician at another health center, there was a gynecologist there. I can’t go to the other. I went using my daughter’s address” (PW4).

“In Paraguay, there are also a lot of things that are free and faster, right? So, I had the consultation there, but later I learned that in Paraguay there was no way to treat” (PW5).

Organizational barriers were identified by the organization of health services, expressed by the inflexible appointment scheduling and the redirection of the user to various services, making it difficult to provide the care that women need.

“We are never assisted. How many times I went to the health center dying, being carried and had to schedule, they didn’t assist on time. On Thursday, the physician does not attend because he makes visits, on Wednesday it is only for pregnant women. Then there’s only Monday and Tuesday, because on Friday they have a meeting” (PW3).

“The physician got sick, they didn’t want to give me another exam or refer me to another physician. The girl said she had to wait three months, if the physician didn’t come back in three months, then they would go to another physician” (PW7).

“You have to get a referral and go to another place, to take exams you have to go to other places. Here they don’t do it anymore” (PW8).

The lack of communication between the different points of attention of the RAS and the lack of accountability by users also proved to be organizational barriers that weakened access to women with breast cancer.

“I went for a visit at the health center. The physician said that I would need to see a mastologist, who would be there in oncology. They said that the physician there is no longer attending because he retired. There is no other physician who attends through SUS. I told the girl [health center receptionist] to call the oncology department. She called and they said that the physician is attending the oncology center” (PW7).

Participants considered public health services remiss and in order to be able to perform the exams for the diagnosis of breast cancer, they sought private health services, even in the neighboring country, Paraguay, thus showing the presence of geographic and organizational barriers for access to exams.

“The physician ordered the ultrasound and they told me that they would put me on the waiting list, so I went to do it in the private service in the same week” (PW3).

“I went, did and paid for the mammogram in Paraguay” (PW7).

(De)constructing the bond: women, professionals and health services

Regarding Basic Health Unit (BHU) professionals, it was found that women identified responsibility for consultations, treatment and referrals, strengthening longitudinality and care.

“I trust them [BHU professionals], if the solution is not there, they refer me” (PW2).

“He [physician] said he would call there [oncology center] and ask for me to be the first in line, things as such, to speed up, referral such as” (PW6).

However, there were also reports of inconsistencies in trust relationships as well as in the accountability of these professionals.

“Because the nurse, if it were up to her, I wouldn’t even have done the ultrasound, because she didn’t want to schedule” (PW3).

“[...] I kept waiting for them to find the referral for an ultrasound, but I didn’t realize it, it took about three or four months [...] (PW10).

It can be seen, in the testimonies, that for some participants the relationship of trust and accountability proved to be weakened, reaching the point of affecting attention, by health centerponing the diagnosis and beginning of treatment. However, with regard to the oncology center service and professionals - specialized service, the relationship was satisfactory, thus highlighting the longitudinality of care.

“Very good, from cleaning women to physicians like that, very good, 100% good service” (PW5).

“I started treatment there [oncology center], but I didn’t know that there were physicians, receptionists, nurses, nutritionists, psychologists, cleaning women. They are very good at treating us. They are really sweet, they treat us well” (PW10).

Upon arriving at the PHC services, participants informed health professionals about their clinical history, considering that they were unaware of it. This and the lack of dialogue were identified as aspects that undermine longitudinality and comprehensive care.

“They [PHC professionals] found out after I had the surgery. Now they know, but no one talked or asked how I was. I went there to

do all the dressings, but no one asked if I needed to get back to the physician for something. There no one asked anything” (PW8).

“I told them [PHC professionals] I had a problem, breast cancer” (PW13).

Participants also mentioned the high turnover of BHU professionals, identifying it as an aspect that hinders the construction of the relationship over time between health professionals and women with cancer.

“I can’t say who are the professionals at the health center, it’s a lot of different people” (PW11).

“I know little [PHC professionals], it’s just that they change a lot” (PW12).

Fragmented care, focused on the biological: interference for comprehensiveness

Participants talked about a fragmented care, to the detriment of health promotion and prevention, focused on the biological character, on the disease, causing obstacles to comprehensiveness.

“Then he [physician] came, looking at the floor with his hands behind his back, stopped in front of me, looking at the floor and didn’t even look at my face, and said where is it? I showed it like this, he came with his finger like this and came back and didn’t say anything. I thought, is this the way to consult? I thought it was weird, but I kept quiet.” (PW3).

“I myself only go there [PHC service] to get a prescription for the medication” (PW9).

Differences were found between the BHU for comprehensiveness, with regard to referrals to exams or specialist physicians, delaying treatment, due to the absence of technologies for the construction of comprehensive care.

“When she [physician] examined me, she already referred me” (PW1).

“I also went to see an optician because I’m losing my eyesight a lot, I’m in line, you have to wait” (PW5).

“It took a fortnight to make an appointment, another fifteen days for me to get to the hospital, it even took a fortnight for them to call me because I was on the waiting list. As soon as they called me, it took another fifteen days to schedule an appointment at the hospital, it wasn’t overnight, it took a long time” (PW11).

(Dis)coordination of care for women with breast cancer within the public health system

As an expression of the fragility of coordination of health services for the care of women with breast cancer, participants reported factors that make medical care difficult, inflexibility of arrival times at the unit (need to arrive at the service well in advance) and facing the lines, making this service unresolving and challenging.

“Often, they don’t even assist us there. Sometimes, we arrive dying and have to make an appointment for when there is a vacancy. Until there’s a vacancy you’ve already healed or died” (PW3).

“[...] we have to go very early, like five o’clock or five-thirty already have to be there” (PW12).

Another important factor is the divergence of information among professionals, which results in a search for attention in other points of the RAS and PHC is no longer the preferred gateway to the health system. Disorganization of the service generates distrust, impairs problem solving and weakens the accountability of care for women with breast cancer.

“I went to the health center there and the girl said she wasn’t even going to schedule an appointment for me, because that’s mastitis. I went to the emergency room, they saw me, I had an ultrasound, and I have four tumors and they are already big. Then the physician there [emergency care] said he had to look for the physician here [health center]. So, I went there last week and the physician here was angry because I went to look for another physician, then I said that I came here and the secretary and the nurse did not want to make an appointment” (PW4).

“I went straight to the hospital, because if I had to go to my health center for them to make an [appointment] it would definitely take much longer” (PW11).

Difficulties in accessing and lengthy examinations essential for diagnosis were also mentioned, highlighting the fragility of coordination.

“It took two years [ultrasound], after I had surgery, chemotherapy and radiotherapy. How will you trust? People die and have no care” (PW3).

“If I needed to do any tests, I had to ask the physicians at the hospital. Same ultrasound, because there [BHU] they were not releasing anything, not even a blood test” (PW11).

“[...] it takes a long time to take the exam at the health center, even to release the paperwork, it took a long time. It took about four months, five months around” (PW12).

The fragile care offered by professionals and the barriers to entry into the reference service were mentioned as impeding factors for problem solving and health care for women with breast cancer, characterizing the lack of coordination.

“Breast cancer is a disease that evolves very fast and disease does not wait? And you have to depend on one and the other, to release this, wait for the system to call you, and the secretary will call you to schedule an appointment” (PW11).

DISCUSSION

Health practices for caring for women with breast cancer in a border municipality pointed out difficulties in PHC, with weaknesses for the construction and strengthening of bonds with services from discontinuity of care, which proved to be fragmented, focused on the biological, attributed to the lack of access and inexperience in coordination within the public health system.

The scientific literature describes barriers to access to health services, especially in border regions, considering overload in services due to the geographical proximity between countries, insufficient public health services in neighboring countries, ease of care and quality of health care in SUS¹². These aspects result in lack of assistance for the local population, with regard to the promotion, prevention and treatment of diseases.

In this study, the geographic and organizational barriers stood out, due to the distance and time spent by users to obtain health care and the way that services are organized to assist their users¹³, making the timely treatment of breast cancer difficult.

Regarding the protocols of care in PHC and the rigidity in the BHUs' opening hours, it is noteworthy that these can affect health practices. Overload in health services due to intense spontaneous demand in these regions¹² and lack of professionals were points evidenced as organizational barriers¹⁴.

Faced with overcoming barriers to access, the participants used persuasion to overcome challenges and ensure care, even needing to cross the international border to have access to the service they need, considering the speed and a more affordable cost. This is necessary because many professionals are linked to bureaucratic relations, which make them not very welcoming and articulators of mismatched information¹⁵, especially when it comes to users who seek health care outside their country of residence¹⁶.

Another important aspect to be highlighted are relational skills, psychosocial preparation to support health interventions and humanized care. Therapeutic linkage and accountability should be

part of the daily lives of women with breast cancer, who become fragile when there is no continuity of care^{5,17}.

The lack of accountability on the part of professionals and services portrays situations of abandonment and distrust. Reception is an essential health action for longitudinality¹⁷.

Some participants described that the nurse was an agent that hindered the longitudinality. This, often the service coordinator, can and should manage in a facilitating way, creating opportunities for longitudinal care, motivating the team to perform qualified and integrated care, in view of its practical-scientific competence and its role in the health-disease process¹⁸.

Longitudinality is constructed from dialogue, listening and interaction between subjects and trust between professional-user¹⁹ and can become a challenge for teams in constant rotation. The lack of communication between services prevented the sharing of information between PHC and specialized care, essential for continued and comprehensive care^{5,20}.

For PHC, generating comprehensive health is paramount and not only involves changing behaviors towards individuals, but the use of soft, soft-hard and hard technologies, which complement health actions²¹. Women with breast cancer have not always had access to these care technologies.

In more than three decades, SUS still faces challenges, a consequence of political and economic contexts that result in lack of budget, underfunding and government and population instability^{22,23}, especially in border regions, due to the lack of specific and effective health policies to meet the cross-border contingent.

The aggravating factor that converges with (dis)coordination of health in border regions involves the inability of health systems to provide adequate resources to meet people's demands, especially for breast cancer. These challenges need to be overcome within SUS, particularly in regions of vulnerability^{5,24,25}.

Care for women with breast cancer in PHC is considered a complex process, because each link between its attributes has unique characteristics that differ from each other and involve unique professional-users and in different settings^{5,26,27}. It is relevant to exalt the relationships between each phenomenon and its context, i.e., how a local change is reproduced in the whole (SUS) and how a change in the whole is reproduced on the parts (PHC)²⁸.

Based on the Complexity Paradigm, the Dialogic Principle was portrayed in duality⁹. From the Dialogic Principle, contradictions are perceived between what is recommended by SUS laws and protocols with what is developed in practice^{7,25}. In the access, longitudinality, comprehensiveness and coordination of care to women with breast cancer the contradictions and discrepancies of ideas and circumstances that appeared.

For access, divergences are related to the lack of reception in the spheres of care. Parts related to geographic (need to cross the international border to access diagnostic tests, at an affordable price) and organizational (fragility in the flow, structuring

and organization of care for women with breast cancer at the municipal level) barriers made it difficult to contemplate the whole, which involved access to health services for diagnosis, treatment and cure of breast cancer.

For longitudinality, the contradictions listed referred to non-responsibility, absence of bond, lack of communication and distrust among professional users, with emphasis on nurses.

The contradictions reported for comprehensiveness were related to the biological and fragmented look to the detriment of health promotion and disease prevention, added to the inefficiency of the technology management process to structure comprehensive care. For coordination of care, divergences involved difficulties in obtaining medical consultations, lack of care flows for reference services in oncology, disagreement between professionals, slowness in the acquisition of exams and ineffective care of health professionals.

Considering the disorders listed based on attributes of PHC and the complexity of the border, the Dialogic Principle makes it possible to contemplate how health services face daily challenges. For a successful PHC, it is necessary to articulate the attributes, organized in an efficient RAS, humanization and inter-country agreements in order to strengthen joint public policies. Professionals need to understand that in situations of “disorders”, it is relevant to reflect to find out if PHC has been efficient within the scope of SUS²⁸.

When the Hologrammatic Principle is associated with attributes of PHC, it is understood that it is necessary to consider that health professionals must know conceptions of care, using attributes of PHC⁵ as a tool to build care and its dynamics with the RAS²⁸.

The figure of PHC is used to understand the specificities and varieties that remain linked to each other in the search and determination of comprehensive care, with efficient practices to care for women with breast cancer. In this scenario, when faced with

social, epidemiological and demographic factors, determinants for the risk of becoming ill, from the perspective of the Recursive Circle Principle, relations and decisions can determine actions and extend care^{9,10}. The effects are causes and producers of the process itself, for women with breast cancer, this principle was expressed in the problems experienced in access, longitudinality and comprehensiveness.

For the Organizational Principle, it is observed that PHC must be as a complex movement in which the attributes proposed for care construct the whole, composed of several parts^{9,15}. This principle provided an understanding of how participants organized themselves (parts) to achieve the attributes (whole) proposed and obtain comprehensive care. In addition to this, to understand how the RAS are organized, it was necessary to know the PHC and the reference service for oncology (the parts) in a border context and the health system and the connections of care actions (the whole).

Connecting the principles of complexity theory with attributes of PHC and breast cancer allowed us to reflect on the health system in the face of a complex problem. Both professionals and users live in a health system with restrained and bureaucratized norms, rules and routines that need to be faced and overcome daily to achieve health care⁹.

To conclude, the study pointed out that essential attributes of PHC were not present in its entirety for the care of women with breast cancer, and although it has shown the complex and vulnerable situation for health care to users in a border region, it reflects the scenario experienced by the population for health care in a large part of the Brazilian territory.

Regarding the study limitations, only women living in Brazil participated, considering the difficulties in acquiring authorizations from services in neighboring countries for data collection. This fact may have made it impossible to understand the rearrangements of public health systems in Paraguay and Argentina, from the perspective of users, to treat breast cancer in the border region.

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