



Health education for indigenous women about breast and cervical cancers

Educação em saúde para mulheres indígenas sobre cânceres de mama e de colo uterino

Educación en salud para mujeres indígenas sobre cánceres de mama y del cuello uterino

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ABSTRACT

Objective: To describe the practical experience of a health education action with indigenous women on breast and cervical cancers. **Data Synthesis:** This is an experience report, conducted by multi-professional residents in Family and Community Health through action in collective health, carried out in June 2017, with adult and elderly women in the Nazaré indigenous community, located in the Lagoa de São Francisco, Piauí, Brazil. The theme of this action was the prevention of breast and cervical cancers, and it was decided to use the “myth or truth” dynamic, in a facilitation conducted by preceptors with their residents, which allowed them to add scientific and popular knowledge, clarify doubts and promote health education. **Conclusion:** The moment provided an emancipatory space for teaching and learning, so that debating the theme of breast and cervical cancers, within an emancipatory environment, required the facilitators to manage the use of a methodology based on Popular Education in Health, enabling the communication with the target audience based on their specificity, this being the greatest learning for the future practices of the program’s residents.

Descriptors: Health of Indigenous Peoples; Health Promotion; Women’s Health.

RESUMO

Objetivo: Descrever a vivência prática de uma ação de educação em saúde com mulheres indígenas sobre os cânceres de mama e cervical. **Síntese dos dados:** Trata-se de um relato de experiência, realizada por residentes multiprofissionais em Saúde da Família e Comunidade por meio de uma ação em saúde coletiva, efetivada em junho de 2017, com mulheres adultas e idosas na comunidade indígena Nazaré, localizada no município de Lagoa de São Francisco, Piauí, Brasil. A temática dessa ação era a prevenção dos cânceres de mama e cervical, e optou-se por utilizar a dinâmica de “mito ou verdade”, numa facilitação conduzida por preceptores com seus residentes, a qual permitiu agregar conhecimento científico e popular, esclarecer dúvidas e promover a educação em saúde. **Conclusão:** O momento proporcionou um espaço emancipador de ensino e aprendizagem, de modo que



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debater a temática dos cânceres de mama e cervical, dentro de um ambiente emancipatório, exigiu dos facilitadores o manejo do uso de metodologia baseada na Educação Popular em Saúde, possibilitando a comunicação com o público-alvo a partir de sua especificidade, sendo este o maior aprendizado para as práticas futuras dos residentes do programa.

Descritores: Saúde de Populações Indígenas; Promoção da Saúde; Saúde da Mulher.

RESUMEN

Objetivo: Describir la vivencia práctica de una acción de educación en salud con mujeres indígenas sobre los cánceres de mama y cervical. **Síntesis de datos:** Se trata de un relato de experiencia realizada por estudiantes multiprofesionales de Salud de la Familia y Comunidad a través de una acción de salud colectiva en junio de 2017 con mujeres adultas y mayores de la comunidad indígena Nazaré localizada en el municipio de Lagoa de São Francisco, Piauí, Brasil. La temática de la acción ha sido la prevención de cánceres de mama y cervical con la dinámica de "mito o verdad" realizada durante una facilitación dirigida por preceptores y sus estudiantes la cual ha permitido unir los conocimientos científico y popular, aclarar las dudas y promocionar la educación en salud. **Conclusión:** El momento ha ofrecido un espacio emancipador de enseñanza y aprendizaje de tal manera que el debate de la temática de los cánceres de mama y cervical en el ambiente emancipatorio ha exigido de los facilitadores el manejo del uso de metodología basada en la Educación Popular en Salud permitiendo la comunicación con el público propuesto a partir de su especificidad que ha sido el mayor aprendizaje para las prácticas futuras de los estudiantes del programa.

Descriptores: Salud de Poblaciones Indígenas; Promoción de la Salud; Salud de la Mujer.

INTRODUCTION

Brazil is considered a country of wide cultural diversity and one that presents challenging intercultural issues, especially concerning the health of indigenous peoples. The Brazilian Institute of Geography and Statistics (Instituto Brasileiro de Geografia e Estatística - IBGE), in its last demographic census, identified 896,917 thousand indigenous people (self-declared), the largest share living in rural areas (572,083 thousand), while the rest migrated to urban areas (324,834 thousand). From the data, there is a considerable demographic growth, which highlights the need for public policies designed by managers and administrative bodies that care for these peoples^(1,2).

The migratory process of indigenous peoples to cities is a phenomenon that results from the constant decrease in their reserves, the need for health services, and a greater relationship with contexts that differ from their daily lives, caused by the approximation of villages with urban peoples⁽³⁾. Contact with civilization leads to an increase in infectious diseases, which are among the biggest causes of death among indigenous peoples in Brazil. However, in recent years, there has been an increase in morbidity and mortality due to external causes and chronic non-communicable diseases (NCDs), with emphasis on diabetes, arterial hypertension, obesity and also neoplasms, resulting from the epidemiological transition scenario that these people have experienced in past decades⁽⁴⁾.

The indigenous population faces several barriers to access to health: physical isolation, inadequacy in the organization of health services, problems in referral to specialized care, lack of culturally appropriate educational materials, and also the contempt of the ethnic perspective in their therapeutic process. Despite the availability of health actions available through the Unified Health System (*Sistema Único de Saúde - SUS*), barriers (indigenous ways of life, languages, cultures, and organization of services) hamper the access of indigenous women to the screening and treatment of breast and cervical cancer⁽⁴⁾.

According to estimates by the National Cancer Institute (*Instituto Nacional de Câncer - INCA*), 316,000 new cases of cancer will be diagnosed in women across Brazil in 2020 (not including non-melanoma skin cancer), with an estimated incidence of 145 new cases per 100,000 inhabitants. It is estimated that breast, colorectal and cervical cancers are the most prevalent in female patients, with 61.61, 19.03 and 15.43 new cases per 100 thousand individuals for each year of the triennium 2020-2022, respectively 29.7%, 9.2% and 7.4% of the total neoplasms⁽⁵⁾.

The first study that analyzed breast cancer mortality in the Brazilian indigenous population found a total of 82 deaths in women between 2000 and 2010. The comparison of crude rates - deaths per 100 thousand women - of 4.72 (in 2000) and 1.97 (in 2010) shows that they are lower than those found in the white population - 46.02 and 53.21, respectively, in the years 2000 and 2010 calculated in the same study. Possible underreporting is attributed to this discrepancy, the low incidence of breast cancer, as well as the pattern of distribution of risk factors in this population⁽⁶⁾.

In Australia, 25% of all diagnosed cancers occur in indigenous women⁽⁷⁾. Worldwide, cervical cancer is the second most common malignancy affecting women, responsible for 471,000 new cases per year and about 230,000 deaths

annually on all continents⁽⁸⁾. In Brazil, there are an estimated 16,590 new cases of cervical cancer for each year of the 2020-2022 triennium, with an estimated risk of 15.43 cases per 100,000 women⁽⁹⁾.

In indigenous women, cervical cancer is considered responsible for high rates of morbidity and mortality, with rates twice as high when compared to non-indigenous women. Studies describe the evolution of human papillomavirus (HPV) infection in this population, as well as evidence the difficulty in accessing these women to complementary diagnostic tests and treatment. A survey carried out at a referral hospital in oncology in the state of Pará, located in the Brazilian Amazon, pointed out that cervical cancer was the malignancy with the highest incidence in indigenous adult women between 2001 and 2011 (76.69% of cases), corresponding to 48.93% of the consultations in the entire indigenous population. An overall HPV prevalence of 39.7% was found in indigenous women from the far north of the Brazilian Amazon, especially in the Yanomami ethnic group⁽⁹⁾.

In other countries, the prevalence of cervical neoplasia among indigenous women deserves to be highlighted. A cross-sectional study investigating HPV infection rates in indigenous women in Australia found a prevalence of 36%⁽¹⁰⁾. A survey carried out with indigenous women from the district of Caaguazú, in Paraguay, during the years 2015 to 2017, showed a prevalence of 13.18% of precursor lesions of cervical cancer⁽¹¹⁾.

Cervical cancer is identified as a serious public health problem, since it is one of the most common tumors among the female population and responsible for high rates of morbidity and mortality in the world. Despite this, because it is a slow evolution change and takes years to reach an invasive stage, cervical cancer has a high potential for the cure when diagnosed early⁽¹²⁾.

The Ministry of Health (*Ministério da Saúde - MS*), within the National Health Policy, prepared the National Policy for the Attention to Health of Indigenous Peoples (*Política Nacional de Atenção à Saúde de Povos Indígenas - PNASI*), a proposal for the indigenous population to have quality access, as well as a differentiated service by SUS, which takes into account their cultural specificities. Currently, Indigenous Health Care is divided into subsystems, in an organization formed by Special Indigenous Health Districts (*Distritos Sanitários Especiais Indígenas - DSEI*), articulated with SUS. DSEIs are decentralized management units, responsible for the administrative and organizational structure of SasiSUS (Subsystem for Attention to Indigenous Health), and articulate indigenous health in an inter-federative way with municipalities, health regions, and states⁽³⁾. PNASI was instituted to adapt the differentiated rights constitutionally guaranteed to the indigenous population, however, there are still difficulties in questions regarding the relationship between gender and health⁽¹³⁾.

The literature calls attention to the vulnerability of indigenous women in the development of diseases and nutritional deficiencies due to physiological and hormonal changes that occur throughout life⁽¹⁴⁾.

Given the above, through their historical and social conditions, indigenous women need special attention, aimed at preventive health actions, aiming at improving life habits and reducing the incidence of diseases, respecting and restoring, mainly, their cultural values⁽¹⁵⁾.

Thus, the involvement of health professionals in cancer prevention actions occurs to the extent that, today, it is a public health problem. The professional must act in the educational process, being responsible for disseminating information regarding breast and cervical cancers to the population, identifying the risk factors of that community, carrying out prevention and early detection actions, and guiding healthy habits⁽¹⁶⁾. It is still relevant to discuss, through health education, myths and truths ingrained in this population about the prevention of breast and cervical cancers.

The National Health Promotion Policy instructs on the valorization of popular and traditional knowledge and integrative and complementary practices for health promotion, consolidating practices aimed at individuals and collectivities is imperative, in a perspective of multidisciplinary work, integrated and in networks, meeting the health demands of the population, with an articulated action between the various actors, in a given territory⁽¹⁷⁾.

Given the above, it is highlighted that Primary Health Care focuses on triggering assistance and educational actions in indigenous communities, for health promotion and disease prevention, which can collaborate to improve the community's living conditions, proposing more effective care projects that are consistent with the understanding and reality of each population group⁽¹⁸⁾.

In a study conducted in the Oriximiná Region, Pará, Brazil, it was mentioned that, in an assembly held with indigenous women, held in May 2016, whose main focus was the health of women, which was attended by nurses who represented the Special Secretariat for Indigenous Health (Sesai), many of the claims raised by women had never been exposed or debated in other assemblies. In addition to exposing more general health service needs, which are already common in other discussion spaces - such as the lack of health spaces, the need to hire an indigenous health agent and the provision of sufficient medicine in the villages, for the first time, peculiar issues related to the health of indigenous women were shown, such as the lack of gynecological stretcher, the lack of adequate structure for gynecological examinations in the villages and the unhealthy reception rooms for women in the puerperium at the Casa de Saúde Indígena (Casai) in the city⁽¹⁹⁾.

The mention of the issue of childbirth in the urban area also drew attention, even in the same study⁽¹⁹⁾, since indigenous women declared that they were not satisfied with being induced to give birth in the city, because doctors do not allow them to enter accompanied and do not authorize the delivery to be performed according to their customs at the hospital. They also pointed out that, in hospitals, the baby's umbilical cord is cut and thrown away, without the mothers' consent, which is not a desirable practice for this population, full of customs and rituals.

The Attention to Indigenous Health is, therefore, a peculiar space of care. Thus, clinical knowledge is relevant for health professionals; however, to meet the proposal of multi-professional residency, in this study, prevention of breast and cervical cancers, communication strategies, and health education will be placed on the agenda, solving doubts of indigenous women regarding the exam, which will allow residents to develop a broader view of health for these women.

Given the context pointed out above, the present study aimed to describe the practical experience of a health education action with indigenous women on breast and cervical cancers.

DATA SYNTHESIS

This is an experience report from a health promotion activities carried out with adult and elderly women of the Tabajara ethnicity, in the Nazaré indigenous community, located in the municipality of Lagoa de São Francisco, Piauí, Brazil, approximately 250 km from the capital of the state.

The visit was the result of an articulation previously carried out between the State Health Secretariat of the State of Piauí (Sesapi), the Multiprofessional Residency Program in Family and Community Health (RPFCH), linked to the State University of Piauí (Uespi), municipal managers of the city visited and the team of the Technical Commission of the Special Indigenous Sanitary District (DSEI), who ensured the necessary conditions for access to the community, being carried out overland.

Sesapi's Direction of Health Surveillance and Attention Unit (*Diretoria de Vigilância e Atenção à Saúde - DUVAS*) and its technical coordinators work with indigenous peoples as part of the *Piauí Tem Índio Sim* project, from the state government of Piauí. This is a project launched in April 2016 that aims to map indigenous territories in the state, identifying existing communities and ensuring the expansion and improvement of access to health care for these peoples⁽²⁰⁾.

The meetings were conducted by residents of the Multiprofessional Residency Course, under the supervision of the preceptors, and the target audience was indigenous women. The content taught during the meetings took place through actions to prevent cervical and breast cancer⁽²¹⁾, chosen by the authors and indigenous women who reported having many doubts and questions about this subject.

The Nazaré indigenous community has a Basic Health Unit (*Unidade Básica de Saúde - UBS*), centrally located and easily accessible, being the location chosen for the activity, since, in parallel, the cytopathological exam was being collected from indigenous women for cervical cancer screening. The physical structure of this UBS, destined to serve the community, lacks an area for meetings and health education, not complying with what is recommended by the Ministry of Health for the allocation of a Family Health team⁽²²⁾. Thus, for the proposed health education activities to be offered, the external space of the UBS was used, in the shade of a tree capable of accommodating all participants.

The health unit has few chairs and only a masonry bench for the allocation of patients. Thus, assistance was requested from the villagers, who promptly lent chairs for the success of the activity. Over time, it was found what the functions and the purpose of this experience would be: promotion, prevention, and recovery of health, using Popular Health Education as an approach⁽²³⁾. A fundamental element of this method is the fact of adopting, as a starting point of the pedagogical process, the prior knowledge of the student, taking into account their historical, social and political determinants, seeking to provide their autonomy.

In this circumstance, it is emphasized the importance of planning a health practice that is not limited to a centrally and/or vertically transfer of ideas or knowledge but to think of an activity that allows problematization and construction, in which participants can establish a dialogue, build and deconstruct concepts, and exchange knowledge⁽²³⁾.

The action consisted of a meeting, held in June 2017, with women only, with the participants divided between the morning and afternoon shifts. We chose to use the "myth or truth" dynamic⁽²⁴⁾, in which each participant receives a plaque with two sides: a red, with "myth" written on it, and a green, written "truth".

The residents, mediators of the activity, read everyday cases that contained statements about the prevention of these two types of cancer, as listed below: "Maria is 60 years old and believes that she no longer needs to have a cytopathological exam because she is already old"; "Teresinha had her uterus removed and says she will no longer do the gynecological exam"; "Francisca had sexual intercourse the day before taking the gynecological exam and,

for this reason, she did not come to the Health Center to do it"; "Ivonete heard from a friend that she must have a gynecological exam every six months to discover cervical cancer"; "Marinete is 53 years old, feels healthy and believes that it is not necessary to go to the health clinic to have tests to find out if she can have breast cancer"; "Rosilda does the breast self-examination, as she believes that it will help her to detect breast cancer".

As each of the cases was read, the participants turned the signs with their answers and gave their opinion on it, thus allowing them to recover the knowledge of each participant and take into account their knowledge and practices. From there, the residents combined their knowledge with that of the participants and closed each case.

When it comes to indigenous health, educational activities need differentiated attention, and they should consider the epidemiology, culture, and possible operational specificities of this public, since these people's health-disease process preserves their traditions, their dialect, and their culture. In this regard, health educators must mediate the tradition of indigenous knowledge with the resources and knowledge of Western medicine⁽²⁵⁾.

During the period of development of the health education activities for the prevention of cervical and breast cancers, important findings were observed, such as the adherence to the proposed activity and also relevant reports of care that women in the community use to promote their health. It was observed, during the realization of the "myth or truth" dynamic, that women think that the exam is only used to identify gynecological disorders, and not as a method of screening for cervical cancer.

Health professionals must be prepared to guide women regarding cytopathological examination, as it is the best strategy for the early diagnosis of cervical cancer precursive lesions⁽²⁶⁾. It is also verified that the lack of knowledge about the purpose of the exam and the disease can harm women in preventive care, as they only seek the Basic Health Unit (UBS) to perform the exam when they have some vaginal discharge caused by bacterial or fungal infections, which can interfere with the collection of cervical cells. A study that analyzed cancer mortality in indigenous peoples in the state of Acre, Brazil, identified cervical cancer (36.4%) as the leading cause of cancer death among indigenous women⁽⁴⁾. Internationally, Australia, a country where indigenous women have shown a notably higher prevalence of cervical abnormalities than non-indigenous women, has advanced in preventing cervical cancer among women through Australia's National Cervical Screening Program (NCSP), introduced in 1991⁽²⁷⁾.

When the case for discussion of the age range recommended by the Ministry of Health was read, there was a lack of knowledge about the age for the exam, because there were several elderly women over 64 years old and with two negative results in the last three years who still felt that the exam was necessary. The Ministry of Health recommends women between 25 and 64 years old as a priority group for cervical cancer screening⁽²⁶⁾.

The incidence of invasive cervical cancer in women up to 24 years of age is very low, and screening is less efficient to detect it. On the other hand, early-onset would represent a significant increase in diagnoses of low-grade injuries, with a high probability of regression, and would lead to a significant increase in colposcopies and an increase in the likelihood of overtreatment, causing a greater risk of obstetric and neonatal morbidity associated with a future pregnancy⁽²⁸⁾.

There is less objective evidence about when women should finish cervical cancer screening. Women with negative cytological screening between 50 and 64 years old expose an 84% low risk of having an invasive carcinoma between 65 and 83 years old compared to women who were not screened. Thus, it is considered that 64 years old, the woman's age without a previous history of the pre-invasive disease to end the screening, is in agreement with the most current knowledge and with the current recommendations⁽²⁸⁾.

It is noteworthy that there was a case that discussed the exam in hysterectomized women. Addressing it was important for the residents because many women who participated in the activity had undergone a total hysterectomy and believed in the need to continue taking the exam. According to the Ministry of Health⁽²⁶⁾, in situations of subtotal hysterectomy (with the permanence of the cervix), a screening routine should be followed, but screening is no longer performed in cases of total hysterectomy, since the possibility of finding injury is low. However, if hysterectomy occurred as a therapeutic resource for cervical cancer or precursor lesion, it is recommended to perform the exam to control and track new lesions.

During the "myth or truth" dynamic, the theme was also addressed: having sex the day before the exam harms the result. Many women were already aware that having sex on the previous day does not affect the exam and they also stressed that they needed only good hygiene. The facilitators added to the information that only the condom lubricant can impair the reading of the slide⁽²⁹⁾, however, it is opportune to carry out the preventive exam taking advantage of the fact that the woman is present at the UBS.

At the end of the dynamic, the women present were shown the technique of performing breast self-examination, as well as the importance of conducting clinical examination by professionals and mammography. Indeed, breast self-examination should not replace the clinical examination performed by the professional, but it is important to encourage

its performance so that women know their bodies, thus being able to detect possible changes in the breasts. It was emphasized that, even if the woman has no complaints regarding the health of her breasts, it is important to have a mammography of women who belong to the age group between 50 and 69 years old. Mammography is currently considered the most reliable and effective technique for the detection of breast cancer, constituting the ideal method for the identification of subclinical lesions⁽³⁰⁾.

To end the health education activities, a space was opened for women to report a little about their health care. Women reported that it is common to use plants in their health practices, such as herbal medicines, in the form of “garrafadas” and teas. It is known that, in recent years, the Ministry of Health has recognized the use of plants as an integrative and complementary practice of health, being a tradition of indigenous peoples⁽³¹⁾.

FINAL CONSIDERATIONS

The action carried out in the Nazaré indigenous community proved to be extremely relevant, as it made it possible for residents to work on health promotion with indigenous women through an education capable of problematizing and building, intertwining scientific knowledge with popular knowledge. This moment provided an emancipatory space for teaching and learning so that debating the theme of breast and cervical cancers within an emancipatory environment required the facilitators to manage the use of a methodology that would enable communication with the target audience, considering their specificity as an indigenous population, which is the greatest learning for the future practices of residents of the program.

It was also verified the relevance of promoting health among indigenous adult and elderly women since breast and cervical cancers have reaped many lives annually, even though it is an easily prevented pathology and with preventive exams offered free of charge in Primary Care the health.

CONFLICTS OF INTEREST

The description of experience is not related to any type of conflict of interest.

CONTRIBUTIONS

All authors contributed to the preparation and design of the study; the acquisition, analysis and interpretation of data; writing and / or revising the manuscript.

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