

ACCESS TO PRE-NATAL CARE AND CERVICAL CANCER PREVENTION ACTION AMONG WOMEN FROM BRAZILIAN LANDLESS WORKERS MOVEMENT

ACESSO DAS MULHERES DO MOVIMENTO SEM TERRA AOS CUIDADOS DO PRÉ-NATAL E DA
PREVENÇÃO DE CÂNCER DE COLO UTERINO
ACCESO AL CUIDADO PRENATAL Y PREVENCIÓN DEL CÂNCER CERVICAL DE LAS MUJERES
QUE PERTENECEN AL MOVIMIENTO SIN TERRA

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KEY WORDS: Rural population. Women's health. Delivery of health care. Health services accessibility.

ABSTRACT: This is a qualitative research that aimed to investigate Brazilian Landless Workers Movement women's access to pre-natal care and cervical cancer prevention. Interviews were done in 2005 with five women in the city of Cajamar, Brazil. The thematic analysis of content made it possible to evidence that access barriers such as territorial delimitation and geographical distance let women use false addresses as mechanisms to receive care. Pap smear tests were performed only during pregnancy. Health care provided for these women was fragmented and they received care solely because of their reproductive condition. Access to health services must be understood as continuous and complete assistance in all phases of a woman's life and they consist of a challenge to reach rural women. Improving access to information and education for these women corresponds to the possibility of exercising the universal right of access to health care based on the principle of equity.

PALAVRAS - CHAVE: População rural. Saúde da mulher. Assistência à saúde. Acesso aos serviços de saúde.

RESUMO: Trata-se de estudo qualitativo com o objetivo de investigar o acesso das mulheres do Movimento dos Trabalhadores Rurais Sem Terra ao pré-natal e prevenção do câncer de colo uterino. Foram realizadas entrevistas com cinco mulheres, no município de Cajamar, Brasil, 2005. A análise temática de conteúdo evidenciou que a base territorial e a distância geográfica constituíam barreiras de acesso, condicionando-as a lançarem mão de endereços fictícios para obterem o atendimento. A realização do exame de Papanicolaou esteve restrita à gestação. O atendimento à saúde mostrou-se fragmentado, sendo que foram atendidas somente por sua condição reprodutiva. A concepção do acesso encerra múltiplas facetas e o serviço deve abranger as diversas fases da vida da mulher, constituindo em um desafio oferecer cobertura às mulheres da população rural. Melhorar o acesso à informação e à educação corresponde à possibilidade do exercício do direito ao acesso universal à saúde baseado no princípio da equidade.

PALABRAS - CLAVE: Población rural. Salud de la Mujer. Prestación de atención de salud. Accesibilidad a los servicios de salud.

RESUMEN: Investigación cualitativa cuyo objetivo fue investigar el acceso de las mujeres del Movimiento de los Trabajadores Sin Tierra a la atención Prenatal y prevención del cáncer cervical. Fueron entrevistadas cinco mujeres en el municipio de Cajamar, Brasil, en 2005. El análisis temático de contenido evidenció que la delimitación poblacional basada en el territorio y en la distancia geográfica constituyen barreras de acceso para la atención de salud, factor que las llevó a la utilización de direcciones falsas para conseguir ser atendidas. La realización del examen de Papanicolaou estuvo restringida a la gestación. La atención de salud de esas mujeres se mostró fragmentada, siendo atendidas apenas por su condición reproductiva. El concepto de acceso engloba múltiples facetas y el servicio debe abarcar las diversas fases de vida de la mujer, constituyendo un desafío ofrecer atención de salud a las mujeres del área rural. Mejorar el acceso a la información y a la educación posibilita que ejerzan su derecho universal a la salud, basado en el principio de equidad.

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INTRODUCTION

The 1988 Federal Constitution of Brazil incorporated various concepts, principles and guidelines regarding the field of Health. The adopted conception of health considers it a result of diverse determinants and not simply the absence of illness, so health was considered as resultant from the conditions of alimentation, housing, education, income, environment, work, transportation, leisure, freedom, access and property of land and access to health assistance.¹

The major advance in Brazilian health care services occurred from the recognition that health is a right of all citizens and the responsibility of the Government. In order to guarantee that right a Unified National Health System or Sistema Único de Saúde (UNHS/SUS) was created incorporating health as a universal social right.²

Considering that health is a right of all Brazilian citizens and that the UNHS/SUS is responsible for delivering health assistance in all national territory, it is assumed that all health problems should be resolved mainly considering population health needs.

Brazilian Landless Workers Movement

One of Brazil's great particularity is its social and economical heterogeneity. Brazil remains one of the most unequal societies in the world. Alongside the industrialised and world's leading exporter of many farming products country, there is a poor one, with a huge gap separating the two sides. Geographical distribution of Brazilian population has rapidly shifted. There has been a major rural-urban migration and most people now live in cities with the great industrialisation and developments in agriculture.³ For instance, in the sixties, almost 60% of its population lived in the countryside while in 2000 only 18% were living in rural areas.⁴ The main reasons for leaving rural areas are unemployment, lower salaries and poor infrastructure of the public services.^{3,5}

The Brazilian agricultural sector is, indeed, characterised by great inequity of land distribution as rural land ownership has been concentrated in the hands of a wealthy few. Aiming deep agrarian reforms which mean land distribution, governmental technical and financial support for rural production and better quality of life in the countryside, a large mass movement was launched in 1984 called Movimento dos Trabalhadores Rurais Sem Terra in Portuguese or Rural Landless Workers Movement (MST).

MST emerged from many popular rural movements originally in four states of the country. Nowadays, it consists of 500.000 families in 23 out of 27 federal units of Brazil – 350.000 already settled down and 150.000 camped out waiting for a governmental resolution. MST strategy regards occupying unused land to create settlements of landless and poor people where they establish cooperative farms, build houses, schools and clinics. Members also march along the country in order to put pressure on the government and speed up the agrarian reform programme.⁶

Specifically in the case of rural workers who belong to MST, the limited access to health services is closely related to the geographical area where camps and settlements are located. The role of life conditions in the health-disease process should not be forgotten as well as the fact that the more unequal a society is the more different the needs of its population will be.⁷ The structure of a movement that does not allow a fixed housing, plus the discrimination faced by the workers of MST in urban areas and their impoverished condition might make their access to health services difficult. Health care in Brazil has been structured in terms of territory, what makes the city a unit in charge of providing the service delivery to its inhabitants and covering its geographical restricted area. So the financial resources are designed to be shared on territorial or geographical basis. In this case, as it is a moving population, health assistance to MST members is not foreseen in the local budget since there are no additional funds to amplify service capacity.⁸

A study conducted in partnership between MST and the University of Brasilia showed that people from MST still face some health problems that have already been eradicated as well as sub nutrition and hunger as causes of infant mortality and many infectious diseases due to the lack of basic sanitation.⁸ They verified that 32.6% of the camps and 23.7% of the settlements did not count on any health service. Considering specifically women's health, most of the female workers from MST had full access to pre-natal care but only half of them started it in the first trimester. On the other hand, cervical cancer prevention care was provided only for 25.0% of camped women. One should be aware that Brazilian Health Ministry recommends the start of pre-natal care as soon as possible with a minimum of six appointments and smear tests at least one every three years.

Therefore, this study takes as reference that the individual's health is a social responsibility and in order to implement the model of health care proposed in the UNHS/SUS, health must be assumed as a social matter and access the fundamental category to be reached in all levels of the health care system and a base of all health policies.⁹

In the search for answers to comprehend the gap between the UNHS/SUS theoretical guidelines, principles and concepts and the real condition of access to the health care services, this study proposes to investigate the access to reproductive health care, taking the pre-natal care and cervical cancer prevention action as parameters, from a particular experience of a small women group of MST.

METHODS

This is an exploratory qualitative research conducted with five 18 to 45 year-old women who had already been through a pregnancy in term and agreed to be interviewed. These women were living in Sister Alberta Camp, part of the MST, located near km 27 of Anhanguera Highway, on the outskirts of Sao Paulo City, quite close to City of Cajamar. The camp consisted of 56 families in 2005 July, when the interviews were done.

Life conditions in the camp were very poor as it had no basic sanitation, no access to clean water nor to electricity. The workers were living in tents made of plastic materials without any bathroom.

Data were collected through interviews given in the camp, in fact, inside the tents. A semi-structured questionnaire was used as a guide and the questions focused women's social and demographic features, history at the movement, reproductive history and assistance to reproductive health services history.

Collected data analysis was based upon Bardin proposal in order to find out what lies behind matters spoken out by the interviewees. Interviews were considered enough when the saturation point of the subject was observed by the researchers.¹⁰

An oral presentation of the results was given to the camp leaderships after the ending of the data collection. This research was approved at the Committee for Ethics in Research at School of Nursing at University of Sao Paulo, Number 437/2005/CEP-EEUSP, and took into consideration all the recommendations for an ethical procedure, including the signature of the informed consent.

RESULTS

Life history

Frequent migrations, family fragmentation and poor life conditions marked these women's childhood. During the interviews, it was possible to verify they were rural-based individuals because they were familiar with primitive rural work. They abandoned this poor life condition in search for better opportunities in bigger cities like Sao Paulo City. Life in a large city was very hard and so the only remaining option was to live in the suburbs, in poor areas, with no basic sanitation. Because of such poverty, migrations were frequent.

Oh it was nice! I liked it [...]. But I really felt like setting roots. We didn't have any roots. So I found it so nice to live in a house, you know, stay there for a long time, not moving [...]. One day we were here, the other day we were there! It's hard! It's so good to make friends, have roots and I have never had that. All the persons I have known during my life remain in the past. This is bad, isn't it? (Interviewee F).

According to these women, the entrance to MST occurred in a moment of great poverty, with unemployment, hunger and roofless. The contact with MST happened through the base service that usually travels around poor areas giving explanations about the movement and inviting people to take part in it.

The move to the camp was certainly an important moment in their lives as in MST they could count on social assistance and a network.

I was facing many problems and I was almost going to live in the streets with my children when a man came to me and said: There is a place I'm gonna take you and there you'll live in a tent but they'll give your children milk, food, clothes and then they'll give you some land to live [...]. When I arrived here in the camp I was treated so well [...]. I was unemployed, not knowing where to go. I was too unhappy. I was feeling really bad. Five children, not knowing what to do, not having anyone to call for help. When I arrived here I was pretty much depressed. I cried and cried. Here I got my self-esteem back. I have done many courses and improved my life (Interviewee F).

The respect among the components of the movement and the possibility to share not only material things but also life projects – an ideological feature of the movement – was currently observed in their interviews.

Everybody knows each other here. Everybody is respected by each other here (Interviewee C).

Access to health services

The interviewed women showed some understanding about principles and guidelines of UNHS/SUS related to health assistance delivery, especially regarding the municipal territory. Although they knew about those principles, the geographical distances and economic difficulties were factors that led these women search for health assistance at the nearest health centre.

I went to a health centre which belongs to Sao Paulo City so I had to give an address from a friend that lives in that city (Interviewee B).

It takes an hour and a half walk to Morro Doce [where the health centre is located] [...]. It's too hard to carry a child and too expensive to reach Morro Doce (Interviewee B).

Access to pre-natal care

The pre-natal care described by the interviewed MST women consisted of six or less appointments with a doctor during pregnancy. Interviews showed they had access to pre-natal assistance but not to the whole structure basic health attention could offer as they initiated pre-natal care at the third month of pregnancy, they did not take any vaccination and could not tell what the aim of pre-natal care represented. They expressed that all decisions about their bodies were taken singularly by the health professional. One woman emphasised how ashamed she felt during the physical exam.

An interesting point is that they would submit themselves to anything in order to keep their foetus healthy. They considered pre-natal care important simply because they believed it was related to the new-born weight.

So my first child was born with many health problems because of the lack of pre-natal [...]. In the second pregnancy, I managed to do it so the boy was born weighting 3800 (g), he was born strong and robust (Interviewee B).

The access to pre-natal care was assured because they had looked for assistance in the City of Cajamar, which was closer, instead of the City of Sao Paulo, which was, in fact, responsible for promoting health assistance to the population of Sister Alberta Camp.

To assure access to pre-natal care, women also created some mechanisms, such as giving false addresses in Cajamar territory. Other times, a health professional made the access easier to these women

in the health centre, allowing their enrolment even knowing they lived in another city.

There was this man when I tried to make an appointment [at the health unit] for the pre-natal care. I even found it strange. He said: Aren't you from the movement? I couldn't have done your enrolment here [...]. I even found it odd. Then I said: but you have already done [...]. He said: Ok, never mind! (Interviewee C).

It is clear that women workers from MST had access to pre-natal care although this access refers only to the number of appointments. Other signs that could suggest good quality care as vaccination or sooner beginning of assistance have not been mentioned.

Access to cervical cancer prevention

Access to cervical cancer prevention was not assured to these women in an unrestricted way once they have only done the Pap smear test during pre-natal care.

Although women had a basic knowledge about the purpose of the exam, they only related Pap to pregnancy or to the period immediately after delivery because it was done mainly during the pre-natal or post-natal care.

Pap smear test I did [...] of him, of him as well and of her [pointing to her three children]. There was a urine inflammation but no other problems, thanks to God [...] (Interviewee C).

Despite the fact that they stated the importance of such cancer screening, they did not attribute its value as priority the same way they did to pre-natal care. Besides, women did the first Pap smear test only after the first pregnancy.

It was when my daughter Lurdinha was born [...]. They told me to come back 40 days after delivery so I could do the smear test [...]. Lurdinha is now nine, so it has been nine years since I did the test (Interviewee D).

It was also said that the delay in getting an appointment to do the smear test the same as in getting the exam result back turned out to be a condition that could complicate the access to cancer prevention. It is important to mention that once again the access was guaranteed both by artifices and by the good will of health professionals.

I was passing in the street, I got the address of that street and I showed it at the reception at the health centre. I told them I had already been a patient there. I talked to the nurse in order to do the smear test and she told me that I just had to be there very early in the morning (Interviewee F).

Other important barriers for these women doing the smear test were the feeling of shame, embarrassment and fear. The fact they considered themselves healthy or the fact they did not have any gynaecological problems were also a reason for not doing a cervical cancer preventive exam.

Ob, I don't feel anything. Why would I do the Pap smear test before I have a problem? I've never been with a doctor anymore, I'm very careless. That's why I don't do the test. I feel really embarrassed [...] (Interviewee D).

DISCUSSION

Access was the central category of analysis in this research, according to some life histories related by a group of women from MST Sister Alberta Camp, located in the limit between the cities of Sao Paulo and Cajamar, Brazil, and their specific experience to access pre-natal care and to cervical cancer prevention.

Analysing this category from these particular MST women experiences it was possible to make the following reflections considering principles of Brazilian Unified Health System.

Universalization of care: territory based access

It is assumed that all interviewed women had access to the pre-natal care even though they had to use some mechanisms to enter into a health centre as its clients. This situation has also been detected in an urban population of women attending to pre-natal service at District of Butanta, Sao Paulo City.¹¹ Therefore, it should be comprehended that organising a health system in geographical and/or spatial territories, in order to properly achieve health needs, must be understood as a way to plan health care and not to restrict access.

Integrity of actions

The referred access concerned only to the minimum of six medical appointments recommended by the Brazilian Health Ministry.¹² It was not possible to consider this pre-natal care had high quality as it began in the third month of pregnancy, also because there was neither vaccination, nor reference of laboratory exams or health education.

A study conducted in Caxias do Sul, South of Brazil, showed that women had a medium of 6.2 pre-natal appointments and half of them initiated

pre-natal care before the second trimester of pregnancy.¹² This result is quite different from those shown in this study, revealing how poor the quality of pre-natal care these MST women was faced to.

Pregnancy might have been the only contact these interviewed women had with health services since they had Pap smear tests only during pre-natal care. Therefore, pregnancy must be seen as a valorous opportunity for the health services to promote woman health, but not the only one. According to the principals of UNHS/SUS, complete care assistance means continuous and articulated preventive and curative actions for individuals and groups in all levels of complexity. However, health care delivered to these women was fragmented and they were assisted solely because of their reproductive condition instead of being assisted as a whole individual with various needs.

Another problem related to the necessary completeness is the delay in doing the smear test and getting results back, conditions that can make users abandon preventive practices and treatment not only among rural workers but also among the urban ones.

According to Brazilian Health Ministry cervical cancers are the fourth cause of death among women in Brazil.¹³ The decline of this kind of cancer incidence and mortality could be possible if prevention and early detection of cervical lesions were made. But it is not so easy because we must consider the gap observed in this research between the right to health assistance access and individual motivation. There are some barriers of women doing the Pap smear test because of feelings of embarrassment, shame and fear, probably for tension and physical discomfort.¹⁴

Therefore the access of these women to reproductive health care, especially pre-natal care and cervical cancer prevention action, depends on the delivery of these actions but it is also related to women needs and feelings on doing prevention.

That is the reason why excellence in health assistance to women can be achieved if health care is spread over all female citizens not only during pregnancy or reproductive age. It would be indispensable that access to health services could be understood not simply as a health care system entrance in a particular moment in women history but as a continuous and full assistance in all phases of woman's life in order to definitely transform women health.

CONCLUSION

We believe that access has to be discussed from the extending concept that highlights its social dimension.⁹ Both pre-natal care and cervical cancer prevention should then support social aspects by providing and developing educational health activities as a tool to decrease limitations in basic care assistance. Home visiting is another factor that could be considered to improve access of women living in rural areas.¹⁵

Not only the interviewees but in general many women from MST have had poor access to health services, especially concerning to reproductive health care. They are certainly too far from the Brazilian Health Ministry recommendations. The inclusion of rural population in the health care service programmes should not be considered an innovative action but a legally guaranteed right acquired since the 1988 Constitution, which is still necessary to be incorporated by Brazilian States and Municipals.¹

In conclusion, improving universal access to health care includes also access opportunities to health education. Although interviewees of MST have had very little schooling, their potential for learning cannot be disregarded. Improving information about the constitutional rights may represent a chance to develop self-care and a possibility of exercising the universal right of access to health care services based on the principle of equity.

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