

## CANCER, POVERTY AND HUMAN DEVELOPMENT: CHALLENGES FOR NURSING CARE IN ONCOLOGY

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*This is a reflection on poverty, human development and their interfaces with Oncology Nursing Care. Objectives: identify the prevailing types of cancer per region; point the challenges posed to nursing care; discuss the possibilities for Oncology Nursing actions in this context. In light of the demographic, epidemiologic and socio-cultural distribution of cancer in Brazil, a systematic articulation of the Oncology care, in situations of poverty and of low human development, represents a challenge for Nursing, as the necessary actions for prevention, early detection, treatment, and rehabilitation, range from low to high complexity. This conception opens the possibility of meeting this population's diverse demands made to the specialized services in Oncology, which are not restricted only to the antineoplastic treatment access, but include needs inherent to socio-economic-cultural factors.*

DESCRIPTORS: poverty; human development; oncologic nursing

## CÁNCER, POBREZA Y DESARROLLO HUMANO: DESAFIOS PARA LA ATENCIÓN EN ENFERMERÍA ONCOLÓGICA

*Una reflexión sobre el problema de la pobreza, el desarrollo humano y su relación con la atención de Enfermería Oncológica. Objetivos: identificar los principales tipos de cáncer por región; señalar los desafíos para la atención de enfermería; discutir las posibilidades de actuación de enfermería oncológica en este contexto. Considerando la distribución demográfica, epidemiológica y sociocultural del cáncer en Brasil, articular de manera sistemática el cuidado de oncología en situaciones de pobreza y de escaso desarrollo humano. Esta operación constituye un desafío para la enfermería, ya que las acciones necesarias para la prevención, detección temprana, tratamiento y rehabilitación, van desde baja hasta alta complejidad. En esta concepción, se abre la posibilidad de atender a las demandas de la población, que llega hasta los servicios especializados de oncología con una diversidad de necesidades, que no se encuentran restringidas al tratamiento antineoplásico, pero también abarcan una serie de carencias inherentes a los factores sociales, económicos y culturales.*

DESCRIPTORES: pobreza; desarrollo humano; enfermería oncológica

## CÂNCER, POBREZA E DESENVOLVIMENTO HUMANO: DESAFIOS PARA A ASSISTÊNCIA DE ENFERMAGEM EM ONCOLOGIA

*Reflexão sobre a questão da pobreza, o desenvolvimento humano e suas interfaces com a assistência de Enfermagem em Oncologia. Objetivos: identificar os principais tipos de câncer por região; apontar os desafios para a assistência de enfermagem; discutir as possibilidades de atuação da enfermagem em oncologia nesse contexto. Tendo em vista a distribuição demográfica, epidemiológica e sociocultural do câncer no Brasil, articular de forma sistemática o cuidado em oncologia, em situações de pobreza e baixo desenvolvimento humano, constituem um desafio para a Enfermagem, visto que as ações necessárias para prevenção, detecção precoce, tratamento e reabilitação vão da baixa à alta complexidade. Nessa concepção, abre-se a possibilidade de atender às demandas da população, que chega aos serviços especializados em oncologia com uma diversidade de necessidades, que não estão restritas ao acesso ao tratamento antineoplásico, mas acrescidas de carências inerentes a fatores socioeconômicos e culturais.*

DESCRIPTORES: pobreza; desenvolvimento humano; enfermagem oncológica

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## INTRODUCTION

This theoretic reflection intends to contextually discuss the issue of poverty and human development and its interfaces with nursing care in oncology. This possibility of articulation implies focusing on practice, considering the perspective of care delivery to cancer patients in poverty situations.

Poverty is a complex phenomenon and can be simply defined as the situation in which a person's needs are not adequately met<sup>(1)</sup>. It should be emphasized that identifying the needs as well as attending them depends on the reference of these terms, which point to the subjective dimension of one's personal needs and fulfilling those needs in a certain social context.

Research on cancer and its demographic distribution reflects populations' living conditions and social development. Cancer, characterized as a chronic disease, can be referenced as a health indicator in Brazil, and, thus, as an indicator of the regional development level. However, some factors have directly affected the epidemiological configuration of cancer in Brazil, such as life expectancy at birth, age composition and internal population migration.

Regarding migration, the population moving from one region to another caused an increase in the process of uncontrolled occupation of large urban centers. This has created clusters of extreme poverty in the periphery of large Brazilian cities. This fact incisively expresses the regional differences, which become exuberant in metropolitan areas<sup>(2)</sup>.

Hence, cancer characteristics of poor regions were included in the cities' morbidity and mortality profile. Thus, they have become an indicator of social classes in common spaces and also appear in incidence and mortality charts<sup>(2)</sup>.

In this sense, focusing on the relation between nursing care in oncology and poverty, the objectives of this reflection are: to identify the main types of cancer per region; to appoint the challenges for nursing care; to discuss the possibilities of nursing care in oncology in this context.

## CANCER AND HUMAN DEVELOPMENT IN BRAZIL

Brazil is going through a demographic transition phase. In this setting, reductions in birth

and mortality rates coexist, with occurrences of acute and chronic diseases, cancer in children, young adults, adults and elderly, as well as cancers from rich and poor countries.

Regarding socioeconomic development, stomach and cervical cancer are health indicators in less developed societies. As for more developed societies, breast and lung cancer are considered indicators<sup>(2)</sup>. Tumors related to young adults, such as oral, penile and cervical cancers, are found in less developed areas with low socioeconomic and cultural conditions<sup>(2)</sup>. In this reflection, the Human Development Index was used to outline the discussion in terms of cancer and its relation to poverty.

The Human Development Index (HDI) is an indicator frequently used to assess populations' socioeconomic development level and quality of life. This index is the synthesis of four indicators: GDP (Gross Domestic Product) *per capita*, life expectancy, literacy rate of people aged 15 years or more, and gross rate of enrolment in the three education levels<sup>(3)</sup>.

According to the Human Development Report for 2006, Brazil's HDI has increased from 0.788 to 0.792 in 2004. This result puts Brazil among the 83 medium HDI nations (HDI between 0.500 and 0.799), but the country is still not among the 63 high HDI nations (equal to or above 0.800)<sup>(3)</sup>. The obtained data show that Brazil advanced in the three HDI dimensions: longevity, income and education.

In terms of longevity, life expectancy in Brazil went from 70.5 to 70.8 years. Nevertheless, this is still the area in which Brazil ranks worst when compared to other countries; occupying the 84<sup>th</sup> place in the global ranking<sup>(3)</sup>.

In education, the literacy rate increased from 84.4% to 88.6%, ranking 62<sup>nd</sup> among the other countries<sup>(3)</sup>.

Income, assessed by GDP *per capita*, was the rate that most enhanced the Brazilian HDI. This rate increased 3.1%, going from US\$7,949 to US\$8,105, setting the country on the 64<sup>th</sup> place in the global ranking<sup>(3)</sup>.

The HDI in Brazil considerably varies among states, from 0.534 in Piauí to 0.869 in Rio Grande do Sul and the Federal District. This variation reflects differences regarding access to health services and education. It also reflects income distribution, as well as quality of life and living conditions of populations in these geographical areas<sup>(3)</sup>.

Another index that derives from HDI, calculated only for developing countries, is the Human Poverty Index (HPI). The HPI measures deprivation in three aspects: short life span (possibility of living less than 40 years); lack of primary education (represented by the high illiteracy rates in adults); and lack of access to public and private resources (people without access to potable water services and high percentages of children with weight below recommendations). Brazil holds the 22<sup>nd</sup> position, among 102 countries around the world<sup>(3)</sup>.

Regarding gender, the measurable index used is the Gender-Adjusted Development Index (GDI), which enlists the same variables of the HDI but considers differences between men and women. In this ranking, Brazil holds the 55<sup>th</sup> position<sup>(3)</sup>.

## THE CANCER SITUATION IN BRAZIL

The priorities of the Brazilian cancer control policy are based on the morbidity and mortality profiles of the country's various states and cities, which vary considerably. By obtaining cancer case estimates according to primary locations, epidemiological information can be provided that is essential to plan health promotion, including early detection and oncology care at every level<sup>(4)</sup>.

In Brazil, there is an estimate of 472,050 new cancer cases in 2006. The most common types, excluding non-melanoma skin cancers, are prostate and lung cancers among men, and breast and cervical cancer for women, with the same magnitude profile seen in the world<sup>(4)</sup>.

It is expected that, in 2006, there will be 234,570 new cases among men and 237,480 among women. It is estimated that non-melanoma skin cancer will be the most frequent among Brazilians, followed by female breast tumors, as well as prostate, lung, colon and rectal, stomach and cervical tumors<sup>(4)</sup>.

The distribution of new cancer cases according to primary locations is rather homogeneous among the country's states and capitals. The South and Southeast show the highest rates, while the North and Northeast show the lowest, with intermediate rates in the Central-West<sup>(4)</sup>. In the Southeast, for instance, breast cancer is the most frequent type among women, with an estimated risk of 71 new cases per 100,000. Excluding non-melanoma skin cancers, this type of cancer is also the most common among women in the

South (69/100,000), Central-West (38/100,000) and Northeast (27/100,000). In the North, it is the second most frequent type (15/100,000), preceded by cervical cancer. In Brazil, breast and cervical cancer are still diagnosed at late stages, which contributes to increased mortality and reduced survival rates<sup>(4)</sup>.

The Brazilian National Cancer Institute (INCA), an organ of the Health Ministry, is responsible for developing and coordinating integrated actions for preventing and controlling cancer in Brazil. It has the strategic view to "Fully exert the governmental role in cancer prevention and control, ensuring that corresponding actions are implemented throughout the country and, thus, contributing to improve the population's quality of life"<sup>(5)</sup>.

Integrated actions have a multidisciplinary character and consist of medical-hospital care, offered directly and free-of-charge to cancer patients, and actions in strategic areas, such as early detection, training specialized professionals, developing research and epidemiological information. Every INCA activity has the goal to reduce cancer incidence and mortality in Brazil<sup>(5)</sup>.

The INCA is responsible for cancer prevention and control in Brazil and develops the following national programs:

1. Expanding oncology care (*Expande* Project). The project's main goal is to structure oncology care integration in Brazil with a view to obtaining high quality standards regarding population coverage. It is estimated that 20 Oncology Centers of High Complexity (CACON) will be created in the country to assist about 14 million Brazilians.
2. National Program for Controlling Cervical and Breast Cancer - *Viva Mulher* - which aims to substantially reduce cervical and breast cancer deaths, offering women more effective access to early diagnosis by means of the cervical smear (Papanicolaou) test and clinical breast exams, in addition to treatment appropriate for the tumor.
3. The National Tobacco and Other Cancer Risk Factors Control Program, which offers continuous education programs for state and municipal health secretariat employees to educate the population at schools, companies, hospitals and local communities about the harms of smoking.
4. The Quality Management Program in Radiation Therapy, whose main aim is to serve every radiotherapy institution that delivers services within the Brazilian Public Health System (SUS), encouraging

and promoting conditions that permit these institutions to apply high-quality and effective radiotherapy, and to offer continuous education to the professionals involved.

5. The Program for Surveillance of Cancer and other Risk Factors aims to collect knowledge about the details of the present status of cancer and its risk factors in Brazil<sup>(5)</sup>.

Regarding population access, services within the Brazilian Public Health System (SUS) that provide oncology treatment are registered by the Health Ministry as CACON - Oncology Centers of High Complexity, or Isolated Chemotherapy or Radiotherapy Services, composing an Oncology Care Network. This service network is coordinated by INCA through the *Expande* Project<sup>(5)</sup>.

CACONs are public or philanthropic hospital units that provide all the human and technological resources needed for integral cancer patient care. They are responsible for confirming patient diagnoses, staging, outpatient and hospital care, oncology emergency care, as well as palliative care<sup>(5)</sup>.

## POSSIBILITIES AND CHALLENGES OF NURSING CARE IN ONCOLOGY WITHIN THE CONTEXT OF POVERTY

Cancer, regardless of its etiology, is acknowledged as a chronic disease affecting millions of people in the world, independently of social class, culture or religion. Receiving a cancer diagnosis is generally terrifying because, in spite of therapeutic advancements, which have improved survival rates and quality of life, there is still a stigma of it being a painful disease that impairs, mutilates and kills. Hence, there is an evident and urgent need for nursing interventions to help people cope with the disease and its consequences, with a view to rehabilitation and improvements in quality of life<sup>(6)</sup>.

Over the last decades, nursing in oncology has evolved to become a specialty. In fact, this shows a substantial progress in professional practice, especially regarding care for patients with a complex disease. There has been an extraordinary and growing understanding about cancer, seeing it not only as a biological, but also as a social, economic, and psychological issue<sup>(7-8)</sup>.

Initially, nurses worked following the so-called "bed-side" care and limited their actions to comforting

measures for hospitalized patients and palliative treatment for terminal patients. However, nurses' work in oncology has grown with the advent of therapeutic protocols conducted with new antineoplastic agents. Simultaneously, clinical assays were introduced, which are necessary for good health care practice. In turn, this implies the need for multidisciplinary team work, including nursing. Thus, nurses turned to clinical research and their care was extended to the communities<sup>(7)</sup>.

With the growing demand for nursing in oncology, it has been encouraged to become a specialty. This is the main formal reason that led to the emergence of oncology nursing organizations, as well as the insertion of oncology in the curricula of undergraduate health courses, specialization courses, continuous education programs and others<sup>(6)</sup>.

Oncology care aims to increase people's life expectancy, and not simply cure the disease. Even according to the biomedical model, the essence of nursing care is to help human beings as a whole, taking the bio-socio-cultural relationship into consideration. Therefore, everyday nursing care should reflect on quality practice, directed to teaching self-care, with the goal to protect clients' autonomy and improve quality of life. Moreover, it should permit the acknowledgement and appreciation of health care professionals by establishing a positive and empathic relationship between caregivers and patients<sup>(9)</sup>.

From this perspective, nursing care in oncology made interventions possible at several levels: primary and secondary prevention; cancer treatment; rehabilitation; and advanced disease. In this sense, nursing care in oncology has evolved to health care focused on patients, families and communities, with a view to educating, promoting psychosocial support, making the recommended therapy possible, selecting and administrating interventions that reduce the proposed therapy's side effects, participating in rehabilitation and promoting comfort and care<sup>(10)</sup>.

Regarding primary prevention actions, nurses are seen by the population and public authorities in cancer as leaders in this type of action, since they inform and educate the population by assessing individuals, identifying risk groups for the disease, and suggesting interventions that change risk behaviors<sup>(10)</sup>.

Educating patients and their families is a fundamental part of cancer treatment, especially if

poverty and extreme deprivation clusters are to be considered. These two factors, along with precarious education, lead to a lack of information and difficult access to health services in many Brazilian regions. Therefore, nurses are responsible for guaranteeing individuals and communities an understanding about the disease process, its prevention and treatment. Moreover, they should educate them to make the decision of taking care of their own health and, thus, allow them to develop strategies to cope with the disease.

In this sense, it appears that nursing professionals hold an important place among clients in the everyday course of therapeutic, different from other multidisciplinary team professionals. This is because nurses receive the patient, make assessments, procedures and forward the problems they cannot solve. Since they are professionals accessible for talking or clearing doubts, they are often recognized as the main link between health team members.

From this perspective, it is indispensable to reflect on nursing practice in terms of the demand for broad technological and human knowledge, the care needed for this specific population and the challenges for applying that knowledge.

It should be emphasized that the academic nursing education issue still contains gaps regarding specific cancer-related theoretical content, as well as a breach between technical/scientific preparation and health care practice<sup>(11)</sup>.

When facing poverty, its economic and social deficits and the care practice *per se*, dilemmas and conflicts emerge. This reveals that the necessary solutions transcend nursing's field of action, gaining structural, economic and social dimensions.

For instance, situations of extreme poverty are a significant challenge in oncology care and home visits in oncology. Planning nursing interventions, as well as the entire therapeutic process in this case, could fail due to the lack of food, inadequate sanitation conditions, poor locomotion and transportation conditions, impaired cognitive capacity for learning and others. However, despite these setbacks, it appears that particularly home visits in oncology have contributed to maintain quality of life as well as the extension of palliative home care<sup>(12)</sup>.

Thus, caring for people in situations of poverty and low human development is a challenge for

oncology nursing, considering that the actions needed for prevention, treatment, and rehabilitation, range from low to high complexity. Therefore, there is a need for creativity when approaching care and education, as well as a need for technology, diagnosis and therapeutic resources, which are sometimes not accessible to the population in poverty situations.

## CONCLUSION

Nursing care practice should be based on respect for human dignity, compassion, responsibility, justice, autonomy and their interrelations. Moreover, it should always consider universal solidarity, with a view to benefiting patients and caregivers<sup>(13)</sup>.

Nursing is responsible for dealing with the everyday reality of oncology care, in which a problem-solving practice is developed. This approach should clarify, instruct and adjust therapeutic conducts to emerging situations, inherent to people with cancer. A practice that uses state-of-the-art technology articulated with humanized care would broaden the dimension of the care offered, adding each nurse's human values to the care, and thus determine professional care quality<sup>(14)</sup>.

This implies listening, observing, reflecting and acting in a way that includes the individual, planning care actions along with clients, respecting their desires, values and habits, and extending the capacity of caring for, recovering, or maintaining their health.

From this viewpoint, it is revealed that nursing care is a possibility of meeting the demands of this population segment in poverty situations, which comes to specialized oncology services with a diversity of needs. These are not limited to antineoplastic treatment. Rather, there are additional needs related to socio-economic-cultural factors.

Thus, despite the fact that most nursing actions are associated with the hospital environment and, consequently, based on the biomedical model, these actions are not limited to treatments that exclusively aim to cure. It is centered, essentially, on people experiencing the health-disease process, focused on promoting welfare and health. Hence, nurses rescue the origins of their profession, which is directed to human beings and not to the pathology<sup>(15)</sup>. That is the permanent challenge of nursing care in oncology.

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