Original Article

TEXTO & CONTEXTO ENFERMAGEM
TEXT & CONTEXT NURSING TEXTO & CONTEXTO ENFERMERÍA

THE IMPLEMENTATION OF A CANCER SURVEILLANCE TECHNICAL GROUP BASED ON HEALTH ADVOCACY

Franciele Budziareck das Neves[1]
Mara Ambrosina de Oliveira Vargas[1]
Laura Cavalcanti de Farias Brehmer[1]
Marcelexandra Rabelo[1]
Fábio Silva da Rosa[1]
Julia Valeria de Oliveira Vargas Bitencourt[2]

[1]Universidade Federal de Santa Catarina, Programa de Pós-Graduação em Enfermagem. Florianópolis, Santa Catarina, Brasil.
[2]Universidade Federal Fronteira Sul. Chapecó, Santa Catarina, Brasil.

ABSTRACT

Objective: To describe the process of implementing a cancer surveillance technical group based on the health advocacy framework.
Method: Convergent Care Research addressing 11 representatives of the support and governance system of the healthcare network in a town in Santa Catarina, Brazil. Data were collected from June 2020 to July 2021 in online meetings called convergence groups. The analysis followed the apprehension, synthesis, theorization, and transference steps.
Results: The motivations for creating the group included the town's cancer epidemiological context, the need to meet the annual health program, and the professionals' duties in this context. Based on the advocacy framework, the group associated the implementation process with concepts such as integrality, humanization, and professional practice in health. Along this path, strategies were acknowledged and supported the group, such as the establishment and appropriation of philosophical and theoretical bases, in addition to actions such as creating a statute, planning activities, developing instruments, and identifying priorities to implement tasks effectively.
Conclusion: Knowledge was exchanged, and a process for providing integral and equitable healthcare in cancer surveillance was developed collectively. Hence, advocacy proved to be a theoretical pillar for the political action of the technical group's members, translating practice into patient rights advocacy.

DESCRIPTORS: Epidemiologic Surveillance Services. Public Health Surveillance. Neoplasms. Health Advocacy.

HOW CITED: Neves FB, Vargas MAO, Brehmer LCF, Rabelo M, Rosa FS, Bitencourt JVOV. The implementation of a cancer surveillance technical group based on health advocacy. Texto Contexto Enferm [Internet]. 2023 [cited YEAR MONTH DAY]; 33:e20230148. Available from: https://doi.org/10.1590/1980-265X-TCE-2023-0148en

A IMPLEMENTAÇÃO DE UM GRUPO TÉCNICO DE VIGILÂNCIA DO CÂNCER ANCORADO NO *ADVOCACY* EM SAÚDE

RESUMO

Objetivo: descrever o processo de implementação de um grupo técnico de vigilância do câncer fundamentado no referencial de *advocacy* em saúde.
Métodos: Pesquisa Convergente Assistencial realizada com 11 profissionais representantes de pontos de atenção e do sistema de apoio e governança da rede de atenção à saúde de um município de Santa Catarina, Brasil. A coleta foi desenvolvida de junho/2020 a julho/2021 em reuniões online denominadas grupos de convergência. A análise seguiu as etapas de apreensão, síntese, teorização e transferência.
Resultados: o grupo evidenciou como motivações para sua criação o cenário epidemiológico do câncer no município, a necessidade de atender a programação anual de saúde, e os compromissos profissionais neste contexto. Em seu processo de implementação, e a partir do referencial do *advocacy* em saúde, o grupo o associou a outros conceitos como a integralidade, a humanização, e o exercício profissional na área da saúde. Neste percurso, foram reconhecidas estratégias iniciais como a definição e a apropriação de bases filosóficas e teóricas para ancorar o grupo, bem como estratégias de ações desde a elaboração de um regimento, planejamento de atividade do grupo, construção de instrumentos, e identificação de prioridades para implementação efetiva dos trabalhos.
Conclusão: houve promoção e compartilhamentos de conhecimentos e, coletivamente, estruturou-se um processo para atenção integral e equânime na vigilância do câncer. Confirmou-se o *advocacy* como pilar teórico para ação política dos profissionais no grupo técnico, e suas práticas traduzem-se em ações de defesa dos direitos dos usuários.

DESCRITORES: Serviços de vigilância epidemiológica. Vigilância em saúde pública. Neoplasias. Advocacia em saúde.

LA IMPLEMENTACIÓN DE UN GRUPO TÉCNICO DE VIGILANCIA DEL CÁNCER ANCLADO EN LA ADVOCACY EN SALUD

RESUMEN

Objetivo: describir el proceso de implementación de un grupo técnico de vigilancia del cáncer, fundamentado en el referencial de *advocacy* en salud.
Métodos: Investigación Convergente Asistencial realizada con 11 profesionales, representantes de puntos de atención y del sistema de apoyo y gobernanza de la red de atención a la salud de un municipio de Santa Catarina, en Brasil. La recolección fue desarrollada de junio/2020 a julio/2021 en reuniones *online* denominadas grupos de convergencia. El análisis siguió las etapas de comprensión, síntesis, teorización y transferencia.
Resultados: el grupo evidenció como motivaciones para su creación el escenario epidemiológico del cáncer en el municipio, la necesidad de atender la programación anual de salud, y los compromisos profesionales en este contexto. En su proceso de implementación, y a partir del referencial de *advocacy* en salud, el grupo lo asoció a otros conceptos como la integralidad, la humanización, y el ejercicio profesional en el área de la salud. En este recorrido, fueron reconocidas estrategias iniciales, como la definición y la apropiación de bases filosóficas y teóricas para anclar el grupo, así como estrategias de acciones desde la elaboración de un regimiento, planificación de actividades del grupo, construcción de instrumentos, e identificación de prioridades para implementación efectiva de los trabajos.
Conclusión: hubo promoción e intercambio de conocimientos y, colectivamente, se estructuró un proceso para atención integral y ecuánime en la vigilancia del cáncer. Se confirmó el *advocacy* como pilar teórico para acción política de los profesionales en el grupo técnico, y sus prácticas se traducen en acciones de defesa de los derechos de los usuarios.

DESCRIPTORES: Servicios de Vigilancia Epidemiológica. Vigilancia en Salud Pública. Neoplasias. Defensa de la salud.

INTRODUCTION

The health advocacy framework dates back to the 1970s when it emerged from social movements based on ethical, legal, and moral aspects implicated in health professionals' actions. It is associated with supporting the individual autonomy of patients in health systems, families, and communities and also with protecting patients' right to self-determination to make decisions concerning the health and disease continuum[1–2].

Health is unequivocally valuable for developing a society's productive capacities and personal and collective life projects, being an essential condition for human and environmental well-being and dignity[3–4]. In this sense, advocacy-guided health actions influence the consolidation of practices, especially when practices are based on public health policies[5,2]. Hence, when considering this framework, one also needs to take into account the multi-professional nature of the health field, aiming to strengthen interdisciplinary work to include advocacy as a potential resource to consolidate health as a citizen's right from an expanded and comprehensive perspective.

Because the Brazilian constitution ensures the right to health, actions are constantly required to materialize it, such as implementing interventions to promote, protect, and recover/rehabilitate patients' health. The Brazilian Unified Health System (SUS) has a complex structure involving its organization, financing, healthcare delivery, and training, which pervades thinking and doing. Hence, there is a permanent search for theoretical support aligned with this right to incorporate it into people's lives. Many actions implemented within the public sphere in the SUS are structured through public health policies. These policies directly affect the provision and availability of healthcare to the population and reflect on outcomes, equity, and the professionals' environmental and sociocultural contexts[6].

Adopting the health advocacy framework to guide practices in a scope less comprehensive than the SUS, such as for Chronic Non-Communicable Diseases (NCDs), is also potentially positive. Such diseases harm individuals' quality of life and impact their productive capabilities, contributing to social and economic problems. When NCDs are on the agenda, cancer epidemiology emerges, which presents high levels of incidence and prevalence worldwide. There have been advancements in treatments and the quality of results since SUS was regulated; however, unequal access to services providing comprehensive healthcare remains. A study addressing the micro-regions of Minas Gerais, Brazil, showed significant distinctions concerning breast cancer mortality and exposed differences in the distribution of resources in the same territory, i.e., women living in areas where there is no healthcare support face more losses than those in urban areas[6–7].

Data on epidemiological surveillance, mainly reporting on cancer, show that only 15% of the world's population is covered by high-quality records[8]. The absence of or poor records compromises the planning and organization of oncology care. Hence, changes are needed to reverse epidemiological indicators, considering that many types of cancer are preventable, though they require timely diagnosis and treatment[9].

Since 2005, the National Oncological Care Policy has aimed to guide the development and consolidation of care for people with cancer. It reinforces the need to recognize the essential aspect of cancer preventive actions and the System's organization. It is paramount that the different services communicate efficiently to establish timely diagnoses and provide treatments within adequate conditions to comply with the "*Lei dos 60 dias*" [60-day Law][10].

A problem emerges in this context, which calls for professionals to advocate for patient rights, i.e., health advocacy – a set of coordinated social, economic, political, and legal actions to provide quality healthcare. These concrete practices organized by committed social actors go beyond their professional skills; hence, the professionals understand their co-responsibility in promoting the full exercise of rights to benefit individual and collective health[10–11].

Thus, considering the epidemiological proportions of cancer worldwide and how cancer affects people's lives and society, there is a need to sensitize actors, hold spaces, and promote actions to advocate for patient health according to SUS' principles of universality, equity, and integrality. The locus of epidemiological surveillance, whose characteristics symbolize public policies and multidisciplinary work processes, motivated this study to describe the implementation of a cancer surveillance technical group based on the health advocacy framework.

METHOD

This qualitative study, Convergent Care Research (CCR), seeks to clarify the complementary relationships between theory and practice, producing knowledge to resolve conflicts and problems. The CCR process involves the conception phase when the researcher understands the research problem; the instrumentation phase, which enables the researcher to plan all operational details of data collection, physical space, participants, and data collection instruments, among other practical aspects; investigation phase, considered a unique moment in the CCR, which allows researchers, through active participation, to examine, probe the interfaces, associations and potential planning based on the instrumentation phase and the next phase, which is analysis[12].

The research context was a Cancer Surveillance Technical Group (CSTG) located in a Municipal Epidemiological Surveillance Service in Santa Catarina, Brazil. This technical group was established in 2019, according to Normative Instruction. Its objectives include investigating cancer deaths, according to Laws 12,732/2012 (60-day law) and 13,896 (30-day law); diagnosing problems faced by those affected by cancer; proposing sustainable and ethical solutions based on legally supported resources; and developing strategically planned actions to raise awareness among all those responsible for decision-making in this context[13–14].

The participants were intentionally recruited. The primary researcher, who held a managerial position in the town's Epidemiological Surveillance service, selected the participants according to the inclusion criterion: being an active Cancer Surveillance Technical Group member. Hence, all the group members were included; only students and residents who occasionally participated in the group meetings were excluded.

The primary researcher simultaneously took on management responsibilities in creating and implementing the CSTG and conducting the study's stages. This double role is fundamental in the development of CCR. The first contact with potential participants was established in an online meeting, during which the research objectives, risks, and benefits were clarified, and a formal invitation was presented. All members of the CSTG agreed to participate and signed free and informed consent forms before initiating the next stage, which consisted of data collection.

Data were collected through online meetings from June 18, 2020, to July 29, 2021. These meetings were held monthly in 2020 and fortnightly in 2021 and lasted two and a half hours each, totaling 14 meetings. The same group participated in all meetings and was called the "convergence group;" the purpose was to develop research simultaneously with healthcare practice[12,15].

The health advocacy framework was introduced as a theoretical assumption at the first meeting. Other frameworks, such as collective health, health surveillance, oncology, and the right to health, were presented in the remaining meetings according to needs identified during the discussions. No script was specifically developed for this study – the participants' discussions emerged from their service experiences. The meeting notes and minutes comprise the corpus of data for analysis. Health surveillance strategies and adherence to the theoretical aspects of advocacy were explored in depth, together with which actions should be performed by health surveillance in the oncology field, in addition to discussing the health services' weaknesses and strengths.

This study's objective expanded during the meetings and dialogical process between care practice and investigation. Emerging themes and interests naturally surface in the development of an investigative process[12]. Therefore, guidelines such as healthcare for people with cancer and the identification of problems patients face in their passage through healthcare services were added and aligned to the advocacy framework.

Specifically, in the fourth and fifth meetings, simultaneous ideas that triggered the effective implementation of the CSTG emerged and were connected with the advocacy framework. Based on the convergence group's practice in health services, the participants recognized the connections between healthcare provided to people with cancer and their actions, characterized by advocacy, giving rise to a continuous constructive process linked to health surveillance.

The primary researcher was entirely responsible for the data collection process. The meetings were recorded and transcribed with no validation from the participants. The database was analyzed according to four processes: apprehension, synthesis, theorization, and transference, which occurred in sequential order, concomitantly with data collection. The interpretation of results corresponded to the synthesis, theorization, and transference processes. The associations and variations of information were examined and coded during the synthesis. Theorization involved identifying and establishing relationships between groups of themes that enabled the prediction of the phenomenon under study. Theorization involves constructions, deconstructions, and reconstructions of formulations based on the literature and the theoretical framework that support this study, enabling us to put knowledge into practice[12,15].

The Institutional Review Board assessed and approved the study project, which complied with all the requirements established by Resolution 466/12, Brazilian Health Council. Additionally, the participants were identified by the letter "M" (Member), followed by a random number from 1 to 11 to ensure confidentiality, and the observation notes were coded "CG" (Convergence Group), followed by a number from 1 to 14 assigned according to the order in which the meetings were held.

RESULTS

Eleven representatives from the town's different public and private services participated: Epidemiological Surveillance (a nurse responsible for Chronic Non-Communicable Diseases, a nurse responsible for Vital Statistics, a nurse director, and a nursing technician, who was the executive secretary); High Complexity Oncology Unit (UNACON) (a physical therapist as the coordinator); Specialized Medical Assistance Unit (UAME) (a nurse as the coordinator); Health Department (a nurse responsible for Primary Health Care); Outpatient clinic of a Private University that serves patients under the Unified Health System (SUS) (a coordinating nurse); Control, Regulation, and Evaluation Service (an administrator appointed by the coordinator); the city's Laboratory (a biologist coordinator); and a Private Laboratory (an administrator) that analyzes most of the town's biopsies.

Three categories concerning the implementation of a Cancer Surveillance Technical Group emerged: "Motivations to create the Cancer Surveillance Technical Group (CSTG), "Implementation strategies," and "Recognizing the CSTG from the Advocacy perspective." These categories are intertwined with the Group's creation, implementation, and consolidation process, considering its dynamic nature and content that converges with each other—Chart 1 and Figure 1 present these characteristics.

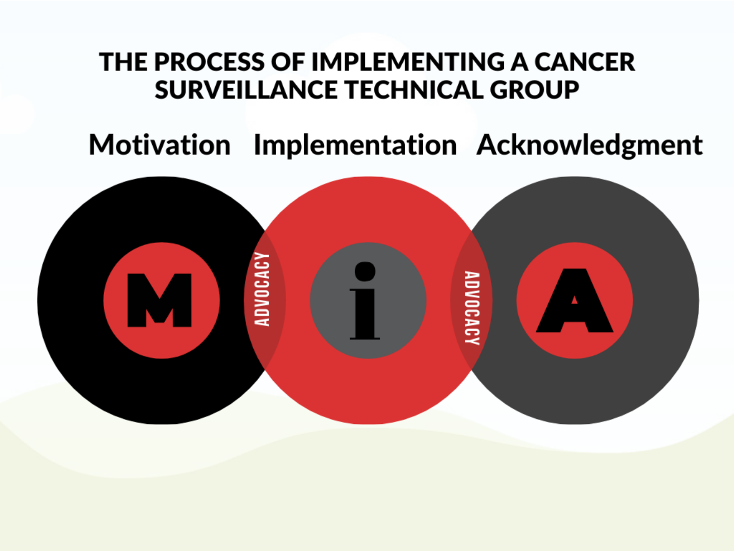

Figure 1 – Intertwinements in the implementation of a Cancer Surveillance Technical Group (CSTG) under the Advocacy framework**.**

Chart 1 – Implementation of a Cancer Surveillance Technical Group: Motivations, Strategies, and Acknowledging Advocacy**.**

Motivations to create the Cancer Surveillance Technical Group		
The city's Cancer Epidemiological Context	**Annual Health Program**	**Professional Commitment**
A historical analysis in the city showed that mortality caused by cancer (...) *has surpassed deaths due to cardiovascular diseases since 2016. Such a situation shows the urgent need to investigate these cases to work on planning based on evidence and develop actions to minimize problems that directly affect the population's health according to laws 12,732/2012 and 13,896/19* (CG1).	(...) *The Annual Health Program has a guideline providing for the implementation of a technical group to investigate deaths caused by cancer, to ensure people with cancer are respected, and to ensure that law 12,732/2012 (60-day law) is complied with. This guideline needed to be included in the program because there were no management instruments specifically determining goals and actions related to chronic non-communicable diseases or cancer* (CG2). *One of the management instruments used in the city is the Annual Health Program. It details annual goals and identifies monitoring indicators, determines the actions that will support the achievement of objectives in a specific year, fulfills the Health Plan goals, and presents the forecast for the allocation of budgetary resources necessary to comply with PAS* (CG3).	*Therefore, based on the city's needs, the following guideline was included in the Annual Health Program 2018: Strengthening the prevention of chronic non-communicable diseases and health promotion, along with implementing and maintaining a Technical Group to investigate deaths with the underlying cause of death being Cancer, in order to ensure people with cancer are respected and that Law 12732/2012* (60-day Law) *is complied with* (CG5).

Chart 1 – Cont.

Cancer Surveillance Technical Group's Implementation Strategies			
Delimitation of philosophical and theoretical bases	**Preparation of Statute and Work Strategy**	**Preparation of Statute and Work Strategy**	**Identification of Priorities**
Health advocacy, which is broadly defined as a process of supporting, defending, or arguing a cause, idea, or policy, provides the basis for the group to perform its activities, aiming to investigate cancer deaths based on laws and diagnose problems, whether due to difficulties of people with cancer to access health services and propose sustainable and responsible solutions, through legal and ethical means, developing strategically planned actions to raise awareness and influence decision-makers to promote the necessary changes (CG7).	*The group prepared an internal regulation, establishing a set of rules to regulate the group's functioning, ensure the correct implementation of tasks according to the guidelines, organize, systematize, and develop a continuous work process. This internal regulation was also officially published through an Ordinance on March 2, 2020, and its members and respective substitutes according to each area and place of activity* (CG10). *The group adopts systematic meetings to discuss patients' deaths, seeking to detect potential causes. It routinely uses meetings to discuss the cases involving deaths, summoning, if necessary, the workers who provided care for such patients or the health department's managers. The objective is to present the cases to these professionals or managers to obtain more information, clarify doubts, point out errors, request changes to the routine or practices harmful to the care of patients, prepare letters of recommendation for the services, propose and strengthen integrated and intersectoral actions to improve the care delivered to people with cancer, prevent avoidable deaths, and support the qualification of healthcare and death surveillance* (CG12).	*To assist in investigations and standardize the cancer death surveillance process and how information is available to the group's members.* *The researcher created an investigation form, considering that the diversity of content provided in the forms and medical records may prevent comparing information, possibly compromising the quality of data discussed in the meetings. According to the healthcare delivery logic, the information obtained from various sources is valuable for planning actions and evaluating health services at municipal, regional, and state levels. Furthermore, the data obtained after the investigation enabled an understanding of how cancer care is organized in the city's health network* (CG13).	*Due to the great demand for investigations and also because there is a member representing women's health in the city, the group agreed that priority would be given to cervical and breast cancer, considering these are the most common, especially among women under 69 years old, as recommended by the first indicator of the Inter-federative Agreement. It aims to present the qualification forms of the 23 indicators established between 2017 and 2021. The first indicator aims to monitor the mortality caused by NCDs, the primary cause of death in the country. It is also a relevant parameter for planning and obtaining agreement on health services at all levels of care aimed at people with chronic diseases* (CG14).

Chart 1 – Cont.

Recognizing the Cancer Surveillance Technical Group from the Perspective of Health *Advocacy*			
Integrality	**Humanization**	**Knowledge**	**Professional Competence**
In addition to rights and duties, the entire context needs to be assessed so that patients enjoy whole health (M1). *I think it has everything to do with it because it's about interests, legislation, meeting deadlines, investigation, and patients. There is a long period between the diagnosis and the beginning of treatment. Patients have the right to start treatment. How? I think it is in line with advocacy and these interests, and that is what we are checking: whether this legislation was complied with and whether patients had access to the resources they needed* (M3).	*It aims to ensure patient rights in the sense of professionals (that is why it is advocacy) advocating for patients. I know a patient has rights, so I will try to ensure that he accesses such rights* (M2). *It is deeply associated with the dissemination of public health, the rights of patients, and the humanization and individualization of patient treatment* (M5).	*It aligns with patients' interests, well-being, and access to knowledge, defending the right of patients, users, and people to access knowledge* (M3).	*But it has to do with the professional, like I, a nurse, advocate for a patient, or I, a doctor, advocate on a patient's behalf. It is not just, "Oh, there is this legislation." I am the one who is taking care of it; I am the one who clarifies it, and I am the one who asks for help. One of the things that happens is that we are educating new professionals and drawing attention to aspects of management that need to be taken care of, what we think professionals know how to do, but in reality, they do not know how to do, and this surfaces in the investigations* (M2).

DISCUSSION

Regarding the motivations that mobilized researchers and study participants, the CSTG was created because of the number of cancer cases detected in the city, which required that a Death Surveillance Technical Group focused on cancer was created, along with the desire of professionals to overcome this health problem.

Therefore, the motivations reveal principles concerning human and citizenship rights. The previous discussion shows that the philosophical bases of advocacy permeated the professionals' understanding of their roles even before they acquired a deeper understanding of it. Defending the right to health is an act of safeguarding, evaluating, valuing, mediating, and recognizing social justice in the provision of health care. Advocacy is a complex process, especially for vulnerable populations, and it requires professionals to be aware of such a role and to be committed and morally responsible[2,16–17].

Specifically within the scope of oncology, the need to advocate for patient rights applies to ameliorate the population's persisting inequities in this and other health fields. A professional who advocates for patients in a health system based on principles and guidelines plays a leadership role in promoting change toward integral and equitable healthcare[18]. Defending patients, families, or collectives focused on equity in an environment, albeit delimited, can be transferred to other environments, mobilize forces, and strengthen the care provided in the service network[19].

Vulnerabilities were identified when we considered the lack of compliance with laws 12,732/12 and 13,896/19, specifically addressing people affected by cancer in Brazil. Having the right to access early diagnoses and treatments to prevent premature deaths is insufficient if there is no knowledge or advocacy. Healthcare providers can include equity-oriented strategies in their practice through leadership, political influence, advocacy, education, and research[18,15]. Taking part in a CSTG is an exercise where professionals can critically evaluate their work processes for themselves and patients to ensure compliance with laws and public policies. Advocacy guides opportunities for comprehensive and humanized healthcare, promoting quality services aligned with public policies and showing professional competence in work processes.

Implementing the CSTG required understanding the philosophical bases that support the group's practices and, from an operational perspective, structuring a statute, developing instruments, and establishing priorities.

Implementing a Cancer Surveillance Technical Group within the scope of health surveillance actions, based on the health advocacy theoretical framework, was not merely about meeting a specific demand to comply with laws or public policies. Having healthcare professionals advocate for patient rights is a health promotion and protection strategy to ensure patients access treatment, recovery, and rehabilitation.

The professionals come across the bureaucracy and many barriers that prevent or restrict their ability to advocate for their patient's rights when implementing healthcare public policies[20]. For example, the nature of one's employment contract may be an impediment, and for this reason, a collective configuration, such as a Technical Group, empowers these workers. Healthcare providers implement public health policies through their actions; hence, they are the protagonists in all planning, implementation, and evaluation processes[21]. Therefore, the distance between policymakers and those implementing such policies must be shortened to give meaning to these actors' actions and lead them to a feeling of belonging, mobilizing health advocacy[22].

Work climate in health services influences health advocacy and its effectiveness. Health advocacy may lead healthcare workers to experience relational conflicts, such as when an advocate is perceived as a threat to a colleague or manager or when objectives are not achieved, and professionals feel frustrated to see their efforts wasted, possibly affecting the psychosocial work environment[23].

There are possibilities to minimize these confrontations when surveillance actions are planned and evaluated collectively and are supported by a theoretical framework.

The participants composing the CSTG represented relevant health spaces in the city's cancer context. For this reason, the statute established that one case of cancer-related death would be discussed in the meetings so that all the participants would have the opportunity to identify the causes and consequently participate in the establishment of strategies intended to avoid such deaths.

An interdisciplinary team was composed because members from different professions could exchange instruments, techniques, methodologies, and approaches to complement each other's resources. Such a dialogue enriches and transforms practice, considering that horizontal relationships enable the exchange of knowledge and participants can tackle tasks together[24].

Additionally, considering the amount of information that the healthcare network has and which shows the flow of health practices, the group developed an instrument to gather the necessary information and facilitate the group's work system, which enabled assertive priority establishing.

Finally, the process in which the group was implemented allowed the recognition of the attributes of the advocacy framework adopted in this study. Thus, advocacy was envisioned as a possibility to integrate healthcare and make it more humane, facilitate patients to access knowledge, and enable healthcare professionals to provide competent responses.

Sharing the experience of implementing the CSTG revealed it as a health surveillance strategy to ensure all the legal rights of people with cancer. Moreover, the theoretical framework adopted here to support advocacy mobilized other experiences, such as solving a problem with a significant impact on cancer mortality and improving the quality of healthcare provided to individuals affected by cancer. Such mobilization was guided by the knowledge and recognition that professionals collectively constructed and learned about their skills in advocating for patients.

The theoretical and philosophical alignment of the health advocacy framework as a guide to the GVTCA implementation process became evident when the convergence groups outlined actions that could provoke social and/or organizational changes based on the legal and fundamental ethical right to health. Health advocacy involves building knowledge collectively, thinking, management, and healthcare based on scientific theories and evidence[18–17].

Nonetheless, it is important to recognize factors in health services that, among other aspects, hinder advocacy. Lack of material and financial resources, inadequate physical spaces, work overload, lack of autonomy, discontinuity of care between levels of care, and a prevalence of hegemonic traditional care models hinder health advocacy[25].

These limitations reflect on the healthcare provided to patients. Hence, patients facing a vulnerable situation caused by cancer are also affected by health system problems. It is also worth considering that exposure to technological treatment devices and fiscal austerity policies since 2015 have impacted healthcare quality, including oncology. This universe of difficulties calls for advocacy, and health professionals providing direct patient care are engaged in this role[26].

The participants started experiencing the positive results of advocacy actions based on the construction of knowledge and its consolidation in surveillance practices. Studies show that health workers experience a feeling of accomplishment and satisfaction when their duties are fulfilled, and patients experience positive outcomes due to advocacy actions implemented in the workplace[27,28,29]. Some aspects facilitate obtaining success in health advocacy, such as the subjective influence of being empathetic with patients, taking their social and religious values into account, in addition to experiences concerning training and level of knowledge, and political-social involvement[30,16].

The decision to implement the CSTG in convergence with the study, i.e., in the same physical and temporal space, provided an opportunity for dialogue, which enabled us to critically reflect on the actions agreed upon beyond management materialized in the ordinance of the group's creation. In this sense, CCR contributed to proposing care models based on processes directly related to care practice[15].

This study's limitation is that it concerns a unique experience. Hence, despite the possibility of applying the method to other contexts, the results are limited to the context addressed here.

CONCLUSION

The Health Surveillance Technical Group comprises professionals from multidisciplinary teams who plan, implement, and evaluate strategies to promote, protect, and recover patient health. When the health advocacy theoretical framework is included in this scope, it assumes an ethically imperative stance to resolve inequities by ensuring patients have their legal and fundamental rights.

Improved understanding of multiple contexts and structures provides practitioners with strategies to apply in individual and community healthcare practices and address the root causes of inequality through leadership, political influence, advocacy, continuing education, and research to build knowledge. These strategies, supported by a theoretical framework, enable to break power hierarchies that sustain health inequities, especially in oncology. Despite laws and scientific evidence highlighting the essential nature of early diagnoses and timely treatment for people with cancer, weaknesses persist in processes in Health Care Networks and Lines of Care.

Health advocacy is a pillar of the political action of professionals advocating for patient rights. Advocacy is implemented through health surveillance to ensure the quality of care provided to cancer patients. Although such actions are implemented in all health settings at a national level, the technical surveillance field comes close to the theoretical dimension of advocacy. From this encounter emerges the recognition of practices, the acquisition of knowledge, and advancements toward consolidating comprehensive and equitable care.

REFERENCES

1. Hanks RG. Development and testing of an instrument to measure protective nursing advocacy. Nurs Ethics [Internet]. 2010 [cited 2021 Oct 15];17(2):255-67. Available from: https://doi.org/10.1177/0969733009352070
2. Abbasinia M, Ahmadi F, Kazemnejad A. Health advocacy in nursing: A concept analysis. Nursing Ethics [Internet]. 2020 [cited 2021 Oct 15];27(1):141-51. Available from: https://doi.org/10.1177/0969733019832950
3. International Council for Nurses (ICN). The ICN code of ethics for nurses [Internet]. Geneva, (CH): ICN; 2021. [cited 2021 Oct 15]. 32 p. Available from: https://www.icn.ch/sites/default/files/2023-06/ICN_Code-of-Ethics_EN_Web.pdf
4. Rosa W. Public Health nursing and transnational agendas: Local to global health advocacy. Public Health Nurs [Internet]. 2017 [cited 2021 Oct 15];34(3):197-9. Available from: https://doi.org/10.1111/phn.12317
5. Blackburn R, Johnson KG, Chaveleh S. Advocacy: The pivotal role of oncology nurses. Clin J Oncol Nurs [Internet]. 2020 [cited 2021 Oct 15];24(1):103-6. Available from: https://doi.org/10.1188/20.CJON.103-106
6. Malta DC, Gomes CS, Barros MBA, Lima MG, Almeida WDS, Sá ACMGN, et al. Doenças crônicas não transmissíveis e mudanças nos estilos de vida durante a pandemia de COVID-19 no Brasil. Rev Bras Epidemiol [Internet]. 2021 [cited 2021 Nov 10];24:e210009. Available from: https://doi.org/10.1590/1980-549720210009
7. Duarte DAP, Nogueira MC, Magalhães MC, Bustamante-Teixeira MT. Iniquidade social e câncer de mama feminino: Análise da mortalidade. Cad Saúde Colet [Internet]. 2020 [cited 2021 Nov 10];28(4):465-76. Available from: https://doi.org/10.1590/1414-462X202028040360

8. Ferlay J, Colombet M, Soerjomataram I, Mathers C, Parkin DM, Piñeros M, et al. Estimating the global cancer incidence and mortality in 2018: GLOBOCAN sources and methods. Int J Cancer [Internet]. 2019 [cited 2021 Nov 10];144(8):1941-53. Available from: https://doi.org/10.1002/ijc.31937
9. Silva MJS, Bergmann A, Siqueira A de SE, Casado L, Zamboni MM. Influência das iniquidades sociais e dos cuidados de saúde na incidência e mortalidade por câncer. Rev Bras Cancerol [Internet]. 2018 [cited 2021 Nov 10];64(4):459-60. Available from: https://doi.org/10.32635/2176-9745.RBC.2018v64n4.211
10. Banna SC, Gondinho BVC. Assistência em oncologia no sistema único de saúde (SUS). J Manag Prim Health Care [Internet]. 2019 [cited 2023 Sep 4];11 Suppl 1:e64s. Available from: https://jmphc.com.br/jmphc/article/view/851
11. Ventura CAA, Fumincelli L, Miwa MJ, Souza MC, Wright MDGM, Mendes IAC. Health advocacy and primary health care: Evidence for nursing. Rev Bras Enferm [Internet]. 2020 [cited 2021 Oct 18];73(3):e20180987. Available from: https://doi.org/10.1590/0034-7167-2018-0987
12. Trentini M, Paim L, Silva DMG. Pesquisa convergente assistencial: Delineamento provocador de mudanças nas práticas de saúde. 3rd ed. Porto Alegre, RS(BR): Moriá; 2014.
13. Brasil. Presidência da República. Lei nº 12.732 de 22 de novembro de 2012. Dispõe sobre o primeiro tratamento de paciente com neoplasia maligna comprovada e estabelece prazo para seu início [Internet]. Diário Oficial da União, Brasília, DF, n.227, 2012 [cited 2021 Oct 18]. Available from: https://www.planalto.gov.br/ccivil_03/_ato2011-2014/2012/lei/l12732.htm
14. Brasil. Presidência da República. Lei nº 13.685, de 25 de junho de 2018. Altera a Lei nº 12.732, de 22 de novembro de 2012, para estabelecer a notificação compulsória de agravos e eventos em saúde relacionados às neoplasias, e a Lei nº 12.662, de 5 de junho de 2012, para estabelecer a notificação compulsória de malformações congênitas [Internet]. Diário Oficial da União, Brasília, DF, n.121, 2018 [cited 2021 Oct 18]. Available from: https://www.planalto.gov.br/ccivil_03/_ato2015-2018/2018/lei/l13685.htm
15. Rocha PK, Prado ML, Silva DMGV. Pesquisa convergente assistencial: Uso na elaboração de modelos de cuidado de enfermagem. Rev Bras Enferm [Internet]. 2012 [cited 2021 Oct 11];65(6):1019-25. Available from: https://doi.org/10.1590/S0034-71672012000600019
16. Maryland MA, Gonzalez RI. Health advocacy in the community and legislative arena. Online J Issues Nurs [Internet]. 2012 [cited 2021 Oct 11];17(1):2. Available from: https://doi.org/10.3912/OJIN.Vol17No01Man02
17. Pettus KI, Lima L. Palliative care advocacy: Why does it matter? J Palliat Med [Internet]. 2020 [cited 2021 Oct 11];23(8):1009-12. Available from: https://doi.org/10.1089/jpm.2019.0696
18. Laari L, Duma SE. Facilitators of the health advocacy role practice of the nurse in Ghana: A qualitative study. Health Sci Rep [Internet]. 2021 [cited 2021 Oct 20];4(1):e220. Available from: https://doi.org/10.1002/hsr2.220
19. Neves FB, Vargas MAO, Zilli F, Trentin D, Huhn A, Brehmer LCF. Advocacia em saúde na enfermagem oncológica: Revisão integrativa da literatura. Esc Anna Nery [Internet]. 2021 [cited 2021 Oct 5];25(1):e20200106. Available from: https://doi.org/10.1590/2177-9465-ean-2020-0106
20. Truant T. Equity in cancer care: Strategies for oncology nurses. Nurs Clin North Am [Internet]. 2017 [cited 2021 Oct 17];52(1):211-25. Available from: https://doi.org/10.1016/j.cnur.2016.11.003
21. Figueira AB, Barlem ELD, Amestoy SC, Silveira RS, Barlem JGT, Ramos AM. Advocacia em saúde por enfermeiros na estratégia saúde da família: Barreiras e facilitadores. Rev Bras Enferm [Internet]. 2018 [cited 2021 Oct 17];71(1):57-64. Available from: https://doi.org/10.1590/0034-7167-2016-0119

22. Davoodvand S, Abbaszadeh A, Ahmadi F. Patient advocacy from the clinical nurses' viewpoint: A qualitative study. J Med Ethics Hist Med. 2016;9:5.
23. Hanks RG. Social advocacy: A call for nursing action. Pastor Psychol [Internet]. 2013 [cited 2021 Nov 10];62(2):163-73. Available from: https://doi.org/10.1007/s11089-011-0404-1
24. Hanks RG, Starnes-Ott K, Stafford L. Health advocacy at the APRN level: A direction for the future. Nurs Forum [Internet]. 2018 [cited 2021 Aug 20];53(1):5-11. Available from: https://doi.org/10.1111/nuf.12209
25. Jakimowicz S, Perry L, Lewis J. Insights on compassion and patient-centred nursing in intensive care: A constructivist grounded theory. J Clin Nurs [Internet]. 2018 [cited 2021 Aug 20];27(7-8):1599-611. Available from: https://doi.org/10.1111/jocn.14231
26. Hanks RG, Eloi H, Stafford L. Understanding how advanced practice registered nurses function as patient advocates. Nurs Forum [Internet]. 2019 [cited 2021 Aug 20];54(2):213-9. Available from: https://doi.org/10.1111/nuf.12319
27. Perry C, Emory J. Advocacy through education. Policy Polit Nurs Pract [Internet]. 2017 [cited 2021 Aug 20];18(3):158-65. Available from: https://doi.org/10.1177/1527154417734382
28. Aiken LH, Fagin CM. Evidence-based nurse staffing: ICN's new position statement. Int Nurs Rev [Internet]. 2018 [cited 2022 Sep 5];65(4):469-71. Available from: https://doi.org/10.1111/inr.12499
29. Lopes-Júnior LC, Lima RAG. Cuidado ao câncer e a prática interdisciplinar. Cad Saúde Pública [Internet]. 2019 [cited 2022 Sep 5];35(1):e00193218. Available from: https://doi.org/10.1590/0102-311X00193218
30. Sundqvist AS, Anderzén-Carlsson A, Nilsson U, Holmefur M. Protective nursing advocacy: Translation and psychometric evaluation of an instrument and a descriptive study of swedish registered nurse anesthetists' beliefs and actions. J Perianesth Nurs [Internet]. 2018 [cited 2022 Sep 5];33(1):58-68 Available from: https://doi.org/10.1016/j.jopan.2016.10.002

NOTES

ORIGIN OF THE ARTICLE

Article extracted from the thesis – Estratégias de vigilância em saúde para pessoas com câncer na perspectiva da advocacia em saúde, presented to the Post-graduation Program in Nursing, *Universidade Federal de Santa Catarina*, in 2022.

CONTRIBUTION OF AUTHORITY

Study design: Neves FB, Vargas MAO, Brehmer LCF, Bitencourt JVOV.
Data collection: Neves FB, Vargas MAO.
Data analysis and interpretation: Neves FB, Vargas MAO, Brehmer LCF, Rabelo M, Bitencourt JVOV, Rosa FS.
Discussion of results: Neves FB, Vargas MAO, Brehmer LCF, Rabelo M, Bitencourt JVOV, Rosa FS.
Redaction and/or content critical review: Neves FB, Vargas MAO, Brehmer LCF, Rabelo M, Bitencourt JVOV, Rosa FS.
Review and approval of final version: Neves FB, Vargas MAO, Brehmer LCF.

FUNDING INFORMATION

This study was financed by the *Coordenação de Aperfeiçoamento de Pessoal de Nível Superior* – Brazil (CAPES) – Finance Code 001.

APPROVAL OF ETHICS COMMITTEE IN RESEARCH

Approved by the Ethics Committee in Research of the *Universidade Federal de Santa Catarina*, Opinion report No. 3.946.643, CErtification for Ethical Appraisal No. 28745820.2.0000.0121.

CONFLICT OF INTEREST

There is no conflict of interest.

EDITORS

Associated Editors: Jaime Alonso Caravaca-Morera, Maria Lígia dos Reis Bellaguarda.
Editor-in-chief: Elisiane Lorenzini.

TRANSLATED BY

Arlete Belluzo.

HISTORICAL

Received: July 01, 2023.
Approved: December 19, 2023.

CORRESPONDING AUTHOR

Marcelexandra Rabelo.
marcelexandrar@gmail.com