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The Oncological Attention Policy in a Municipality of The Lagos Region of Rio De Janeiro

A Política De Atenção Oncológica Num Município Da Região Dos Lagos Do Rio De Janeiro

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ABSTRACT

Cancer currently represents a public health problem with a growing incidence in Brazil, as well in the world. Objetive: to analyze the quality of cancer care based on the vision of SUS users who have already received some kind of assistance. Topics on aging oncology, and control actions were reviewed. Methodology: This is a field research, whit a quantitative, descriptive and exploratory approach, data collection was performed through the application of a form. The participants of this research were cancer patients, over 18 years old, treated by the SUS and Cabo Frio residents, the research scenario was a UNACON, located in the municipality already mentioned. Results: in the face of the results obtained, this research identified some gaps in the assistance from the system users' reports. The result were presented in five topics that comprise the dimensions covered by the PNPCC: Health promotion, prevention, Early diagnosis, Timely Treatment and Hospice Care .Conclusion: it can be seen that, just as in the country, the municipality cannot meet the needs of all clients in an equitable and timely manner. Due to progressive increase of those affected by the disease, the tertary care structures should grow similary so that they could guarantee the population'srights, full care and therapeutic offer, as recommended by the cancer policy.

Keywords: Oncology; Health Policy; Health Management.

RESUMO

O câncer atualmente representa um problema de saúde pública com incidência crescente no Brasil, assim como no mundo. Objetivo: analisar a qualidade da atenção oncológica a partir da visão dos usuários do SUS que já receberam algum tipo de assistência. Foram revisados tópicos sobre envelhecimento, oncopatias, legislação e ações de controle. Metodologia: Trata-se de uma pesquisa de campo, com abordagem quantitativa, descritiva e exploratória, a coleta de dados foi realizada através da aplicação de um formulário. Os participantes dessa pesquisa foram pacientes oncológicos, maiores de 18 anos, tratados pelo SUS e munícipes de Cabo Frio, cenário da pesquisa foi uma UNACON, localizada no município já citado. Resultados: Em face dos resultados obtidos, esta pesquisa identificou algumas lacunas na assistência a partir do relato dos usuários do sistema. Os resultados foram dispostos em cinco tópicos que compõem as dimensões abrangidas pela PNPCC: Promoção da saúde, Prevenção, Diagnóstico precoce, Tratamento oportuno e Cuidados paliativos. Conclusão: Percebe-se que, assim como no país, o município não consegue suprir a carência de toda clientela de forma equitativa e tempestiva. Devido ao aumento progressivo de acometidos pela doença, as estruturas de atendimento terciário deveriam crescer similarmente para que pudessem garantir os direitos da população, de atendimento integral e devida oferta terapêutica, assim como preconizado pela política oncológica.

Palavras-chave: Oncologia; Política de Saúde; Gestão em Saúde.

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Introduction

It is known that population longevity is increasing at increasing age levels and, associated with irregular and unhealthy living habits, has been influencing the progressive increase in the number of people affected by the most varied types of diseases, among which neoplasms[1]. Higher impacts are observed in developing countries, not only because of the association between cancer and cancer, but also because of the low amount of resources available for their early diagnosis and treatment, which are generally very costly[2].

It is important to remember that CA is the term used to denote a large group of diseases characterized by rapid and disordered cell multiplication, causing the formation of malignant tumors. These types of neoplasias tend to be aggressive and uncontrollable, contributing factors to high mortality rates worldwide[3].

CA currently represents a public health problem, and its incidence has been increasing in the world, as in Brazil. The National Cancer Institute (INCA) points to the occurrence of about 576 thousand new cases in 2014, an estimate that will also be valid for 2015. These data reinforce the size of the problem of this disease in the country[4].

It should be noted that its control is directly linked to prevention and early detection. It is important to remember that the assistance provided to the population permeates all levels of attention, including actions for health promotion, prevention, early detection, timely treatment and palliative care[5].

It is important to emphasize that palliative care focuses on quality and not on the duration of life. They offer humane and compassionate care to people in the later stages of an incurable disease, so they can live as comfortably as possible.

Thus, it was fundamental to implement a national program as a cancer control strategy. Currently, the National Policy for Cancer Prevention and Control (PNPCC) is established by Ordinance No. 874, of May 16, 2013 with the purpose of improving the quality of care and, consequently, reducing the morbidity and mortality profile still high in the country[5]; and SAS / MS No. 741, dated December 19, 2005, establishes norms and criteria for the habilitation of High Complexity services in the Oncology Attention Network[6].

As a strategy to control the disease, Comprehensive Oncology Care Centers (CACONs) and High Complexity Oncology Care Units (UNACONs) have been implemented throughout the country, with

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the purpose of expanding the coverage of care and the purpose of provide patients with a definitive diagnosis, determine staging of the disease and offer quality treatment according to the established guidelines[5,6].

The municipality of Cabo Frio-RJ has been implementing a UNACON since 2008, which has the capacity to care for patients living in the Lagos Region, affected by the most prevalent types of cancer in the country[7]. Thus, the Federal Government makes available the transfer of the budget ceiling of Medium and High Complexity (MAC) to this unit, ensuring the right to full assistance of SUS users patients[8].

Therefore, this study aims to implement the National Policy for Prevention and Control of Cancer in the municipality of Cabo Frio - RJ. In this context, it aims to analyze the quality of cancer care, based on the vision of users of the Unified Health System (SUS) who have already received some kind of assistance.

This study aims to contribute as a topic for debates and discussions with the purpose of improving the management process of the Cancer Policy of the City of Cabo Frio and, consequently, provide better oncological care to patients treated in the Public Network of this locality. In addition to contributing to the scientific community for future studies.

Method

For the accomplishment of this article we used the method of field research with quantitative, descriptive and exploratory approach. It has a characteristic of quantitative field research, since after the collection of reports of the users of the system the PNPCC quality analysis was carried out in the municipality of Cabo Frio - RJ, later, the evidence was translated into numbers.

Field research is used as a method to obtain information and knowledge that answers or proves hypotheses, in addition to clarifying possible phenomena or relation between them[9].

It has an exploratory-descriptive profile, since it approached the cancer patients who received some type of treatment of the system, to know if the experience of these goes against the actions recommended by the PNPCC, the questions addressed were analyzed without interference of the researcher and, from this point , possible gaps could be identified.

The study scenario was a UNACON, located in the municipality of Cabo Frio - RJ. Because it is the reference unit in high complexity treatment, it is understood that the patients treated there have already passed through all levels of attention. This counts with three offices, destined to two doctors and one for nurse, a large room

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destined to the chemotherapeutic treatment and waiting room. Patients with a confirmed diagnosis of oncopathies, older than 18 years, treated by the SUS and the residents of Cabo Frio, participated in this study. Subjects who were not willing to participate in the study were excluded from the study, who had to interrupt their participation due to some physical or psychological decompensation and who were waiting for some confirmation of their diagnosis.

Field research was based on legality in Resolution No. 466 of the National Health Council (CNS), of December 12, 2012 authorizing the study with humans in Brazilian territory, for the entry into the field was made prior contact and only after the documented authorization of the responsible coordinator did the field research begin[9]. The project was sent to the Ethics and Research Committee (CEP) of the Veiga de Almeida University and approved under opinion no. 2,229,943. Additionally, the Informed Consent Term (TCLE) was used with the interviewed patients and the protection of the respective images using fictitious names.

At the beginning, data were collected pertaining to the characteristics of the participants such as gender, age, schooling, among others. The investigation was based on a structured interview with the use of a form containing 17 closed questions. In this, the participant was questioned about the variables contemplated by PNPCC (actions of promotion, prevention, early detection, timely treatment and palliative care). The answers obtained are related to the patients' experience during the period they were assisted in the levels of basic, secondary and high-complexity care.

Thirty-six participants were interviewed every Wednesday, since it is the day of greatest flow of care to SUS patients during the month of September 2017. During the days of the research, the team became more receptive and only six subjects within the inclusion criteria refused to respond to the form.

The results were presented according to the descriptive statistical method, since it transformed the experience of the patients into numbers that translated PNPCC functionality, converting these data into percentage and presenting in tables and graphs.

In this way, the quality evaluation of the PNPCC offered in the city of Cabo Frio - RJ was performed by community users.

Results

On the basis of a socio-epidemiological profile of oncological patients living in the first (81%) and second (19%) districts of Cabo Frio - RJ, with 36

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participants presenting ages ranging from 40 to 82 years, with 92% 50 years, it should be highlighted a greater predominance of females (67%).

As for schooling, it was found that the sum of the participants with training up to the average level is 83%, followed by 11% with higher level and 6% of illiterates. It is known that schooling is directly linked to socioeconomic factors.

Another important factor to highlight is the incidence of cancer by gender. In this study, 50% of the women were diagnosed with CA, followed by CA, intestinal, ovary, endometrial and stomach with 8% respectively, as well as CA, liver, uterus, esophagus and spine. In men, the predominance is in the cases of CA of prostate (42%), followed by CA of intestine (25%) and CA of head, stomach, lung and bone with 4% each. The values highlighted are in line with national levels[4-10].

To analyze the data, the discussion was divided into five topics that comprise the dimensions covered by the National Policy for Cancer Prevention and Control (PNPCC): health promotion, prevention, early diagnosis, timely treatment and palliative care.

Health promotion

In this topic, participants were asked about the knowledge regarding the risk factors for the development of cancer and their habits of life before the disease and the results can be observed in Table 1.

Table 1. Relationship between population knowledge about risk factors and self-care. Cabo Frio, RJ, Brazil, 2017.

Risk Factors	Exhibition N	Exhibition (%)	Knowledge N	Knowledge (%)	TOTAL
Inadequate feeding	11	31	17	47	
Sedentary lifestyle	24	67	21	58	
Unprotected sun exposure	29	81	28	78	
Smoking	15	42	35	97	
Inadequate Alcohol Consumption	1	3	24	67	
Obesity	-	-	17	47	
Unprotected Sex	-	-	25	69	
Pesticides	-	-	31	86	

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Irregular vaccination	11	33	-	-	
Prevention		**Yes**		**No**	
Received a preventive lecture	9	25	27	75	36 (100%)
Looked for medical attention	24	67	11	33	36 (100%)
Performed regular examinations	24	67	11	33	36 (100%)

Note: (N=36)

Source: research data

It is noticeable that a good part of the interviewees reported knowing the predisposing factors for cancer and, curiously, some maintain the risk behavior. The reason for this knowledge may be related to the implementation of public health promotion policies that give priority to actions, such as: healthy eating, physical activities and prevention of tobacco and alcohol use[11].

Prevention

On this subject, only a small percentage (25%) of the participants stated that they had already received a preventive speech against cancer, of these, the majority (44%) reported as a place of work offer, followed by health units (33%) and others (22%).

In general, the majority (67%) sought medical attention and performed routine exams. When questioned about the frequency of medical care, 39% responded annually, 17% every six months, and 11% reported another frequency, ranging from monthly to biennial. It was observed that 33% did not seek outpatient care and consequently did not perform routine exams (Table 1).

Most participants said they had never received a talk about cancer prevention, but the key to reducing the incidence of cancer is education of the population, a basic action that clarifies the development of the disease and the possibility of preventing it. The Family Health Strategy (ESF) is the gateway to the health service and the most conducive place to develop educational activities[12].

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Early diagnosis

In this item, the members of the research reported the difficulty points for the discovery of the disease, as can be seen in Table 2.

Table 2. Main difficulties faced by SUS users in the diagnosis of cancer. Cabo Frio, RJ, Brazil, 2017.

Dificulties	**Yes (N)**	**Yes (%)**	**No (N)**	**No (%)**	**TOTAL**
Medical consultation	5	14	31	86	36 (100%)
Diagnostic Tests	11	33	25	67	36 (100%)
Biopsy	8	22	-	-	
Magnetic Resonance Imaging	4	11	-	-	
Endoscopy	2	6	-	-	
Ultrasonography	2	6	-	-	
Others	4	11	-	-	
Exam Costs	**Own account (N)**	**Own account (%)**	**SUS (N)**	**SUS (%)**	
	14	39	22	61	

Note: (N=36)

Source: research data.

It is observed that the majority of the interviewees did not report difficulties to the referral to the specific medical consultation and nor to the accomplishment of diagnostic tests, in addition, they confirm that the costing of these examinations was carried out by the SUS, regarding those that presented difficulties it can be justified by the progressive increase of cases of the disease[4].

Timely treatment

In this dimension, the participants reported the treatments performed and the main difficulties faced to perform them, such data can be noted in Table 3.

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Table 3. Oncological care treatment offer. Cabo Frio, RJ, Brazil, 2017

Diagnosis x Treatment	Participants (N)		Participants (%)		TOTAL
Up to 60 days	20		56		
Up to 60 days before resolution	5		14		
Up to 60 days after resolution	5		14		
Did not know how to respond	6		16		
Main Treatments	-		-		
Chemotherapy	30		83		
Radiotherapy	25		69		
Surgery	14		39		
Difficulties in treatment	**Yes (N)**	**Yes (%)**	**No (N)**	**No (%)**	**TOTAL**
	7	19	29	81	36 (100%)
Radiotherapy	6	17	-	-	-
Surgery	1	2	-	-	-
Use Medication at Home	11	31	25	69	36 (100%)
Purchased	3	27		-	
SUS	8	73		-	
TOTAL	**11**	**100**		**-**	
Palliative care					
Home visit	3	8	33	92	36 (100%)
Psychological Counseling	3	8	33	92	36 (100%)
Offer emotional support to the family	9	25	27	75	36 (100%)

Note: (N=36)

Source: research data.

It is observed that the great majority of the participants managed to be attended in up to 60 days, a fact that corroborates with the national laws on the subject.

Among all the treatments offered by the SUS, it was possible to observe that the most used are chemotherapy and radiotherapy. And the main difficulties reported for the beginning of the treatments are linked to radiotherapy (Table 3).

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Palliative care

In this topic, the participants described the functionality of palliative care in the municipality of Cabo Frio - RJ (Table 3).

When observing these results, it was possible to verify that the majority of the patients do not receive palliative care as regulated, therefore evidences that the professionals involved in the assistance of these people present lack of palliative training[13].

Discussion

Although cancer affects people of all age groups, it becomes clear that older individuals are more likely to develop the disease[4-14-15]. The fact that a greater number of females may be related to the higher survival rate of males, this phenomenon can be explained by the higher rate of violent deaths that are more common among males during youth, health services[15].

This phenomenon does not differ in the city of Cabo Frio - RJ, where the resident population is 95,396 women, 4,565 more when compared to the resident male population[16]. Even so, a recent study of the disease's incidence in the country points out that men are more affected by cancer than women because of lower rate of self-care and greater exposure to risk factors[4-17].

It is known that people with lower levels of schooling may be more predisposed to risk factors due to lack of information and because of the lower purchasing power, they have greater difficulty to perform routine consultations and exams, directly interfering in the development of the disease and her diagnosis[18].

Breast cancer is the most common cancer in the world among women, it is the largest cause of cancer deaths in the female population. In Brazil, more than 57 thousand new cases were estimated for the years 2014/2015. Among the main risk factors are: age, reproductive factors, family history and overweight. In men, prostate cancer is the second most common in the world, and the most prevalent type in the country, losing only to the non-melanoma skin tumor (TU), with almost 69,000 new cases estimated for 2014 and 2015 in Brazil, being the only risk factor for development is age[4].

The non-functioning of health policies is related to the disagreement between the programmed goals and actions of effective practices, due to lack of resources or knowledge limitations of professionals[19].

The health professional has the role of mobilizing agent, it is fundamental that it has a proactive character taking advantage of the moments with the patient to guide him in preventive and educational practices to improve the quality of life[19].

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The primary care services should carry out actions to promote health, since they carry out the follow-up throughout the life of the patients. Health education must be present in group activities, which take information to the collective and also in the individual consultations. It is fundamental to disseminate self-care and guide the possible warning signs of cancer[19].

The PNPCC is the principle of health promotion that aims to identify and intervene on the factors that cause the disease, developing strategies for intersectoral development and the responsibility of government and society[5].

These factors raise the risk of individuals developing not only cancer, but also several chronic diseases, provided they are exposed cumulatively. The good news is that individuals who abandon these habits and adopt a healthy life, reduce development risks, that is, these factors are modifiable and thus an individual struggle in the battle against cancer. From this discovery, it is estimated that 30% of cases can be prevented[16].

The expansion of the basic health network is a strategic plan in the fight against the main chronic diseases. This service covers about 60% of the national population, acting in specific territories carrying out actions of promotion, health surveillance, prevention, care and continuous monitoring[15].

Cancer control is directly linked to promotion and prevention actions. Factors such as smoking, alcohol consumption, high calorie food intake, overweight, the impact of pesticides, the practice of sexual intercourse without a condom and unprotected sun exposure are determining factors for the emergence of new cases. A permanent education on healthy living habits is the basis for prevention, reduction of health-related harm and protection of life and, consequently, reduction of incidence[4-5].

In order to reduce the number of cases, the prevention and control of the disease need to guarantee the same degree of care as the care services. Simple strategies like smoking control, healthy eating incentive, human papillomavirus (HPV) vaccination and hepatitis, practice physical activities, respectively, are the prevention of lung, stomach, bowel, cervical, liver, breast, prostate and others[4].

Primary prevention against cancer is related to the adoption of healthy life habits and abandonment or reduction of exposure to risk factors, it works as health promotion. Secondary prevention is incorporated by technologies for screening certain groups and early detection of new cases[20].

Prevention is the principle of PNPCC, in order to have control of the disease, the objective is to eliminate, reduce and control risk factors of physical, chemical and

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biological origin, intervening in the causal agents of the disease, in addition, the integration of the action of early detection is essential[5].

The government's recommendations for screening and early detection5. Screening are tests performed on asymptomatic persons belonging to a target population, in order to identify precursor or carcinogenic lesions in the initial state. Early detection uses signs and symptoms presented by the patient, associating exposure to risk factors, in an attempt to discover the disease as soon as possible[20].

The purpose of early detection is to screen pre-cancerous or CA cells still located in the region of initial origin, with no occurrence of metastases. With the achievement of this objective, the relation between effect and cost is positive and the possibilities of cure and survival of the patient increase, besides generating a better quality of life for the patient[16].

Through the identification of risk factors and self-care practices, early detection is achieved and timely treatment is initiated, these actions are directly linked to an increase in survival time and reach of curability[4-5].

As a result of the demographic change that the country is going through, associated with the progress of the industrial and urban process, technological and scientific advances, the country is formed by an increasingly aging population with life habits that exposes to risks, with greater possibilities to develop chronic diseases. The growth in the number of those affected by cancer is due to this phenomenon[4].

If the numbers of new cases continue to increase, it is possible that the specialized cancer treatment network will not be able to perform diagnoses, treatment and due follow-up, as a result, deaths will be more frequent[4].

In order to speed up the diagnostic tests, patients use their own financial resources. Due to the high cost of these examinations, these seek the help of relatives to be able to pay, this difficulty compromises the budget of this family[20].

Early detection is one of the principles and guidelines of comprehensive care within the PNPCC[5]. It is important to mention that the Federal Government provides a budget transfer for actions of medium and high complexity, which ensures the diagnosis and assistance of the patients who use the system. In the case of private service providers, the processing of authorizations generates the payment for oncological services performed[8].

It is worth remembering that according to the PNPCC, it is part of the Responsibilities of the Operational Structures of Health Care Networks in the Basic

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Attention Component to implement actions of early diagnosis through the identification of signs and symptoms and to promptly send the person with suspected cancer for diagnostic confirmation performing a service of reference and against reference[5].

UNACONs are hospitals that have the technical conditions, physical facilities, equipment and human resources appropriate to provide specialized assistance of high complexity, with the objective of drawing the definitive diagnosis and treating the types of cancer that most affect the Brazilian population. While the CACONs have all the characteristics of a UNACON only differentiates by treating all types of cancer[6].

The number of UNACONs and CACONs is calculated to meet at least 1,000 new annual cases. However, the oncology care network seems not to be sufficient to attend all the patients who need diagnosis and treatment. A survey conducted by the Oncology Attention Network Support Division updated on June 3, 2011, estimated that the entire national territory needed 375 UNACONs and CACONs. At that time there were 264 authorized services, thus totaling 639 establishments to meet an estimated demand of 489,270 new cases[8].

At present, the cancer network has 276 hospitals qualified to provide assistance to about 576 thousand new cases[4-16]. That is, analyzing these data shows that from 2011 until now only 12 establishments have been accredited and the number of patients affected by the disease is increasing, pointing out that there is still a lack. Faced with this fact, this insufficiency of resources does not only affect the early diagnosis, but also the beginning of timely treatment[8].

The enactment of Ordinance No. 876, dated May 16, 2013, established as law 60 days to start the first treatment, which may be surgery, radiotherapy or chemotherapy[20].

The malignant tumors have accelerated growth and are very aggressive to the organism, because of the rapid multiplication there is great possibility of the formation of new tumors beyond the place of origin, affecting other tissues, initiating a process called metastasis. From this process it becomes increasingly difficult to curability, so the importance of an early diagnosis and early treatment[4-20].

With the evolution of current treatments some types of metastatic cancer can have cure, but most do not. Although treatments are available to all patients with metastases, only a minority becomes curable. In general, these treatments have the purpose of controlling the evolution of the disease or attenuating the symptoms generated by the metastases, in these cases the therapy can contribute to prolong the

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survival. However, most people with metastases come to death[13].

This difficulty related mainly to the radiotherapy service is related to the deficit in the number of radiotherapeutic devices, causing delay in the beginning of the treatment[8-20], besides the inconvenience of performing the treatment in another city, depending on the help of relatives and friends of the weakness caused by the treatment[20].

A survey of the Inca evidenced a shortage of 135 units of service or equipment, but according to a report of the Court of Audit of the Union published in 2011 these numbers are even higher, since it was not counted the establishments that stopped providing services for SUS[8].

The lack of radiotherapy services is not only relative to the Region, but to the national level. At present, there are 357 radiotherapy devices throughout the country, of which 269 are intended for SUS users, but 680 machines are needed to cover the entire population[12|].

According to a survey conducted by the Brazilian Society of Radiotherapy, the radiotherapy service covers about 65.9% of the demand, and reveals that when services are performed they do not occur in a timely manner. The average waiting time for diagnosis at the start of radiotherapy is 113.4 days, approximately four months, directly affecting the patient's health[20].

Regarding the State of Rio de Janeiro, 27,816 new cases required radiotherapy. According to Ordinance No. 741 of December 19, 2005 (6), each radiotherapy device can treat 600 patients per year, and in the state there are 16 devices, then 9,600 of these will be guaranteed treatment while 18,216 are not taken care of[16].

A UNACON should offer minimally chemotherapy and surgical treatments, but the radiotherapy intervention must be formally referenced to another unit that provides the service, guaranteeing the right of treatment prescribed to the patient[5].

As for those who require treatment medication at home (31%), most of them (73%) say they do not buy, since they are offered by SUS (Table 3).

Of the participants who use home drug therapy, the majority affirmed that they receive this assistance through the SUS, however it is noted that not all of them enjoy the constitutional right to full therapeutic care[11].

Oncological treatment is the responsibility of municipal, state and federal managers, failure to provide prescribed medications is a failure in planning and entails lawsuits or self-financing to meet this need[11-12].

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The highly complex services in oncology accredited by the SUS also function as components of the support system providing essential pharmaceutical assistance for home, outpatient and hospital treatment according to the terms of Law No. 12,401 of April 28, 2011[5-11]. In view of the types of therapeutics discussed, palliative care aims to contribute to the alleviation of suffering and improve the quality of life without focusing on the curability of the disease[5-8-19].

Regarding the Responsibility of the Operational Structures of the Healthcare Networks of the PNPCC, in the Basic Attention Component, it is explicit the incumbency to perform home care and participate in palliative care to cancer patients in an articulated way with other health services. These views should bring clear information to the family and patient, ensure emphasis on pain control, provide relief from suffering and quality of life with support and safety[5].

The therapy offered to cancer patients varies according to the type and stage of the disease, whether they are divided into treatments that aim at the cure or complete elimination of cancer cells, those that control the evolution of the disease, prolonging the survival, and in cases where there is no more possibility of curability are initiated the palliative treatments that provide the relief of the symptoms caused by the disease[20].

Palliative care, besides containing the physical symptoms caused by the disease, includes psychotherapeutic and spiritual actions from the moment of diagnosis confirmed until death, this support is offered not only to the patient but also to the family. In order for this service to obtain a satisfactory service, the professional service providers must receive a permanent education beyond the psychotherapeutic measures and spiritual structure. Such care should be provided at outpatient clinics, at home and at medium and high complexity hospitalizations[13].

In view of the results obtained, this research was in line with the objective and analyzed the quality of the cancer policy in the municipality already mentioned, identifying some gaps in the care from the report of the users of the system.

Conclusion

In view of the results obtained, it was possible to verify the need to expand the proposal of continuing health education, in addition to cancer care, so that it can cover the entire demand of patients who need diagnosis and treatment, as well as ensure the current policy.

It is known that as long as health promotion and prevention do not get the same focus as care, secondary and tertiary

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care services, the increase in cancer morbidity and mortality numbers will increase. For this reason, it is important that, in addition to increasing the coverage of the basic network, it is essential to enable the professionals involved to better use and implement public health policies.

Another important point for suggestion is to bring more health-related knowledge to schools, contributing to the formation of a new cycle of citizens who, when educated from an early age, carry the importance of healthy lifelong habits and future generations. So, possibly, the better will be the adherence of these practices and then better quality of life will have in the future.

There was a failure to follow the care lines, regarding the timely referral of patients with the suspected disease for confirmation. The delay in performing referral and referral services to chart the definitive diagnosis leads them to pay for these examinations with their earnings, thus making part of their income while the offer should be free.

Regarding oncological care offered by UNACONs and CACONs, it is noticeable that, just as in the country, the municipality cannot meet the needs of all clients in an equitable and timely manner. Due to the progressive increase of those affected by the disease, the tertiary care structures should grow similarly so that it could guarantee the population's rights, full care and due therapeutic offer, as recommended by the cancer policy.

It is hoped that this study will contribute to the improvement of the management process of the oncological care of the municipality, consequently to improve the offer of care so that it occurs as recommended.

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