Social and Cultural Aspects related to Prostate Cancer in the Point of view of Patients and Social Assistants professionals

doi: https://doi.org/10.32635/2176-9745.RBC.2019v65n2.125

Aspectos Socioculturais que envolvem o Câncer de Próstata na Ótica dos Usuários e Assistentes Sociais

Aspectos Socioculturales que involucran el Cáncer de Próstata en la Óptica del Usuario y Assistentes Sociales

Francisca Valéria de Morais Moura[1]; Josinês Barbosa Rabelo[2]

Abstract

Introduction: In Brazil, it is estimated 68,220 new prostate cancer cases in 2018 and in 2019. With the study, it was possible to observe that the low demand and the difficulty of access to the health-care services are related to some social and cultural aspects. **Objective:** To understand the sociocultural aspects that involve the diagnosis and treatment of prostate cancer in the perspective of both the patients and social workers. **Method:** This is a qualitative, descriptive and exploratory research. The method of content analysis was used. Data were collected through a semi-structured interview with open and closed questions. The study included 70 men diagnosed with prostate cancer and three social workers working in the area investigated. **Results:** In relation to the demand for health-care units, 79% of the interviewed men answered that they did not seek it frequently. As for the reason(s) for not consulting a doctor, the answers indicate lack of symptoms, job-related issues, male chauvinism and prejudice. **Conclusion:** The present study investigated the social profile of the patients treated for prostate cancer in the rural area of Pernambuco called "Agreste" and the social-cultural aspects involving the diagnosis and treatment of prostate cancer. It is necessary to improve health education for men, promoting the debate about the subject, further to the implementation of actions to favor the early diagnosis, aiming to reduce the incidence and prevalence of the disease.

Key words: Prostatic Neoplasms; Cultural Characteristics; Early Diagnosis; Health Promotion.

Resumo

Introdução: Para o Brasil, estimam-se 68.220 casos novos de câncer de próstata para cada ano do biênio 2018-2019. Com o estudo, foi possível observar que a baixa procura e a dificuldade de acesso aos serviços de saúde têm relação com alguns aspectos sociais e culturais. **Objetivo:** Compreender os aspectos socioculturais que envolvem o diagnóstico e o tratamento de câncer de próstata na ótica do usuário e do assistente social. **Método:** Trata-se de uma pesquisa de abordagem qualitativa, descritiva e exploratória. Foi utilizado o método de análise de conteúdo. Os dados foram coletados por meio de uma entrevista semiestruturada, contendo questões abertas e fechadas. Participaram do estudo 70 homens com diagnóstico de câncer de próstata e três assistentes sociais atuantes no local pesquisado. **Resultados:** Quanto à procura pela Unidade de Saúde, 79% dos homens entrevistados responderam que não procuravam com frequência. Em relação aos motivos pela baixa procura ao médico, foram apontados ausência de sintomas, em função do trabalho, machismo e preconceito. **Conclusão:** Verificou-se no presente estudo o perfil social dos usuários que realizam tratamento para câncer de próstata no Agreste de Pernambuco e os aspectos socioculturais que envolvem o diagnóstico e tratamento do câncer de próstata. Torna-se necessária a educação em saúde voltada para os homens, promovendo o debate sobre a temática, além da implementação de ações que promovam o diagnóstico precoce, buscando reduzir a incidência e prevalência da doença.

Palavras-chave: Neoplasias da Próstata; Características Culturais; Diagnóstico Precoce; Promoção da Saúde.

Resumen

Introducción: Para Brasil, se estima que 68,220 casos nuevos de cáncer de próstata para cada año del bienio 2018-2019. Con el estudio, se observó que la baja demanda y la dificultad de acceso a los servicios de salud están relacionadas con algunos aspectos sociales y culturales. **Objetivo:** comprender los aspectos socioculturales que implican el diagnóstico y el tratamiento del cáncer de próstata desde la perspectiva del usuario y el trabajador social. **Método:** Esta es una investigación cualitativa, descriptiva y exploratoria. Se utilizó el método de análisis de contenido. Los datos fueron recolectados a través de una entrevista semiestructurada que contenía preguntas abiertas y cerradas. El estudio incluyó a 70 hombres diagnosticados con cáncer de próstata y tres trabajadores sociales, que trabajaban en el lugar encuestado. **Resultados:** En cuanto a la búsqueda de la Unidad de Salud, el 79% de los hombres entrevistados respondieron que no buscaban con frecuencia. En cuanto a las razones de la baja demanda al médico, indicaron ausencia de síntomas, debido al trabajo, e informaron machismo y prejuicios. **Conclusión:** En el presente estudio, se verificó el perfil social de los usuarios que se someten a un tratamiento para el cáncer de próstata en Agreste de Pernambuco y los aspectos socioculturales que implican el diagnóstico y el tratamiento del cáncer de próstata. Es necesaria una educación sanitaria centrada en los hombres, promoviendo el debate sobre el tema, y la implementación de acciones que promuevan el diagnóstico precoz, buscando reducir la incidencia y prevalencia de la enfermedad.

Palabras clave: Neoplasias de Próstata; Características Culturales; Diagnóstico Precoz; Promoción de la Salud.

[1] Departamento de Serviço Social. Centro Universitário Tabosa de Almeida (Asces-Unita). Caruaru (PE), Brazil. Orcid iD: https://orcid.org/0000-0003-3206-4247

[2] Departamento de Serviço Social. Asces-Unita. Caruaru (PE), Brazil. Orcid iD: https://orcid.org/0000-0002-9415-390X

Address for Correspondence: Francisca Valéria de Morais Moura. Rua Leão Coroado, 67 – Boa Vista. Recife (PE), Brazil. CEP 50060-250. E-mail: valeriamoraism@hotmail.com

This article is published in Open Access under the Creative Commons Attribution license, which allows use, distribution, and reproduction in any medium, without restrictions, as long as the original work is correctly cited.

INTRODUCTION

According to "Instituto Nacional de Câncer José Alencar Gomes da Silva (INCA)", it is estimated for Brazil in 2018 and 2019 the occurrence of 600 thousand new cases of prostate cancer each year. Excepting non-melanoma skin cancer (around 170 thousand new cases) will occur 420 thousand new cancer cases[1].

Information disclosed by INCA[1] indicate to Brazil an estimate of 68,220 new prostate cancer cases for each year of 2018-2019. The most frequent cancers are prostate (68 thousand) in men and breast (60 thousand) in women. For the Northeast Region, it were estimated 15.820 new cases of prostate cancer in 2018. In Pernambuco, for the same year, it occurred 3,050 new cases of prostate cancer and, in Recife, the estimate was 590 new cases. These values correspond to an estimate risk of 66.12 new cases for each 100 thousand men.

For prostate cancer, the patient can be asymptomatic and with silent evolution[2]. Some men do not present symptoms or difficulties to urinate, excessive urge to urinate or blood in the urine; in the advanced stage, bone pain, generalized infection or kidney failure[3]. With the absence of symptoms, it is common the male to resist in seeking a doctor. This can hamper the early diagnosis and consequently the treatment.

The main prostate cancer risk factors are age, cancer family history and race/ethnicity. However, age is the only risk factor well established for the development of the disease[4]. The identification of risk factors, preventive measures, early detection mechanisms, treatment and rehabilitation are conducted in health facilities, in programs, campaigns and/or other actions involving several professionals, among them, the social worker.

Social Work in oncology is called in to assist the patient and its family. These are skilled professionals to identify the social demands and intervene in the social context of the patient's life at the unit where the social worker develops its practice, understanding the social question and referring the patient to the social-care network. Grounded in the theoretical-methodological, ethical-political and technical-operational dimensions to ensure the access to public policies, the materialization of the rights and quality of life of the patients [5]. Under this perspective, the professional is called to do the welcoming procedure. In the visit, a social interview is conducted to get acquainted with the social economic context where the patient is immersed, referring it to the social-care network, in addition to prompt the public policies that meet the necessities of the users, granting not only the access to health, but also the assistance, social security, transportation among others.

In relation to poor search for healthcare services, it stands out the meaning of masculinity and prejudice as well as social and cultural aspects of the social context the male lives in. Cancer is a disease that affects the life of the individual, biologically, psychologically and socially. Overall, it is also a disease, which is seen as a synonym of suffering and death.

In this direction, the present study has the objective of understanding the social cultural aspects that involve the diagnosis and treatment of prostate cancer in the perspective of the patient and understand how these aspects interfere in the daily life of the person in treatment.

METHOD

The present article is the result of a Multiprofessional Residency of Cancer and Palliative Care. Descriptive and exploratory study with qualitative approach.

The data were collected through semistructured interviews with men with prostate cancer and social workers. The data were classified, analyzed and interpreted with the technique of content analysis [6], whose themes are: male health; chauvinism and prejudice; masculinity and prevention of prostate cancer; symptoms of prostate cancer and difficulties for the diagnosis; emotional impact at diagnosis; knowledge about prostate cancer; social and family support and the role of the social service to care for men with prostate cancer.

The core question of the research was to know how oncologic patients and social workers realize the inference of social cultural aspects in the diagnosis and treatment of prostate cancer. As hypothesis, it is understood that social and cultural aspects as level of education, sexism, prejudice, popular belief, economic status among others interfere in the manner how the sick individual received the diagnosis and gets involved in the treatment of prostate cancer.

The research had as empiric field the Caruaru Oncology Center (CEOC) and "Hospital Santa Águeda" (HSA), both private facilities that attend health insured and National Health System (SUS) patients and are reference against cancer in Pernambuco "Agreste". Data collection occurred in September 2018.

Seventy men diagnosed with prostate cancer that were in treatment or clinical follow up were enrolled in the study. Three social workers have also joined the study who work at CEOC and HSA, being two residents of the Multidisciplinary Residency Program of Cancer and Palliative Care, forming the total number of social workers that attend in both institutions.

The criteria to select the patients were: age range between 50 and 59 years old, be aware of the diagnosis

of prostate cancer, in treatment or clinical follow up and who accepted to participate upon signing the Informed Consent Form (ICF), in addition to authorization to publish the results with scientific finality.

The criteria to select the social workers were: act in the local where the data were collected and be present in the daily practice while caring for the selected group to join the research and signing the Informed Consent Form, in addition to authorizing the publication of the results in scientific journals.

In compliance with Resolution number 466 of 2012, of the National Ethics Committee, the present study was submitted to the Institutional Review Board for Research with Human Subjects of "Centro Universitário Tabosa de Almeida (Asces-Unita)". It was approved through report number 91879918.7.0000.5203. It was ensured the privacy of the data collection in a private room and avoiding the exposure of the interviewee, assuring its anonymity and secrecy of the collected information.

RESULTS AND DISCUSSION

Social cultural profile of the research subjects

The sample was formed by 70 men with ages ranging from 50 to 69 years old. The study ensured the comprehension of the social cultural profile of the patients in follow up and how these aspects involve the diagnosis and treatment of the prostate cancer. It is an important instrument to understand the universe where there are immersed (Table 1).

It was observed in the study that the age range of more prevalence (51%) is between 70 and 79 years old, corroborating the data of INCA[4], when it affirms that less than 1% of prostate cancer is diagnosed in men younger than 50 years. Most of the prostate cancers occur in men older than 65 years old.

The great majority (83%) of the interviewees lives in the region "Agreste" of Pernambuco, all participate of the Treatment Program Off the Residence (TFD). This program establishes that the expenses of transportation of SUS patients off their residence city can be charged through the System of Ambulatory Information (SIA-SUS)[7].

The relation between the region where they live and the occupation justified that half of the interviewee (50%) being retired farmers with the family income consisting of at the most two minimum wages as the main source of income.

The history of family cancer was present in the interviewees' narrative, around 53% affirmed they had history of family cancer. Some reported the father had prostate cancer, others, that relatives had cancer in other part of the body.

Table 1. Social cultural profile

Variables	Category	N	%
Age	50-59	05	7%
	60-69	18	26%
	70-79	**36**	**51%**
	80-90	11	16%
Region	Mata Sul	06	8,5%
	Agreste	**58**	**83%**
	Sertão	06	8,5%
Race/ ethnicity	Caucasian	21	30%
	Black	**49**	**70%**
History of family cancer	Yes	**37**	**53%**
	No	18	26%
	Do not know	15	21%
Education	Illiterate	20	29%
	Literate	19	27%
	Elementary complete	**21**	**30%**
	High School incomplete	02	3%
	High School complete	05	7%
	College	03	4%
Occupation	Farmer	05	7%
	Retired farmer	**35**	**50%**
	Autonomous	05	7%
	Retired payer	23	33%
	Beneficiary of Special Compensation	02	03%
	Others	05	7%
Family income	1 minimum wage	19	30%
	Until 2 minimum wages	**44**	**68%**
	> 2 minimum wages	02	3%

In respect to race/ethnicity, 70% of the interviewees claim they are black (including browns and blacks) as put in studies that affirm that prostate cancer is 1.6 times more common in black men when compared to Caucasian men[4].

Low education is part of the interviewees' profile, 27% are illiterate and 57% failed to complete the elementary school I. In the study of Campos et al., it was identified the similarity in the profile of the interviewee, 53.2% were illiterate. The remaining were classified as having incomplete junior high school (17.8%), complete junior high school (6.5%), elementary incomplete (1.6%),

elementary complete (4.8%), high school incomplete (14,5%) and college incomplete (1.6%)[8]. In this scenario, complementing the socioeconomic profile, another study presents the profile of the interviewee demonstrating low education and that the misinformation reaches more intensely the male population with low level of education and socioeconomic power [9].

With the social workers interviewed, one works as social worker for 11 years, has post-graduation degree and is a preceptor of Social Work at CEOC and HAS by the Program of Multiprofessional Residency in Cancer and Palliative Care. The other two interviewee were conducted with social workers graduated two years ago and residents by the Program of Multiprofessional Residency in Cancer and Palliative Care of Asces-Unita. It is important to underline that the three professionals interviewed are part of the total sample of social workers active at CEOC and HSA.

Health of the male and prostate cancer

Prostate cancer is a public health problem since it leads to male mortality and morbidity. Therefore, it is necessary that preventive actions guided to avoid the onset of diseases are implemented and reduce the incidence and prevalence in the population.

Prostate cancer in Brazil is the second most common in men and the sixth type more common in the world. The incidence rate of prostate cancer is six times bigger in the developed countries when compared to countries in development [3].

Prostate cancer is considered a cancer of the third age, because nearly 75% of the world cases are diagnosed after 65 years old. According to INCA, in Brazil it is observed the raise of the incidence rates, justified by the evolution of the diagnosis methods (exams), improvement of the quality of the information systems and expansion of the life expectancy. INCA draws the attention to the growth of these tumors. Some may rise rapidly and spread to other organs and eventually leading to death. However, the majority grows slowly, taking around 15 years to reach 1 cm^3 and do neither show any signs during life nor threaten the male's health [3].

Sexism and prejudice

When asked whether they sought any health facility regularly in the region they lived, 21% responded yes and 79%, no. Next, they were questioned about the motives why they did not seek for a doctor earlier and 56% claimed they were asymptomatic, 40%, heedless, 16%, because of their jobs, 13%, because of sexism and 9%, for prejudice for not seeking a doctor (Chart 1). Noteworthy, the interviewee indicated more than one reason, as a patient stated: "I did not seek for a doctor earlier due to lack of information, "I was careless" with my health and because I had no symptoms, did not want to miss my job".

The study ratifies how patriarchalism is strict with men because it blocks its comprehension about the care a person must have and that this does not mean weakness or loss of masculinity. About this, Saffioti[10] indicates that it is not about a private, but a civilian relationship instead; it configures a hierarchical type of relation that pervades every room in the society and represents a structure of power based in the ideology and violence [10].

Under Couto and Schraiber[11] perspective, sexism is a system of ideas and values that creates, reinforces and legitimizes the domination of the male over the female. [...] This domination, fruit of a symbolic violence, can be recognized in the social imaginary, is considered the result of a long process of construction on how "to be a man" and "to be a woman"[11].

Sexism and prejudice were present in the narrative of some patients as the reason for not seeking for a doctor. It is reasonable to say that sexism kills men for various reasons and one of them is that health is not

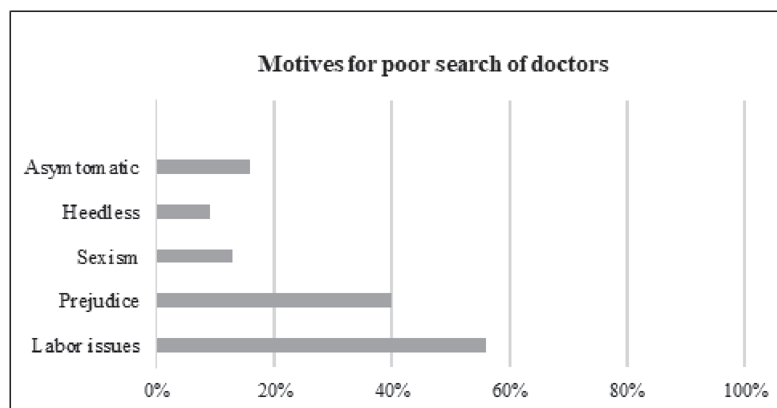

Chart 1. Motives for poor search of doctors

always a priority. Men must care for themselves as much as women do. Consequently, gender equality is a path to bury carelessness and violence against women male usually commit.

In the early stages of cancer, it is common that significant symptoms are inconspicuous[12], which justifies the meager relevance interviewee gave to see a doctor while symptoms are not evident for early detection and better prognosis. According to Figueiredo, men have difficulties to be attended in healthcare services because for them: the Health Basic Unit is a place where women go, women form the majority of the staff and waiting time is long[12].

Masculinity and prostate cancer prevention

Courtenay[13] indicates that health-related beliefs and costumes can be used to demonstrate hegemonic masculinity, with denial of weakness or vulnerability, physical or emotion control, the posture of being strong and robust, showing aggressive behavior and physical domain. Yet, according to Gomes et al.[14]: "in a relational perspective of gender, it can be seen as a symbolic space to structure the identity of being male, through dispositions to be obeyed by those who wish to be ascertained of their masculinity".

Masculinity and prostate cancer prevention were associated, since it was verified that prejudices and fear to do the rectal examination is seen as possibility of losing masculinity. The male, for cultural reasons, is adamant to do the prostate exam, the rectal examination. The patient reported as difficulty for the diagnosis: "I was afraid of the rectal examination and did not go to the doctor, further to the waiting time for consultation and exams at SUS".

This manner of seeing the exam derives from the fact that prostate affects the male sexual sensibility. Even a temporary change can bring the sensation of impotence, which evidences the importance of the early diagnosis that must be done in the annual preventive exam by all men after 45 years old, whether or not symptoms are present. For men with family prostate cancer history, the guidance is to do the preventive exam from 40 years old[15].

In this direction, eight interviewees claimed the treatment affected their sexual performance. The low number of interviewees who spoke about the subject creates the conception that for most of them sexuality is still a taboo and that possibly they are ashamed of asking the doctor about it, being fearful to follow the treatment recommended for fearing it would affect the sexuality.

Symptoms of prostate cancer and difficulties of diagnosis

Cancer symptoms manifestation time varies and may or may not cause changes in the urinary rhythm. This fact can be an indicator for not seeking for a doctor and, consequently, late diagnosis and treatment of the disease.

Early treatment is one of the best forms of obtaining successful results of prostate cancer treatment with possibility of cure. For this to be possible, it is necessary to do periodical exams of rectal examination and the prostate specific antigen – PSA [16].

For an absolute diagnosis, considering the symptoms, it is necessary that the physician gather all the information. As such, others exams can be used as ultrasound, transrectal magnetic resonance imaging, computerized tomography, echography, urography, urinary endoscopy, biopsy among others [16].

In this direction, when questioned what the symptoms that made them see a doctor were, 61% reported pain or difficulty to urinate, 9%, other symptoms, 13%, asymptomatic, 10%, were investigating another pathology, 13%, routine exams.

In this scenario, 54% believed that it was the delay to seek for a doctor, 33% claimed they did not have difficulties, 19%, the delay to do exams at SUS, 10%, prejudice or sexism and 3%, that the delay time waiting for the consultation hampered its diagnosis (Chart 2).

Considering that the researches show the propensity for not doing the preventive exams, Souza et al. describe as hindering elements for the rural population to do routine exams, more difficulty to access health services in addition to tradition and cultural strictures [17].

The interviewee reported the delay of seeking medical assistance as the main cause for difficulties of diagnosis; in addition, they also mentioned the delay to do exams at SUS and the time to wait for a consultation. In this context, the study of Ramos et al.[18] indicates exactly the difficulty of access to medium and high complexity services that happens because of SUS incapacity to meet the demand with specialized and proper support for diagnosis and treatment of neoplasms or lack of resources of the patient.

It is valid to emphasize the promulgation of the law known as 60 days[19], which disposes about the first treatment of the patient with proved malignant neoplasm and establishing the time to its beginning. However, the waiting time to make the exams and consultations at SUS to close the diagnosis is an issue and be able to initiate the treatment, because the law ensures the beginning of the treatment only after the diagnosis is confirmed, not counting the time of beginning the investigation of the pathology.

Emotional impact of the prostate cancer diagnostic

Attempting to understand what feelings the patients had while receiving the diagnosis, it was asked them how

they felt when they heard the news: 49% claimed they were calm, 27%, feeling of sadness, 23%, concern, 20%, feeling of much fear, 19%, optimism, 16%, insomnia, 7%, despair and shame and 3%, considered suicide (Chart 3).

While receiving the diagnosis, the interviewee expressed their feelings, most of them claimed they were calm with the diagnosis as already discussed along the article, this response may be a reflection of the socially constructed masculinity. It is common to have the feelings as the interviewee reported them, because it is a diagnosis still seen by great portion of the population as a death sentence. In that direction, the studies of Ramos et al.[18] present, likewise, feelings of fear/apprehension with cancer, sadness, depression, self-destruction, prevention, suffering and solidarity among the interviewee. Complementary to the study of Barros and Melo[20], the emotional repercussions more verbalized were: insomnia, suicidal ideation, fear, sadness, acute sadness, anxiety, apprehension with the diagnosis and treatment, tension, feeling of incapacity and impotence, concern with the economic condition of the family, compromised self-esteem, disgust, isolation, guilt because delayed in seeking for a health service. This input reinforce the understanding that the cancer treatment and diagnosis directly reflect on the daily life of the interviewee, with physical, emotional and social impact.

Previous knowledge about prostate cancer

It was intended to observe whether the interviewees knew about the universe of prostate cancer before the diagnosis, the research revealed that 84% of them affirmed they have heard about prostate cancer and that 16% knew nothing about prostate cancer before the diagnosis. In the present study, the majority of the interviewee claimed they were aware of prostate cancer through friends, media, campaigns as Blue November or relatives.

The interviewees were asked, based in their experience with prostate cancer, what they would like to tell other man that do not have the disease. The following

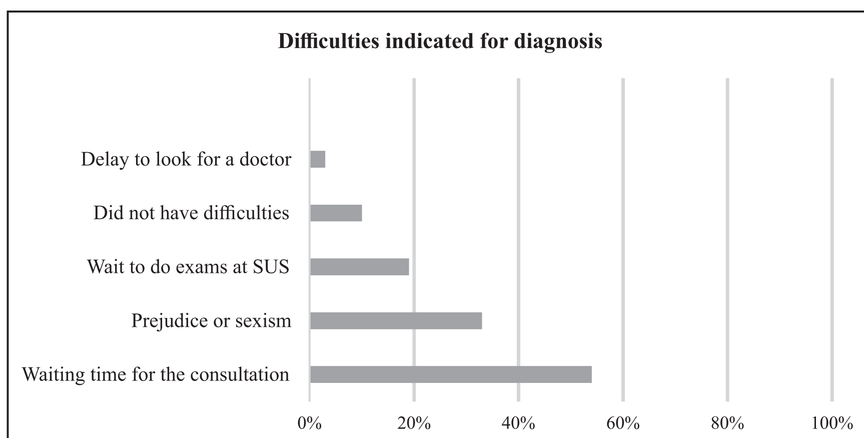

Chart 2. Difficulties indicated for diagnosis

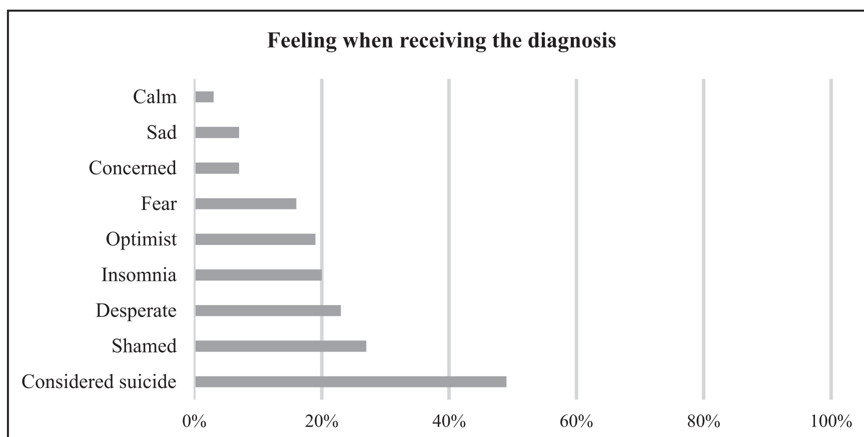

Chart 3. Feeling when receiving the diagnosis

statement was found in the patient narrative: "I advise to let prejudice and fear aside and see a doctor soon to avoid delay of the diagnosis, this would have helped me a lot". As seen in Table 2, 74% advised to be examined earlier; 59%, to see a doctor regularly, 24% warned men to let prejudice and shame apart. It is noteworthy that the interviewee gave more than one response.

It is notorious the importance of campaigns "November Blue" because it is a progress for the health policy of the male. In this perspective, it is necessary to intensify the campaigns during the whole year, offering access to SUS through exams and consultations that favor the early diagnosis. To stimulate the male public, it is indispensable to have permanent education in health with lectures and actions that bring information about prostate cancer.

Table 2. Knowledge the interviewees had about prostate cancer

Variables	Category	N	%
Have you any knowledge about prostate cancer?	Yes	**59**	**84%**
	No	11	16%
How did you know about prostate cancer?	Friends	**34**	**58%**
	TV	28	47%
	Campaign "November Blue"	23	39%
	Relatives	14	24%
Does your family participate of your treatment?	Yes	**66**	**94%**
	No	04	06%
Was your social life affected?	Yes	17	24%
	No	**53**	**76%**
What advice would you give about prostate cancer?	Do exams earlier	**52**	**74%**
	See a doctor regularly	41	59%
	Abandon prejudice and shame	17	24%

Social and family support

When asked about the involvement of the family in the treatment, 94% of the interviewee affirmed that they are present in the treatment and only 6% responded no, they were not. Studies indicate that the involvement of the family is essential at any moment of getting ill by cancer, granting the emotional support and adherence to treatment [21].

The social life was affected, as reported by 24% of the interviewee while 76% claimed it was not. Studies indicate that, because of the disease, there are cases where the male pulls away from social living or has little time for leisure, which can impact its quality of life and create a feeling of not belonging to the group, if sociability is considered. [22]. The involvement of relatives in the treatment can be connected to a good social living, the interviewee say. However, on account of the stigma of the disease diagnosis[23] or because of the treatment, the time waiting for a visit to the doctor, to receive medications and return to the origin city associated to physical and psychological aspects are facts that corroborate some impacts of the social living.

Cancer diagnosis and treatment of a dear family member is always burdensome. The situation triggered already in the diagnosis uses to change the form how relationships unfold and interdependence within the family, which can bring up internal conflicts or, in the other hand, reclaiming loss bonds and even sort our old conflicts [24].

The action of the Social Service in oncology became a fairly comprehensive practice, leading the professional to develop actions in prevention, assistance and palliative care with the patients, relatives and close friends, encouraging them to participate in the process of recovery of health, indicating they are citizens and are entitled to rights that need to be respected[24].

Role of social service in attending men with prostate cancer

The male, when finding out he has prostate cancer and when looking for attendance, needs to be welcomed by the multidisciplinary team that offers care not centered in the disease alone, but that goes far beyond the fight against the disease. Therefore, it is considered its psychosocial condition and of its family, the access to the assets of citizenship, as the required infrastructure to have adherence to the treatment to produce its general well-being.

It is important to highlight that the Social Service understands that health is unrelated only to physical factors, but sees the human being as a psychosocial unit inscribed in a specific reality. Consequently, as indicated by Andrade[25], are specific of the social worker the knowledge and approach about the socioeconomic reality of the family as well as the cultural aspects that form this universe.

The social worker should know the social context of the ill that is being followed up, attempting to provide social care services based in the demands and necessities of each patient. The Social Service has also the role of motivating the family to accept and participate of the treatment and motivate actions that contribute for a better integration

between the multiprofessional team that provide care to this public, ensuring a full and humanized care.

It is necessary to highlight that the role of the social worker is not limited to providing services, but the promotion, capacitation and conscientization, stimulating them to claim their rights to improve the health services and to meet their necessities.

From this articulated work and proximity to the patients' reality and their family it was possible to verify that the social workers interviewed identified chauvinism, prejudice and masculinity as elements present in the narratives of the sick followed up by the professionals as hinders to search for diagnosis and treatment. About these social cultural aspects, it was asked to the social workers whether they considered that they interfered in the patients' quality of life. To them, "Large part of the patients report they did not search for health services because they believe they do not need or manifest their deep prejudice against the exam" (A.S.01), since "The culture that the male needs to be strong interferes directly in the diagnosis of prostate cancer, which delays the diagnosis, hampering the treatment and cure" (A.S. 02) and understand that "Culturally, women are those who dedicate more time to their care and also to the family" (A.S 03).

The interviewed social workers also indicated the poor search for health services by the patients. The social workers, concurring with the narrative of the patients interviewed, also mentioned some of the motives for this: "Usually, prejudice with the exam weighs on the patients to not search for health services" (A.S 01). Therefore, the access to goods and services need to be considered as well, because "[...] the difficulty to get an ambulatory attendance in SUS is a great hurdle, further to the inhibition, more common among men" (A.S 03).

The understanding about the role of the Social Service in male oncology was mentioned by the social workers as:

> Guide the users about the necessity of routine medical follow up and encourage educational actions about cancer risks and forms of prevention and help the patients to overcome the prejudices (A.S 01).
>
> Act directly with the patient and family to improve the quality of life of the patient in the beginning of the treatment (A.S 02).
>
> Overall, Social Services attends all the oncologic patients cared at the health unit, guiding them about their social rights and facilitating the access to the services that complement the treatment, in addition to the materialization of actions and projects aimed at the prevention of other diseases, bringing well-being, quality of life and self-esteem of the patients (A.S 03).

As affirms Andrade [25], to know and understand the patient and its family in their boundaries and possibilities are the first step for a proper care. According to the author, listening and welcoming are unavoidable actions as the recognition of the correct moment for the intervention.

As the social workers state, educative practices are developed in their professional tasks to sensitize the patients in relation to prostate cancer, which are "Guidelines about the importance of self-care and the necessity of searching qualified health services" (A.S 01). "In our daily life and throughout the year punctual actions are created addressing prevention, but more specifically for prostate cancer only in the months of October and November" (A.S 03).

As perceived by Silva et al.[23], the role of the social worker in following up the oncologic patients occurs with the construction of the social profile of the patient, guidelines about the treatment of the disease and promotion of educative actions.

CONCLUSION

This research aimed to design the social profile of the patients who undergo prostate cancer treatment in "Agreste" of Pernambuco and learn about the sociodemographic aspects involving the diagnosis and treatment of this disease.

The research has also attempted to produce data and reflect about them with the objective of thinking how to approach the male population to steer them to primary and secondary prevention [2] of prostate cancer and the relevance of the early diagnosis.

It was possible to verify the vision of the social worker in face of the sociocultural aspects that the caregivers identify in their daily tasks, being relevant for the development of actions that contribute for the access to social rights of the oncologic patient.

It was observed the role of the social worker in defending the quality of the services and the intersectoral approach of the attendance based in this perspective of the public policies[24]. The research evidenced that there is a deficiency of publications about Social Work in oncology and indicate the necessity of more scientific productions addressing this theme.

The research revealed that aspects as low education, low instructional level, masculinity, prejudice and difficulties in accessing health policies, social work and social security are factors that can compromise the search for specialized

help, resulting in delay of medical visits and late access. Therefore, when the patient reaches the healthcare unit, it has already the symptoms of the disease, which hampers the early diagnosis and consequently its good prognosis, which results in procedures of higher complexity. Concluding, the hypothesis of the research was confirmed.

Health education for the male public with promotion of actions and lectures with accessible language that address this public is of utmost relevance. Further to the intensification of campaigns for prostate cancer detection, offer access to the health policy during the whole year to ensure the effectiveness of the right to health as disposed in Law number 8.080 of 1990[26]. And that, in fact, it happens the promotion of health in the Brazilian male population, with reduction of morbidity and mortality as established in the National Policy of Full Attention to the Male Health (PNAISH)[27].

CONTRIBUTIONS

Francisca Valéria de Morais Moura participated of the conception and design of the study, analysis and interpretation of the data, wording and critical review of the manuscript and approved the final version for publication. Josinês Barbosa Rabelo participated of the wording and critical review with intellectual contribution and approved the final version for publication.

DECLARATION OF CONFLICT OF INTERESTS

There are no conflict of interests to declare.

FUNDING SOURCES

None.

REFERENCES

1. Instituto Nacional de Câncer José Alencar Gomes da Silva. Estimativa 2018: incidência de câncer no Brasil [Internet]. Rio de Janeiro: INCA; 2017. [acesso 2018 jun. 14]. Disponível em: http://www1.inca.gov.br/inca/Arquivos/estimativa-2018.pdf.
2. Bacelar Júnior AJ, et al. Câncer de próstata: métodos de diagnóstico, prevenção e tratamento. BJSCR [Internet]. 2015 mar./maio. [acesso 2018 nov. 28];10(3):40-46. Disponível em: https://www.mastereditora.com.br/periodico/20150501_174533.pdf.
3. Instituto Nacional de Câncer José Alencar Gomes da Silva. Tipos de câncer: câncer de próstata [Internet]. Rio de Janeiro: INCA; [2012]. [modificado 2019 jul. 24; acesso 2019 jan. 21]. Disponível em: https://www.inca.gov.br/tipos-de-cancer/cancer-de-prostata.
4. Instituto Nacional de Câncer José Alencar Gomes da Silva. Estimativa 2016: incidência de câncer no Brasil [Internet]. Rio de Janeiro: INCA; 2015. [acesso 2018 jun. 14]. Disponível em: http://www.inca.gov.br/estimativa/2016/.
5. Santos CM. A dimensão técnico-operativa e os instrumentos e técnicas no serviço social. Rev Conexão Geraes [Internet]. 2013 [acesso 2018 mar. 18];(3):25-30. Disponível em: http://www.cress-mg.org.br/arquivos/Revista-3.pdf.
6. Bardin L. Análise de Conteúdo. Lisboa: Edições 70; 2011.
7. Ministério da Saúde (BR). Portaria nº 55, de 24 de fevereiro de 1999 [Internet]. [acesso 2019 jan. 16]. Disponível em: *bvsms.saude.gov.br/bvs/saudelegis/sas/1999/prt0055_24_02_1999.html.*
8. Campos HLM, Dias FMV, Moraes SC, et al. Aspectos culturais que envolvem o paciente com diagnóstico de neoplasia de próstata: um estudo na comunidade. Rev Bras Cancerol [Internet]. 2011 [acesso 2019 jan. 17];57(4):493-501. Disponível em: http://www1.inca.gov.br/rbc/n_57/v04/pdf/05_artigo_aspecto_culturais_envolvem_paciente_diagnostico_neoplasia_prostata.pdf.
9. Paiva EP, Motta MCS, Griep RH. Conhecimentos, atitudes e práticas acerca da detecção do câncer de próstata. Acta Paul Enferm. 2010;23(1):88-93. doi: http://dx.doi.org/10.1590/S0103-21002010000100014.
10. Saffioti H I B. Gênero, patriarcado, violência [Internet]. São Paulo: Editora Fundação Perseu Abramo; 2011 [acesso 2019 jun. 18]. Disponível em: https://edisciplinas.usp.br/mod/resource/view.php?id=885853.
11. Couto MT, Schraiber LB. Machismo hoje no Brasil: uma análise de gênero das percepções dos homens e das mulheres. In: Venturi G, Godinho T, organizador. Mulheres brasileiras e gênero nos espaços públicos e privado: uma década de mudanças na opinião pública [Internet]. São Paulo: Editora Fundação Perseu Abramo; 2013 [acesso 2019 jun. 17]. p. 47-61. Disponível em: https://edisciplinas.usp.br/mod/resource/view.php?id=505785.
12. Figueiredo W. Assistência à saúde dos homens: um desafio para os serviços de atenção primária. Ciênc Saúde Colet. 2005;10(1):105-109. doi: http://dx.doi.org/10.1590/S1413-81232005000100017.
13. Courtenay WH. Constructions of masculinity and their influence on men's well-being: a theory of gender and health. Soc Sci Med. 2000;50(10):1385-1401. doi: https://doi.org/10.1016/S0277-9536(99)00390-1.
14. Gomes R, Nascimento EF, Rebello LEFS, et al. As arranhaduras da masculinidade: uma discussão sobre o toque retal como medida de prevenção do câncer prostático. Ciênc Saúde Colet. 2008;13(6):1975-1984. doi: http://dx.doi.org/10.1590/S1413-81232008000600033.

15. Srougi M, Ribeiro LA, Piovesan AC, et al. Doenças da próstata. Rev Med (São Paulo) [Internet]. 2008 [acesso 2019 jan. 21];87(3):166-77. Disponível em: http://http://www.revistas.usp.br/revistadc/article/view/59075/62060 br.

16. Maia LFS. Câncer de próstata: preconceitos, masculinidade e a qualidade de vida. Rev Recien [Internet]. 2012 [acesso 2019 mar. 20];2(6):16-20. Disponível em: https://www.recien.com.br/index.php/Recien/article/download/42/81.

17. Souza LM, Silva MP, Pinheiro IS. Um toque na masculinidade: a prevenção do câncer de próstata em gaúchos tradicionalistas. Rev Gaúcha Enferm. 2011;32(1):151-158. doi: http://dx.doi.org/10.1590/S1983-14472011000100020.

18. Ramos C, Carvalho JEC, Mangiacavalli M. Impacto e (i)mobilização: um estudo sobre campanhas de prevenção ao câncer. Ciênc Saúde Colet. 2007;12(5):1387-1396. doi: http://dx.doi.org/10.1590/S1413-81232007000500036.

19. Presidência da República (BR). Lei n°12.732, de 22 de novembro de 2012 [Internet]. [acesso 2019 jan. 17]. Disponível em: http://www.planalto.gov.br/ccivil_03/_Ato2011-2014/2012/Lei/L12732.htm.

20. Barros EN, Melo MCB. Câncer de pênis: perfil sócio-demográfico e respostas emocionais à penectomia em pacientes atendidos no Serviço de Psicologia do Hospital de Câncer de Pernambuco. Rev SBPH [Internet]. 2009 [acesso 2019 jan. 17];12(1):99-111. Disponível em: http://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S151608582009000100008.

21. Mathias CV, Girardon-Perlini NMO, Mistura C, et al. O adoecimento de adultos por câncer e a repercussão na família: uma revisão da literatura. RAS**.** 2015;13(45):80-86. doi: https://doi.org/10.13037/ras.vol13n45.2818.

22. Mathias CV, Beuter M, Girardon-Perlini NMO. Experiência da família rural ao ter o pai/esposo com câncer de próstata. Rev Rene. [Internet]. 2015. [acesso 2019 jan. 22]; 16(4):486-95. Disponível em: https://www.redalyc.org/pdf/3240/324041519005.pdf.

23. Silva DM, Dendasck CV, Oliveira E. A atuação do assistente social no acolhimento ao paciente oncológico. Revista Científica Multidisciplinar Núcleo do Conhecimento. 2017;5(8):39-51. doi: https://doi.org/10.32749/nucleodoconhecimento.com.br/saude/paciente-oncologico.

24. Xavier BB, Gentilli RML. Afetos e cooperação familiar como coadjuvantes do tratamento de câncer de mama em mulheres. Serv Soc Rev. 2012;14(2):73-95. doi: http://dx.doi.org/10.5433/1679-4842.2012v14n2p73.

25. Andrade, Letícia. O papel do assistente social na equipe. In: Carvalho RT, Parsons HA, organizador. Manual de cuidados paliativos. 2. ed. São Paulo: ANCP; 2012. p. 341-344.

26. Presidência da República (BR). Lei n° 8.080, de 19 de setembro de 1990 [Internet]. [acesso 2019 jan. 18]. Disponível em: *www.planalto.gov.br/ccivil_03/Leis/L8080.htm.*

27. Ministério da Saúde (BR). Portaria nº 1.944, de 27 de agosto de 2009 [Internet]. [acesso 2019 jan. 18]. Disponível em: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2009/prt1944_27_08_2009.html.

Recebido em 24/4/2019
Aprovado em 25/6/2019