Socioeconomic Profile of People with Cancer of the Larynx and Oral Cavity Being Treated at National Cancer Institute

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Perfil Socioeconômico de Pessoas com Câncer de Laringe e Cavidade Oral em Tratamento no Instituto Nacional de Câncer

Perfil Socioeconómico de las Personas con Cáncer de Laringe y Cavidad Oral en Tratamiento en el Instituto Nacional de Cáncer

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ABSTRACT

Introduction: Cancer is one of the main public health problems in the world. The main risk factors for head and neck cancer are smoking, alcoholism, and others associated with the current economic model, explaining the association between socioeconomic inequalities and incidence/mortality. **Objective:** To know the socioeconomic profile of people with cancer of the larynx and oral cavity, enrolled in the head and neck clinic at HCI/INCA from February to July 2017. **Method:** The methodological path used is divided into two axes: the narrative literature review and conceptual definition of terminologies used in the research and the questionnaire applied with sick people. This is an exploratory investigation that aims to raise qualitative elements for the construction of the socioeconomic profile. **Results:** The results describe the socioeconomic profile, demonstrate the magnitude of socioeconomic conditions and how these can impact the oncology treatment process. **Conclusion:** These issues are challenging for the work of health teams that, when faced with complex situations, need to develop the dialogue between different types of expertise to support shared decisions.

Key words: head and neck neoplasms; socioeconomic factors; tobacco use disorder; public health**.**

RESUMO

Introdução: O câncer é um dos principais problemas de saúde pública do mundo. O câncer de cabeça e pescoço apresenta como principais fatores de risco o tabagismo, o etilismo, entre outros fatores associados ao modelo econômico vigente, explicitando a associação entre desigualdades socioeconômicas e incidência/mortalidade. **Objetivo:** Conhecer o perfil socioeconômico das pessoas com câncer de laringe e cavidade oral, matriculadas na clínica de cabeça e pescoço do HCI/INCA no período de fevereiro a julho de 2017. **Método:** O caminho metodológico empregado se divide em dois eixos: revisão de literatura narrativa e definição conceitual de terminologias utilizadas na pesquisa; e questionário aplicado com pessoas adoecidas. Trata-se de uma pesquisa exploratória que visa levantar elementos qualitativos para a construção do perfil socioeconômico. **Resultados:** Os resultados apresentam o perfil socioeconômico, demonstram a magnitude das condições socioeconômicas e como estas podem impactar no processo de tratamento oncológico. **Conclusão:** Tais questões são desafiadoras para o trabalho em equipes de saúde, que, diante de situações complexas, precisam desenvolver a interlocução entre diferentes saberes para subsidiar decisões compartilhadas.

Palavras-chave: neoplasias de cabeça e pescoço; fatores socioeconômicos; tabagismo; saúde pública.

RESUMEN

Introducción: El cáncer es uno de los principales problemas de salud pública en el mundo. El cáncer de cabeza y cuello presenta como principales factores de riesgo el tabaquismo, alcoholismo, entre otros asociados al modelo económico actual, explicando la asociación entre desigualdades socioeconómicas e incidencia/mortalidad. **Objetivo:** Conocer el perfil socioeconómico de las personas con cáncer de laringe y cavidad oral, inscritas en la clínica de cabeza y cuello del HCI/INCA de febrero a julio de 2017. **Método:** La ruta metodológica utilizada se divide en dos ejes: la revisión bibliográfica narrativa y definición conceptual de terminologías utilizadas en la investigación y el cuestionario aplicado a las personas enfermas. Se trata de una investigación exploratoria que pretende levantar elementos cualitativos para la construcción del perfil socioeconómico. **Resultados:** Los resultados presentan el perfil socioeconómico, demuestran la magnitud de las condiciones socioeconómicas y cómo estas pueden impactar en el proceso de tratamiento del cáncer. **Conclusión:** Tales cuestiones son desafiantes para el trabajo de los equipos de salud que frente a cuestiones complejas necesitan desarrollar la interlocución entre diferentes conocimientos para subvencionar las decisiones compartidas.

Palabras clave: neoplasias de cabeza y cuello; factores socioeconómicos; tabaquismo; salud pública.

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INTRODUCTION

Head and neck cancer have high rates of morbidity and mortality in the world population and is currently considered one of the main public health problems in the world.

According to estimates by the National Cancer Institute (INCA)[1], for each year of the 2023-2025 triennium, there will be 39,550 new cases of head and neck cancer in Brazil, 19,970 in men and 19,580 in women. This total represents the sum of oral cavity (mouth), larynx and thyroid cancers.

The increase in cancer incidence and mortality is due, in part, to population growth and aging, as well as to the prevalence related to its risk factors, especially smoking and alcohol consumption associated with the current socioeconomic development model[2].

Head and neck cancer encompasses several types of tumors. For the purposes of this research, tumors of the oral cavity and larynx were chosen. This choice refers to its consequences in people's lives and its impact on their socioeconomic profile. These consequences "range from speech, communication and swallowing difficulties to changes in the face and neck regions, factors that compromise body image and social reintegration"[3].

According to INCA[1] data, risk factors for these types of tumors are related to alcoholism and smoking. In addition, the risk is increased when there is associated consumption of alcoholic beverages and cigarettes. The etiology of the disease may also be associated with other factors such as human papillomavirus (HPV), occupational exposure issues, among others.

Regarding the epidemiological profile for head and neck cancer, the incidence is considerable in low-income men aged between 50 and 70 years old [3]. Added to this is the fact of late access to health services, high mortality rates and reduced disease survival rates[4,5].

Regarding existing public policies to combat the disease, in the world, the prevention and control of chronic non-communicable diseases (NCDs) seek to control risk factors through guidelines, especially in primary care, aiming at reducing cases and also paying attention to aspects that revolve around survival[6].

In Brazil, actions to combat cancer are documented in the Strategic Action Plan to Combat NCDs in force from 2011 to 2022[7], in addition to the National Policy for Cancer Prevention and Control (PNPCC) in the Health Care Network for People with Chronic Diseases established by Ordinance nº. 874/2013. Both aim to reduce smoking and alcohol consumption[8].

Considering the magnitude of this type of illness in people's lives, the present study aimed to know the socioeconomic profile of people with cancer of the oral cavity and larynx enrolled in the Head and Neck Clinic of Cancer Hospital I/INCA, from February to July 2017.

Knowledge of this profile is part of a set of activities relevant to the professional practice of social workers, considering what is contained in the document Parameters for the Performance of Social Workers in Health Policy[9]: "the performance of Social Work in the health area consists of: knowing the living and working conditions of users, as well as the social determinants that interfere in the health-disease process". Understanding this reality will require the construction of a methodological path that can help consolidate data on the socioeconomic profile of this group.

METHOD

The methodological path used in this research is divided into two axes: the narrative literature review in view of the conceptual definition of terminologies used in the research and the applied questionnaire, organized from central categories for the survey of the socioeconomic profile of this group of people enrolled in the head and neck section. This study is based on qualitative exploratory research for the construction of the socioeconomic profile.

Through quantitative data, it is possible to carry out a qualitative analysis that encompasses factors such as: social and economic changes, social mobility strategies, as well as other factors that translate the movement into the social reality of people[10]. This is fundamental to define the socioeconomic profile, since it is not only about collecting reality data and verifying and comparing variables, but also about understanding how they are expressed in relation to several other aspects of social life.

For this, a review of narrative literature was conducted as it is a broad analysis of publications that aim to describe and discuss a given topic from a theoretical or conceptual point of view. Thus, there was a lack of research on the understanding of the socioeconomic profile of people with head and neck cancer.

Studies were found in PubMed, SciELO and Google Scholar databases that reveal the concern with the knowledge of this profile, especially with the objective of subsidizing the implementation of prevention and rehabilitation programs and dimensioning the relevance of head and neck cancer in public health[11-13]. However, the review pointed out the importance of outlining some definitions, such as "socioeconomic profile", in addition to other terminologies that will be used throughout this article.

The term "socioeconomic profile" was searched; however, it was found that it was not categorized with the

Descriptors in Health Sciences (DeCS). Therefore, we opted for direct research in the informed databases, in which the terms "socioeconomic condition", "socioeconomic situation", "socioeconomic studies" and "socioeconomic profile" were found. Considering the inaccuracies between them and the importance of defining the term "socioeconomic profile", a definition was constructed that encompassed such understanding. The analysis was restricted to articles written in Portuguese. Descriptive studies and other literature reviews were selected.

After this stage, a questionnaire was applied, immediately after the social interview with the person under treatment, unaccompanied or accompanied by a family member. Data were collected and recorded manually, through questions, interactions, and answers, without the use of a recorder.

The performance of the social interview is part of the daily life of social workers. It is an instrument used in order to know the socioeconomic context so that, based on a careful social evaluation, the professional can proceed with the necessary interventions and guidelines on social rights and other resources that can contribute to access and continuity of treatment.

The questionnaires were applied from March to December 2017 by the three social workers, working in the clinic at the time of outpatient or ward care, in the Social Work service rooms. The action was carried out with 161 people enrolled in the head and neck clinic diagnosed with cancer of the larynx (32 people) and oral cavity (129 people). Before applying the questionnaire, the person was invited to participate in the research, and the Informed Consent Form (ICF) and issues involving identity confidentiality were presented.

Data were organized based on the construction of structured categories in the questionnaire script, with reference to the categorizations used by the Brazilian Institute of Geography and Statistics (IBGE)[14] and the State Center for Statistics, Research and Training of Public Servants of Rio de Janeiro (CEPERJ)[15]. For the analysis and presentation of the data, these categories were regrouped as follows: **identification:** gender, age, place of birth, education, ethnic-racial issue; **labor status:** social security and labor relationship – profession, occupation and income; **family dynamics**: participants in the interview, with whom they live, marital union, marital status, number of children, care dynamics, support network; **housing:** type of property, rural or urban area, region of the city; **use of tobacco, alcohol:** the history of the use of alcohol, tobacco; and **access to treatment:** how the vacancy for treatment was made possible.

The research assumes that some conceptual definitions need to be revisited, mainly because they are present in social health research, but still lack prominence in the field. In the literature, the appropriation and use of terminologies appropriate to an approach that is based on socioeconomic studies in the health field is not identified. Thus, the conceptual definition of "socioeconomic profile" was stipulated as fundamental, and the definition of the term "sick person/person" as an option in relation to more usual terms in health as a patient/user.

The study complied with Resolution nº. 466/2012[16] of the National Health Council and was approved by the INCA Research Ethics Committee under opinion number 812007 (CAAE: 61882416.2.0000.5274).

RESULTS

The results were organized from the two axes of the research: review of narrative literature/conceptual definitions and application of the questionnaire to obtain the socioeconomic profile of the participants.

LITERATURE REVIEW AND CONCEPTUAL DEFINITIONS

There are studies in the literature that seek to investigate the association between socioeconomic conditions and head and neck cancer, using variables such as education and occupation. In the case of Brazil, in addition to these, the income variable emerges, which places it among the countries with the worst socioeconomic conditions present in underprivileged population groups[17].

As Mioto[18] states, socioeconomic studies are a fundamental part of the professional action of social workers, as they bring the possibility of knowing the reality of people, groups and populations in order to understand and intervene with a focus on equity and social justice and ensuring universal access to rights. The socioeconomic profile in this research can be understood as a description of the social and economic traits/characteristics/behaviors that define specific population groups within a given institutional, social and economic structure. Knowledge of the socioeconomic conditions of the people participating in the research allows us to trace a socioeconomic profile, enabling us to relate such information with different social indicators[19] and illness.

The definition of the word "person" originates from Latin, derived from "persona" and points to the meaning of the human creature**,** which has the power of choice and free will. According to Rogers[20], the term associates the person with the ability to appropriate their feelings and experiences, essential aspects for human relations. The term "user" is used as a sociological category that refers to the "user of the public service" that manifests itself through social and cultural mediations in community and institutional spaces, in the struggle for public

recognition[21]. The use of the word "patient" refers to the idea of a sick person who depends on medical care.

Such definitions aim to contribute to a better understanding of the categories built in this research, in their amplitude and correlation, to outline the profile of the group under treatment.

SOCIOECONOMIC PROFILE OBTAINED FROM THE APPLICATION OF THE QUESTIONNAIRE.

Cancer is considered a disease that manifests itself in people of different profiles. Specifically analyzing head and neck tumors, based on the research conducted, 77% are men and 23% are women.

In contemporary society, the male population is more exposed to risk factors for several reasons. According to Silva et.al.[22], "it is estimated that, in Brazil, 11.2% of men and 5.2% of women are alcohol consumers and dependent" in 2007. The authors highlight, based on their research, that "alcoholic patients had a higher prevalence of males", similar to that demonstrated by the World Health Organization (WHO) in 2018[23].

With regard to age, the present research identified that there is a prevalence among the elderly, who represent 55% of the studied group. According to Law no. 10.741/2003[24], an elderly person is considered from the age of 60.

A significant portion is composed of people in the age group between 60 and 69 years old (38%). The aging of the population and prolonged exposure to risk elements are directly related to this finding. Regarding this analysis, the study published highlights that:

> The aging process has been seen as one of the greatest challenges of contemporary public health, since in developed countries it represents a significant portion of the population and in developing countries, such as Brazil, the increase in the elderly population has growth rates much higher than those of the general population. Parallel to this, it was found that an important risk factor for cancer is aging[25].

Regarding the place of birth, the studied population is mostly from the Southeast Region of Brazil, with 84%. There are 14% from the Northeast, 1% from the North Region and 1% was born in another country. The highlight is Rio de Janeiro, State where the hospital is located and 70% are born.

Another relevant observation refers to the level of education: most have a low level of education, that is, 41% have incomplete elementary school, 11%, complete elementary school and 14% are people without education or with less than one year of schooling. Only 4% have completed higher education.

According to Callucci[26], in a report published by Folha de S. Paulo in 2004, "low education delays the diagnosis of cancer and reduces the chances of cure". In addition, he states based on research that, "in the case of cancer of the mouth and oropharynx [...]: patients with fewer years of schooling had survival rates of 44% in the early stages [...]".

Low education is associated with precarious socioeconomic situation:

> Social inequalities in health can manifest themselves in relation to health status and access to and use of health services for preventive or care actions. In the Brazilian population, according to data from the World Health Survey, self-assessment of health status varies markedly with education level. [...] The use of preventive services shows more pronounced differentials according to education and occupation[27].

Regarding the ethnic-racial issue, the participants declared themselves: 48% brown, 42% white and 10% black. These data demonstrate the main aspect to be analyzed: the researched group is composed of black women and men. Camelo et al.[28] clarified that blacks and browns live with a greater threat of illness and death.

> Racial inequalities in health in Brazil are profound and several studies point out that blacks and browns have great disadvantages compared to whites in different health-related outcomes such as infant mortality, maternal mortality ratio, infectious diseases, chronic diseases, and health risk behaviors. Thus, blacks and browns in Brazil have higher mortality from practically all causes when compared to whites and, consequently, lower life expectancy and worse self-rated health. These inequalities are absolutely unnecessary, avoidable, and unjust and should therefore be interpreted as inequities[25].

Religion is another dimension addressed in the context of health. In this sense, it is important to emphasize that religiosity can become a support for coping with illness, as it aims to alleviate pain and anguish in the face of treatment. Thus, in the interviews, the Catholic religion stands out in relation to the others, representing 58% of the interviewees. Then, the evangelical presented 25% of the total, 4% were spiritists, 1% considered themselves members of Umbanda/Candomblé, and 9% had no religion. Ferreira et.al.[29] points out, based on a study on spirituality and religiosity, the following question:

> In addition, it was observed that most of the participants interviewed used religiosity as a source

> of support in coping with cancer. Religiosity, when well incorporated into the patient's life, helps them with the consequences that cancer will bring to their daily lives and will essentially influence their life and way of living during treatment[29].

According to these authors[29], the influence of religiosity can help in the development of attitudes of hope and strength that positively impact quality of life during treatment.

Some data on the monthly income of each person interviewed stand out: 39% received a minimum wage and 28% had no income of their own. The highest income, six minimum wages, corresponds to 2% of the total. Regarding the origin of income, the most significant data are: 30% did not have any type of social security bond, 29%, retirement, 9%, continued benefit (BPC), only 4% had a work and social security card (CTPs) signed and only 2% had a public bond. When it comes to family income, 11% are from families without income, 6% had an income below a minimum wage, 22% received a minimum wage, 18%, two and 10%, three. Given these data, it is noteworthy that such families need to face a serious diagnosis living in a precarious economic situation. In this universe, two groups of professions stand out: 33% are workers in the production of industrial goods and services and 30% are service workers, commercial sellers in stores and markets.

These factors, which are added to others, are challenging for people who need to face cancer treatment.

FAMILY DYNAMICS, CARE, AND GENDER RELATIONS

At the time of the survey, the presence of the family was identified, since 84% of the interviewees participated accompanied. The majority, which corresponds to 70%, live with direct family members, 18%, with direct and indirect family members, 10%, alone and 3%, with indirect family member or friend.

Regarding the people participating in the research, 56% had a marital union, however, only 25% of them were married and 6% had a stable union contract registered in a notary's office. This data is relevant, considering the possibility of access to death pensions and the requirements of the INSS and other Social Security systems, with regard to proof of union.

Of the interviewees, 15% had no children; 47% had up to two children; 19%, three; 21%, more than three. This data demonstrates the relevance of this type of bond in care, especially when it concerns the participation of daughters, as shown below in the identification of primary caregivers.

Among the survey participants, 81% indicated women as primary caregivers. The four most cited groups of caregivers were: partners/ wives (34%); daughters (22%); sons (11%); and sisters (10%). The sisters are in the group, in the fourth most indicated place, however, the brothers were presented as the main caregivers only by 2% of the interviewees. The protagonism of women as caregivers is observed, reflecting the sexual division of labor that positions care as a female activity.

> The sexual division of labor is the form of social division of labor arising from the social relations of sex; this form is historically adapted to each society. It is characterized by the priority allocation of men to the productive sphere and women to the reproductive sphere and, simultaneously, the occupation by men of functions of strong added social value (political, religious, military etc.)[30].

The support network was present in 40% of the families consisting only of women, while 5% were men, and the remaining 55% were composed of men and women. Among the networks with the participation of men and women, 45% have an equal number of men and women; 33% have more women; 22% have a higher number of men. Thus, there is an inequality of participation between genders in the quantitative aspect, and it should be noted that this involvement was not qualitatively evaluated.

However, Costa[31], in qualitative research on female care work in families with people undergoing treatment for head and neck cancer, analyzed how men participated. "[...] a sexual division of labor in participation in treatment was identified, as the involvement of men is often restricted to transportation or financial support". It was noticed in the research carried out by the author that, in the division of activities, women assume direct, intensive care, which demands more time/presence.

In this discussion, it is essential to emphasize the social devaluation of care work, which is carried out predominantly by women free of charge. Kergoat[30] states that the sexual division of labor encompasses "two organizing principles": separation and hierarchization. The first divides jobs into feminine and masculine and the second designates different values, in this sense socially masculine activities have greater prestige, in addition to being better paid.

In view of the socioeconomic indicators that reflect a reality of impoverishment and social vulnerability, the variable about family dynamics, care and gender relations gains expression in countries such as Brazil, where, due to so many difficulties in terms of effective public policies, it is the family that assumes the responsibility to mediate and mitigate the effects of such an adverse reality.

Regarding the type of property, 84% lived at home and 16% in an apartment. Regarding the property, 76%

lived in their own property; 15% in rented property; 6% in assigned property; and 2% in possession. It is 10% without basic sanitation.

Among the people interviewed, 89% lived in urban areas and 11% in rural areas. Urban population index slightly lower than the Region, considering that, according to the National Household Sample Survey (PNAD)[32], the percentage of urban population in the Southeast is 93.14%.

The predominance of the place of residence is the Metropolitan Region of Rio de Janeiro (83%). The other Regions reported were: Serrana, Baixadas Litoraneas, Centro-Sul Fluminense, Medio Paraiba, Norte-Fluminense and one in another State.

Considering that the majority, 58%, do not reside in the city of Rio de Janeiro, it is necessary to access the Out-of-Home Treatment (TFD) program, SAS Ordinance nº. 55, of February 24, 1999[33], which aims to guarantee the access of patients living in municipalities and states to care services in others, since many do not have the conditions to pay for travel, with TFD being the only guarantee of transportation for access and continuity of treatment.

The Study of the Health System Performance Evaluation Project (PROADESS) of the Oswaldo Cruz Foundation (Fiocruz)[34], which analyzes the access of more vulnerable populations to health services, identified that:

> The greater the complexity of the necessary procedures, the greater the need to seek treatment in other municipalities. For example, almost 80% of patients who needed hospital care for cancer had to be admitted outside their place of residence[34].

In addition, even those who reside in Rio de Janeiro do not necessarily have ease of travel considering the size of the city. Due to the location of the hospital, the users who are at more favorable distances are those who live in the Central Region or South Zone, which represents only 4% of them. Among those who live in the city, the majority, 53%, are resident in the West Zone, while 9% reside in the South or Central Zone.

As previously mentioned, people who smoke and those who regularly consume alcoholic beverages are more likely to develop cancer of the oral cavity and larynx[35].

Regarding the survey data, 81% of people reported a history of smoking, of which 20% remain in tobacco use. Regarding alcohol, 77% have a history of consumption and 24% reported abusive use. Regarding alcohol consumption, "alcoholism is considered a disease by WHO. The constant, uncontrolled and progressive use of alcoholic beverages can seriously compromise the proper functioning of the body, leading to irreversible consequences"[35]. However, for the purposes of this research, abusive use is presented from the perception of the participating people. The oncological treatment appeared as a moment of interruption of consumption, since only 8% declared that they continued the use of alcohol.

In Brazil, smoking has fallen significantly in recent decades, as a result of the actions carried out by the National Tobacco Control Policy (PNCT). In 1989, the percentage of adult smokers was 34.8% and, in 2019, 18.5%[35].

Unlike smoking, the consumption of alcoholic beverages has a growing trend in the country. According to the National Health Survey, in 2019, 26.4% of the population aged 18 years or older used to consume alcoholic beverages once or more a week, which represents an increase of 2.5 percentage points compared to 2013 (23.9%)[36].

Compared to the same period in 2019, among the population aged 18 years or older, the prevalence of users of smoked or non-smoked tobacco products of daily or occasional use was 12.8% (20.4 million people), compared to 14.9% in 2013. However, "although the frequency of smoking is declining in the population, the largest fraction of cancer, in general, in Brazil, is attributable to tobacco"[36].

In a publication of study results on head and neck cancer attributable to tobacco and alcohol, Kfouri et al.[37] found that: "fractions attributable to smoking were more expressive than for alcohol consumption in all cities studied". Thus, the authors concluded that, despite the decrease in tobacco use in Brazil, in the population affected by head and neck cancer, smoking has an important prevalence. They also highlighted that, considering that "the genetic burden in the occurrence of cancer is in the order of 5% to 10% and that 90% to 95% are due to modifiable risk factors", the study on types of head and neck cancer attributable to tobacco and alcohol points out that changing lifestyles excluding alcohol or tobacco consumption may reduce the burden of cases[37].

The form of access to the hospital for residents of the State of Rio de Janeiro occurs through the State Regulation System (SER). Those from other states have access through the National High Complexity Regulation Center (CNRAC). Some situations can also be assessed directly by the emergency department or by the hospital's general triage department.

However, 18% of the surveyed group stated that access was through personal contact. The others declared that they went through official paths, the unit's regulation and screening center.

The use of the personal contact route presupposes that these people found it difficult to access the principle of integrality of sus, which, as Pinheiro[38]

states, "(...) is intended to combine actions aimed at the materialization of health as a right and as a service". Thus, comprehensiveness provides for the right to health at all levels of care.

DISCUSSION

In this study, we verified the prevalence of head and neck cancer among elderly people over 60 years of age. This factor generates a significant impact on the lives of these individuals, due to the volume of limitations that can occur, since the diagnosis often involves invasive and mutilating treatments.

The socioeconomic needs of people undergoing cancer treatment are permeated by deficiencies in access to information. Low education and limited access to information can contribute to establishing barriers to understanding complex treatments that require decision-making[39]. This context requires a support network in which other people can share decisions and support treatment, given that families from more vulnerable groups have numerous difficulties in enabling care[40]. As the literature points out, this type of care has been historically performed mostly by women[30].

It should be noted that low education is associated with precarious socioeconomic situation, factors that reinforce social inequalities and, consequently, affect access to health services. It is important to highlight that the black population has the worst indicators of access to goods and social services compared to white individuals, factors that are expressed in the results of this research. Thus, it is concluded that black people are more vulnerable to getting sick from head and neck cancer, as well as subject to the possible adversities resulting from the diagnosis.

With regard to socioeconomic status, it can be said that, when discussing cancer, it is necessary to understand that socioeconomic factors interfere in this context, from diagnosis to treatment. Some studies[41] show that patients with head and neck cancer with lower socioeconomic status have a worse prognosis, generally considering that they are related to difficulties in accessing and adhering to treatment, the type of treatment received and the emergence of complications.

Cancer treatment is central to the lives of people undergoing treatment and their families. They need support in hospital visits, in care related to surgeries, procedures, dressings, and follow-up when there is greater health fragility. Thus, knowledge about the constitution of families and their modes of organization becomes relevant for the improvement of health practices and actions.

The results of the research reveal the materialization of the sexual division of labor, with the care assumed mostly by women. In this sense, it appears that the care work done, especially by women, should be remunerated. Thus, the importance of subsidizing public policies is emphasized, so that social *care* is guaranteed as a right, especially in home care[40].

As for the displacement for treatment, patients residing in Rio de Janeiro also present difficulties, considering the geographical dimension of the city. Displacements are frequent, given the need for hospital visits, especially for those undergoing radiotherapy or chemotherapy.

It is noteworthy the relevance of the impact of smoking and alcohol consumption on public health, which makes the strengthening of public policies aimed at the prevention and control of diseases a fundamental strategy in the fight against head and neck cancer.

CONCLUSION

The research demonstrates the magnitude of socioeconomic aspects in the lives of people sickened by head and neck cancer who come to INCA for cancer treatment and how much living conditions affect and can make this process more complex. In view of the data presented and understanding that health is a field of dialogue and interaction, we sought to contribute to the expansion of health knowledge that, in addition to the technical specificities of the areas involved, should encompass the understanding of the social, territorial and cultural dimensions of the population served. Such issues are fundamental for the work in health teams that, in the face of complex situations, especially in oncology, need to develop the dialogue between different types of knowledge to support shared decisions.

CONTRIBUTIONS

All authors contributed to the design, planning of the study, analysis, and interpretation of the data, as well as the writing, review and approval of the final version to be published.

DECLARATION OF CONFLICT OF INTERESTS

There is no conflict of interest to declare.

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