Cervical Cancer Prevention and Screening: Barriers and Facilitators from the Perspective of Users of the Unified Health System

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Prevenção e Rastreamento do Câncer do Colo do Útero: Barreiras e Facilitadores na Perspectiva de Usuárias do Sistema Único de Saúde

Prevención y Detección del Cáncer del Cuello Uterino: Obstáculos y Factores Facilitadores desde la Perspectiva de las Usuarias del Sistema Único de Salud

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ABSTRACT

Introduction: Cervical cancer, also known as cancer of the cervix, is a type of cancer that originates in the cells of the cervix. This cancer is most often caused by persistent infection with oncogenic types of human papillomavirus (HPV), such as HPV-16 and HPV-18, which are primarily transmitted through sexual contact. **Objective:** To understand the barriers and facilitators faced by users of the Brazilian Unified Health System (SUS) in undergoing the Papanicolaou test, as well as strategies for the prevention of cervical cancer. **Method:** A descriptive study with a qualitative approach, conducted with 20 SUS users from two Primary Health Care Units in Manaus, Amazonas, located in the eastern and western areas of the city. Data were collected through semi-structured interviews conducted using a specific interview guide. The data were subjected to thematic network analysis. **Results:** Eight organizing themes and one global theme emerged. The main barriers were related to specimen collection days and work routines. The main facilitating factors included the presence of female health professionals and the implementation of individualized health education. **Conclusion:** The users demonstrated high vulnerability but maintained a high level of adherence to cytopathological screening. Although most participants undergo the test annually, the continuity of screening depends on access to accurate information, quality of care, and the establishment of strong bonds with health professionals.

Key words: Uterine Cervical Neoplasms; Prevention; Barriers; Facilitators; Unified Health System.

RESUMO

Introdução: O câncer do colo do útero, também conhecido como câncer cervical, é uma forma de câncer que se origina nas células do colo do útero, a parte inferior do útero que se conecta à vagina. Esse câncer é frequentemente causado pela infecção persistente com tipos de papilomavírus humano (HPV) oncogênicos, como o HPV-16 e o HPV-18, que são transmitidos principalmente por via sexual. **Objetivo:** Compreender barreiras e facilitadores das usuárias do Sistema Único de Saúde (SUS) à realização do exame Papanicolau e formas de prevenção do câncer do colo do útero. **Método:** Estudo descritivo com abordagem qualitativa, realizado com 20 usuárias do SUS de duas Unidades Básicas de Saúde de Manaus/AM — localizadas nas Zonas Leste e Oeste da cidade. A coleta se deu por entrevistas semiestruturadas, conduzidas com roteiro próprio. Os dados foram submetidos à análise de redes temáticas. **Resultados:** Emergiram oito temas de organização e um tema global. As barreiras englobam principalmente dias de coleta e rotina de trabalho. Como facilitadores, destacam-se a presença do profissional do sexo feminino e a implementação da educação em saúde individualizada. **Conclusão:** As usuárias apresentam alta vulnerabilidade, mas mantêm elevada adesão ao exame citopatológico. Embora quase todas realizem o exame anualmente, a continuidade do rastreamento depende de boa informação, qualidade do atendimento e vínculo com os profissionais.

Palavras-chave: Neoplasias do Colo do Útero; Prevenção; Barreiras; Facilitadores; Sistema Único de Saúde.

RESUMEN

Introducción: El cáncer de cuello uterino, también conocido como cáncer cervical, es una forma de cáncer que se origina en las células del cuello uterino, la parte inferior del útero que se conecta a la vagina. Este cáncer es causado con frecuencia por la infección persistente con tipos oncogénicos del virus del papiloma humano (VPH), como los tipos VPH-16 y VPH-18, que se transmiten principalmente por vía sexual. **Objetivo:** Comprender las barreras y los facilitadores que enfrentan las usuarias del Sistema Único de Salud (SUS) para la realización del examen de Papanicolau y las formas de prevención del cáncer de cuello uterino. **Método:** Estudio descriptivo con enfoque cualitativo, realizado con 20 usuarias del SUS de dos Unidades Básicas de Salud de Manaos, Amazonas, ubicadas en las zonas este y oeste de la ciudad. La recolección de datos se llevó a cabo mediante entrevistas semiestructuradas, realizadas con un guion propio. Los datos fueron sometidos a un análisis de redes temáticas. **Resultados:** Surgieron ocho temas organizadores y un tema global. Las barreras se relacionaron principalmente con los días de realización del examen y la rutina laboral. Como facilitadores, se destacaron la presencia de profesionales de sexo femenino y la implementación de educación en salud individualizada. **Conclusión:** Las usuarias presentan alta vulnerabilidad, pero mantienen una elevada adhesión al examen citopatológico. Aunque casi todas se realizan el examen anualmente, la continuidad del cribado depende de una adecuada información, la calidad de la atención y el establecimiento de vínculos con los profesionales de la salud.

Palabras clave: Neoplasias del Cuello Uterino; Prevención; Barreras; Facilitadores; Sistema Único de Salud.

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INTRODUCTION

Cervical cancer, also known as cancer of the cervix, originates in the cells of the cervix, the lower portion of the uterus that connects to the vagina. This cancer is most often caused by persistent infection with oncogenic types of human papillomavirus (HPV), such as HPV-16 and HPV-18, which are primarily transmitted through sexual contact[1].

Cervical cancer can be identified early (Pap smear test) and prevented (HPV vaccine); however, it remains a relevant cause of death among Latin American women[2]. The contrast between guidelines and practice is stark: there are policies for primary and secondary prevention by the Ministry of Health[3], but adherence to tests and vaccination remains insufficient and heterogeneous across Regions[4].

Access difficulties, added to socioeconomic and geographic factors, reduce the number of tests performed and vaccinations administered, increasing regional inequalities[5]; barriers, such as fear, shame, and low literacy/information, in addition to economic and logistical embarrassments, determine non-adherence[6,7].

In this scenario, cervical cancer is the third most common cancer type in women worldwide[8]. The National Cancer Institute (INCA)[4] highlights cervical cancer as the third type of cancer that will affect women of the country the most during the 2026-2028 triennium, with a total of 19,310 new cases a year estimated for the country, with an emphasis on the North and Northeast Regions, where it stands as the second most common neoplasm. In the North, the States of Pará and Amazonas present the most alarming data in the whole Region. Between 2012 and 2018, the Mortality Information System (SIM) recorded 1,926 deaths from cervical cancer in the State of Amazonas. Additionally, in 2023, the reference hospital for cancer treatment in Amazonas notified 174 deaths from cervical cancer, approximately four deaths a week[9-11].

Cervical cancer screening is an important strategy for reducing morbidity and mortality associated with this neoplasm. The cytopathological test, recognized worldwide as efficient and safe, enables the identification of precursor lesions and initial disease alterations in asymptomatic women before evolving into invasive forms[12]. Moreover, it seeks to fulfill Brazil's commitment to the Sustainable Development Goals (SDGs), supported by the Global Strategy to help eliminate cervical cancer as a public health issue by 2030, reducing its incidence to less than four cases per 100 thousand women and its mortality coefficient to less than two per 100 thousand women[13].

Although the literature acknowledges the influence of individual, sociocultural, and organizational factors in the performance of the cytopathological test, gaps persist regarding the integral understanding of these elements from the perspective of users, especially in Amazonian contexts marked by territorial inequalities, geographical barriers, and specificities in the organization of healthcare services.

In this context, the articulated analysis of barriers and facilitators from the perspective of users enables us to understand how these dimensions are interrelated in the day-to-day and condition access and adherence to cervical cancer screening. Such an analysis qualifies the interpretation of services' utilization and guides interventions in Primary Health Care (PHC), with an emphasis on care organization (schedule predictability, workflow transparency, timely feedback), contextualized health education, and the offer of material support (transportation, extended hours)[14].

Furthermore, the qualified hearing of users favors the identification of gaps in the assistance journey, guides resource allocation, and contributes to promoting equity in access and adherence to screening. Therefore, this study aims to understand the barriers and facilitators faced by users of the Brazilian National Health System (SUS) in undergoing the Pap smear test and strategies for preventing cervical cancer.

METHOD

Descriptive study with a qualitative approach. Data collection was done through semi-structured interviews. This study has been conducted following the Consolidated Criteria for Reporting Qualitative Research (COREQ)[15] checklist.

A qualitative approach was chosen because it captures participants' points of view in a horizon of meanings, motivations, and values, reaching interpretive depth that is not restricted to previously operationalized variables. Furthermore, it adds flexibility and inventiveness to the design and conduction of the study, preserving the rigor that characterizes scientific research[16].

This study was conducted in Manaus, capital of the State of Amazonas, Brazil, at two Basic Health Units (BHU) between July and October 2025. The municipality presents a Municipal Human Development Index (MHDI) of 0.737, and the Primary Care network has 288 BHU, distributed across the North, South, East, West, and Rural districts, in addition to riverine UBS and mobile units[17]. The BHUs were selected by convenience: one in the East DISA (*Clínica da Família Desembargador Fábio do Couto, Valle, Av. Brigadeiro Gurjão, Jorge Teixeira*) and the other in the West DISA (BHU O-46, *Rua Raimundo Maio, Parque São Pedro, Tarumã*)[18].

The inclusion criteria were "people with a uterus" registered in the BHU area, aged 25 to 64 years, who are sexually active[19]. This can include transgender men and non-binary people assigned female at birth[20,21]. The exclusion criteria were women, trans men, and non-binary people assigned women at birth with no cognitive conditions or other conditions that impaired the communication process.

The invitations were made in person at the premises of the two BHUs. At BHU O-46, participation was restricted to users who came in for the Cervical Cancer Screening Test (CCST). At the *Clínica da Família Desembargador Fábio do Couto Valle*, the participation included both users seeking the test and women present for other appointments (consultations, vaccination, among others). There were no refusals or dropouts from the study. The number of participants and end of data collection were defined according to the theoretical saturation criterion, understood as a point at which information begins to reiterate patterns and analytically converge, indicating that new inclusions would tend not to add substantially new information to the investigated phenomena[9,22].

The research team was composed of six members; three researchers conducted field interviews. To guide the semi-structured interviews, a script was used containing the following questions: 1. What are the main challenges you face in regularly undergoing cervical cancer screening tests (such as Pap smear)? 2. Can you describe any difficulties you have found when accessing healthcare services for prevention and screening of cervical cancer? What factors influence your decision to seek or not seek these services? 3. What do you consider to be the main reasons why some people, within the health unit's coverage area, might not be adhering to preventive and screening measures for cervical cancer? 4. What information or resources do you think would be useful to improve access and adherence to cervical cancer prevention and screening practices? 5. How has your experience with healthcare professionals influenced your decision to undergo screening tests or follow recommendations for prevention? Is there something that could be improved in the service to facilitate adherence? 6. What information have you received, or which campaigns you have attended, on the importance of cervical cancer screening and prevention? How did this information impact your attitudes and behaviors in relation to these practices? 7. If you had access to educational materials or technology on cervical cancer prevention and screening, what specific information or resources would you like to see included to help you overcome barriers and promote adherence to these practices?

No pilot test of the collection instrument was done. The interviews were conducted at a single time, without repetition, with an average duration of up to 10 minutes, in the presence of the participant and the researcher in a private environment within the study's context.

At first, the researchers visited the BHU to check the space and prepare it for the interviews (aspects such as good lighting, ventilation, and accommodation were considered). After the users agreed to participate, the team scheduled the best day and time for their interview, and the participants signed a Free and Informed Consent Form and a Recording and a Voice Usage Recording Agreement. Before the interviews, the team verified the recorder's functioning, welcomed the users, informed them of the average conversation duration (up to 40 minutes), and reassured them of their anonymity.

The data analysis sought to attribute analytical meaning to the empirical material. The socioeconomic information retrieved in the first part of the interviews was organized in Excel spreadsheets to describe and support data management. The interviews were transcribed in full, reviewed, and anonymized using Google Docs and the Easy Transcription application. The codes U1 to U20 were used to identify the participants without exposing their names. Next, the researchers proceeded to fluctuating reading and iterative manual codification, followed by reflexive memo recording and auditory trail maintenance, ensuring transparency and traceability of the interpretive process. The codification process, along with thematization of the basic, organizational, and global themes, was conducted using the MaxQDA[23] software.

The strategy used to organize and systematize qualitative data was thematic network analysis[24]. This technique enables the identification of three levels of themes: basic themes, organizational themes, and global themes. The analysis was conducted according to the proposed steps, starting with the text reduction or disaggregation phase, which includes building a codification board, segmenting the material, and identifying and refining themes. Next came the text exploration phase, in which thematic networks were built by organizing themes, selecting basic themes, reorganizing themes, identifying global teams, and verifying and improving resulting networks. Then, the team proceeded to describe and interpret these networks, exploring their relationships and meanings. Finally, during the integration phase, the thematic networks were summarized, and the identified patterns were interpreted and articulated with the research objectives and the relevant literature.

This research has been approved by the Research Ethics Committee of *Universidade do Estado do Amazonas*, report number 7.606.678 (CAAE (submission for ethical review): 87130325.0.0000.5016), in compliance with Resolution 466/2012[25] of the National Health Council.

RESULTS

The study included 20 female users of SUS who attended the BHU to collect material for the CCST test, aged between 25 and 64 years, single (11/20; 55%), self-declared brown (16/20; 80%), and heterosexual (20; 100%). The predominant education level was High school (12/20; 60%), the main occupation was domestic worker (9/20; 45%), and family income was mostly provided by social welfare programs like *Bolsa Família* (12/20; 60%).

Regarding sexual and reproductive life, (19/20) 95% had initiated it before 18 years old, (14/20) 70% reported having had up to four partners throughout their lives, (12/20) 60% had up to three pregnancies (13/20), 65% informed having had three deliveries; (15;20), and 75% reported using contraceptive methods. In cytological screening, 45% (9/20) of participants reported having initiated CCST collection after 25 years old, (18/20) 90% are screened annually, (18/20) 90% had their last screening in 2024, and (19/20) 95% received a negative result; (13/20) 65% reported having been vaccinated against HPV, as shown in Figure 1.

From the interviews, the analysis of thematic networks revealed the global theme "Barriers and facilitators in the journey of cervical cancer screening and prevention at PHC" (Figure 2). This network articulates experiences of daily and institutional obstacles — like time/distance, care workflow organization, and feelings connected to the procedure — with mechanisms to support access, engagement, and information. Together, these elements clarify, from the perspective of users, which factors impair or encourage cervical cancer preventive tests and prevention practices.

In light of the global theme, eight organization themes were identified (Figure 3), systematized in two complementary analytical axes: barriers (four themes), which describe structural, organizational, affective, and informational conditions that restrict care; and facilitators (four themes), which show relational resources, service arrangements, informational strategies, and individual and contextual motivators capable of supporting adherence to cervical cancer screening and prevention practices. Hermeneutic units, understood as meaning segments derived from the participants' narratives, and detailed descriptions, which consist of detailed explanation of contents and meanings attributed to the data during the analytical process, were used.

In the barriers' axis, the analysis showed four organizational themes that additionally explain why cervical cancer screening and prevention are not consolidated as regular practice among PHC users.

The first theme, "Conditions of access and organization of daily life", composed of four basic themes, reveals that distance from the BHU, restricted hours for collection, and care responsibilities (particularly with small children) place CCST at the bottom of their list of priorities. The participants report that "It's far from my home and the access is hard" (U2), they need to get there at "5-6h" (U6), and that they "have two babies... And it's only one day" (U2). Such time and logistical embarrassments shorten the care windows and favor absences or delays.

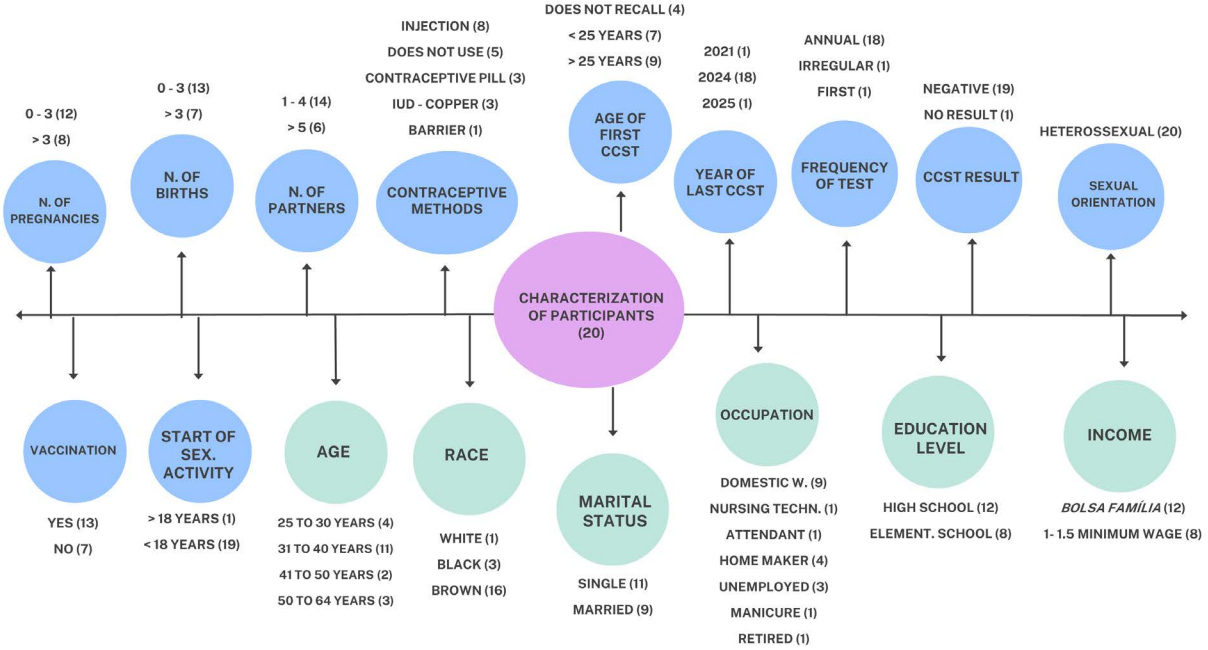

Figure 1. Participants' characterization process

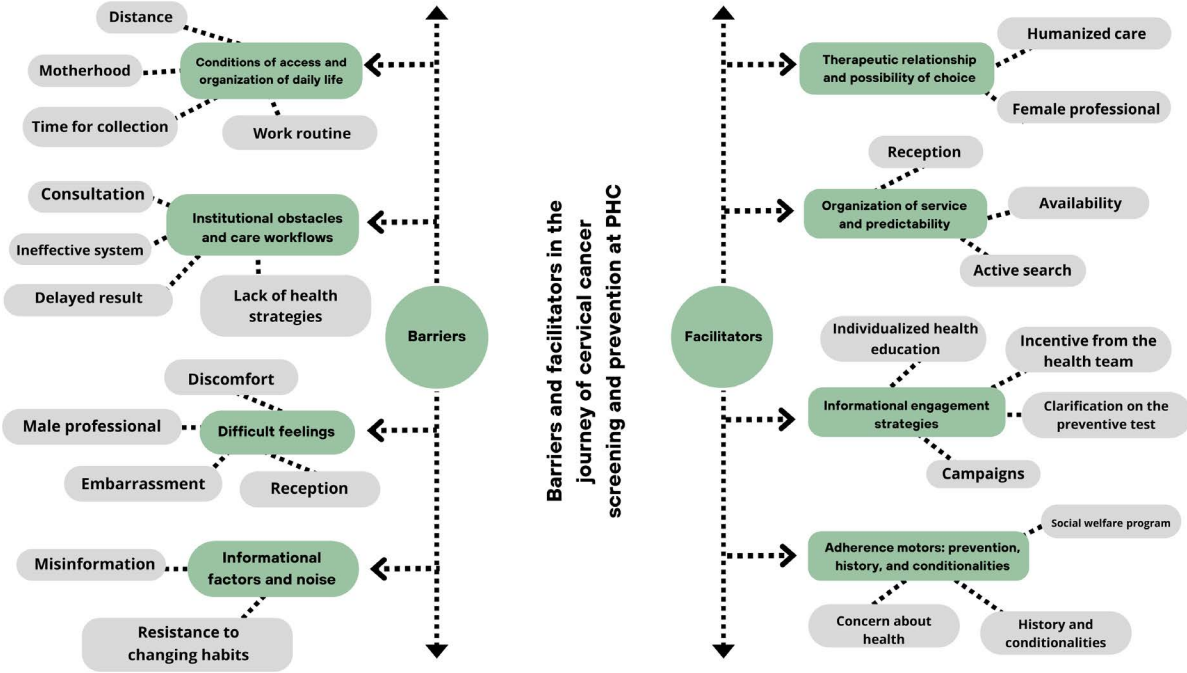

Figure 2. Thematic network
Caption: PHC = Primary Health Care.

The second theme, "Institutional obstacles and care workflows", composed of four basic themes, concerns obstacles produced by the service itself, noticeably the delay in releasing results and regulation gaps (for example, the SISReg system), which compromise the reliability and continuity of care.

The participants describe long waits — "it took forever, three months" (U2); "it should be at least one month... Sometimes it's 2–3 months" (U13) — and associated the care flow to a "horrible" system (U16), term that, in the reports, condensates: workflow opacity ("we enter [our data] in SISReg… so they can call us", U11), scarce openings, and discouraging waiting time ("we come… it takes forever… sometimes we just give up", U3) and fragmentation of service ("they just collect [material]… they should go deeper than that", U15). Together, the lack of transparency about steps and timeframes, slowness in delivering results, and a poorly responsive regulation system discourage their return and weaken timely follow-up.

The third theme, "Difficult feelings" (fear, shame, and discomfort), constituted by four basic themes, shows that the intimate character of the procedure can cause embarrassment and avoidance of attendance, mainly when the user is not welcomed properly. The women describe the test as something that "causes discomfort" (U16) and report experiences of insensitive treatment ("lie there… something quite brute", U2). When not mediated, these negative feelings convert into non-adherence or delayed screening.

Finally, the fourth organizing theme, "Informational factors and noise", structured by two basic themes, points to deficits in the offer and circulation of clear, contextualized, unrestricted information. The users cited a lack of actions in the community — "they never went to my home… and I live nearby" (U19) — and conceptual ambiguities, like a lack of knowledge of the relationship between HPV and cervical cancer ("I didn't know it was related to cancer", U20). The low capillarity of information distribution results in weak, less actionable prevention and, consequently, less present in women's routine.

In addition to the gaps described, the analysis highlighted a set of facilitators that, when present, alleviate barriers and support adherence to screening.

The first organizational theme in the facilitators axis is called "Therapeutic relationship and possibility of choice", integrated by two basic themes. The quality of the clinical encounter — humanized service and clear explanations — transforms the first contact into a longitudinal bond, favoring regular follow-up visits. The participants reported that "they explain well… make us want to come back" (U9), and the possibility of choosing a female professional increases the comfort with an intimate procedure ("it helps… because it's intimate", U4). In operational terms, it is a relational facilitator that reduces anxiety, qualifies the experience, and consolidates care pathways.

The second organizational theme, "Organization of service and predictability", encompasses three basic themes,

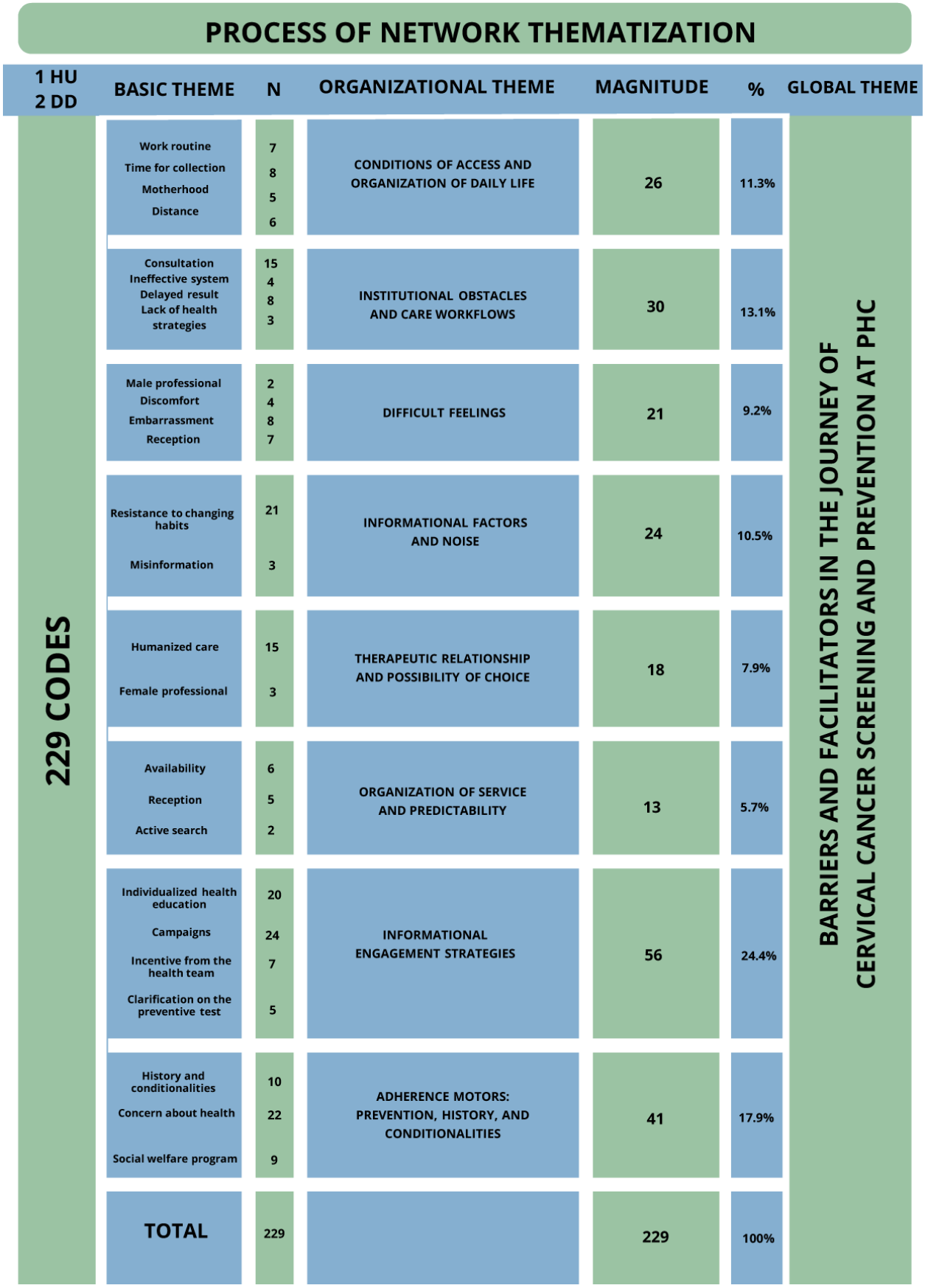

Figure 3. Process of network thematization
Captions: HU = Hermeneutic units; DD = Detailed descriptions.

highlighting that responsive care arrangements — such as extended schedules and respected timeframes for delivering results — increase the predictability of the journey and reliability on the service. The demand for "explain what is going to be done at the time" (U20) highlights the value of structured feedback and a transparent workflow from test to result, including clear timeframes and feedback ("if they could spend at least one month… to reach back to us", U13). Together, these elements convert the intention into effective commitment and reduce losses to follow-up.

"Informational engagement strategies" was the third organizational theme in the facilitator axis, composed of four basic themes. It corresponds to health education actions that operate as decision triggers and reinforce care-related memory. Multi-modal communicational strategies — visible campaigns, demonstration of the procedure, and recurrent reminders — increase health literacy, self-efficacy, and emotional preparedness, reducing uncertainties and normalizing CCST as routine practice.

The participants report that "lectures bring concerns that make us do it" (U7) and that external signage ("putting information signs at the front… reminding us from month to month", U15) amplifies readiness, especially when the message is concrete, contextualized, and repeated in different contact points (BHU, territory, and media). To summarize, health education, when planned and continuous, converts intention into commitment and supports periodic screening maintenance.

The organizational theme "Adherence motors: prevention, history, and conditionalities" is structured across three basic themes. The motivation to undergo CCST emerges from the convergence between self-care and family experiences ("I care about my health", U5; "there are cancer cases in my family", U14), boosted by social conditionalities ("the factors that play an influence... mostly the *Bolsa Família*", U2) that act as contextual reinforcements. Messages that articulate risk and benefit and invite autonomy tend to support adherence beyond document requirements, favoring the continuity of screening as a routine practice.

DISCUSSION

The characterization of the 20 participants highlights a majority contingent of brown, single women aged 37 years, on average, who have completed at least high school, who mostly work as domestic workers or rely on social welfare programs. This profile is consistent with the findings from other studies conducted in Brazil, especially in more vulnerable Regions, like the North, where there is a predominance of women in similar socioeconomic conditions of access to cervical cancer screening[26,27].

The findings indicate that irregularities in CCST result from interdependent barriers — distance, care responsibilities (motherhood), restricted days/hours, work demands, and embarrassment in the face of an intimate procedure. These elements, of individual, sociocultural, and institutional nature, overlap with each other and narrow windows of care, favoring delays/absences, and producing discontinuity of screening. Such multicausal configuration corroborates the literature on adherence as a contextual and cumulative phenomenon[28], pointing to the need to interfere in the architecture of access (schedule, predictability of workflows, reception), and not only in individual behavior[29]. Moreover, these barriers directly reverberate on the first contact access at PHC, by impairing the timely insertion of users in the service and continuous utilization of preventive actions.

The presence of children may increment concerns with health and, therefore, stimulate Pap smear[30]. However, these findings, related to the motherhood theme, demonstrated that the routine of caring for children predominantly operated as a restriction, emerging as one of the main challenges to regularly screening for cervical cancer. In other words, motherhood can motivate in terms of attitude, but within the studied context, it prevailed as a practical barrier.

The barriers in the level of service, weaknesses in infrastructure, poorly responsive consultation/scheduling models, and communication failures translate into prolonged waiting times, difficulty scheduling, and discontinuity between the steps of care, aligning with what the literature describes about the organizational role in adherence to screening. Particularly, the delay in returning results constitutes a critical gap even after collection, with a potential to break the bond, reducing trust and causing loss to follow-up[31,32]. These findings show weaknesses in the coordination of care and longitudinality, essential attributes of PHC, since they compromise the proper follow-up with users throughout the care journey. Therefore, the problem is not restricted to access to the test collection but includes the capacity of the service to support care throughout time, articulating how users are welcomed, follow-up, and timely response to the needs presented.

The findings from the generator theme "difficult feelings" place adherence less as a purely rational decision and more as an affectionate-relational experience, in which body exposure, shame, fear of pain/result, and not-so-welcoming interactions operate as strong barriers to showing up[33]. In interpretive terms, the intimate character of CCST activates sociocultural markers — modesty, gender norms and stigma — which, without qualified mediation, convert into avoidance of delayed screening[34].

This scenario displaces the discussion to the quality of the clinical encounter: people-centered communication practices, step-by-step explanation, reinforced informed consent, possibility of choosing the professional (including their gender), ensured privacy, managing discomfort, and clear feedback configure devices capable of reformulating the experience, reducing anxiety, and transforming concern into action[35]. Facing "difficult feelings" is not peripheral to screening, but a structuring condition of care within PHC.

The findings that make up the generator theme "gaps and informational noise" converge with the literature by indicating that low health literacy and limited understanding of the relevance of CCTS support non-adherence[36], while the procedure's discomfort remains a recurring barrier[37]. The low capillarity of actions outside the health units, exemplified by the lack of community visits (U19), and conceptual ambiguities (for example, ignorance of the HPV-CC relationship, U20) make prevention less actionable; in contrast, qualified access to information is associated with higher screening frequency, especially among women with higher education levels[38].

It is important to highlight that the alleged "lack of interest" of users often occurs in contexts characterized by scarce resources and failures in the organization of services[31]. In this scenario, not undergoing the test should not be solely attributed to an individual decision, but understood in light of the actual conditions of access and difficulties encountered throughout the care journey. Thus, adherence to screening does not rely solely on the will of women, but also on existing conditions that make care possible, understandable, and viable within their daily lives.

In the facilitators' axis, the "therapeutic relationship and possibility of choice" was key: humanized care, active listening, and clear explanations convert the first consultation into a bond ("they explain well… make us want to come back", U9), and the possibility of choosing a female professional increases comfort in the intimate procedure[32]. In the opposite sense, negative interactions (neglect, judgment, hurry) wear down trust and push users away from the services[31]. In practical terms, people-centered communication, clear feedback, and choosing the professional's gender constitute plausible levers to support adherence and reduce loss to follow-up.

Organizational determinants, predictability of schedules, transparent workflows, and structured feedback serve as central mechanisms to reduce uncertainty, strengthen trust, and support adherence to CCST, thereby shifting the debate from "individual behavior" to access. Agreed timeframes and communication in the act operate as verifiable commitments, anchoring expectations and decreasing transaction costs (time, displacement, childcare), with impact on return and continuity[37]. In summary, organizational predictability must be treated as a proximal determinant and quality standard in cervical cancer prevention.

In addition to physical access[38], clarity about risks, signs/symptoms, and therapeutic pathways organizes more informed decisions, while programmatic arrangements, such as schedule flexibility and strategic location of collection points, boost the mobilization effect of information, especially in vulnerable contexts[39]. Informational engagement strategies must be treated as a structural component of service design, articulated with organizational measures that reduce uncertainty and consolidate care journeys.

Regarding adherence motors, the literature indicates that a family history of cancer works as a strong inducer of screening search, while conditions of social welfare programs operate as external triggers that convert intention to commitment[40,41]. Furthermore, HPV vaccination is associated with a higher frequency of CCST[42], a finding that relates to the high proportion of vaccinated women in our sample. Analytically, adherence emerges from convergence between internal motivations (self-care and family experiences) and contextual reinforcements (ex.: program requirements), being more sustainable when risk/benefit messages are articulated with autonomy supports (informed invitations, actual choices), and organizational predictability of the service. This avoids exclusive dependence on document requirements and favors screening maintenance as a routine practice[36]. At the same time, these findings indicate that cervical cancer prevention does not rely solely on campaigns or normative recommendations, but on acknowledgment processes, bonds, and meaning production that make care relevant in the actual experience of women.

As a new aspect, the study shows that barriers and facilitators do not work in isolation or linearly, but intertwine within the care journey, producing approaches or successive distances between users and the service. More than identifying obstacles to the test, the findings show that cervical cancer prevention, within the context of PHC, is a relational and organizational experience, crossed by material conditions, feelings, information, and care functioning modes. Additionally, some limitations must be observed in this study. Noteworthy is the absence of feedback regarding the transcripts and the lack of result validation with the participants, steps that could have contributed to greater interpretive depth and analytical robustness of the findings.

CONCLUSION

The 20 women cared for in the public network (SUS) present high social and reproductive vulnerability —

brown, low-income, relying on social welfare programs, early sexual life start, and multiple births. Despite this context, there was high adherence to the cytopathological test (90% reported undergoing it annually, with most having done the last test in 2024 and 95% having negative results). The results indicate that cervical cancer prevention is related to the interaction between access to information, structural conditions of the services, and quality of professional-user relationship.

In the barriers' axis, we highlight factors that extrapolate the will of users — distance, restricted hours, delay in delivering results, and instability/regulatory opacity (for example, SISReg), added to poorly resolutive consultations. On the other hand, facilitators — concern about health, family history, social conditions (ex., *Bolsa Família*), educational campaigns, clear guidance, and empathetic care — favor adherence to the test and preventive practices.

Interventions focused exclusively on expanding the availability of the test prove insufficient; it is necessary to take an integrated approach addressing the organizational, relational, and informational dimensions of care. In this regard, the study provides insights into improving PHC practices by highlighting the need to enhance the reception process, reduce institutional barriers, and organize care workflows — characterized by greater transparency, defined timeframes, and person-centered communication — to consolidate continuous and comprehensive care within the SUS.

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Jonathan Queen Rosas Pereira and Ariano Wagner Alves de Oliveira contributed to data acquisition, analysis, and interpretation. Elizabeth Teixeira contributed to the wording and critical review. Alex Martins contributed to the study design, wording, and critical review. Lucas Lorran Costa de Andrade and Thalyta Mariany Rego Lopes Ueno contributed to the study design, planning, wording, and critical review. All the authors approved the final version for publication.

DECLARATION OF ARTIFICIAL INTELLIGENCE USE

Artificial intelligence (AI) was used only to translate the topic "Abstract", to modify the references, and translate the articles referred to in this review. The analysis, interpretation, or synthesis of results is the sole responsibility of the authors, with no AI intervention.

DECLARATION OF CONFLICT OF INTERESTS

There is no conflict of interest to declare.

DATA AVAILABILITY STATEMENT

All the contents associated with the article are included in the manuscript.

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