SALUD COLECTIVA, Buenos Aires, 9(2):215-233, May - August, 2013

Prevention of cervical and breast cancer in health services and non-governmental organizations in the city of Buenos Aires

La prevención del cáncer de cuello de útero y de mama en servicios de salud y organizaciones no gubernamentales de la Ciudad Autónoma de Buenos Aires

Ponce, *Marisa*[1]

[1]*PhD in Social Sciences. Postdoctoral fellow at the National Scientific and Technical Research Council, Gino Germani Research Institute, Faculty of Social Sciences, Universidad de Buenos Aires. Argentina*
marisaponce24@gmail.com

ABSTRACT The article analyzes actions for the prevention of cervical and breast cancer in public, private, and employment-based health services and in non-governmental organizations in the city of Buenos Aires. The article seeks to reflect on the reach and limitations of the approaches implemented in the three subsectors of the health care system and the community to prevent women from suffering or eventually dying as a consequence of these diseases, in the fragmented context of a health system with great heterogeneity in access and deep social inequalities in the use of preventive actions. The study utilizes a broad definition of prevention which integrates education, awareness-building and early detection of pre-carcinogenic and carcinogenic lesions, among other medical and non-medical components. The results were obtained using semi-structured interviews with subjects from public hospitals, employment-based health care services, private medical companies and non-governmental organizations with work in cancer prevention. These results show that contrary to a comprehensive approach, each institution limits its actions to only one aspect of prevention, implementing predominately isolated or disconnected actions inadequate to generate an autonomous and well-informed demand for treatment and health care among women.
KEY WORDS Cervix Neoplasms Prevention; Breast Cancer Prevention; Health Services; Non-Governmental Organizations; Argentina.

RESUMEN Este artículo analiza las acciones de prevención del cáncer de cuello de útero y de mama en servicios de salud públicos, privados y de la seguridad social y en organizaciones no gubernamentales de la Ciudad Autónoma de Buenos Aires. Su propósito es reflexionar acerca de los alcances y las limitaciones de los enfoques preventivos implementados en los tres subsectores del sistema de salud y la comunidad para evitar que las mujeres se enfermen y se mueran por causa de esas enfermedades, en un contexto fragmentado del sistema de salud con fuertes heterogeneidades en el acceso y agudas desigualdades sociales en el ejercicio de la prevención. La investigación parte de una definición amplia de prevención, que integra la educación, la concientización y la detección temprana de lesiones precancerosas y de cáncer, entre otros componentes médicos y no médicos. Los resultados obtenidos a partir de entrevistas semiestructuradas a referentes de hospitales públicos, obras sociales, empresas de medicina privada y organizaciones sociales que trabajan en el tema del cáncer muestran que, en contraposición a un abordaje integral, cada institución recorta su accionar en torno a un eje de la prevención, y predominan respuestas aisladas y desarticuladas que no alcanzan a generar en las mujeres una demanda por cuidados y asistencia de manera autónoma e informada.
PALABRAS CLAVES Prevención de Cáncer de Cuello Uterino; Prevención de Cáncer de Mama; Servicios de Salud; Organizaciones no Gubernamentales; Argentina.

SALUD COLECTIVA, Buenos Aires, 9(2):215-233, May - August, 2013

INTRODUCTION

In Argentina – as in many other countries around the world – breast cancer constitutes the principal cause of cancer death among women. It is estimated that every year nearly 17,000 new cases are diagnosed, and approximately 5,400 women die from this disease. As breast cancer is difficult to prevent, health policy should focus on early detection and the provision of adequate treatment (1) (a).

Cervical cancer constitutes the second cause of cancer-related death in women nationally. Although this disease is preventable, estimates show that every year 3,000 new cases are diagnosed and approximately 1,800 women die of this disease (2). Despite the fact that the burden of disease is less than in other Latin American countries, there are significant contrasts among mortality rates in different Argentine provinces (3).

Breast cancer mortality rates also vary across jurisdictions. In the period from 2003-2007, the Autonomous City of Buenos Aires presented the highest breast cancer mortality rate (28 per 100,000 women versus 22.4 nationwide) (1), while during the 2004-2006 period it presented the lowest cervical cancer mortality rate (3.8 per 100,000 women versus 7.2 nationwide) (4). In this jurisdiction, social inequalities in cancer care persist among women belonging to different socioeconomic groups (5-8).

Many studies on cervical and breast cancers in Argentina show that the actions taken by institutions and healthcare providers have had a great impact on preventive, diagnostic, and therapeutic practices for these diseases (1,3,5-13). Among such studies, those that analyzed barriers in access to Papanicolaou (Pap) tests and mammograms, as well as the factors that made women with abnormal Pap smears discontinue medical care in the stages of diagnosis, follow-up, and treatment in public and/or private hospitals of the Buenos Aires Metropolitan Area and other areas of the country, indicated problems in implementing public policies aimed at prevention through health services and related to the physical and human resources available. The poor institutionalization of government programs, the absence of the educational function of medical consultation, the lack of training in performing mammograms and interpreting Pap test results, lengthy waiting periods for receiving medical attention, delays in obtaining the results and administering treatments, the absence of follow-ups in cases of positive results, and monitoring and evaluation were some of the problems identified. However, other studies have shown that positive relationships established between patients and healthcare professionals and strategies developed by doctors and healthcare teams (tracking the women to give them the results) had a positive influence on the understanding of abnormal Pap test results and the women's consistency during follow-up and treatment.

In the context of a fragmented and highly heterogeneous health system in terms of access that displays notorious social inequalities in preventive practices related to women's sexual and reproductive health (14-17), this article (c) aims to reflect on the scope and limitations of the approaches to cervical and breast cancer prevention in public, private, and social security sector healthcare services and non-governmental organizations (NGOs) in the Autnomous City of Buenos Aires, intended to reduce the magnitude of these diseases.

Cancer prevention and health institutions

Throughout history, disease prevention has been intrinsically linked to beliefs and evidence regarding health and its determinants, based on the demographical, epidemiological, socioeconomic, political, cultural, and technological aspects of a given society at each historical moment (23). After the modernization of western societies and their progressive medicalization from the 18th century onwards (24), the preventive model which had been based on the isolation of diseased individuals shifted towards the recognition of rights and the notion of citizenship, linked to improvements in environmental and social conditions, education, community participation, and interdisciplinary/intersectoral integration, leading to the expansion of the field of prevention beyond the healthcare system and medical field (25-27). As a result of these conceptual changes, the strict biomedical approach gave way to a more comprehensive,

SALUD COLECTIVA, Buenos Aires, 9(2):215-233, May - August, 2013

complex, and multidimensional approach (28,29). From the 1970s onward, with the recovery of the 19th-century social medicine approach, the greater complexity of these conceptual frameworks has been expressed through a variety perspectives, including primary health care (PHC) (30) and health promotion (31,32) – concepts supported by international health organizations (33,34) – as well as the concept of vulnerability (35). The incorporation of a broader perspective on issues of health and disease and the strategies to prevent them has nevertheless had little repercussion in terms of concrete action (29,36-38). One of the persisting problems is the predominant model of medical care, which aims at curing disease and focuses on the structure of hospitals and the development of highly complex technology rather than promoting primary health care and preventive action. Another problem is found in the healthcare model based on the medical discipline, with solutions dependent on access to health care services and the expansion of health care, in that it hinders multidisciplinary work and structures preventive actions and health education through the dissemination of information and recommendations to modify individual behavior (39) without taking into account socioeconomic, historical, cultural, and gender-based aspects that condition preventive practices (40-48). Following Sergio Arouca (36), our view is that the principal problem of preventive medicine is the difficulty in making it into a political movement capable of implementing change.

According to a comprehensive approach to health (27-49) (d), cervical and breast cancer care is a process made up of different components: primary prevention, which includes education, awareness building, Human Papilloma Virus (HPV) vaccination campaigns; secondary prevention or early detection of pre-carcinogenic or carcinogenic lesions; diagnosis, follow-up, and treatment of these diseases; providing support to women in whom some type of lesion has been detected; and other measures aimed at improving their quality of life and general welfare. These actions can be facilitated by the articulated and coordinated work of different social groups. Collective action allows for the creation of political, social, and cultural conditions necessary for developing healthcare habits, that for women are mediated by their tendency to prioritize other people's needs over their own as well as the social norms and beliefs that shape their behavior.

Early detection of pre-carcinogenic and carcinogenic lesions (via Pap tests for cervical cancer and mammograms for breast cancer) is highly effective in reducing morbidity and mortality caused by these diseases (50) when accompanied by a quality diagnosis, appropriate treatment, and adequate follow-up (51). This requires the proper organization and operation of healthcare services. From a comprehensive perspective, the concept of prevention cannot be considered separate from the diagnosis, follow-up, and treatment of disease, nor from other factors that influence health care, such as the right to education, among others. In other words, it is of no use informing women of the factors that may cause cancer or simplifying the access to Pap tests and mammograms if it cannot be guaranteed that the remaining stages of care will be correctly followed through (1-3).

A significant challenge in cervical and breast cancer prevention is having women adopt certain habits to detect these diseases, which are often invisible at early stages. In order for prevention to be effective, it is essential that women periodically attend healthcare centers for Pap tests and mammograms, collect their results, and follow through with treatment if pre-carcinogenic lesions or cancer are detected (11-13). In order to prevent cancer, it is absolutely necessary that women do not postpone treatment and continue to receive medical care throughout their entire life, even when they may have to attend to family or work issues (52-54). In contexts of social vulnerability, structural poverty, and violence (55), there are larger challenges present and women face a series of urgent problems: how can they prioritize visits to healthcare centers when they experience necessities such as lack of food, housing, and employment? It should also be noted that it is difficult for some women to overcome feelings of embarrassment when exposing their bodies in gynecological and breast exams, the fear of pain or suffering during examinations, and the fear of cancer, disability, or death (56). In cases such as these, an inevitable question arises: how can cancer prevention be made the result of autonomous and informed action demanded by women?

SALUD COLECTIVA, Buenos Aires, 9(2):215-233, May - August, 2013

Unlike instrumentalist, utilitarian, and individualistic interpretations, prevention is primarily a political and social practice (57) that cannot be reduced to a medical procedure or an action preemptive to a disease (27). It would also be inaccurate to interpret it as evidence of the medicalization process (40), whereby women are required to submit to gynecological and breast examinations under norms imposed by medical protocols seeking to detect disease in the female population. Rather, prevention symbolizes a set of critical and reflexive actions regarding life, the awareness of one's own existence, the capacity to act autonomously, and above all, the exercise of the right to health (58). These principles support the notions that health care fosters action in different areas of life, promotes independent decision-making, and implies the acknowledgment of other rights. It should be asked, then, if work should be done to change the social representations of cancer prevention so as to be thought of and experienced as a set of practices that can help women improve their well-being, create conditions for a dignified life, and exercise their rights as citizens.

Recognizing the importance of a collective and comprehensive approach to cervical and breast cancer prevention implies raising questions about the relevance of family-based, medical, cultural, recreational, religious, and workplace actions (among others) that could build cancer prevention awareness. How could these actions be integrated such that effective practices are developed? (39) How could women who do not use healthcare services access Pap tests and mammograms? What would be necessary for women to collect test results and not discontinue their treatment? What contributions could be made to change representations of cancer and detection techniques? What strategies could help diminish women's feelings of embarrassment? In this line of inquiry, new questions regarding health institutions emerge, around which this article is focused: what actions do the different subsectors of the healthcare system perform? What role do civil society organizations play? What differences and similarities do actions by governmental and non-governmental institutions (whether public or private) have? What are the guiding principles in the design of these actions and what is the operative logic with which they are applied? How are interdisciplinary and intersectoral actions organized and articulated?

The findings of this study were interpreted in the theoretical framework of the collective health (59-60) and comprehensive health care perspectives (61). Both perspectives posit that healthcare institutions are the places where public policies are implemented and resignified and where healthcare institutions and professionals act as mediators, facilitating or encumbering practices for healthcare users. According to Foucault (62), healthcare institutions can also be defined as heterogeneous power apparatuses (through discourses, architecture, and laws as well as philosophical, scientific and philanthropic propositions) where what is said and what is not said are also elements of these apparatuses.

OBJECTIVES AND METHODS

The objective of this article is to analyze and compare preventive actions aimed at cervical and breast cancers implemented by healthcare services and NGOs in the City of Buenos Aires. This study employed qualitative methods to obtain primary data from 16 semi-structured interviews conducted in 2009; interviews were conducted with nine doctors and gynecologists at public hospitals, the medical director of a union-run healthcare plan, two professionals at a private health insurance company, a public official at the office of the Health Services Superintendent, and three professionals and administrative employees at NGOs (Table 1). Non-participant observation was also carried out in waiting rooms at three public hospitals, one community health center, and in a meeting conducted by NGOs working on cancer issues, held in 2009 in the City of Buenos Aires. Two observations were carried out in each hospital, one at the health center, and one at the NGO meeting. An observation guide was used for health service observations and a separate one was used for the NGO meeting. Written observations were recorded in a field notebook and the contents were included in the analysis. In addition, some institutional documents such as periodic reports, web sites, and graphic campaigns on cervical and breast cancer prevention created by private health insurance companies and NGOs were analyzed.

SALUD COLECTIVA, Buenos Aires, 9(2):215-233, May - August, 2013

The units of analysis used in this study were each institution, and the units of data collection were the individual respondents at these institutions. The nonprobability intentional sample was made up of: 1) two acute care general hospitals providing secondary care under the Buenos Aires municipal government which implement cervical and breast cancer prevention programs and a public tertiary care hospital specializing in oncology; 2) a union-run healthcare plan and the office of the Health Services Superintendent; 3) two private medical insurance companies; and 4) three NGOs working with cervical and breast cancer prevention (henceforth referred to as La Unión, La Red and El Movimiento) (e). Although it was originally our intent to analyze a larger number of institutions, there were some difficulties in interviewing representatives from the union-run health plans and the private sector because they either did not respond to requests to participate in the study or they stated that they did not have enough time and put up bureaucratic barriers (requiring notes be sent in advance, multiple phone calls, and so on). In contacting representatives at public hospitals we did not encounter many difficulties.

The first contact with respondents was made through key informants. Respondents were informed of the purpose of the study and were told that their participation was entirely voluntary. They were also informed about the measures that would be taken to preserve their anonymity and that of their institutions, the confidentiality of the data provided, and the possibility of obtaining the reports with the findings if they so desired. The study did not need the approval of an ethics committee, as this was not a requirement of the financing agency when the research took place. Nonetheless, due to the type of questions included in the interviews and consistent with international conventions on health research (63-67) and the ethical values of social science research (68), informed consent was obtained.

Audio recordings of interviews obtained with the respondents' consent were transcribed in order to process and analyze the collected information. A general reading was carried out to identify the different dimensions of the study, both those derived from each semi-structured interview guide used in each sub-sample and those that arose during the interview. The information was coded using the Non-numerical Unstructured Data Indexing Searching and Theorizing (NUD*IST) software, which allowed for the analysis and comparison of data obtained for the different institutions under review.

Respondents were identified according to their position or profession and any information that could reveal their identity or that of their institution was excluded. The real names of the NGOs were replaced with pseudonyms. Furthermore, respondents were assured that no other person would have access to the information provided and were also informed about the use of the information to be gathered and the scope of the study's dissemination.

The respondents' views on prevention, the formulation of problems, the reasoning cited, and the establishment of priorities contributed to an outline of the responses to women's health problems. While all respondents were interested in prevention

Table 1. List of interviews with members of healthcare services and non-governmental organizations. City of Buenos Aires, 2009.

Type of Institution	Informant Number	Type of Informant
Public secondary care hospital	1	Head of Gynecology
	2	Gynecologist specialized in climacteric
	3	Gynecologist
	4	Social worker
Public secondary care hospital	5	Head of Gynecology
	6	Gynecologist specialized in breast pathology
	7	Gynecologist
Public tertiary care hospital	8	Head of Gynecology
	9	Head of Breast Pathology
Office of Health Services Superintendent	10	Public official in the are of management of prevention policies
Union-run healthcare plan	11	Medical Director of union-based health center
Private health insurance company	12	Medical Director
Private health insurance company	13	Member of preventive programs department
NGO La Unión	14	Breast cancer specialist
NGO La Red	15	Member of health promotion area
NGO El Movimiento	16	Member in charge of prevention talks

Source: Own elaboration.

SALUD COLECTIVA, Buenos Aires, 9(2):215-233, May - August, 2013

and in providing a critique of the activities of their institutions, it should be noted that there was certain bias in the testimonies of some respondents occupying management positions, who may have tended to disclose solely positive aspects.

FINDINGS

Public hospitals

In the two acute care general hospitals women are not encouraged to have Pap tests and mammograms performed, despite the fact that a governmental program aimed at cervical and breast cancer prevention exists in these institutions. Examinations are performed on women who actively seek out medical services, but in most cases such visits are not for prevention but can be attributed to the appearance of health problems. The high priority given to the treatment of disease coupled with the necessity of providing immediate attention to urgent problems make it difficult for the hospital to become a space for developing knowledge and practices related to prevention: "*The hospital is only prepared to handle contingencies*" (Chief of Gynecology at a general hospital). The absence of strategies directed at attracting women to healthcare services, along with the possibility of effectively satisfying this demand, are influenced by budget and time constraints, lack of infrastructure and human resources, and the fact that reaching out to women is considered to be the responsibility of other governmental agencies. Although doctors stated the importance of establishing lines of communication with the population of women who use public health services, no institutional action was taken to put such measures into practice. Other structural problems are related to the low levels of institutionalization of preventive programs at the public hospitals of the Buenos Aires city government and the limited articulation among hospitals and community healthcare centers, factors that diminish the participation of hospitals in coordinated actions: "*We forget that community healthcare centers exist*" (Gynecologist at a general hospital).

In this context, the practices adopted by many doctors and healthcare teams contribute to filling the gap generated by the absence of prevention policies: many professionals put preventive techniques into practice while providing medical attention by transmitting messages that help dismantle misconceptions and fears related to cancer and its detection methods:

> *I explain to them that it does not mean that they have something, but that we are not going to wait until they do, that a person does not change from healthy to unhealthy overnight, that it is a process that takes months to develop*. (Gynecologist at a general hospital)

At the cervical pathology department of another general hospital, preventive action is expanded to include men: once a week a medical consult devoted to the prevention and treatment of Human Papillomavirus (HPV) infection – the main cause of cervical cancer – operates, exclusively directed at the male partners of women diagnosed with this condition who have been asked to attend.

Most medical practices are focused on treating women with pre-carcinogenic lesions and cancer. In one general hospital, cancer diagnoses are communicated in what are known as "oncological feedback" sessions, in which the patient, her relatives, the doctor, and a psychologist participate in order to provide women with a supportive network:

> *This has signficantly improved follow-up; patients go through with treatment and that may lead to success*. (Gynecologist at a general hospital)

In the oncological hospital, doctors' messages are addressed to women who must start oncological therapies. Doctor-patient relationships come to be based on what specialists have called the "oncological habit" – the ability to establish affective relationships and communicate positive messages to women undergoing a disease as severe as cancer.

> *There is always good news to convey that she can hold on to in moments of anxiety: that she came in time; that if she didn't come in time, she can be operated on; that if she is going to be operated on, she will be taken care of; that she is young; that she will be*

SALUD COLECTIVA, Buenos Aires, 9(2):215-233, May - August, 2013

> *able continue working. This needs to be mixed with a lot of affection and physical expressiveness. Affection relaxes tension and improves communication*. (Doctor at an oncological hospital)

These practices allow women to develop trust in their doctors, incorporate the preventive measures that they recommend, and follow through with treatment. Medical visits are an environment conducive to the transmission of guidelines for care in which much importance is attributed to communication, affection, and the development of capacities based on the adoption of language used by the women themselves, as well as the interactions of the women with their partners and relatives. The scope and reach of these interventions are limited, given that they arise from the particularities of each case, and consequently care is promoted solely at the individual level, meaning that no comprehensive preventive policy is present.

Union-run healthcare plans

The viewpoint of the authorities at the Health Services Superintendent's Office regarding the role of prevention in union-run healthcare plans is to guarantee access to medical care and the preventive programs aimed at the early detection of cancer that they implement. On the other hand, the role of health education is attributed to other social actors:

> *Awareness is a social issue; union-run healthcare plans can contribute to this, but it is not a role specific to them. It is the role of the State, the media, NGOs. The work to be done is much broader*. (Official at the Health Services Superintendent's Office)

In 2007, the office of the Superintendent – which controls the healthcare services coordinated by national trade unions – provided financial support to these social security institutions in order to develop preventive plans that included cervical and breast cancers. The project was executed for two years but was then discontinued. In both the creation and the suspension of this prevention policy, authorities' definitions of the role of the Superintendent's Office were decisive; these definitions revealed contrasting positions according to the different meanings attributed to the monitoring function. If control is defined in a broader sense, the officials who participated in the 2007 project considered that the agency should not limit its tasks to supervising the compliance with established policies, but instead should work toward the creation of a new regulatory framework that could foster new action. Nonetheless, their successors in the ensuing administration (who opposed this approach) withdrew the project.

Union-run healthcare plans carry out different actions to facilitate members' access to Pap tests and mammograms such that the emphasis in preventive action related to cervical and breast cancers is placed on early detection. According to the respondent from one such healthcare plan, most women have preventive tests done periodically, which contributes to the early detection of pre-carcinogenic lesions and the successful treatment of the disease.

The professional/work-related identity of the union coordinating the healthcare plan in question was recognized as an essential feature of the prevention work performed:

> *Teachers in particular are characterized by the promotion of education and prevention*. (Medical Director at union-based healthcare center).

The institutional policies of prevention are set jointly by doctors and educators who meet in a Board of Directors in their different roles: representatives of the different trade unions that make up the healthcare plan, the authorities of the healthcare plan, medical directors of its centers, and different medical specialists.

The actions to prevent cancer in women include the creation of healthcare centers specialized in women and children's health, that function as primary care centers where women are instructed to perform preventive tests in order to detect signs of cervical and breast cancers:

> *We were able to eliminate gynecological care from the multi-specialty medical offices and to structure gynecological services to*

SALUD COLECTIVA, Buenos Aires, 9(2):215-233, May - August, 2013

reinforce the notion of prevention. (Medical Director at a union-based healthcare center)

The pathological anatomy service is charged with contacting women who do not collect their test results and informing doctors about the situation when necessary. The institution also has a care unit for adults over age 65, where medical attention is focused on endometrial and breast cancers, as these diseases are common among the elderly. In addition, this union-sponsored healthcare plan conducts campaigns on cervical cancer detection via a mobile medical office that visits schools in the City of Buenos Aires where its members work. Furthermore, it encourages women to act as health agents in their workplaces. The medical visit is a crucial component in this strategy because it is the space in which doctors and members interact and coordinate joint action. In this interaction, doctors provide brief trainings for women who talk about sexuality in schools. Sexually transmitted diseases are considered a relevant problem among young people, including the lack of perception of the risks of HPV infection.

As a strategy for building awareness, informative brochures are distributed in all healthcare centers belonging to the union-sponsored healthcare plan. Massive health education campaigns are more difficult to conduct due to scarce social security resources. Thus, it is expected that this action be carried out by the federal government.

Private medical insurance companies

Similar to the union-run healthcare plan analyzed above, cervical and breast cancers are not prevalent problems among the users of private health insurance services. In this subsector, the creation of preventive strategies is more often the result of governmental norms and stipulations (Mandatory Health Program) or recommendations of international health organizations than the initiative of the institution itself. In contrast to what happens in public hospitals, private medical companies often face the problem of excessive supply or demand of medical care related to cervical and breast cancer prevention. This shows a clear contrast between the different subsectors of the healthcare system and the important social inequalities that form part of it.

For private medical insurance companies, prevention has economic repercussions and preventive strategies are established in line with a market-based logic:

The problem of prevention in the private system has its twists and turns [...] *if a company dedicates a large part of its resources to prevention, that will generate costs. In a younger population, this improvement in health is not perceived until some time goes by. It is possible that this population, in which preventable pathological events are uncommon, will think that the cost increase is unnecessary, and consequently opt for another provider*. (Medical Director at a private health insurance company)

These decisions are strongly related to the idea that prevention is an aspect undervalued by users. This can be interpreted from an individualistic-behavioralistic theoretical perspective (69), in which subjects are capable of acting autonomously, considering costs and benefits of alternatives, utilizing available information, and making decisions that can better contribute to their welfare. Under this conception, companies provide information in institutional catalogs and brochures that members receive in their homes and that are available at the company's administrative offices.

Institutional communications are useful for informing women of the importance of cervical and breast cancer detection methods and the frequency with which they should be applied, since many women exceed necessary controls. Recently, companies have shown a stronger commitment to evaluating the preventive practices of their users, encouraging them to consult their doctors for Pap tests and mammograms, especially women who have not had gynecological controls over the previous years. Actions are carried out through mail campaigns in which companies send letters to their users (one of the companies was still designing this type of campaign and the other had already implemented it). The company that had already implemented this initiative selected 5000 women who had had neither a Pap test nor a mammogram over the previous eighteen months. Half of those women were invited to carry out the tests. They were sent letters that

SALUD COLECTIVA, Buenos Aires, 9(2):215-233, May - August, 2013

included mammogram referrals, given that this practice (unlike Pap smears) is not performed by their physician in their office, but in specialized diagnosis centers. After six months, the number of screenings performed by users who received this communication was compared to that of those who did not receive it. The results showed that there was very little difference in the preventive practices of the two groups, which provided more questions than answers and highlighted the difficulties with prevention strategies:

> *Part of the problem has to do with people's interest; I believe we should go on teaching, informing.* (Member of the Preventive Programs Department at a private health insurance company)

Non-governmental organizations

La Unión is the oldest of the organizations analyzed; it was created by a group of women who donated personal funds. Currently, it has several offices in various locations throughout the country that work on cancer prevention and diagnosis, including cervical and breast cancers. At its headquarters located in the City of Buenos Aires, specialists provide medical care and talks are organized for the community. The NGO has a mobile medical office that visits different neighborhoods in greater Buenos Aires as well as cities throughout the country, and provides mammograms to uninsured women between ages 40 and 65 belonging to lower socioeconomic strata. It also offers accommodation for women from other provinces that must travel in order to receive treatment in public hospitals of the City of Buenos Aires. Although there are no formal ties between the NGO and the public hospitals, certain contacts facilitate women's access to the hospitals in order to start receiving cancer treatment.

La Red is part of a company dedicated to international trade, with a community action division that carries out activities for women's social development. In the area of health, breast cancer has become the company's main "cause" at the international level, which is reflected locally in the line of actions implemented following the model of its US headquarters: financial support for breast cancer early detection campaigns and walkathons. La Red and La Unión work together in breast cancer detection campaigns via the mobile medical office. La Red absorbs the maintenance expenses for the mobile medical office and donated the mammography equipment. Among the fundraising strategies implemented by this NGO is a women's network that promotes solidarity-building activities, establishing a calendar to celebrate special activities which encourage female participation in roles related to healthcare and extend these functions into the field of community action.

El Movimiento differs from the two previous NGOs because it is an organization formed by women who have survived breast cancer, and its goal is to provide support to women in treatment. For that purpose, the organization organizes self-help and reflection groups coordinated by psychologists specialized in oncological patients. It also has a wig service, gives make-up courses, and offers lessons on how to make turbans – activities that help to counteract some of the effects produced by treatment. This NGO was created as a patient movement and acts as a mediator between women, health institutions, and governmental agencies, often initiating legal actions when there are obstacles to treatment and sending letters to governmental authorities requesting information. A common problem faced by uninsured women is the difficulty in obtaining drugs for cancer treatment:

> *Many women discontinue treatment because they have to face bureaucratic problems out of their control, which is very serious.* (Member of El Movimiento)

The women of this organization use their personal experiences as a way to facilitate awareness-raising talks given to other women at their workplaces, mostly schools or private companies. Thus, the participants in these talks are primarily professionals with medical coverage. As part of its secondary prevention program, the NGO provides free access to a limited number of mammograms annually, signing agreements with private diagnostic centers where they refer women for care.

The three NGOs analyzed above offer social aide or community action based on the values normally attributed to traditional benefit societies:

SALUD COLECTIVA, Buenos Aires, 9(2):215-233, May - August, 2013

> *It is an institution that has always been led by women with the medical counsel of doctors; they are here out of passion and generosity, not for the pursuit of personal glory, recognition, or economic interest*. (Doctor from La Unión)

These organizations are self-sustaining and do not receive government resources, operating with donations of private companies and the voluntary service of women. The creation of an institutional identity not linked to any political party gives the organizations moral qualities that place them outside the realm of special interests and transform them into representatives of common interests.

It can be observed that social action is spatially fragmented, given that centers and public spaces where most support services and consciousness-raising activities take place are located in the neighborhoods of the City of Buenos Aires where middle- to higher-income sectors are concentrated. Thus, women who participate in these activities tend to belong to the same social class and live in the area. As a result, women from lower-income sectors find it more difficult to participate and benefit from these activities. However, breast cancer detection campaigns are mainly implemented in the neighborhoods of greater Buenos Aires and other cities throughout the country, and thus these campaigns target women from lower socioeconomic strata. Such campaigns provide free access to mammograms but they do not focus on consciousness-raising activities and health education. The NGOs recognize these social inequalities and consider that their activities should be addressed to women from lower socioeconomic groups, although working with this population in particular does not appear to be an established priority and some NGOs admit to experiencing difficulties in carrying out alternative proposals.

The intersectoral approach

For the representatives of the organizations included in our analysis, strategic interaction is considered an effective tool for the development of policies aimed at the prevention of cervical and breast cancers. "*The fight against cancer is an enormous objective, it requires the involvement of diverse forces, with different origins*" (a doctor from La Unión). This point of view is consistent with the position of many government officials, for whom the prevention of these two cancers relies on coordinated action based on the creation of spaces for women to interact with each other:

> *Discussions about cancer prevention within families, raising consciousness among women's partners, encouraging the prevention of cervical and breast cancer at the workplace, generating demands on companies through union representatives, and setting agendas through non-governmental organizations*. (Official at the Health Services Superintendent's Office)

However, the negative views that each organization holds with respect to the others (mainly regarding their interests and capacities) makes working from an intersectoral approach difficult to put into practice.

The fragmentation, heterogeneity, and specificity of the healthcare system (70) condition the relations among public hospitals, union-run health care and private medical insurance companies and lead each institution to develop actions within its particular realm and directed at the population it covers. "*There are big gaps between the three systems*" (Director of a union-based healthcare center). Regarding community action, NGOs have only recently taken steps to articulate a movement capable of creating a common action agenda and thus direct demands at the State. Although communication among the organizations has improved in recent years, not until very recently have they become aware of the different activities carried out by the other organizations. Lower levels of training in certain issues – such as social rights related to health care – were also mentioned as a factor conditioning the interaction with other organizations in spaces of debate and in the development of certain areas, such as patients' rights. The assessment of some NGOs regarding the first meeting of social organizations of the City of Buenos Aires working for the prevention of cancer is that the possibility of a future alliance would depend on the organizations not forgoing their own identity and continuing to work toward their present specific objectives.

SALUD COLECTIVA, Buenos Aires, 9(2):215-233, May - August, 2013

Regarding the articulation of actions among the different healthcare subsystems and NGOs working on these issues, it was observed that although public hospitals and many NGOs share the detection of cervical and breast cancers in uninsured women as common objective, they do not coordinate articulated actions. From a medical standpoint, the ideas that NGOs have limited means of action (limited technological and economic means, infrastructure, and human resources) and that their function should be to build awareness in order to support the preventive programs of the State, lead to a general indifference toward collaborative work. Similarly, in the case of the union-run healthcare plan included in this study, articulating actions with NGOs was not seen as a possibility, as it was considered that the organizations had not found their place in society and it would be difficult to assign them a function within the organization. Although it is true that many collaborative actions could be designed, such as awareness-building talks organized by the NGOs for women waiting to receive medical attention at a union-based healthcare center, no initiatives have been put into practice thus far. Furthermore, in the private subsector, while many medical insurance companies "lend" their facilities to NGOs so that they may carry out their activities, they do not generally participate in collaborative work.

The coordination of actions among the institutions analyzed and other healthcare, community, educational, or cultural sectors, primarily bring together private medical insurance companies and NGOs, which are usually linked to scientific societies for the development of preventive strategies. One of the NGOs also receives support from laboratories for the publication of its institutional literature, although it should be noted that these sectors tend to refrain from taking part in prevention campaigns and health education given that their their primary interventions are in diagnosis and treatment. Although agreements have been signed between NGOs and private diagnostic centers for free mammograms, as was mentioned above, none of these activities have included a multi-sector approach capable of transcending the biomedical perspective.

Relations with government agencies are also weak. Representatives of the institutions in this study consider prevention to be complex issue influenced by social, cultural, political, and economic factors, and hold that the State should be the primary force to encourage changes in individual behavior regarding healthcare given that it has the operational capacity and sufficient resources to do so. These institutions agree that their function should lie somewhere between the action carried out by the State and that of individuals, that is, extending the reach of preventive programs led by different governmental agencies and helping to build awareness of the importance of prevention, despite the fact that these notions regarding their role are not reflected in concrete actions.

Relations between the institutions considered in this study and the municipal government of the City of Buenos Aires are practically nonexistent. The most significant collaboration can be observed in the area of community action. An example of this is the support given by governmental agencies to the development and dissemination of prevention campaigns on violence against women, implemented by one of the NGOs analyzed. In the social security subsector, the existence of political confrontations with representatives of the political party currently in charge of health policy in the City of Buenos Aires has been mentioned as the main obstacle to collaborative action.

FINAL CONSIDERATIONS

In order to analyze and contribute to the knowledge on institutional determinants and facilitators affecting the prevention of cervical and breast cancers, this study has characterized and compared the actions carried out by different healthcare providers and NGOs in the City of Buenos Aires, as well as the objectives guiding these actions. As in similar studies conducted in Argentina (1-3), the guiding principle of this study was that a comprehensive approach based on an effective articulation of cancer care and an appropriate coordination of intra- and inter-institutional actions, when compared with preventive approaches that limit their action to the individual level or carry out isolated and intermittent interventions, have greater potential for increasing cancer prevention practices and assuring that women continue through in

SALUD COLECTIVA, Buenos Aires, 9(2):215-233, May - August, 2013

the stages of diagnosis, treatment, and follow-up when pre-carcinogenic or carcinogenic lesions are detected, especially in the case of women who do not utilize healthcare services. Unlike previous studies that have analyzed the public and/or private environment of the healthcare system, this study describes the institutional strategies of the three subsectors that integrate them with the community. The purpose of gathering the perspectives of various actors is related to the complex and multidimensional nature of health, disease, and prevention, and the varying forms health coverage takes in Argentina.

This study's findings have shown that the healthcare institutions studied lack a comprehensive strategy for the prevention of cervical and breast cancers and have little influence on building awareness among women regarding the importance of their prevention. Each organization generally limits its action to only one aspect of cancer prevention and care (information, access to detection methods and treatments, strategies to deal with the disease), in order to change women's behaviors through their specific institutional actions, which seem unlikely to create significant levels of consciousness or persist over time.

Strategies differ among the three health subsystems. In public hospitals, practices are devoted to assuring that women comply with treatment indications; interdisciplinary work contributes to this purpose, although the specific nature of medical care in the doctor's office results in a limited scope of preventive actions, capable only of generating changes at the individual level. Nevertheless, consistent with another study conducted in the Buenos Aires Metropolitan Area (11), the omission of institutional preventive policies is attenuated by the initiative and determination of many professionals and health teams who perform a teaching role in medical consultations and initiate certain concrete mechanisms of action, such as educating about the prevention of HPV infection among men.

Unlike public hospitals, union-run healthcare plans and private medical insurance companies focus their action on the early detection of pre-carcinogenic and carcinogenic lesions and have a more significant capacity for intervention: preventive action goes beyond healthcare institutions to the workplaces or homes of female affiliates. The action of union-run healthcare plans is based on a diverse approach (including medical centers for women and detection campaigns outside of health centers), and often includes a solidarity-based model of management aimed at recruiting the participation of beneficiaries in the design and implementation of prevention policies, a strategy that contributes to encouraging certain values and healthcare practices in other areas such as education. Contrary to this broader approach, private health insurance companies transfer the responsibility for healthcare to their female affiliates and implement normative actions based solely on institutional communications. These strategies have not achieved their purpose thus far, of on the one hand increasing the access to preventive exams in women who do not attend gynecological consults, and on the other of changing the behaviors of women that lead to excessive demand for consultations. These experiences reinforce the idea that access to information and health insurance coverage cannot produce changes in healthcare attitudes and behaviors on their own and demonstrate the necessity of designing interventions to reach all women, regardless of their socioeconomic status and the type of healthcare coverage they possess.

NGOs are institutions that produce social relationships within the community and assume greater commitment in advocating for women's health issues. They differ from the other institutions in that they develop varied methods of prevention that favor a more comprehensive approach. In addition to facilitating access to cancer detection methods, NGOs implement various strategies aimed at building awareness, sensitizing community members, and providing support to women who receive oncological treatment, although the results of a recent study covering different areas of the country showed that awareness campaigns promoting the early detection of carcinogenic lesions were almost exclusively composed of massive campaigns carried out during the month of October in the context of "Breast Cancer Awareness Month" (1). Unlike the "follow-up" strategy implemented by many institutions within the healthcare system, NGOs work by accompanying women, an approach that leads to closer relationships with them. Many organizations are able change public spaces into meeting places, where recreation becomes another possible way to build awareness around cancer.

SALUD COLECTIVA, Buenos Aires, 9(2):215-233, May - August, 2013

However, a distrubing observation arising from this research is the scarcity of strategies developed by both NGOs and public hospitals to encourage the prevention of cancer among socially disadvantaged women. Among the actions designed and implemented by NGOs and public hospitals for women of more disadvantaged socioeconomic sectors, there is a predominance of an assistentialist approach in which women are considered beneficiaries or clients rather than rights-bearing subjects. That free access to cancer detection methods is the only solution offered these groups may be interpreted as one of the reasons that there continues to be a lower prevalence of preventive practices among these women in comparison with their counterparts from middle- and higher-income groups, and that is it consequently more difficult to mitigate the marked social inequalities with respect to prevention practices.

The differences observed in the preventive approaches of different healthcare institutions may be attributed to the absence of intergovernmental and intersectoral spaces that would facilitate discussion of the conceptual aspects of preventive actions, in order to develop coordinated strategies to help increase awareness of cancer prevention, modify social representations of the disease and its detection methods, and construct collective actions that would redefine, as a principle and a set of social practices, health care as a right of citizenship. The limited number of collective actions makes it difficult to constitute the prevention of cervical and breast cancers as a legitimate social right, thus reinforcing social, cultural, and gender-based factors that condition women's attitudes and behaviors regarding health care. The lack of collaborative actions among the institutions of the healthcare system and their limited relations with NGOs also hinder the articulation of collective demands to the State as well as the supervision of existing public policy. Although these institutions recognize the importance of cancer prevention, their conception of reality puts them in a position external to the situation, given that they attribute the responsibility for intervention almost exclusively to the State. If this lack of intergovernmental and intersectoral space remains, the isolated and disconnected nature of the cancer prevention actions of these institutions will persist (f).

Although working from a collective and comprehensive approach to health and prevention may be a complex and even impossible objective to fully realize (27), it must be considered a "regulating" model for the practices, actions, policies, and programs that define the orientation of such work. In other words, the State and other sectors of society (including healthcare institutions) must consider women as rights-bearing subjects, and carry out actions that enable them to think about their health problems and how to solve them, guaranteeing resources for their participation in the programs aimed at preventing cervical and breast cancers. Collective action gains relevance in the development of preventive practices resulting from actions that are autonomous, well informed, and demanded by the women themselves.

ENDNOTES

a. Unlike cervical cancer, the primary cause of which is infection by one of the many genetic srains of Human Papillomavirus (HPV), breast cancer cannot be prevented. Therefore, the idea of breast cancer prevention adopted in this study refers to the possibility of preventing the development of the disease into its advanced stages, including death.

b. The Metropolitan Area of Buenos Aires includes the City of Buenos Aires and the closest ring of counties of the Buenos Aires Conurbation.

c. This article is a part of larger dissertation research conducted from 2005 to 2010 for a PhD in Social Sciences at the Universidad de Buenos Aires (8). Its objective was to identify the factors that favor or hinder cervical and breast cancer prevention in the City of Buenos Aires from an approach integrating three dimensions: 1) preventive policies of the municipal government of Buenos Aires, 2) the actions of health institutions, and 3) the preventive practices of women from different socioeconomic groups. Many results arising from the first and second points have been discussed in "Los enfoques de prevención del cáncer de cuello de útero en los programas gubernamentales (CABA y Nación, 1998-2009)" [The approaches to cervical cancer prevention in governmental programs (City of Buenos Aires and the Nation, 1998-2009)] (18); "Prevención del cáncer de cuello de útero y el cáncer de mama, redes sociales y

SALUD COLECTIVA, Buenos Aires, 9(2):215-233, May - August, 2013

mediaciones: un estudio en la Ciudad Autónoma de Buenos Aires, Argentina" [Prevention of cervical and breast cancer, social networks and interventions: a study in the City of Buenos Aires, Argentina] (19). With respect to the third point, see: "Percepción de riesgo y opiniones sobre el cáncer de cuello de útero y el cáncer de mama en mujeres adultas de la Ciudad de Buenos Aires" [Risk perception and opinions about cervical and breast cancer in adult women in the City of Buenos Aires] (20); "Trayectorias de cuidados del cáncer génito-mamario en mujeres adultas" [Trajectories of genito-mammary cancer care in adult women] (21) and "Juventud, Cultura y Salud: Cambios generacionales en el cuidado de la salud sexual y reproductiva de las mujeres" [Youth, Culture and Health: Generational changes in the care of sexual and reproductive health of women] (22). This article presents previously unpublished results related to the second point analyzed – the actions of health institutions – the purpose of which was to describe and compare the way each institution approaches cancer, including: the implementation of preventive actions; the justifications, objectives, follow-up, scope, and limitations of these actions; the population receiving these actions; as well as inter- and intra-institutional articulation.

d. The idea of a comprehensive approach is opposed to fragmentation, that is to say, to accepting a limited view of health problems that reduces them to one or more aspects and disregards others. This idea also rejects reductionism and the objectification of individuals, and in contrast encourages the idea of a broader approach to understanding health problems and solutions centered on people.

e. Acute care general hospitals carry out the detection and diagnosis of cervical and breast cancers, and provide outpatient care and hospitalization services to women in different stages of the disease. The oncological hospital works in the prevention and diagnosis of the disease and has high-complexity equipment and technology for the treatment and rehabilitation of severe oncological diseases. Women who are treated in these three hospitals mainly belong to low and medium-low socioeconomic strata and live in the City of Buenos Aires or in the Buenos Aires Conurbation. The oncological hospital is a nationally recognized clinic visited by women from other provinces as well as women from middle and high socioeconomic strata with health insurance coverage who seek the confirmation of diagnoses and treatment advice, after which they continue receiving medical attention from their union healthcare plans or private health insurance companies. The union-run healthcare plan analyzed covers, among its female affiliates, women belonging to middle and lower-middle socioeconomic strata in the City of Buenos Aires and other districts, whereas the private medical insurance company includes women in medium and medium-high socioeconomic strata living in the same city. On the other hand, the NGOs analyzed here have the particularity of having been created and administered by women, although they present differences in the type of institution, organizational structure, the actions they carry out, and the population they work with. The main offices of the three organizations are located in the City of Buenos Aires, although some of their activities take place outside of the city. The populations of women each organization works with belong to different socioeconomic groups and their profiles vary according to the type of activity carried out.

f. At the time of publication and since the launch of the National Program for the Prevention of Cervical Cancer in 2008 and the creation of the National Cancer Institute in 2010, different actions in relation to cervical and breast cancer care have been implemented in several provinces of Argentina. These actions enlist the participation of leaders of governmental programs, health service staff, biomedical and social science researchers, NGOs, and women who belong to a number of organizations, which suggests that there would be changes in the approach to resolving these problems (personal communication with members of the National Ministry of Health).

ACKNOWLEDGMENTS

I would like to thank the National Scientific and Technical Research Council for the funding granted for the development of the dissertation entitled "Mujeres y salud: la prevención del cáncer de cuello de útero y el cáncer de mama en la Ciudad Autónoma de Buenos Aires" [Women and health: the prevention of cervical and breast cancer in the Autonomous City of Buenos Aires] (2005-2010). I would also like to thank the Gino Germani Research Institute for serving as my place of work and the interviewees for their time.

SALUD COLECTIVA, Buenos Aires, 9(2):215-233, May - August, 2013

BIBLIOGRAPHIC REFERENCES

1. Viniegra M, Paolino M, Arrossi S. Cáncer de mama en Argentina: organización, cobertura y calidad de las acciones de prevención y control: Informe final julio 2010: Diagnóstico de situación del Programa Nacional y Programas Provinciales [Internet]. Buenos Aires: Organización Panamericana de la Salud; 2010 [cited 13 Mar 2013]. Available from: http://publicaciones.ops.org.ar/publicaciones/pubOPS_ARG/pub67.pdf.

2. Ministerio de Salud de la Nación, Programa Nacional del Cáncer Cérvico-uterino. El cáncer de cuello de útero afecta principalmente a las mujeres mayores de 35 años [Internet]. Buenos Aires: MSAL [cited 13 Mar 2013]. Available from: http://www.msal.gov.ar/cancer-cervico-uterino/.

3. Arrossi S, Paolino M. Proyecto para el mejoramiento del Programa Nacional de Prevención de Cáncer de Cuello Uterino en Argentina: Informe final: Diagnóstico de situación del Programa Nacional y Programas Provinciales [Internet]. Buenos Aires: Organización Panamericana de la Salud; 2008 [cited 13 Mar 2013]. Available from: http://publicaciones.ops.org.ar/publicaciones/pubOPS_ARG/pub64.pdf.

4. Ministerio de Salud de la Nación, Programa Nacional del Cáncer Cérvico-uterino. Mortalidad por cáncer de cuello de útero por provincias 2004-2006 [Internet]. Buenos Aires: MSAL [cited 13 Mar 2013]. Available from: http://www.msal.gov.ar/cancer-cervico-uterino/datos-epidemiologicos.html.

5. López E, Findling L. Prevención de la salud reproductiva y construcción social del riesgo: eslabones entre las prácticas individuales y las acciones públicas. Revista de la Maestría en Salud Pública. 2003; 1(2):1-18.

6. Gobierno de la Ciudad de Buenos Aires, Dirección General de Estadística y Censos. Encuesta Anual de Hogares de la Ciudad de Buenos Aires: Aspectos referidos a la salud 2002. Encuesta Anual de Hogares [Internet]. 2004(3) [cited 13 Mar 2013]. Available from: http://www.buenosaires.gov.ar/areas/hacienda/sis_estadistico/nuevoinforme/EAH-salud.zip.

7. Giraudo N, Discacciati V, Bakalar K, Basualdo N, Dreyer C. Barreras al acceso del rastreo de cáncer de cuello uterino en la Ciudad Autónoma de Buenos Aires. Archivos de Medicina Familiar y General [Internet]. 2006 [cited 16 Nov 2012]; 3(2):7-21. Available from: http://archivos.famfyg.org/revista/index.php/amfyg/article/viewFile/39/39.

8. Ponce M. Mujeres y salud: la prevención del cáncer de cuello de útero y el cáncer de mama en la Ciudad Autónoma de Buenos Aires. [Thesis for the degree of Doctor in Social Sciences]. Buenos Aires: Universidad de Buenos Aires, Facultad de Ciencias Sociales; 2010.

9. Ramos S, Pantelides EA. Dificultades en la prevención secundaria del cáncer de cuello de útero: Las mujeres y los médicos frente a una citología cervical de resultado positivo. Buenos Aires: CEDES; 1990. (Documento CEDES 43).

10. Petracci M, Romero M, Ramos S. Calidad de la atención percibida: perspectivas de las mujeres usuarias de los servicios de prevención del cáncer cérvico-uterino [Internet]. Buenos Aires: CEDES; 2002 [cited 13 Mar 2012]. Available from: http://www.cedes.org.ar/Publicaciones/IF/2002/1847.pdf.

11. Paolino M, Pantelides E, Bruno M, Maceira V, Peña L, Godoy J, Farao S, Arrosi S. Determinantes sociales del seguimiento y tratamiento de mujeres con PAP anormal en Avellaneda, Provincia de Buenos Aires. Revista Argentina de Salud Pública. 2011; 2(8):21-27.

12. Zamberlin N, Thouyaret L, Arrossi S. Lo que piensan las mujeres: conocimientos y percepciones sobre cáncer de cuello de útero y realización de PAP. Buenos Aires: UNICEF, OPS, Ministerio de Salud de la Nación; 2011.

13. Paolino M, Arrossi S. Análisis de los motivos del abandono del proceso de seguimiento y tratamiento por parte de mujeres con lesiones precursoras de cáncer de cuello uterino en la provincia de Jujuy: implicancias para la gestión. Salud Colectiva. 2012; 8(3):247-261.

14. López E, Tamargo MC. La salud de la mujer. In: Infancia y condiciones de vida: Encuesta especial para el diagnóstico y la evaluación de las metas sociales. Buenos Aires: INDEC; 1995. p. 189-193.

15. Sistema de Información, Monitoreo y Evaluación de Programas Sociales (SIEMPRO), Consejo Nacional de Coordinación de Políticas Sociales. Encuesta de Condiciones de Vida 2001. Buenos Aires: SIEMPRO; 2003.

16. Pantelides EA, Binstock G, Mario S. La salud reproductiva de las mujeres en la Argentina 2005: resultados de la Encuesta Nacional de Nutrición y Salud. Buenos Aires: Ministerio de Salud de la Nación; 2007.

17. Arrosi S, Ramos S, Paolino M, Sankaranarayanan R. Social inequality in Pap smear coverage:

SALUD COLECTIVA, Buenos Aires, 9(2):215-233, May - August, 2013

identifying under-users of cervical cancer screening in Argentina. Reproductive Health Matters. 2008; 16(32):50-58.

18. Ponce M. Los enfoques de prevención del cáncer de cuello de útero en los programas gubernamentales (CABA y Nación, 1998-2009). In: Kornblit AL, Camarotti AC, Wald G, compiladores. Salud, sociedad y derechos. Investigaciones y debates interdisciplinarios. Buenos Aires: Teseo; 2012. p. 159-182.

19. Ponce M. Prevención del cáncer de cuello de útero y el cáncer de mama, redes sociales y mediaciones: un estudio en la Ciudad Autónoma de Buenos Aires, Argentina. In: Pinheiro R, Silveira R, Lofego J, Gomes da Silva JA, organizadores. Integralidade sem fronteiras: itinerários de justiça, formativos e de gestão na busca por cuidado. Rio de Janeiro: CEPESC, IMS, UERJ, ABRASCO; 2012. p. 255-265.

20. Ponce M. Percepción de riesgo y opiniones sobre el cáncer de cuello de útero y el cáncer de mama en mujeres adultas de la Ciudad de Buenos Aires. Revista Argentina de Salud Pública. 2012; 3(13):6-12.

21. Ponce M. Trayectorias de cuidados del cáncer génito-mamario en mujeres adultas. In: López E, Findling L, editoras. Salud, familias y vínculos: el mundo de los adultos mayores. Buenos Aires: Eudeba; 2009. p. 109-133.

22. Ponce M. Juventud, Cultura y Salud: Cambios generacionales en el cuidado de la salud sexual y reproductiva de las mujeres. In: Margulis M, Urresti M, Lewin H, et al. Familia, hábitat y sexualidad en Buenos Aires: investigaciones desde la dimensión cultural. Buenos Aires: Biblos; 2007. p. 203-225.

23. Rosen G. De la policía médica a la medicina social: Ensayos sobre la historia de la atención a la salud. México: Siglo Veintiuno Editores; 1985.

24. Foucault M. La vida de los hombres infames. La Plata: Altamira; 1998.

25. Nunes ED. Saúde Coletiva: História de uma idéia e de um conceito. Saúde e Sociedade. 1994; 3(2):5-21.

26. Paim J, Almeida-Filho N. Saúde coletiva: uma "nova saúde pública" ou campo aberto a novos paradigmas?. Revista de Saúde Pública. 1998; 32(4): 299-316.

27. Mattos R. Cuidado prudente para uma vida decente. In: Pinheiro R, Mattos R, organizadores. Cuidado: as fronteiras da integralidade. Rio de Janeiro: IMS, UERJ, CEPESC, ABRASCO; 2008.

28. Laurell AC. El estudio social del proceso salud-enfermedad en América Latina. Cuadernos Médicos Sociales. 1986; 37:3-18.

29. Evans RG, Stoddart GL. Producir salud, consumir asistencia sanitaria. In: Evans RG, Barer ML, Marmor TR, editores. ¿Por qué alguna gente está sana y otra no?: Los determinantes de la salud de las poblaciones. Madrid: Díaz de Santos; 1996.

30. Eibenschutz C. Atención Primaria de la Salud. Salud, Problema y Debate. 1989;(19):19-24.

31. Sigerist H. Hitos en la historia de la salud pública. México: Siglo Veintiuno Editores; 1981.

32. Terris M. Conceptos de la promoción de la salud: dualidades de la teoría de la salud pública. In: Organización Panamericana de la Salud. Promoción de la salud: una antología. Washington DC: OPS, OMS; 1996.

33. Organización Panamericana de la Salud, Organización Mundial de la Salud. Declaración de Alma-Ata: Conferencia Internacional sobre Atención Primaria de Salud. Alma-Ata: OMS; 1978.

34. Organización Panamericana de la Salud, Organización Mundial de la Salud. Promoción de la salud: logros y enseñanzas extraídas entre la Carta de Ottawa y la Carta de Bangkok. Washington DC; OMS; 2006.

35. Ayres JR, Franca Júnior I, Junqueira Calazans G, Saletti Filho HC. El concepto de vulnerabilidad y las prácticas de salud: nuevas perspectivas y desafíos. In: Czeresnia D, Freitas CM, compiladores. Promoción de la salud: conceptos, reflexiones, tendencias. Buenos Aires: Lugar Editorial; 2008.

36. Arouca S. El dilema preventivista: contribuciones a la comprensión y crítica de la medicina preventiva. Buenos Aires: Lugar Editorial; 2008.

37. Menéndez E. Modelo médico hegemónico y atención primaria. In: Segundas Jornadas de Atención Primaria de la Salud. Buenos Aires: Asociación de Médicos Residentes del Hospital de Niños Ricardo Gutiérrez, Comisión Argentina de Residentes del Equipo de Salud; 1988.

38. Marmor TR, Barer ML, Evans RG. Los determinantes de la salud de una población: ¿Qué puede hacerse para mejorar el estado de salud de una nación democrática? In: Evans RG, Barer ML, Marmor TR, editores. ¿Por qué alguna gente está

sana y otra no?: Los determinantes de la salud de las poblaciones. Madrid: Díaz de Santos; 1996.

39. Czeresnia D. El concepto de salud y la diferencia entre prevención y promoción. In: Czeresnia D, Freitas CM, compiladores. Promoción de la salud: conceptos, reflexiones, tendencias. Buenos Aires: Lugar Editorial; 2008.

40. Menéndez E. La enfermedad y la curación. ¿Qué es la medicina tradicional?. Alteridades. 1994;7(7):71-83.

41. Doyal L. What makes women sick: Gender and the political economy of health. London: Macmillan; 1995.

42. Corin E. La matriz social y cultural de la salud y la enfermedad. In: Evans R, Barer M, Marmor T, editores. ¿Por qué alguna gente está sana y otra no? Madrid: Díaz de Santos; 1996.

43. Macran S, Clarke L, Joshi H. Women's health: dimensions and differentials. Social Science and Medicine. 1996;42(9):1203-1216.

44. Durand T, Gutiérrez MA. Tras las huellas de un porvenir incierto: del aborto a los derechos sexuales y reproductivos. In: Avances en la investigación social en salud reproductiva y sexualidad. Buenos Aires: AEPA, CEDES, CENEP; 1998.

45. Castro R. La experiencia subjetiva de la salud y la enfermedad. In: La vida en la adversidad: el significado de la salud y la reproducción en la pobreza. Cuernavaca: UNAM, CRIM; 2000.

46. Rohlfs I, Borrell C, Anitua C, Artazcoz L, Colomer C, Escribá V, García-Calvente M, Llacer A, Mazarrasa L, Pasarín MI, Peiró R, Valls-Llobet C. La importancia de la perspectiva de género en las encuestas de salud. Gaceta Sanitaria. 2000; 14(2):60-71.

47. Lacerda A, Pinheiro R, Guizardi FL. Espaços públicos e Saúde: a dádiva como constituinte de redes participativas de inclusão social. In: Martins PH, Bivar C, Campos R, organizadores. Polifonia do dom. Recife: Editora Universitária UFPE; 2006.

48. Martins PH. Repensando sociologicamente a noção linear de determinantes sociais. In: Pinheiro R, Martins PH, organizadores. Avaliação en saúde na perspectiva do usuário: abordagem multicêntrica. Rio de Janeiro, Recife: CEPESC, IMS, UERJ, Editora Universitária UFPE, ABRASCO; 2009.

49. Pinheiro R, Burg Ceccim R. Experienciación, formación, cuidado y conocimiento en el campo de la salud: articulando concepciones, percepciones y sensaciones para efectivizar la enseñanza de la integralidad. In: Pinheiro R, Burg Ceccim R, Koifman L, Araujo de Mattos R, compiladores. Enseñar salud: la integralidad y el SUS en los cursos de nivel de grado en el área de la salud. Buenos Aires: Teseo; 2009.

50. Organización Mundial de la Salud. Programas nacionales de control del cáncer: políticas y pautas para la gestión. Washington DC: OMS; 2004.

51. Organización Panamericana de la Salud. Análisis de la situación del cáncer cervicouterino en América latina y El Caribe. Washington DC: OPS; 2004.

52. Viveros M. Saberes y dolores secretos: Mujeres, salud e identidad. In: Arango LG, León M, Viveros M, compiladores. Género e identidad: Ensayos sobre lo femenino y masculino. Bogotá: TM Editores, Ediciones Uniandes, Programa de Estudios de Género, Mujer y Desarrollo; 1999.

53. Palma-Campos C. Mujeres con diabetes mellitus e hipertensión: Vivencia de su salud y autocuidado a partir de la construcción de la identidad femenina. Revista Mujer Salud. 2002: 51-58.

54. Coria C. Otra vida es posible en la edad media de la vida. In: Coria C, Freixas A, Covas S, compiladores. Los cambios en la vida de las mujeres: Temores, mitos y estrategias. Buenos Aires: Paidós; 2005.

55. Wald G. Promoción de la salud a través del arte: estudio de caso de un taller de fotografía en "Ciudad Oculta", la villa Nº 15 de la Ciudad de Buenos Aires. Salud Colectiva. 2009; 5(3):345-362.

56. López Carrillo L, Vandale Toney S, Alonso P, Fernández C, Parra MS. Cáncer cervicouterino y mamario en la mujer mexicana. In: Langer A, Tolbert K, compiladores. Mujer: sexualidad y salud reproductiva en México. New York: Population Council; 1996.

57. Douglas M. La aceptabilidad del riesgo según las ciencias sociales. Barcelona: Paidós; 1996.

58. Ortiz Ortega A, compilador. Derechos reproductivos de las mujeres: un debate sobre justicia social en México. México: Edamex, Universidad Autónoma Metropolitana; 1999.

59. Martins PH. Usuários, redes de mediadores e ações públicas híbridas na saúde. In: Pinheiro R, Mattos R, organizadores. Cuidar do cuidado: responsabilidade com a integralidade das ações de saúde. Rio de Janeiro: CEPESC, IMS, UERJ, ABRASCO; 2008.

60. Martins PH. Redes sociales: un nuevo paradigma en el horizonte sociológico. Cinta Moebio. 2009;(35):88-109.

61. Pinheiro R, Burg Ceccim R, Koifman L, Henriques RMM. Matriz analítica de las experiencias de enseñanza de la integralidad: una proposición observacional. In: Pinheiro R, Burg Ceccim R, Koifman L, Mattos R, compiladores. Enseñar salud: la integralidad y el SUS en los cursos de nivel de grado en el área de la salud. Buenos Aires: Teseo; 2009.

62. Foucault M. Saber y verdad. Madrid: La Piqueta; 1991.

63. Asociación Médica Mundial. Declaración de Helsinki: Principios éticos para las investigaciones médicas en seres humanos [Internet]. 1964 [cited 20 Nov 2012]. Available from: http://test.e-legis-ar.msal.gov.ar/leisref/public/showAct.php?id=4902&word.

64. National Commission for the Protection of Humans Subjects of Biomedical and Behavioral Research. Informe Belmont: Principios y guías éticos para la protección de los sujetos humanos de investigación [Internet]. 1978 [cited 20 Nov 2012]. Available from: http://test.e-legis-ar.msal.gov.ar/leisref/public/showAct.php?id=6719&word.

65. Consejo de Organizaciones Internacionales de las Ciencias Médicas. Pautas éticas internacionales para la investigación y la experimentación biomédica en seres humanos [Internet]. 2002 [cited 20 Nov 2012]. Available from: http://test.e-legis-ar.msal.gov.ar/leisref/public/showAct.php?id=5619&word.

66. Nuffield Council on Bioethics. Ética de la investigación relativa a la atención sanitaria en los países en desarrollo [Internet]. 2002 [cited 20 Nov 2012]. Available from: http://test.e-legis-ar.msal.gov.ar/leisref/public/showAct.php?id=7282&word.

67. Organización Panamericana de la Salud, Red Panamericana para la Armonización de la Reglamentación Farmacéutica, Grupo de trabajo en Buenas Prácticas Clínicas (GT/BPC). Buenas Prácticas Clínicas: Documento de las Américas [Internet]. 2005 [cited 20 Nov 2012]. Available from: http://test.e-legis-ar.msal.gov.ar/leisref/public/showAct.php?id=7283&word.

68. Macklin R, Luna F, Figueroa G, Ramos S. Ética, investigación y ciencias sociales. México DF: El Colegio de México; 2001.

69. Manzelli H, Pecheny M. Prevención del VIH/SIDA en hombres que tienen sexo con hombres. In: Cáceres CF, Pecheny M, Terto Júnior V, editores. SIDA y sexo entre hombres en América Latina: Vulnerabilidades, fortalezas, y propuestas para la acción. Lima, Perú: UPCH, ONUSIDA; 2002.

70. Belmartino S. La atención médica argentina en el siglo XX: instituciones y procesos. Buenos Aires: Siglo Veintiuno Editores; 2005.

CITATION
Ponce M. Prevention of cervical and breast cancer in health services and non-governmental organizations in the city of Buenos Aires. Salud Colectiva. 2013;9(2):215-233.

Received: 6 August 2012 | Revised: 12 February 2013 | Accepted: 23 March 2013

The translation of this article is part of an interdepartmental collaboration between the Undergraduate Program in Sworn Translation Studies (English < > Spanish) and the Institute of Collective Health at the Universidad Nacional de Lanús. This article was translated by Daniela Di Lauro and Mariela Sesin, reviewed by Mariela Santoro and modified for publication by Joseph Palumbo and Vanessa Di Cecco.