THE SOCIAL REPRESENTATIONS OF WOMEN OF REPRODUCTIVE AGE ON CERVICAL CANCER PRECURSOR LESIONS[1]

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ABSTRACT: The aim was to identify the social representations of women of reproductive age regarding cervical cancer precursor lesions and analyze their consequences in relation to treating and preventing them. It is qualitative research, based in the Theory of Social Representations, and was undertaken in 2009 in a public hospital in the city of Rio de Janeiro, with 30 women of reproductive age. The data was collected through semi-structured interviews. Lexical analysis was applied using the Alceste 2010 software, the results being organized into five thematic classes: disease coming from sex: from the man/partner; cure: medical care and conventional treatment; disease which comes from the street; need for changes in living habits; and the despair of the discovery of the lesions. It is concluded that the social representations of the women with cervical changes refer to interactions relating to the experiencing of sexuality, impacting the social use of their bodies, with implications for their married lives.

DESCRIPTORS: Oncology nursing. Women's health. Cervical intraepithelial neoplasia.

REPRESENTAÇÕES SOCIAIS DE MULHERES EM IDADE REPRODUTIVA SOBRE LESÕES PRECURSORAS DO CÂNCER CERVICOUTERINO

RESUMO: Objetivou-se identificar as representações sociais de mulheres em idade reprodutiva acerca das lesões precursoras do câncer cervicouterino e analisar suas repercussões frente ao seu tratamento e prevenção. Pesquisa qualitativa, com base na Teoria das Representações Sociais, realizada em um hospital público do município do Rio de Janeiro, com 30 mulheres em idade fértil, no ano de 2009. Os dados foram coletados mediante entrevista semiestruturada. Aplicou-se análise lexical através do software Alceste 2010, organizando-se os resultados em cinco classes temáticas: doença que vem do sexo: do homem/companheiro; cura: cuidado médico e tratamento convencional; doença que vem da rua; necessidade de mudanças de hábitos de vida; e o desespero da descoberta das lesões. Concluiu-se que as representações sociais das mulheres com alterações cervicais aludem a interações acerca da vivência da sexualidade, repercutindo no uso social de seu corpo, com implicações para a vida conjugal.

DESCRITORES: Enfermagem oncológica. Saúde da mulher. Neoplasia intraepitelial cervical.

REPRESENTACIONES SOCIALES DE MUJERES EN EDAD REPRODUCTIVA SOBRE LESIONES PRECURSORAS DEL CÁNCER CERVICAL UTERINO

RESUMEN: Se objetivo identificar las representaciones sociales de mujeres en edad reproductiva acerca de las lesiones precursoras del cáncer cervical uterino y analizar sus repercusiones frente a su tratamiento y prevención. Investigación cualitativa, basada en la Teoría de las Representaciones Sociales, realizada en un hospital público de La ciudad de Rio de Janeiro, con 30 mujeres en edad reproductiva, en el año de 2009. Los datos ha sido recolectados mediante entrevista semi-estructurada. Se aplicó análisis lexical a través del software Alceste 2010, se organizando los resultados en cinco clases temáticas: enfermedad que viene del sexo: del hombre/compañero; cura: atención médica y tratamiento convencional; enfermedad que viene de la calle; necesidad de cambios de hábitos de vida; y desespero de la descubierta de las lesiones. Se concluyó que las representaciones sociales de las mujeres con alteraciones cervicales aluden a las interacciones acerca de la vivencia de la sexualidad, repercutiendo en el uso social de su cuerpo con implicaciones para la vida conyugal.

DESCRIPTORES: Enfermería oncológica. Salud de la mujer. Neoplasia intraepitelial del cuello uterino.

INTRODUCTION

Cervical cancer is a serious public health problem in Brazil, as it is a disease with one of the highest mortality rates in the female population.[1] The identification of cervical changes caused by cervical cancer stands out as a relevant factor in the prevention and early detection of the disease, in the combat against the morbi-mortality from this type of neoplasm. The Cervical Cancer Precursor Lesions (CCPLs) are defined by the presence of changes in the original epithelium, which constitute the pre-cancerous lesions which can progress to this type of tumor.[2]

The CCPLs directly affect the woman's body, which brings values and meanings which are fundamental to female identity, as it is through the body that the relationships of womanhood, sexuality, gender and social questions are exposed and gain importance. This process of elaboration is influenced by previous experiences of reference systems and of the subjects' values, and involves the activation of emotions which, in articulation, contribute to shaping representations on the reality, as the social representations take on an important role in the elaboration of collective ways of seeing and experiencing the body, based on the diffusion of models of thinking and behavior related to it.[3]

In relation to this pathology, one has to take into account not only the existence of the wound or lesion in the cervix, but also the manifestations of a subjective universe in relation to the female body, which produces representations and which, in its turn, influences how the women think and act in the face of the condition, including changing their life trajectories, being reflected in their social contexts, and interfering with the expectations for the future – such as, for example, being able to bear children.

This is because the CCPLs can affect both the reproductive phase and the experience of female sexuality, both of which are important in a woman's life. Both must be experienced in healthy and satisfactory ways, sexuality being a category which transcends the biology of the physical and pathological processes, incorporating female experiences and subjectivity.[4]

In the approach to women with a view to preventing CCPLs there has to be investment in the understanding of the importance of the historical-cultural influences and of female sexuality in complying with public health campaigns, precisely because such lesions involve the body-sexuality-womanhood triad. These influences affect how women face the preventive examination, and the meanings which they attribute to the examinations and to the pathology can be used for the planning and adaptation of guidance for prevention.[5]

The CCPLs are constituted as biological, social and cultural constructs, and are a source of meanings and representations in the women's consciousness, which is influenced by their social milieu, values and beliefs, as well as by the media. Because they affect the female body and affect sexuality, such lesions become relevant to the women, mobilizing their thoughts and emotions, in particular when these women are in the reproductive phase, because gynecological illnesses are objects of concern for the full exercising of womanhood, through reproduction, as many doubts emerge in the aspect of knowing whether they will or will not be able to become pregnant, should they be affected by such a condition.

As a result of caring for women with these alterations in the cervix, a variety of behaviors was observed. Some women showed themselves to be highly committed to the treatment, while others believed that they already had cancer and that they were going to die. This diversity led us to develop a study which would emphasize the social representations which these women have in the face of this issue, seeking to unveil the contents which constitute these representations, and based on this to understand their attitudes to care and treatment in the light of their experiences with cervical changes.

In the light of the above, on studying the CCPLs it is fundamental also to understand and investigate the subjectivities which involve this situation's complexity for women's health, precisely because it is a pathology strongly related to the experience of the female body and its sexuality. As a result, studies which incorporate this issue not only from a uniquely and exclusively biological and technical approach, but which value and emphasize the social individual as a thinking subject, become relevant.[6] In the meantime, research involving social representations stands out, principally in the area of public health, as it evidences the knowledges, the emotions and the conducts in the face of the infirmities, the care and their treatment, as the comprehensiveness of psychosocial questions, and not only of those relating to the diseases' epidemiology and the technologies linked to the treatment processes, becomes important such that one may adapt not only the conducts and procedures, but also the

health promotion actions in the light of the reality of those experiencing the problem.[7]

The results of research in the field of social representations offer another angle from which the health professional can consider how to care, by means of strategies for capturing the service users according to their values and the elements which constitute their daily lives, grounded over the course of their lives. The nursing professionals' practice is outlined as involving acting in a different way, attending these women's needs and expectations, not only with a view to treating them, but also with a view to caring for them, taking into account their values and their insertion in a subjective, social and individual production, in which one finds the subject of the disease.[8]

In this perspective, this research's objectives were to identify the social representations of women of reproductive age regarding the cervical cancer precursor lesions, and to analyze their repercussions in the light of the attitudes regarding the treatment and prevention of this type of cancer.

METHODOLOGY

This is analytical research, with quantitative treatment of the data, and qualitative analysis of content, of the lexical type. The Theory of Social Representations (TSR) was defined as this study's theoretical framework, as it values the sociocultural and psychosocial aspects which involve the objects[7] which, in this research's case, are a pathology restricted to the female universe. It was sought to elucidate the social representation's contents, applying the processual aspect of the theory.

The research objects in Social Representations (SRs) are psycho-sociological, maintaining relations between the subjects' subjective and social universes, due to the importance which they acquire in their daily lives. In the light of the TSR, in the formation of the representations, the women process the information deriving from the scientific universe with that circulating in daily conversations and with the knowledges from their own experiences. This theory is applied to studies on the universe of knowledge arising from 'common knowledge' and invested in unveiling the practical knowledges which guide the subjects and contribute to the processes of formation of conducts.[9] This explains its application in this research.

The setting was a federal public institution located in the city of Rio de Janeiro, emphasized as a center of excellence in work with cervical conditions. 30 women participated, who met the following inclusion criteria: a diagnosis confirmed through colposcopy and histopathological examination of CCPL; being in the process of being treated in the institution in question; being over 18 years old; and being in the age range of the reproductive period and in a fertile condition. Women were excluded if they were still waiting for confirmation of their diagnosis, if they were less than 18 years old, if they were not in a fertile condition or if they refused to participate. These criteria were chosen because the SRs are formed in line with the psychosocial references which guide the women, it falling to the researcher to select the variables which can focus on the construction of such representations. In the case of this research's object, it was considered that the thinking and acting of women with CCPL differ, principally, because of the women's phase of life, in relation to reproduction, as the pathology in question, the object of representation, can affect this condition. In this regard, the age range varied between 20 and 45 years.

The data was produced between February and June 2009, through semi-structured interviews which lasted approximately sixty minutes and were recorded electronically.

The texts of the interviews were transcribed in full and identified by the codes which reflected the interview number, in sequential order, in accordance with their undertaking and the women's ages. The entire *corpus* of text was submitted to processing using the Alceste 2010 software, which carries out a mechanized lexical analysis of content using the technique of descending hierarchical analysis of textual content, that is, "it operates a pragmatic approach to the text centered in lexical co-occurrence [...] in a contextual unit of the text".[10:89]

This program applies quantitative techniques of grouping of words, through their lexicons, identifying the essential information present in a text by the statistical significance of words measured by the frequency with which they appear, in Chi-squared tests (X^2). The value of X^2 indicates the word's importance in the construction of the lexical class created by the program, guiding the selection of the most significant segments of text and organizing them in classes, which indicate the meaning attributed by the subject to the object investigated. In this way, the researcher undertakes the qualitative analysis of the content present in the excerpts selected by the program as representative of each lexical class.

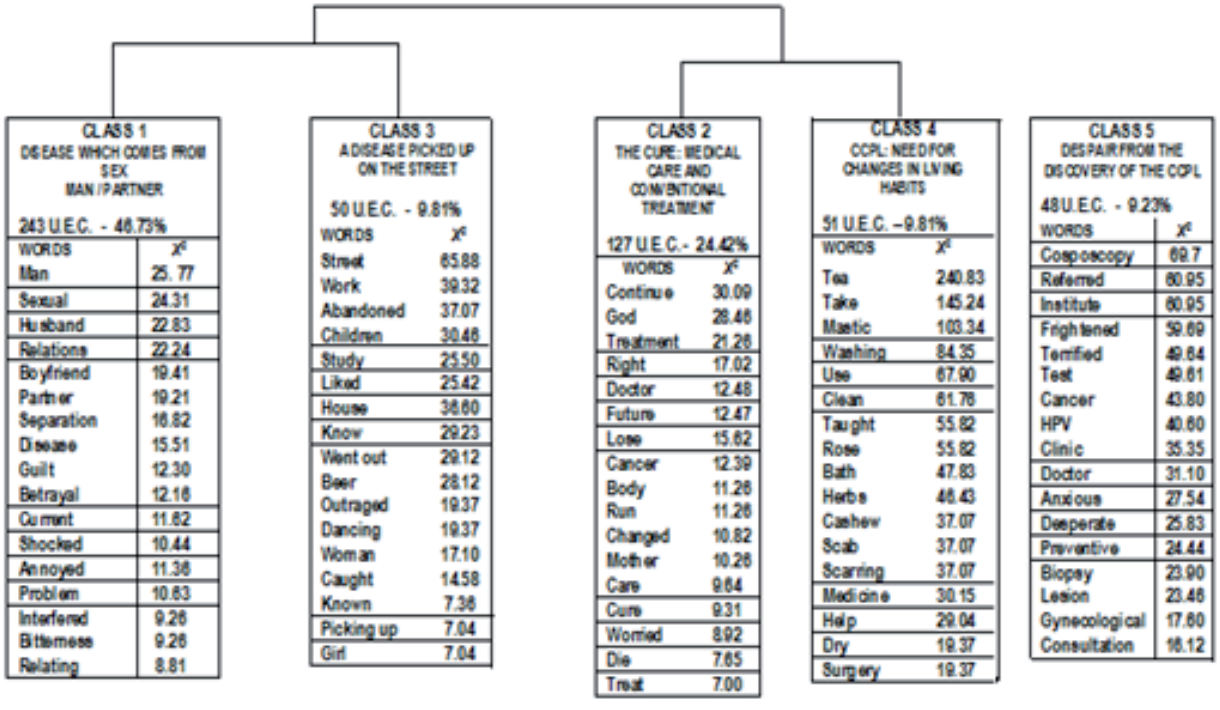
Each interview corresponds to one Unit of Initial Context (UIC) which, in its turn, creates Units of Elementary Context (UECs) selected by the software in the light of the classes, which correspond to the units of analysis of text, represented by excerpts of content present in the interviews. In the process of the analysis of the material, the program presented a bloc called the dendrogram, and organized the quantitatively relevant lexicons in five classes, by their incidence in the discourses. These classes grouped the UECs which, after the researcher's analytical and interpretive reading, were nominally identified by the meanings which such lexicons and grouped UECs raise. Following this organization, in a process of analysis and interpretation, the contents of the classes and their UCEs were discussed in the light of the theoretical framework adopted in the research.

In relation to ethical aspects, the research satisfied Resolution n. 196/96, which involves research with human beings, and was approved by the Ethics and Research Committee of the Anna Nery School of Nursing/the São Francisco de Assis University Hospital of the Federal University of Rio de Janeiro, under Protocol n. 02/2008. All the subjects signed the Terms of Free and Informed Consent, absolute confidentiality and the participants' anonymity being ensured.

RESULTS AND DISCUSSION

After the processing of the texts, the *corpus* was divided into 906 UECs, with the program selecting 520 UECs for analysis, corresponding to use of 70.40% of the *corpus*.

The five classes of the *corpus* indicated that the subjects' verbal production, illustrating the SRs, which were elaborated based on the co-existence with the CCPLs, presented the following topics: class 1 – disease which comes from sex: from the man/partner; class 2 – cure: medical care and conventional treatment; class 3 – Cervical cancer precursor lesions: a disease picked up on the street; class 4 – Cervical cancer precursor lesions: need for changes in living habits; and class 5 – Despair from the discovery of the cervical cancer precursor lesions.



Key: x^2 - Chi-squared.

Figure 1 - Dendrogram of descending hierarchical classification effected by the Alceste Program Software

The existence of a significant link between classes 1 and 3 is identified, in relation to the appearance of the problem, and the way in which it was installed in the lives of the women interviewed, that is, the origin of the CCPLs. However, class 1 demonstrates that the lesion comes from

sex, especially from the male figure, from the partner, but not necessarily as the consequence of unfaithfulness. This is different from class 3, in which the origin is in betrayal by the husband, in promiscuous sex, centered on the figure of a woman met on the street. In this one can observe two poles of one and the same origin centered on the male sex, setting out the conducts for the adoption of immediate stances, such as distancing from the partner and the rapid search for a cure.

Class 4 illustrates that in coming face-to-face with the problem, the women become aware that they need to change their behaviors and care for themselves better; while class 5 brings the negative feelings mobilized in the face of the discovery of the health problem and the consequences which the same can bring for their lives.

Because of the thematic proximity between classes 1 and 3 and 2 and 4 the classes are presented and discussed in that order.

Class 1 - Disease which comes from sex: from the man/partner

Class 1 is made up of 243 UECs (46.73%), whose contents reveal the belief that the CCPLs have their roots in the sexual act, with the figure of the man as the disease's transmitter. The women understand that the man is the transmitter of the problem. It is he who contaminates them, through sexual relations, leading them to acquire the cervical changes. In spite of this, there is a feeling of acquiescence with the situation.

A man generally never knows. I saw those warts on him, but warts can appear on anybody. My husband had them on his fingers too, but he had no idea. It didn't mean he had been unfaithful, he had a previous marriage, not even his ex-wife knew (I1, 44 years old).

The women classify the CCPLs as a problem coming from men, but not as a problem which arose from unfaithfulness, being able to arise by chance. In this context, it is not a disease which can be blamed on the partner. The women recognize that the man, as the means of transmission, is more propense to sex, having previously had other partners and other sexual relationships, which may be the cause of the problem.

So he has the virus and later, over time, it shows up, and my husband is a man who used to have a really active sex life (I8, 45 years old).

The male figure appears as the principal vector of the transmission of the disease and shows how this representation is grounded in the sexist discourses produced in culture. The disease is explained through the acceptance that the man – who historically has always been more closely linked with sex and sexual pleasure – exercises practices which meet the needs inherent to his sex.[11] Further, it should be noted that the women's situation of subordination has a strong influence on their health.[12] That being the case, these questions may be linked to the medical discourse, when this indicates sexual relations as being the form of contagion. The scientific discourse substantiates this reality, because of the fact that the conceptions regarding health/illness have their own characteristics in line with the cultural context of the individual who makes up society, and because the illness is seen as a historically-constructed psycho-social phenomenon.[13]

It is important to perceive how this process of construction of these women's representations is articulated, through a paradigmatic medical model, which becomes part of their daily routines, being capable of defining and influencing their affective-conjugal relationships.

Class 2 - Cervical cancer precursor lesions: a disease picked up on the street

This class included 50 UECs (9.81%). It differs from class 1 in that, for these women of reproductive age, the problem originates in the street, from other women, mobilizing feelings of betrayal and rebellion. The problem comes from the street, from sex, and involves other women, one night stands, drinking and prostitution. As a result, the betrayal is linked to the lesions, causing a difficult coexistence with a problem which was brought into the home by the partner.

In my head, it meant this: he'd got himself another woman somewhere, who gave it to him, and he passed it on to me (I27, 29 years old).

He would be out with women and might have ended up passing it on to me. He got up to all sorts on the street, he would go with any type of woman (I15, 28 years old).

The context of the betrayal, of the disease caught in the street, brings a pejorative connotation of promiscuity to the origin of the CCPLs. The new element is established when the women discover that their problem came from outside, from other women, into their hearth place, into their home. In this regard, they anchor the origin of the disease in something outside, in the betrayal, and in a pre-existing system of thinking: mistrust

and disloyalty. The images are not separate from the subjects' creative potential and end up being reorganized in a new form.[14] They aim at and give shape to the CCPL, as a disease which comes from the street. This leads the women to change tactics to deal with the new situation; they look more to themselves, they care more for themselves, and, partially, cease to dedicate themselves to their partners. They think that if these were able to be unfaithful, they should distance themselves from them – by, for example, avoiding sexual relations with them, given that in this way they are also distancing themselves from the cause of the disease. However, it is a process which intrigues the woman and as a result she acts in a way appropriate to the situation.[7]

If I go out, I don't need to worry – lunch? He can do that, he can do the washing, he learnt as a result of his unfaithfulness, he used to have his clothes all ironed, his trainers washed, and him out on the street having fun. It's different now. I'll take care just of myself, to get well, I don't want to know about him any more (I26, 30 years old).

Outraged with what their partners did, because of their having given them the disease, the women use sexual abstinence as a weapon and also put the partner to work participating in domestic chores. This is different from class 1, in which the male figure was the principal element in the origin of the CCPLs; in this class, it is denoted that the problem did not only arise from the man, but from his promiscuity, from the street, from another woman, and from outside the home. To understand the problem, the woman blames others (the partner and another woman) who brought the problem into her home from outside it, bringing disliking. The projection of actions which are not socially-accepted is related to a system of primary defense.[15] In this context, given the disease's origin, representations are formed triggering behaviors which are configured as strategies for dealing with the situation and not putting the women's lives at risk: they distance themselves from their partners, those who brought the CCPL to within their bodies. This being so, the thinking results in the judgment and attribution of values in regard to a representation.[16]

Finally, the interviewees, in the face of the discovery of the problem, perceive the need to change life style, freeing themselves from habits which are harmful to their health. The uterus, for these women, is active, providing motherhood and reproduction. They believe that the problem's origin came from the companion/partner and the promiscuous companion/partner. They opt for conventional treatment, as they hope for a rapid cure, because they still wish to be mothers.

Class 3 - Cure: medical care and conventional treatment

This class included 127 UECs (24.42%) and detected that the practice of care is inserted into these women's lives when they find out about the CCPL. They follow the doctor's recommendations and what he or she prescribes, as they are interested in curing the problem fast.

I changed how I thought, how I cared for myself. If I have a problem, I'm going to see what it is. I'm going to find a doctor and find out. And if he gives you the treatment to do, you do everything properly so things will work out (I18, 42 years old).

Now, I take care to feed myself better, to treat myself better, to attend check-ups, to keep on with the treatment, not to give up on it (I22, 44 years old).

The women believe in the cure for the CCPL and, because of this, follow the doctors' advice, trek to hospitals to undertake tests, concern themselves with continue with treatment, not missing consultations, and also change their life style so as to care for themselves better.

Throughout the history of health in Western society, one can observe a process of medicalization of the care, which ended influencing the re-elaboration of the popular knowledges, supported in the concrete experience in conjunction with their experiences with the health professional. The social knowledges of health care were, little by little, de-prioritised, but this knowledge has its own explanatory bases and must not be overlooked, given that it guides the subjects in their daily actions.[17-18] This being to do with the field of women's health, one can observe that the biomedical discourse manipulates the female body and, through the medicalization and the medical intervention, the conducts are defined which are most appropriate to its care.[19]

In the meantime, it should be emphasized that there is competition between the reified medical-scientific discourse and folk knowledge, and although there is a study showing that service users use 'folk resources' to resolve their health problems prior to attending the official health service,[20] the women in this research communicated exactly the opposite, in mentioning care practices related to the CCPLs: they opt for medical therapies rather than alternative therapies, evidencing

the belief in the effectiveness and efficacy of the medical treatment, in support of their desires for motherhood.

I don't go for that business of drinking teas, I'm scared. Sometimes I apply a cream to get clean, but stuff with teas or herbs, no. I'm scared. I think these things with herbs take too long, and I still want to have children (I15, 28 years old).

This UEC shows the importance of understanding the cultural context in which everyday care practices are established, along with its role in the construction of representations regarding the women's own experiences in the health network in relation to health/illness, and the women's expectations in relation to their own bodies.

Women are more confronted with health questions during their lives due to their place in the reproduction of the species, in everyday and in family life.[21] In this way, the women with CCPL are part of a context which involves questions of motherhood and reproduction, added to negative feelings regarding their womanhood and sexuality, interacting with conjugal conflicts in the face of such lesions. Because of this, they follow the medical instructions, concern themselves with undertaking the correct treatment and hurry to free themselves of the condition, as that way they will not be prevented from having children and will be able to have sexual relations with their partners.

The medical actions, seen as discourses and as legitimate practices of treatment, indicate marks of progression and change in the course of the disease, and lead the women to be favorable to following the treatment, thus demonstrating two dimensions of the social representations: the information and the attitude.[7]

Class 4 - Cervical cancer precursor lesions: need for changes in living habits

This class included 51 UECs (9.81%), whose contents show the movement of the women in search of changes in life style following the discovery of the CCPL. This class also presents the dimension of the attitude as one of the dimensions in which the social representation is structured, as the women of reproductive age with CCPL decide to change how they care for themselves, altering their living habits as a way of resolving the problem.

I walk now, I go to school on foot, I eat less, take more liquids, eat more salad. I eat plenty of greens and fruits (I26, 30 years old).

Habits are changed, principally leaving behind habits which are harmful to one's health such as smoking, drinking and eating poorly, among others. These women believe that new conducts will benefit the process of treatment for the CCPL and cure it faster. It is a race to improve a problem which could lead them to develop a more serious disease. Further, they seek to care more for themselves, as the 'common knowledge' which underpins the social consciousness of the women with CCPL is associated with a feeling of lack of care and attention to oneself, this being taken as a reason for their having the problem.

Today, I think differently: I think that before everything else, there is me. I have to like myself more, you end up leaving yourself to one side, abandoning yourself. I am going to be more beautiful (I25, 41 years old).

The practices of caring for the body are guided by representations which result from social experiences.[22] These women, in experiencing situations in which another did not care for them, revise their everyday practices and establish actions to protect their health. In this way, in feeling that their womanhood, youth, reproductive capacity and sexuality are threatened, they recognize the need to change their ways of thinking and acting in relation to their health and to the uses of their bodies, according to the notion of quality of life which they know, relating the way of life, the conditions of life and the life style, because when the subject is health, the notions are united in a social result of the construction of standards of comfort which society establishes and of the subjective dimensions of the quality of life.[23]

Class 5 - Despair from the discovery of the cervical cancer precursor lesions

This class is made up of 48 UECs (9.23%) and indicates the feeling of despair and worry which strikes the women after the discovery of the problem. The UECs' contents indicate that it is in the medical-hospital journey that they experience the disquiet of having the CCPL, as the conception that the wound is a malignant lesion, which could lead to sexual or reproductive problems – or even to death – brings feelings of fear and dread.

So I fell into despair, started crying and asked him [the doctor] *if the wound was malignant* (I16, 35 years old).

I became worried, I thought it was a serious wound, that I had cancer, I was terrified, straightaway

I thought I was going to lose my uterus, have no sex life, that sort of thing (I 23, 29 years old).

As many women do not know what the disease really is, doubts and conflicts appear in relation to the diagnosis. The fear of dying and having a very serious illness come to the surface when they go through the serious situation of other women who also live in the same environment where ideas, conversations and information regarding a bad illness and death are found in circulation. The fear appears to the women of reproductive age of having a disease which is linked to finitude due to cancer. There is a fear of losing the uterus, an organ which belongs only to women and which has functions inherent to their biological nature.[21] The CCPLs are a new knowledge, the unknown which creates anxiety and fear, and the women seek to anchor this new element in something which is familiar to them, as in order to understand and deal with the problem it is necessary to bring the unknown into a familiar environment[7]. In this regard, some women incorporate the idea that they need help, as if they do not, the disease could progress and lead them to die. This class refers to a situation of risk of having a serious illness, which causes a process of symbolisms and meanings to emerge. In the face of the unknown, the women of reproductive age begin to think and act, adopting a position of defense in the face of the threat of developing cancer without even making their dreams of motherhood come true, as class 4 illustrates, which brings changes in life style.

In the meantime, the role of nursing in the care for the women is noteworthy, having views to implement actions which contribute to their being better able to understand the processes which lead them to become ill, as well as to reduce the mortality from cervical cancer through promoting "the construction of a culture of prevention, the broadening of the women's access to the health services, the undertaking of diagnostic tests, and the identification and appropriate monitoring of women at risk".[24:344-5]

The results obtained through the analysis of the lexical content of the classes generated by the Alceste program clearly show the SRs' affective dimension, in the interaction which the women establish between the subjective experiences in the experience of the problem and the relationships which they establish with the objective perceptions of their everyday family life with their partners, influencing how they reconstruct the meanings of their conjugal relationship, and the conducts to their partners and themselves,[25] which contributes enormously to considering educational actions aimed at preventing this condition and promoting women's health.

CONCLUSION

The results show content which makes up the SRs regarding the CCPL, allowing one to understand how the women think and act in the light of their experience with this health problem and the various meanings which are marked in their lives. Considering their representations, evidence is presented of the knowledge that the CCPLs are linked to sex, but the Through information which circulates, and symbolisms which emerge regarding the experiences of the women with cervical changes, thoughts and actions are generated to deal with the situation. The association made between the lesions and malignant wounds leads them to wake up to self-care, with changes in living habits and the search for conventional medical treatment. This treatment evidences and objectifies the biomedical emergency of the body with lesions, but at the same time serves as a means for protecting the maintenance of female matters, of their sexuality and reproductive function in preparation for motherhood, threatened by the disease. This being so, the nurse, as a health care professional, must improve her perspective on practice, directed toward a social and cultural context of the disease in a female body, with a view to understanding better these women's attitudes regarding the CCPLs.

The results produced in this research indicate that it is necessary for there to be greater dissemination to women of what CCPLs are, linking the social uses of the body and the implications of these for conjugal life to these discussions. Through this, a qualified care endowed with a broader vision of the issue is sought, so as to meet the real needs of women with this pathology, so that they may understand better the situation they are experiencing and, in this way, be able to care better for themselves and for their families, thus contributing to the reducing of morbi-mortality from cervical cancer in the female population.

As limitations of the research, one may note the number of women who participated and their restriction to a specific group: that of women of a fertile age with CCPLs. In view of the fact that the social representations are understood in the light of the social groups who engender them, the extension of the research to other social groups may produce

important results for a wider discussion of the object and the nursing care directed to the women.

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