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ORIGINAL ARTICLE

A STUDY ABOUT THE COMPLETENESS OF ASSISTANCE FROM PROFESSIONAL PRACTICES AT ATTENTION TO WOMAN

UM ESTUDO SOBRE A INTEGRALIDADE DA ASSISTÊNCIA A PARTIR DAS PRÁTICAS PROFISSIONAIS NA ATENÇÃO À MULHER

UN ESTUDIO ACERCA DE LA INTEGRALIDAD DE LA ASISTENCIA DE LAS PRÁCTICAS PROFESIONALES EN LA ATENCIÓN A LA MUJER

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ABSTRACT

Objective: recognizing the practices of professionals of nursing and medicine focusing on comprehensive care to women's health. ***Method:*** a field study of qualitative nature carried out between October 2013 and February 2014. The sample consisted of professionals, care and medical records. For the triangulation of data there were used the participant observation techniques, document analysis and semi-structured interview. The material was submitted to thematic content analysis. The study was approved by the Research Ethics Committee, CAAE nº 17402513.3.0000.5182. ***Results:*** the organization of the service does not include the cross-cutting and intersectoral approach of actions. The focus of attention is centered on complaints of users to the detriment of the determining factors in health/disease/care process. ***Conclusion:*** indicates the need to change care practices. It is expected that the study will guide actions and contribute to transforming element for health care of women of full mode. ***Descriptors:*** Comprehensive Health Care; Professional Practice; Women's Health.

RESUMO

Objetivo*:** conhecer as práticas dos profissionais de enfermagem e medicina com foco na integralidade da assistência à saúde da mulher. ***Método*:** estudo de campo de natureza qualitativa desenvolvido entre outubro de 2013 a fevereiro de 2014. A amostra foi composta por profissionais, atendimentos e prontuários. Para a triangulação dos dados utilizou-se as técnicas de observação participante, análise documental e entrevista semiestruturada. O material foi submetido à análise de conteúdo temática. A pesquisa foi aprovada pelo Comitê de Ética em Pesquisa, CAAE nº 17402513.3.0000.5182. ***Resultados*:** a organização do serviço não contempla a transversalidade e intersetorialidade das ações. O foco da atenção é centrado nas queixas das usuárias, em detrimento dos aspectos determinantes no processo saúde/doença/cuidado. ***Conclusão: indica-se a necessidade de mudanças das práticas assistenciais. Espera-se que o estudo possa nortear ações e contribuir como elemento transformador para assistência à saúde das mulheres de modo integral.

Descritores: Assistência Integral à Saúde; Prática Profissional; Saúde da Mulher.

RESUMEN

Objetivo: conocer las prácticas de los profesionales de enfermería y de la medicina que se centran en la atención integral a la salud de las mujeres. ***Método:*** estudio de campo de naturaleza cualitativa llevado a cabo entre octubre de 2013 y febrero de 2014. La muestra estuvo conformada por profesionales, el cuidado y los registros médicos. Para la triangulación de los datos se utilizaron las técnicas de observación participante, análisis de documentos y entrevistas semi-estructuradas. El material fue sometido al análisis de contenido temático. El estudio fue aprobado por el Comité de Ética en la Investigación, CAAE nº 17402513.3.0000.5182. ***Resultados:*** la organización del servicio no incluye el enfoque transversal e intersectorial. El foco de atención se centra en las quejas de las usuarias, en detrimento de los factores determinantes en el proceso salud/enfermedad/atención. ***Conclusión:*** indica la necesidad de cambios en las prácticas de cuidado. Se espera que el estudio guíe las acciones y contribuya a la transformación de elementos para el cuidado de la salud de las mujeres de modo completo. ***Descriptores*:** Atención Integral de Salud; Practica Profesional; La Salud de la Mujer.

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INTRODUCTION

In Brazil, completeness was initially inserted as a principle of the Unified Health System (SUS).It is understood as a set of notions related to expanded assistance with coordination of actions of professionals in a broad conception of the human being endowed with feelings, desires, anxieties and rationalities.[1]

Full attention will go beyond ensuring access to all levels of care in health services, but these services can be articulated in order to providing preventive activities since the healing, not only with biological focus, also considering the psychological, social, spiritual and cultural dimensions.[2]

In this sense, in the context of care for women should reflect the commitment to implement health actions that contribute to the guarantee of human rights and reduce morbidity and female mortality from preventable and avoidable causes. Among the priority areas of attention stand out those related to sexual and reproductive health, which aim to comprehensive care under the gender perspective: humanization of care; attention to reproductive planning; combating domestic and sexual violence; prevention and treatment of sexually transmitted diseases, cervical cancer and breast.[3]

Thus, attention to women through the perspective of completeness it is anchored in three aspects: public policies that meet the demands of women; organization of the service and health professional practices.[4]

Public policies aimed at women suffered intense changes from the 80s, moving the biologicist and reductionist focus of attention, starting to contemplate the sexual and reproductive health, focusing on the cultural context and the individual needs.[3]

Regarding the service organization, it is understood that health services should be articulated in order to ensure expanded assistance, raising the possibilities to effectively meet the needs, for the woman should not be seen in a fragmented way.[2] In this sense, the Family Health strategy (FHS), due to its service organization model, is constituted as a scenario that favors the implementation of this work of logic, since it has the care technologies, human and material, necessary for full health care.

To achieve the goals of care, professional practices should be developed in three dimensions: counseling; educational activities and clinical activities. These activities should be implemented in an integrated manner, having always the understanding that any visit to the health service is in an opportunity for professional intervention and to health problems that are not always manifested in the complaints of the user.[5]

Thus, counseling is a process of active listening, individualized and user-centric. It implies the ability to establish a relationship of professional-user confidence, in view of the redemption of internal resources of the person that he has been able to recognize themselves as subjects of their own health and transformation.[6]

Educational activities, in turn, are designed to provide the knowledge to free and informed choice, being fundamental to the quality of care provided. It is time for health care that provides reflection on issues related to sexual and reproductive health with a focus on health promotion actions, such as healthy living habits, citizenship and human rights.[5]

Clinical activities should consider the conduits for promotion, prevention, protection and recovery of health, under a transdisciplinary approach. Through care, complex and diverse technologies, should help in the management of demands and relevant health needs in their area, observing risk criteria, vulnerability, resilience and ethics, considering that every demand, health need or distress must be upheld.[7]

From the understanding of the role of the health professional in comprehensive care to women it is wondered: What care practices implemented in the FHS focused on attention to women? Thus, the aim of this study is:

- Recognizing the practices of nurses and physicians focusing on comprehensive care to women's health.

METHOD

Article drawn from the project << ***Sexual and reproductive health: a study about comprehensive care from professional practice in the care of women*** >>, linked to the Institutional Program for Scientific Initiation of Volunteers, of the National Scientific and Technological Development Council (CNPq), term 2013-2014.

This is a descriptive study of a qualitative nature. The research was carried out in three Family Health Units of the municipality of Lagoa Seca-PB, between October 2013 and February 2014. For the production of the data the following techniques were used: participant observation, document analysis and semi-structured interview.

Participant observation consists in the direct contact of the researcher with the research object for information about the

reality in their own context. It allows capturing different situations and problems that are not obtained through questions. In turn, the document analysis is the examination of stable data not received analytical treatment. A semi-structured interview of individual character is characterized by the seizure of values, attitudes and opinions of respondents about certain issues surrounding the problem analyzed.[8] It is justified the triangulation of the data, because this strategy allows the expansion of the scope of analysis integrating different perspectives for understanding the phenomenon examined.[9]

The subjects of the research process were nursing (3) and the Medicine professionals (3) of FHS, responsible for the health care of women. Professional practices were assessed through observation in the waiting room and clinical care for 15 shifts and the consequent analysis of medical records. In this sample, it was possible to analyze 53 calls for women and 96 records, among which stood out pre-natal consultations and gynecological, since the calls are too focused on control/treatment of diseases, moving away from the focus on woman. Interviews with the professionals were recorded with the aid of portable recorder in order to allow the literal transcription and maximize the reliability of the statements in the exhibition. The duration of the interviews ranged from 10" to 17". During the tabulation of data and display the interviews, fictitious names were used, for professionals and FHU, preserving the confidentiality and the anonymity.

There were excluded from the sample queries and charts of children under 18 as well as the care offered by professionals accompanied graduate students. Similarly, they excluded those documents filled by academics and/or teachers, as well as the records kept by other professionals (dentists, technical, the nursing, etc.) and professionals who did not act in FHU during the implementation period research.

To look at the data we used the Thematic Content Analysis Technique.[10] Thus, the close reading of data collected through participant observation, documents (records) and interviews with professionals was held; the data were organized and categorized focused on guiding question of the study; the categories were analyzed and interpreted in accordance with the relevant theoretical framework.

The study followed the ethical and legal principles set out in Resolution 196/96, in force at the time, the National Health Council that guides research involving human subjects and was approved by the Research Ethics Committee of the University Hospital Alcides Carneiro, Federal University of Campina Grande, under CAAE 17402513.3.0000.5182 and protocol 393.956.

RESULTS AND DISCUSSION

♦ Characterization of study subjects:

In the investigated scenario, work teams correspond to extended teams, since they are composed of a nurse, a doctor, a nursing technician on average 4-8 CHA, a dental surgeon and an assistant in oral health.

Regarding the work regime, the FHS team must meet a weekly shift of 40 hours;[5,7] however, the schedules of professional teams do not reach this goal, there is a weekly holiday, besides the same make a shift between 8:00h to 12:00h and 13:00h to 15:00h.

It notes that all professionals are effectivated. This professional bond is related to lower occupational stress, as professionals with unstable employment contracts revealed problems related to workload and professional involvement with the professional instability and career, and the remuneration received and socio-professional status.[11]

In the analyzed situation, most professionals were female (4), aged between 33-63 years old, the training time was 4-36 years completed the degree in public institution (4), the time of work at the FHS ranged from 3 to 18 years, have a specialization (3) and Mastership in progress (1).

We clarify that in nursing the professional predominance is of the female gender, associated, in particular, to the socio-cultural values that reveal the responsibility of care to women;[12] however, in medicine this feminization occurred only in 2009. Thus, professionals who have completed graduation prior to this period are predominantly male.[13]

The age and length of training of participants favors assistance, as more young people with little work experience professionals are more sensitive to professional stress [14], and are more prone to accidents at work.[15]

About the updates/relevant courses that research subjects performed, the most prevalent were: Introductory in family health (5); Violence against women (5); Cancer of the cervix (5); Reproductive planning (4); Management of STI / AIDS (2); Epidemiological Surveillance (4); Prenatal (1). The service education has great relevance for health

professionals, as it promotes the renewal of knowledge and simultaneously benefits the health service.[7,15]

The highlighted features professionals favor a guided assistance in its entirety, since these professionals have experience and technical-scientific knowledge that contribute to a comprehensive conception of the human being.

♦ A look at the service organization from the perspective of integrality of care

In the researched scenario, municipal management does not use for planning and decision-making analysis and monitoring indicators and health information systems as well as instruments to measure user satisfaction.

Two of FHU had part of basic medicines to care for women available in the service itself. With regard to biopharmaceuticals, the FHU have all belonging to the basic vaccination schedule, even in discontinuity in one of the units. It is noteworthy that when these inputs are missing, as well as in FHU 3, which has no basic pharmacy and vaccines room, users are referred to the Municipal Health Center. The unavailability or availability of inputs for other services may represent a barrier to access. Since the lack of minimum working conditions such as sufficient amount of material or suitable physical structure hinders the development of the comprehensive care.[16]

It was noted that the planning of health care activities is not in line with the profile and needs of the population; it is not considered the demand for services in terms of frequency, risk and vulnerability. As an example, it is emphasized that the work schedules are virtually identical in the analyzed teams, not justified fact, for all have distinct population profile. Furthermore, it is noted that the FHU 1 has low social and economic indicators, the FHU 2 covers the countryside and the FHU 3 has better social and economic conditions as compared to the first two. The distinctive profile of the population should comprise the planning and implementation of FHS actions.

On this point, there is the importance of Situational Strategic Planning (PES), which proposes the organization of interventions and the results of production on a certain reality. In addition, the PES involves community participation, requires the disclosure of information about the potential of health services and their use by the user provides for the establishment of priorities, resource allocation and programmatic orientation, with the aim to solving services.[17]

The service book, called by the team as schedule, is organized primarily for attention to prenatal care, family planning, child care, Hiperdia, collection of material for cytology, team meeting and home visit. In this respect we observe the gap with the proposal by the current health policy, because the division of the agenda according to health problems (Hiperdia), life cycle and sex (child and woman of childbearing age), hinders access user to the health service, for example, the subjects of the male and female in their different ways of being a man and being a woman.[7]

Such a practice could be related to several factors leading to professional to have as a priority the achievement of specific health programs, such as charging for the achievement of goals, lack of management support and professional ignorance about care.[18]

As a result of organizational form of the service schedule, it was observed that the average waiting time for treatment of women even exceeds two hours, the minimum waiting time 13" and the maximum time 2' and 50". To make matters worse, there was no holding any waiting room activities, such as education in public health. Exception made to those executed by the group Pro/ PET-Health; however, without the participation of any member of the team, either CHA or other professional service. As with other lines of attention, individualized care in queries is the primary care strategy performed by health professionals in the FHS.[18]

It was identified that met the users do not face the problem of delay between the scheduling time and the implementation of care. This aspect can be regarded as positive, since the shortest time to the schedule favors the comprehensive care, since the delay in treatment is a factor that weakens the user's access to health services.[19]

As gaps in comprehensive care identified in the drafting of service agenda, stands the absence of actions elsewhere involving the planned action in the FHS action territory, such as schools, kindergartens, community centers, and other social facilities. An organized service requires the preparation of consolidated information access to all government services/not existing governmental and social facilities as a strategy to facilitate communication between the teams and expand the integration and intersectoral actions, as well as to guide the population in Search for services.[20] The

performance of intersectoral action, the prerogative of the FHS, is a fundamental and irrevocable axes for the development of a comprehensive care.[21]

It is emphasized that the organization of services in the analyzed scenario envisages essential points for comprehensive health care, but these points do not work in coordination and are not guided in their entirety the prerogatives of the National Policy of Primary Care.

♦ The practices in counseling and health education: a gap in attention to woman

In the analysis of dimension advice, it was found that such action is not covered by the professional practices. As evidenced in a single service performed by/nurses from BHU 3 related to risk factors for cancer of the cervix.

Counseling is not understood by professionals as a dialogue with the user aiming the perception of vulnerability. In contrast, counseling is understood as the investigation of personal habits, centered on the complaint.

> *The first thing I do is ask her, because often the woman has no complaints, hidden, often she does not want, think she's exposing [...]. I always wondered all, every kind of relationship I had, advise, advice do some things, for example, urinary infections by E. coli (P2)*

It is inferred that the FHS professionals only develop clinical listening, focusing on complaints. However, the extended listening can identify needs that go beyond health services, contributes to the perception of other factors than biological strictly, allowing identify elements that contribute to aggravate certain problem or hampering their adherence to therapeutic proposals.[22]

From the understanding they have about counseling, it was found that professionals refer to counseling notion to STIs.

> *In cytological consultation, it turned to the prevention of STIs, [...] the question of self-examination of the breasts, the importance of cytological, to keep up, to present any symptoms that run away from what is normal. [...]. We treat it as a whole (P1).*

It is noteworthy that although mention in interviews conducting counseling, this practice was not observed during consultations or even registered in the evaluated records.

Some professionals maintain a distorted view of completeness, restricting the provision of assistance with purely biological and fragmented approach, disregarding the individual aspects affecting women.[23] As an example: socioeconomic status, ethnicity, education, sexual orientation and disabilities.

Construction of comprehensive care to women's health suggests overcoming grounded on vocational training paradigm still on curative care, enhancing service to biological symptoms. Thus, it is essential that the construction of university education professionals need to consider a more humanistic profile, critical and reflective, aware, considering the cultural and ethical views and promoting citizenship.[22]

By disregarding the user vulnerabilities, hinders the identification of health problems. However, counseling is essential for a comprehensive care; its realization should take place in all calls to the woman, because it is an essential tool to minimize the anguish caused by doubts and lack of information.[24]

As well as counseling, educational activities are compromised as a strategy for comprehensive care to women, being contemplated in the three units, on an individual basis, in the form of guidelines, also focused on complaint alleging that do not realize education in public health for lack of time.

> *Usually [the health education] is on top of the symptoms even (P3).*
>
> *It's actually more if I notice she has some difficulty to understand treatment of the disease itself, the own symptom that she's referring to (P6).*

Professional transmit only information they consider necessary and do not seek to know what are the barriers that hinder the exercise of autonomy in the experience of sexual and reproductive rights, for each of the women.[25]

It was found that the issue of violence, recurrent investigated in service, is muted in terms of health education, according to the report:

> *Violence against women is something we have to work harder, because we listen too about the issue of the office (P1).*

Indeed, despite considering a major problem, actions involving the issue of violence against women do not make up the professional interventions effectively. Health education, for example, constitutes one of the main FHS work tools. However, the performance of vertical practices based on diseases, which do not include the educational practice and the proposed health promotion, predominate.[26]

It is noteworthy that health counseling and education actions are prerogatives of the FHS. Being the responsibility of remaining team members, such as CHA, technician or nursing assistant, doctor, dentist, health buccal

technician.[7] However, this practice was not observed in any of the FHU.

♦ Professional practices focusing on clinical activities

The dimension clinical activities was contemplated by the professionals; however, these activities are still centered on complaints, as well as the biological aspects of the user, reaffirming what has been observed in the dimension counseling and educational activities.

This aspect is confirmed in the statements when questioned about the developed clinical activities, as the following excerpt:

> *According to the complaint I'm investigating other causes of disease, but usually I'm going through the complaint (P4).*

Clinical activities yet performed are as biomedical paradigm, being held in the form of individual consultations, focusing on disease and ruled on complaints, distancing themselves from the FHS prerogatives.[27] In this paradigm, the user is hearer of health information and is in a passive condition, summing up to answer the questions made by professionals on health.

From the analysis of the medical records, it was found that the data are recorded incompletely (Table 1). It is understood that the medical record is a confidential document, personal, private and confidential, since in their records containing personal information relating to their health history obtained by professionals to watched.[28]

Table 1. Record of clinical care (chart). Lagoa Seca (PB), 2014.

Aspect	Information	FHU 1		FHU 2		FHU 3	
		n	%	n	%	n	%
Anamnesis	Complete	0	-	0	-	9	28,2
	Incomplete	22	68,7	25	78,2	21	65,6
	Non performed	10	31,3	7	21,8	2	6,2
General physical examination	Complete	0	-	0	-	0	-
	Incomplete	4	12,5	0	-	28	87,5
	Non performed	28	87,5	32	100%	4	12,5
Specific physical examination (breast)	Complete	0	-	0	-	5	15,6
	Incomplete	2	6,2	13	40,6	8	25
	Non performed	30	93,8	19	59,4	19	59,4
Physical examination (gynecological)	Complete	0	-	0	-	0	-53,2
	Incomplete	14	43,7	16	50	17	46,8
	Non performed	18	56,3	16	50	15	
Conduct of health promotion	Realized	13	40,7	11	34,4	2	6,3
	Non performed	19	59,3	21	65,6	30	93,7
Health protection pipes	Realized	30	93,7	31	96,9	22	68,8
	Non performed	2	6,3	1	3,1	10	31,2
Conduct of health recovery	Realized	8	25	6	18,8	1	3,1
	Non performed	24	75	26	81,2	31	96,9

Regarding history, the observation of the calls showed that personal habits such as smoking, alcoholism and drug use are not questioned in all cases, the family history is directed to cancer research, professionals generally do not question menstrual history, sexual and obstetric at every visit. At no time was carried out questioning about sexual partners.

On physical examination, the teams do not perform the general physical examination in the majority of their calls, contradicting the speech:

> *The physical examination, see the main complaints, physical examination is paramount (P1).*

Concerning the specific physical exam, composed of the clinical breast exam (ECM) and the gynecological examination, it was observed that both are performed incompletely.

The practice of ECM is infrequent, being neglected in most calls and when performed does not follow the proper technique. The gynecological examination, in turn, is carried out incompletely, being summed up the collection of material for cytology. As part of procedures that include comprehensive care to women's health, these tests should be performed at every visit, regardless of age, including in pregnant women.[2,5]

The general, specific physical examination (breasts and genitalia), and collection of material for the Pap smear last less time than with history, filling in the cytological examination request form and the record of the data in the chart, according to the notice of attendance.

Regarding the promotion measures, protection and recovery of health, it was observed that the actions are restricted to guidance on the complaints of users, immunization, test ordering and prescription medications. It is noteworthy that in test ordering, the focus of attention is focused on the prenatal; however, narrowly because the

exams for diagnosis and prevention of cervical and breast cancer were not performed during pregnancy. So in other calls to the woman, lab tests were not ordered routinely, only when the user had a specific complaint.

> *Test ordering also [performed], more in line with the complaints (P3)*
>
> *I get kind of caught regarding test ordering, the question of marking, because for the pregnant woman there is a certain ease, but for other women [...] when you have dysuria complaint, any other complaint, I try to investigate, but this question of offering, usually I brake because I know it's more complicated. It is not as a routine thing. (P1)*

It is understood that assistance to women is not restricted to a query or test ordering is something surplus, as it covers the act of receiving and (re) meet the health needs, culture and creation / consolidation of links; however[16], the request of screening and early detection to specific health problems consist of a fundamental right, it supported the principle of comprehensive care.

As regards home visits to women, professionals mentioned that are related to the puerperal visit or established disease situation as speech below:

> *Visits with women generally are puerperal visits we question the issues of breastfeeding [...] is view as a whole, [...] we immediately go on questioning whether has complaints, according to the need (P1).*

This approach is suitable for prioritization strategy and access to care, considering that the puerperal visit is a priority attention to women and children. However, this limited the postpartum strategy does not address other priority groups such as children, adolescents, pregnant women, individuals with chronic diseases, drug addicts, elderly, users with walking difficulties and other/ healthy users.[29]

Please note that control strategies in health surveillance, such as the immunization of priority groups, except for the woman during pregnancy, and the notification of diseases by health services was not mentioned by the professionals interviewed were either carried out during the collection data. Inferred so, regulatory frameworks, such as the compulsory notification of cases of violence are insufficient when unaccompanied by training in skilled and sensitive health issue of complete assistance.[26]

It should be noted that the assistance to women is restricted to prenatal care, collection of material for cytology and family planning, being performed primarily by nurses.

> *The more guidance examination for women is usually the mother, the gynecological examination is usually not done, or [is done] by his own nurse (P6)*
>
> *The cytological [...] lies with the nurse. Family planning, generally the nurse makes (P4)*
>
> *The visit is made by nurse and childbirth if necessary by the doctor (P6)*

The restrictive focus of attention and the lack of multidisciplinary interaction with division of labor exempts women's guarantee of a multiplicity of perspectives and knowledge that is related to completeness. The reflecting on a hegemonic care model still predominates in health services.[23]

A comprehensive health care also suggests recognition of the limitation of uniprofessional performance to account for the health of individuals and populations needs, suggesting changes in power relations between health professionals.[12]

Deprive the wife of a comprehensive care implies a situation of disrespect the dignity and sexual and reproductive rights, constituting a form of violence that does not suggest physical aggression, but proceeds from a normalization in the culture, discrimination and submission.[30]

So, there is that the gaps in services for comprehensive health care to women relate to no understanding of the primary work process, as well as failure of ethical/professional deficiency in meeting the specific professional laws, and the principles and guidelines of SUS and its specific programs, such as the National Program for Integral Attention to Women's Health.

Although health services and professional practices contemplate points favorable to the implementation of comprehensive care, make it necessary to cross-cutting and coordination between the actions.

CONCLUSION

The meanings of completeness relate to public policy, the organization of health services and professional practices. They must be articulated in order to guarantee assistance that meets the human being in the biopsychosocial, cultural and spiritual dimensions, focusing on individual needs.

This analysis demonstrated that despite the positive points listed, the service organization does not address the cross-cutting and intersectoral actions. The focus of attention, in turn, is centered on complaints of users, to the detriment of the determining factors in health/disease/care.

It emphasizes the responsibility of municipal managers and university education institutions to foster and promote professional skills in support of improvements in assistance to users under the axis of completeness, breaking the traditional paradigm of biomedical care.

As a material in respect, it is emphasized that the triangulation data capture enabled, from different perspectives, professional practices, allowing identify contradictions between discourse and practice of professionals, which would not be possible with use of methods alone.

This study has a limitation to the analysis of the restriction of/to professional nurses and medical; however indicates the need for changes in care practices. It is expected that the study will guide actions and contribute to transforming element for health care of women of full mode.

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