GYNECOLOGICAL CONSULTATION AND ITS POTENTIAL TO PRODUCE COMPLETENESS OF ATTENTION IN HEALTH

A CONSULTA GINECOLÓGICA E SEU POTENCIAL PARA PRODUZIR A INTEGRALIDADE DA ATENÇÃO EM SAÚDE

LA CONSULTA GINECOLÓGICA Y SU POTENCIAL PARA PRODUCIR LA INTEGRALIDAD DE LA ATENCIÓN EN SALUD

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ABSTRACT

Objective: to analyze the gynecological consultation offered in health services and its potential to produce comprehensive care. Method: exploratory and descriptive study with qualitative approach conducted with women users of primary care network, with a focus on gynecological consultation in two Basic Health Units (BHU) in two counties of Rio Grande do Sul State. Data collection took place through Focal Group, using a semi-structured script. After reading the testimonials, data was entered into the program NVivo 10 and subjected to Content Analysis Technique in the Thematic modality. Results: the gynecological consultation meets, to some extent, the principle of comprehensive care and this is due to precariousness and discontinuity of actions between specialties and services. Conclusion: We must redirect the organization of practices, especially the gynecological consultation in its operating mode, valued by the concepts of the perspective of comprehensive health, relationship and sensitive listening. Descriptors: Completeness in Health; Nursing; Gynecology.

RESUMO


REFERENCES
INTRODUCTION

In Brazil, Primary Care (PC) is characterized by a set of health actions in individual and collective extent, including promotion and protection of health, disease prevention, diagnosis, treatment, rehabilitation, harm reduction and the maintenance of health in order to develop a comprehensive care directed to the health of the population.

Over the past decade, the Ministry of Health (MOH) has allocated major investments towards the consolidation and implementation of the Unified Health System (SUS) in order to ensure its principles, particularly the comprehensiveness of health care. In this context, basic attention has been evaluated, reoriented and organized by various regulations, ordinances and decrees aiming to strengthen its consolidation.

In this scenario, the Decree nº 7508, which regulates the Law nº 8080 on the provision and organization of SUS, was issued in June 2011 proposing a set of articulated actions and health services in increasing levels of complexity, in order to ensure the comprehensiveness of health care. This decree calls for the establishment of Health Care Networks where PC, again, is highlighted.

In 2011, the Ordinance nº 2488, approving the National Policy of Primary Care, establishes the review of guidelines and standards for the organization of primary care and, in this context, the actions aimed at women's health is a priority of the government. In turn, since 2004, with the creation of National Policy of Integral Attention to Women's Health (NPIAWH), the government has led, through programmatic actions, to increasing access to resources and services for comprehensive health promotion. Among the initiatives are those that aim to reduce inequities and inequalities in health care of women.

With regard to comprehensive care to women's health, primary care used to be characterized by little resolutive power, with discontinuity in the therapeutic course and with limited regulation of assistance, compromising the comprehensiveness of health care.

In the context of PC, we understand the gynecological consultation as ample space for production of comprehensive care to women's health. This implies taking the notion of comprehensiveness as a bet on the potential of leveraging and producing organization of the care network to women's health in order to strengthen the principles and guidelines of SUS.

Based on these, we are interested in deepening our knowledge on the gynecological and its potential to produce comprehensive care.

OBJECTIVE

- Analyze the gynecological consultation offered by health services and its potential to produce comprehensive care

METHOD

Exploratory and descriptive study with qualitative approach conducted with women users of primary care network, with a focus on gynecological consultation of two Basic Health Units (BHU) in two counties of Rio Grande do Sul State, identified as county A and county B. These were selected after analyzing indicators of access and quality of women's health care of an ecological descriptive epidemiological study which is a component of one of the stages of a major project entitled "Using technologies of completeness in the care provided to women in the primary care network: analysis of scenario in relation to gynecological care" supported by the Government Collaborative Network for Health (UNITED NETWORK) and in collaboration with the School of Nursing of the Federal University of Rio Grande do Sul.

County A has 130,988 inhabitants, HDI of 0.726, belongs to the 1st Regional Coordination of Health of RS and organizes its assistance with FHSs and BHUs. Assistance in secondary and tertiary care is carried out in the county.

The county B has a population of 2,503 inhabitants, HDI of 0.77, belongs to the 19th Regional Coordination of Health of RS. The county organizes its health care by PC and in cases of diagnostic support of greater technological density, it uses the Regional Health Consortium.

After submission and approval by the Ethics Committee of the UFRGS (Opinion nº 685.673), contact with the managers of the Family Health Strategies (FHSs) selected for the study was made. After authorization, it was requested to community health workers to do an invitation to women in the territory of scope for further formalizing their consent to participate, which was given by signing the Instrument of Consent.

Selection criteria for the study were: women who used the basic service, aged over 18 and who would receive gynecological
consultation in the selected health unit. Women who made use of services other than the basic service, women under the age of 18, and who received gynecological consultations in the supplementary health services, were excluded. Initially, authorization from the manager of the unit of each county was requested. Subsequently, data collection was carried out in the selected BHU between August 2013 and April 2014. Twenty-two women participated in the study.

Data collection was carried out by Focal Group (FG). The choice of this method was due to technical capabilities to explore ideas, opinions and different views generated in discussion groups, mobilizing critical-reflexive consciousness of the participants.9

We used a semi-structured script for driving discussions in the group of women. This addressed access to health services, quality of gynecological consultation and health needs of women. The groups had an average duration of two hours, being held in three meetings, one in the county A and two in the county B. Statements were recorded by a tablet and transcribed, in order to maintain the reliability of the testimony.

After reading testimonials, these were entered into the program NVivo 10, software that supports qualitative and mixed methods research, to support the organization of data and, after this step, the analysis of data was proceeded in the light of the theoretical framework of health needs; comprehensive care; health technologies; and gynecological consultation.10-13

In order to guarantee anonymity, identification of women is given by the letter W and a number according to the order of speeches (W1, W2 ...).

Data were subjected to Content Analysis Technique in the Thematic modality, which allows contemplating the empirical data in their singularities, in their social and historical context.14

RESULTS

The analytical map that emerged from the data analysis included four major axes: Health needs of women that result in demands; Women’s perception of their own resolutive capacity over their health needs; Flows of the offered action and; Access of women to health services. This article will analyze the analytical axis: Women's perception of their own resolutive capacity over their health needs through its sub-categories: gynecological consultation: where are the health needs and demands of women? and access and power to make use of care technologies.

DISCUSSION

♦ The gynecological consultation: where are the health needs and demands of women?

This category covers the scope of government responses to the demands and health needs of women, as well as the ability of professionals to use the expanded concept of health in the gynecological consultation. Expanded health is understood here as an abstract phenomenon involving ways of being and produce and/or recreate life in its uniqueness and multidimensionality. In this perspective, one must question the speeches that emphasize the concept of health only by its biological dimension, what ensures a fragmented conception of the human being, as well as authoritative and normative character of ways to intervene in the reality of individuals and communities.15

In order to incorporate, however, this concept into health practices, it is necessary to search and integrate approaches that take into account the health needs in a socio-historical perspective. In this sense, the expanded clinic can be an effective tool in managing the complexity of health work which is necessarily transdisciplinary and has the aim to avoid the fragmentation of the work process.16

On this track of thought, we will use in this study the definition of “gynecological consultation” as a meeting between user and health professionals, besides contemplating an expanded clinical approach and meeting the demands set out by health programs and policies targeted at women that value their health needs and singularities beyond complaints, signs and symptoms related to sexuality, reproduction and biophysiological dimension of their health.13

The data reveal other needs and demands additionally to those related to the biological aspects such as access, waiting times for specialist consultations, among others, as shown by the statements below:

I also think that, if there were here a place to make a mammography, an ultrasound, it would be better [...] but because there isn’t, we are forwarded and we receive the service the same way. (W12)

What happens is that you have to travel twice … for example, the ultrasound with the gynecologist, once to take the exam and the other time to show the exam to the doctor, so, that had to change … then, we have to go one day to consultation and...
another day to do ultrasound. (W16)

In addition to the waiting time for receiving service, the convenience of schedules, the procedure to schedule, other topics were highlighted by women, such as ease of contact with the professionals, the comfort and ambience of services. It is noteworthy that women would like that the consultation and examinations were performed always in the same place and the same professional.

Another relevant fact was the desire to have access to information on the results and referrals to specialties with greater agility:

I just have all consultations here, but the service, I did in Rodeio Bonito when I was pregnant, there with the doctor, but otherwise, I receive care only here at the health center, except for the mammography I did in the municipality of [...]. What's in here, I use right here, I take the chance, right? You have the opportunity here, and what's not here, we go to the place where there is (W08).

Regarding health needs identified by women, some were related to the taxonomy proposed by Cecílio: to have a link with the professional or the team, autonomy and free will to decide how to live. It should be noted that the need for good living conditions in this study was not identified by women.

Regarding the relationship with the professional, it is evident that the quality of care goes also for the quality of the relationship, that is, it entails recognizing women as subjects of needs, which are manifested in different ways, expressed through the body and the speeches. As indicated by the data below:

I feel good taking the exam with her, because we start already talking with each other, about other things, asking one to another as if we were friends, it is very interesting to have this bond. (W04)

My consultation takes a long time, I make the breast exam, make collection and talk about food, the ‘fat’, we talk a lot, it’s very good. (W02)

The expressions “she’s talking, making the service” and “we start already talking with each other, about other things” indicate that women feel cared for and welcomed with respect to their demands and needs once the conversation and expanded listening become constituent elements of the gynecological consultation.

Considering the action of listening as a prime aspect to seize the health needs, it elaborates on light technologies (relational) of live work in action where there is a meeting between professional and user, in which a set of expectations and productions operates, creating inter-subjectively, moments of speech, listening, interpretations, in which there is production of acceptance and complicity, with relations of bonding and acceptance.12,18

Another important aspect mentioned by women was the duration of the consultation and its association with the quality of the attention and care offered:

My consultation takes about 20-25 minutes, she always asks how I am, makes collections, analyse the breasts. (W03)

My consultation lasts a long time, I make the breast exam, make collection and talk about food, the ‘fat’, we talk a lot, it’s very good. (W02)

The following statements reflect that care is an event in which there is the presence of various technological tools, among them the technological valises representing a toolbox between material and non-material knowledge and its consequences, making sense according to the space they occupy or for the purpose that they envisage.19

In this perspective, the working mode of the consultation desired by women corroborates what is defined as gynecological consultation, that is, as the meeting between user and health professionals where the subjectivity and singularity of women are valued.19

There is still, however, evidence that consultations prioritize aspects of the biology and anatomy of the female body:

[…] During the consultation she asks me only about the gynecological part, asks if I take medicine. (W03)

The collection, it has about two years ago that I do not do […] the gynecological consultation took about 10 to 15 minutes. (W05)

The third aspect that emerged from the data was the autonomy of users to “walk the life”, the prime role of women in accessing services and for throughout the gynecological consultation, the responsibility, the autonomy.20 Data suggest that the procedures and professional attitudes print a large influence on the decisions of women when it comes to using the offered technologies:

The gynecological exam is uncomfortable, the position is uncomfortable, the doctor is from another unit. (W03)

Based on these, the lack of participation of women in the therapeutic process is evident. The lack of autonomy increases dependency or resistance to treatment, promoting an endless succession of consultations, tests and procedures, the center of life.21
Another aspect identified was the responsibility of women during gynecological consultation, signed by the history of sickness in the family, which also ultimately influence the decision making of women with respect to use the service and making them to become attached to services and health professionals:

[...] The health unit schedules it, then I go, my doctor said that is an important test for us to do, I never quit doing it. (W02)

I do because my mother and my sister had breast cancer, so I know I have to do it. (W05)

Based on the exposed in this category, it is observed that women have little autonomy to decide on the flow and care practices. This fact is evidenced in the accounts of service flows, as access is restricted and defined by the management of healthcare network, which, in turn, does not always take into account the singularities and subjectivities of women.

♦ Access and power to use care technologies

The following category covers the access to gynecological consultation, the reasons for seeking the services and decision-making in carrying out procedures offered in the consultation.

The individual needs and demands are expressed by spontaneous demand for health services, translated by collective aspirations since they mirror the search for social rights such as a healthy, active and enjoyable life.72

In this context, although the universality is constitutionally assured and is one of the principles of the SUS, which articulates the actions and health services based on a perspective of completeness, this is expressed, in the practice, through the professionals' ability to respond to the manifested suffering.6

In this study, we understand access as a step to be overcome by the user when seeking the satisfaction of a health need, including the lack of geographic, economic, sociocultural barriers and organization and gender.23

The data indicate that women seeking access to health services because they recognize the importance of self-care, thus assuming autonomy in the search for the service, regardless of the opinion of people nearby, such as that of the partner/husband.

I do my mammogram, if SUS is offering me the opportunity, why would I not take it? No way, of course I’ll go and take care of myself. (W04)

My husband is always very attentive; he asks if I have scheduled to see the doctor. So, if I go to the doctor, when he's at home, he goes with me, he takes me there. (W02)

That story that the husband does not allow the woman to take the exam, I think it's ignorance of his part, because I too, last week I went to make my mammogram and my husband said 'why poor people want to have mammograms?' (W05)

This autonomy, however, gradually disappears to the extent that women do not find all health technologies needed to meet their needs. This is due to limited options of choices related to professional services and therapies offered by the health care network to meet the demands and needs of women.

In this sense, the data show some intervening factors that justify the search for access to health actions offered to women by health care networks, that confirm the claims of authors mentioned above. The proximity to BHUs, agility in delivering the result of the examination, and the reception by the professional conducting the sample collection are relevant and influent factors in the decision making to carry out the consultation and/or screening test, as it is indicated by the following lines:

[...] In the health unit, the results of the screening test take 30 days to get ready, but we hear that with health insurance plans it takes about four days, it is faster. (W01)

So, if here was just as it is in private services, it would be easier, you make a phone call, you schedule, and you know what day there you'll go there and they'll serve you, then all the exams, all scheduled. (W02)

My mammogram, they themselves schedule here in the unit, they just called me at home to remind me. (W05)

This study showed that, additionally to the reasons provided by public health policies related to gender and power issues, there is another reason why women do not access services. This would be the fear of being sick or receiving a negative diagnosis. This reinforces previous studies that discuss the reasons that lead women to seek the health service to have a consultation.24 This is indicated by the statements below:

I see in the case of my family, they keep saying, I will schedule my gynecologist, but they keep procrastinating, afraid of [...]. then you have a problem and you have to go running to the doctor to take the fallopian tubes and the uterus off. (W03)

I think it's because of fear of knowing that you have the disease [...] (W01)

The lack of autonomy in the choice of care technologies was highlighted by the users. In the view of women, this happens partly...
because they are directed or conducted by the health care network to consume certain technologies, established by health programs, most often defined by a decision of the local health manager, and not according to their wishes, as indicated by the following data:

[...] I have not done a mammogram because I'm not old enough yet, because we cannot make it before a certain age, but what if I have a risk factor? (W01)

Some municipalities here in the region participate in the consortium, and thus it takes some time to get the consultation because you will never get an appointment for tomorrow, the consortium serves more than 26 municipalities(W16).

However, women acknowledge, even with little autonomy, that they feel assisted because the service tries somehow to get resoluteness to their demands, as in the case of inter-municipal consortiums:

[...] We, or the family, we are always well assisted, it may delay, we have to wait, but you never leave empty-handed [...] if you need them to take you to another place for further care, they take us, without any cost. (W08)

I take the pressure medicine here, I also did spine surgery, my referral came from here, I went to several municipalities, all referrals came from here, I do my preventive exams, the breast exam I've even done electrocardiograms of my heart, everything comes from this health unit. (W08)

The data exposed so far confirm that in most cases the actions offered come from preprogrammed management projects, even if guided by a national health policy, where there is no participation of women in the definition of strategies and actions that address their health needs beyond the epidemiological and biological aspects.

FINAL CONSIDERATIONS

Considering the objectives of the study, the data revealed that health services offer health actions still not sufficiently articulated between levels of care, prioritizing, in most cases, the actions of experts with the focus on programmatic actions and of epidemiological interest. The importance of the use of soft technologies in the consultation stage, such as strengthening the link between users and professionals and the consequent adherence to health programs for women, is evident.

In this sense, the listening, welcoming, and the autonomy to choose and interaction with the services were highlighted by women, thus highlighting the need to redirect the way of organizing practices, including the gynecological consultation.

The gynecological consultation may have its operating mode potentiated if this is founded by the constructs of expanded clinic and sensitive listening.

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