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RESEARCH | PESQUISA

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Social and gender inequalities in women's needs for user embracement

Iniquidades sociais e de gênero nas demandas de mulheres por acolhimento

Iniquidades sociales y de género en las demandas de acogida de las mujeres

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ABSTRACT

Objective: to analyze the demands of women from the point of view of multi-professional teams. **Methods:** This is a qualitative study developed in a Family Health Unit of a Health Sanitary District in Salvador, Bahia, Brazil. A focus group was conducted, and the empirical material was analyzed using the Discourse Analysis technique. **Results:** twelve health professionals aged between 27 and 60 years and working for two to 13 years in the Family Health Strategy participated in the research. The professionals characterized the users with social and economic vulnerability and the demands of affective-emotional order related to gender inequities, with an overload of domestic work and family care. The health team constitutes a support point and offers welcoming and sensitive listening. **Conclusion and implications for practice:** affective deprivation and wear and tear due to domestic and family functions and the relationship with the partner mark women's demands for care. Professionals perform practices from the perspective of integrality, but there are institutional and team limits in dealing with singularities. Overcoming these limitations requires opening paths to the empowerment of women, which does not portray the problematized reality, and support professionals in meeting the principle of integrality in the context of women in social and economic vulnerabilities.

Keywords: User Embracement; Family Health Strategy; Integrality in health; Interpersonal Relations; Women's health.

RESUMO

Objetivo: analisar demandas de mulheres segundo o olhar de equipes multiprofissionais. **Métodos:** estudo qualitativo desenvolvido em Unidade de Saúde da Família de um Distrito Sanitário de Saúde em Salvador, Bahia, Brasil. Realizou-se grupo focal e o material empírico foi analisado pela técnica de Análise de Discurso. **Resultados:** participaram da pesquisa 12 profissionais de saúde com idades entre 27 e 60 anos e atuação de dois a 13 anos na Estratégia Saúde da Família. As profissionais caracterizaram as usuárias com vulnerabilidade social e econômica e as demandas de ordem afetivo-emocional relacionadas a iniquidades de gênero, com sobrecarga do trabalho doméstico e do cuidado à família. A equipe de saúde constitui ponto de apoio e oferece acolhimento e escuta sensível. **Conclusão:** carência afetiva e desgastes pelas funções no âmbito doméstico, familiar e pela relação com o parceiro marcam as demandas de mulheres por cuidado. Profissionais realizam práticas na perspectiva da integralidade, mas há limites institucionais e da equipe em lidar com singularidades. Construir a superação requer abrir caminhos ao empoderamento das mulheres, o que não retrata a realidade problematizada. Implicações para a prática: subsidiar profissionais no atendimento ao princípio da integralidade diante de contextos de mulheres em vulnerabilidades sociais e econômicas.

Palavras-chave: Acolhimento; Estratégia Saúde da Família; Integralidade em saúde; Relações interpessoais; Saúde da mulher.

RESUMEN

Objetivo: analizar las demandas de las mujeres desde la óptica de equipos multidisciplinarios. **Métodos:** estudio cualitativo realizado en la Unidad de Salud de la Familia de un Distrito de Salud de Salvador, Bahía, Brasil. Se realizó un grupo focal y se analizó el material empírico mediante la técnica de Análisis del Discurso. **Resultados:** participaron de la investigación 12 profesionales de la salud, con edades entre 27 y 60 años y actuando de dos a 13 años en la Estrategia Salud de la Familia. Los profesionales caracterizaron a los usuarios con vulnerabilidad social y económica y las demandas afectivo-emocionales relacionadas a las inequidades de género, con sobrecarga de trabajo doméstico y cuidado de la familia. El equipo de salud es un punto de apoyo y ofrece acogida y escucha sensible. **Conclusión:** la carencia y el desgaste afectivo por las funciones domésticas, familiares y la relación de pareja marcan las demandas de cuidado de las mujeres. Los profesionales realizan prácticas desde la perspectiva de la integralidad, pero existen límites institucionales y de equipo en el abordaje de las singularidades. Construir la superación de desafíos requiere abrir caminos al empoderamiento de las mujeres, lo que no retrata la realidad problematizada. **Implicaciones para la práctica:** subsidiar a profesionales en la atención al principio de integralidad ante contextos de mujeres en situación de vulnerabilidad social y económica.

Palabras clave: Acogimiento; Estrategia de Salud Familiar; Integralidad en Salud; Relaciones Interpersonales; Salud de la Mujer.

INTRODUCTION

The user embracement favors the construction of a relationship of trust, bond, and co-responsibility between the users, the team and the service through dialogue, empathy, access and coherence between the organization of the services offered and the users' needs.[1] Such aggregated dimensions favor integrality, which proposes a care that respects singularities, with guaranteed access to health services and resolute actions.[2]

Qualified listening is part of the user embracement and is a means of facilitating the formation of bonds in interpersonal relationships, since it goes beyond superficialities and enters the subjectivities of the people who seek health services, allowing professionals to know the demands, contexts of life, and suffering. It is a light technology centered in the respectful and reflective interaction between users and professionals, which enables humanization in the work process, the promotion of comfort and satisfaction of patients, favoring positive transformations towards integrality in health.[3,4]

In the context of the Family Health Strategy (FHS), the bond is constituted by horizontalized interpersonal relationships, based on dialogue, continuously built and expanded, in proportion to the user embracement of the person who seeks these health services and those who offer the actions. In this process, the establishment of trust broadens the interaction between the user and the health team, facilitating the voice and identification of demands, autonomy, therapeutic adherence, and the achievement of resoluteness.[5]

The integrality of care must go beyond professional practice. Besides the technical and scientific knowledge of the multiprofessional team for good care practices, it is necessary to associate knowledge with aspects such as access, availability of equipment and supplies, intersectoral articulation, service organization, regulation, and Information and Communication Technologies (ICTs).[6]

In a broader concept, integrality unites distinct aspects, which complement each other in health care: the adequate professional performance, referring to acting in the promotion, prevention, rehabilitation and cure of people motivated by the health needs presented; the organization of health services to meet spontaneous and programmed demands with the objective of expanding the population's access; and the perspective of building policies, through comprehensive governmental actions, to solve individual and collective health problems in favor of social justice.[7]

In the scope of women's health, the integrality in health and the analysis of gender in health must be the guiding axes of the practices carried out with the valorization of singularities and of the context in which women are inserted.[8] This emphasis is also given when stating that comprehensiveness requires, from health professionals, a commitment to the quality of care and the use of soft technologies such as listening and the user embracement, to meet the needs.[9]

Taking into account the specificities of women's health demands, this article presents a broader research sample whose results show social and gender inequalities in women's demands for care. The study aimed to analyze the demands of women from the point of view of multi-professional teams.

METHOD

This is an exploratory study with a qualitative approach that uses integrality and gender as categories of analysis. The dimensions of integrality encompasses professional health practices that ensure access and resoluteness and, when directed to women, it involves gender issues by considering social and cultural determinations that influence women's way of life and the process of health and illness.[8] Gender is a structuring system of gender relations that defines social roles for women and men.[10]

The study was developed in a Family Health Unit (FHU) that concentrates four teams from different units of a Health Sanitary District in Salvador, Bahia, Brazil. The choice of the place for the study was made because it is a field of practice for nursing education and the site of other research already carried out with women users of the coverage area. These studies indicated the need for new studies with health professionals.

The researcher's contact with the FHU occurred initially with the unit manager in a face-to-face meeting. The researcher and the support team did not previously know the unit manager, or the members of the health team. The first contact with the manager was due to the interest in conducting the research in the locality and, after his authorization; the researcher introduced herself to the professionals and invited them to participate in the research, which would involve health workers who assisted women.

In this study, the manager indicated a nurse of the unit to be established contact. Later, this nurse recommended another person from the health team, and so on, successively. The inclusion criteria were to be part of the minimum team of health professionals of the FHS, to have worked in the FHU for at least six months, and, as exclusion criteria, to be away from the service due to vacation or health problems.

The participants were contacted personally at the service. From the total of four teams with 52 people, 18 eligible professionals remained after the application of the criteria, two people refused to participate due to undeclared personal commitments, 14 accepted to participate in the research, and two people did not inform the reason for giving up, resulting in 12 participants. In this article, speeches from seven participants were selected as representative of the whole group due to repetition of content. They were identified, in the text, with the initial (P) of participant followed by numbering according to the order of the speeches for the preservation of identity.

The empirical material was produced by means of the focus group technique. This technique produces a wide range of responses from the discussion among people gathered around a specific theme. It investigates the perspectives on a certain social phenomenon, giving rise to questions and stimulating the search for relevant answers.[11]

The focus group was conducted by the master's student, lead author, with the support of a doctoral student, a master's

student, and a graduate student in Nursing. They all underwent training, and the team was trained by the professor who led the research group. Data production occurred under the instruction and coordination of the researcher in two moments, both lasting an average of two hours due to data saturation. The data collection took place in the meeting room in the unit and only the participants and the researchers were present.

The focus group was conducted through the application of a pre-established script consisting of socio-demographic characterization, educational data, and the following guiding themes: characteristics of the women who sought the services; women's demands and actions/solutions in the care of women.

A dynamic presentation of the group was used and a layout of the unit was shown, depicting the structure of the service with its internal divisions and the flow of women in that service, and then the professionals were asked to discuss the topics.

No pilot testing or repetition of interviews was conducted. The focus group was recorded by audio recording and transcribed in full by the main researcher, without returning to the participants for comments and/or corrections. The field diary used to record the context was equivalent to the transcriptions analyzed.

The data analysis was carried out using the technique of Discourse Analysis according to Fiorin, an interdisciplinary reference in the area of Linguistics that considers discourse to be a combination of sentences that expose people's thoughts and values about their socially determined internal and external worlds. For the author, discourse is a social position and ideological formations are materialized in language.[12]

In the direction given by the author, the following steps were taken: reading the entire text to identify figures and themes that lead to the same block of meaning; grouping the significant elements (figures and themes) that add up or confirm each other in the same plane of meaning; deprecation of the central themes and formation of the empirical categories.

The data coded by two researchers resulted in themes such as gender violence, affective neediness, women's central place in the family, machismo, social roles, sensitive listening, user embracement, and bonding derived from the collected data. These were organized in word and used in the analysis to form the two categories. The participants gave positive feedback after the presentation of the results to the team.

The project was approved by the Research Ethics Committee of the Federal University of Bahia under Opinion No. 1.239.456. The ethical aspects of the research provided for in Resolution No. 466/12 on the regulation of research involving human subjects were respected and the writing was guided by the Consolidated Criteria for Reporting Qualitative Research (COREQ) guide.[13,14]

RESULTS

Twelve professionals from the four FHU teams participated in the research: three Community Health Agents (CHAs), three Oral Health Agents (OHAs), three dentists, two nurses, and one nursing technician. The participants were between 27 and 60 years old and had worked for 5 to 38 years, of which 2 to 13 years in the FHS. Two professionals had refresher courses in women's health and violence against women, one in Stork Network and one in breastfeeding.

The results show women's demands for user embracement arising from the social context in which they live and from gender constructions that mark relationships established with partners and with the family. The empirical categories resulting from this reality, expressed by the professional view of the women they care for, are presented below.

Gender relations as a focus of the professional look at women's lives

The FHS users in the area where the research was carried out were characterized by the professionals as women of reproductive age or elderly women whose lives are marked by social and economic vulnerability, lack of affection, and submission to male power. The following statements confirm these assertions.

> The women that are arriving here, what I get is that they suffer a lot, they suffer machismo at home, do you understand? A lot! Suffering too much in life! (P1)
>
> The woman is from a very vulnerable population, we have a history that goes through machismo, [...] violence [...]. Women holding up the family, supporting everything. Woman who works, woman who takes care of the house, woman who takes care of the children, who brings the children. It is even difficult to bring the man, but the woman is like the center of the family. (P2)
>
> Despite life, despite the fact that we are in the 21st century, the woman is still... still has that culture that she was born to be domestic, to be a mother, to wash, cook, iron, right? (P3)
>
> Always very worried about giving up what is hers, right, her right, to put... ah, doctor, can I not put my husband because he is worse off than me. And, sometimes, the husband doesn't care about anything, he doesn't bother about anything. A very big protection. (P4)

In conditions of deprivation and in life circumstances where social inequities, among them gender inequalities, take away women's freedom to make choices, listening and speaking maintain their place in care, as seen in the following category.

Building bonds through sensitive listening and welcoming demands

The women's daily lives generate demands of affective-emotional order and the health service, through its team, constitutes a point of support and security. The valorization of the relational dimension and the singularity of women demand sensitive listening to gender issues and the needs that present themselves, as can be read in the following statements.

> There is this thirst for care [...] this affective need [...] many times, they really come because they like being here, because they want to be here, because they feel embraced [...]. This woman that comes to us is a woman that wants to be looked at, listened to, to have her wishes met. Very maternal [...]. Many times, some of them even use the unit here as a refuge. (P5)

> One of the biggest things that we have observed is this, the need they have to expose what they are feeling at that moment, and they are also grateful, many times, they come back to thank us, they come back through words. (P6)

> It is an exchange. They talk about life's secrets and come here afterwards just to see us, I want to have a word with them, tell them something good. So, there are several life stories. We identify with each other [...]. You know the woman, you know the son, she brings her son, she brings her daughter, and then she ends up bringing her family too [...]. (P2)

However, professionals recognize that structural issues override the team's ability to provide support, and assume a group position that indicates a commitment to providing answers within institutional limits, as seen below.

> Of course the unit is not a perfect unit, it has its problems, besides the structural ones of each work process, we sometimes get stuck on some problems, we try, as much as possible, to solve them, and if we can't help and solve them, we give a forwarding [...]. (P7)

DISCUSSION

In this study, machismo and violence are portrayed as factors that are part of the lives of users of the FHS. They influence the health status of women, with negative repercussions on their quality of life, and generate demands for care, which increases the demand for the service.

In the context in which women's demands are inserted, gender inequalities are evident and, thus, even though they are considered the center of the family, women are still in a place of lesser value. Working and being the provider of the home do not prevent them from remaining submissive to their partners, which generates the need for support and assistance in the face of the difficulties they experience. In the health service, they establish, with the multiprofessional team, a bond and trust through the user embracement they receive, having the FHU as a shelter.

The representations of women and men in society are derived from a culture that preserves the foundations of social gender relations so that, even with some advances in contemporaneity, such values are still preserved. In these structuring systems of sociocultural constructs, which vary according to each society, there are structuring representations that influence behaviors, expressions, and identities in a given society and determine the political, family, and work organizations.[15]

The social segregations resulting from gender issues, besides generating socioeconomic disparities, legitimize violence as a form of domination. The damage to women from violence causes damage to physical and psycho-emotional health, resulting in disorders such as post-traumatic stress, anxiety, depression, depreciation of self-image, eating disorders, and suicide attempts.[16]

In cases in which women experience situations of violence, a survey pointed to listening as a strategy of FHS professionals. In addition to being a tool that enables the identification of needs, it allows the building of trust and empowerment to face the problem.[17]

Qualified listening is a tool that guides the production and management of care and work processes. It is related to sensitivity about what is communicated through gestures, words, actions, emotions, tone of voice, and requires silence, empathy, and impartiality from the receiver in order to meet the subjectivity of the person.[18] When care is qualified, it becomes possible for the user to be served according to her demands, which requires openness to diversity, respect for singularities and the formation of a bond between those who care and those who are cared for, making health practices guided by integrality prevail.

From the perspective presented in this study, according to the position taken by professionals, sensitive listening guides practices and relationships. In the literature, such listening comprises part of the communication process and is a facilitating tool for approaching service users, with a focus on health promotion and quality of life, and values the two-way conversation and verbal and non-verbal language. It aims at the identification of health demands inserted in the social context and changes the work process, because the perception that women have of the professional interest through listening generates a feeling of comfort and encourages their free expression, which strengthens the bond and the responsibilities of the health teams with the users.[19]

The user embracement is an indispensable condition for care as a light technology that promotes access to services and bonding as part of a process that requires reflection and broader and systematized actions by the team to contribute to changes. On this path, there must be encouragement to active participation in the care process in a citizen relationship between users, team, and service through effective communication.

Thus, the integrality is glimpsed, which adds, in its composition, listening, user embracement and bonding, and is the guiding principle of care practices in order to meet the health needs of the population. A preventive and health promotion perspective, curative interventions, access to services, adequate care at all levels of complexity, and good professional practices with the valorization of subjectivity and of the biopsychosocial context of the users are conditions for the effectiveness of the care provided.[20]

In the same direction as the results of this research, a study in Andalusia, Spain, revealed that a strategy of socio-educational groups, carried out by a multidisciplinary team with women in primary care, was perceived by health professionals as a

space for humanization, which promotes well-being, increased self-esteem, mutual support and increased social relations by enabling health service users to express their opinions, feelings and feel heard, creating an environment of respect and trust.[21]

In this study, the bond and trust are built in the relationship between women users and the health team. However, the effective user embracement requires responses so that it is expressed as partial under the limits of structural order that relate to the organization of services and practices, to which is added the socioeconomic context in which women are inserted and the gender inequalities that accompany them.

Although in adversity, we walk towards comprehensive care, seeking to establish sensitive listening, user embracement, and relationships of bonding and trust. The purpose is to favor conditions to improve the quality of life of these women facing a reality in which gender violence, emotional deprivation, and social and economic vulnerabilities go hand in hand.

It is noteworthy that the incorporation of the gender approach to the practices is a condition for integrality, because, in the valorization of contexts, gender inequalities permeate life, demands and relationships. The user embracement through listening, words, and actions will have the potential to contribute to the empowerment of women if the problematized reality offers subsidies for their autonomy, even in the midst of social and economic adversities, which is not portrayed in this study. Thus, there are institutional and professional limits at the level of subjectivities and objective conditions for the confrontations of gender inequalities.

The main limitations of this research were related to the safety conditions of the researchers, since the unit is located in a place of social vulnerability and high rates of violence, and the impossibility of generalization due to its regional character. However, it brings, as contributions, a knowledge that can subsidize professional practices in the FHS for an action committed to meeting the principle of integrality, in a context in which women are in social and economic vulnerabilities, with strong marks of gender inequalities. In addition, it constitutes a basis for intervention research aimed at integrality in the space of primary care services.

CONCLUSION

The professionals participating in the research presented as the main health demands of women users of the FHS those of an affective-emotional order related to suffering due to machismo and violence, affective deprivation, accumulation of functions and vulnerabilities arising from gender issues. Once they are welcomed, with sensitive listening, the health service participates in the construction of practices sustained on new bases. The users entrust the service with their demands, a relationship of trust is built, the FHU becomes a reference for user embracement for women, and a bond is established, as advocated by the approach of integrality.

In a context in which women are recognized in their demands, the professional team has carried out health practices in which the user embracement is exercised, one of the dimensions of integrality. There are structural limitations, but the bond and trust have been built between women and the health team, as advocated by the approach of integrality, and the relational dimension is strongly valued by the research participants.

Thus, the service moves towards the completeness of women's health care through good professional practices with the use of soft technologies in the FHS. However, building the overcoming goes through the empowerment of women, which does not portray the problematized reality.

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Data collection or production. Nayara de Jesus Oliveira.

Data analysis. Nayara de Jesus Oliveira. Edméia de Almeida Cardoso Coelho.

Interpretation of results. Nayara de Jesus Oliveira. Joise Magarão Queiroz Silva. Renata Fernandes do Nascimento Rosa. Patrícia Figueiredo Marques. Mariza Silva Almeida. Edméia de Almeida Cardoso Coelho.

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