Chapter 11

National policy of integral care for women's health in Brazil: from genesis to contemporary challenges

https://doi.org/10.56238/methofocusinterv1-011

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ABSTRACT
Following the demands initiated by the Health Reform Movement, the demands for policies that fully met women's health demands began to be increasingly present in the spaces of social movements, especially in the national and international feminist organization. In this sense, in 1986, the Ministry of Health created the Program for Integral Assistance to Women's Health (PAISM) in order to provide prevention and recovery of women's health at all stages of their lives. In 2004, the Program became the National Policy for Integral Attention to Women's Health (PNAISM), proposing a set of guidelines aimed at humanization and quality in women's care. In this sense, through a bibliographic and documentary study, this article presents an analysis of the trajectory of pnaism constitution, also seeking to understand the possibilities and challenges put to its execution. It is perceived that the PNAISM, as a strategy of response of the State to the female demands constituted socially and historically, brings in its scope clear objectives about its purpose of intervention, but that do not materialize in its entirety because they are under the condition of unsatisfactory investments by that same State, as well as other social policies

Keywords: social rights, health policy, women's health

1 INTRODUCTION

During the 1970s, Brazil experienced contradictory experiences: on the one hand, economic growth fostered by multinational financing and the country's indebtedness was observed; and, on the other, the irregular growth of cities under the lack of basic sanitation and the absence of health and education policies (CEAP, 2017). Such contradictions enhanced the dissatisfaction of the population with the military government, causing social movements to resist the dictatorial political regime to strengthen and demand, in an increasingly active way, political and social changes.

Within this context of struggle for a new model of society and state emerges the Health Reform Movement, which argued that, parallel to the necessary social and political changes, health should be guaranteed as a duty of the State and a universal right. Thus, health care should be integral; its management, democratic; and its control through community participation.

However, it is observed that the female population did not immediately achieve their rights of integral care to their health during these historical periods and the care to women's health, as well as autonomy over their body, were still neglected by the absence of policies for this purpose. According to Costa et. al. (2019), due to the influence of Eurocentric customs, women's care spaces acted on the field of obstetric-puerperal care, whose objective was to control the birth rate and, consequently, the demographic growth seen as revealing the increase in poverty and expressions of the social issue, since the 1950s.

The demands for policies that fully met women's health demands began to be increasingly present in the spaces of social movements, especially in the national and international feminist organization, requiring a more attentive look about women's health. Thus, the feminist movement was a privileged space for emerging contents, such as women's health, to gain greater visibility in discussions held at international conventions and organizations.

Sob this conjuncture, in 1986, the Ministry of Health with the objective of enabling a dialogue between the State and the feminist movement, proposes the creation of the Program of Integral Assistance to Women's Health (PAISM), with the purpose of providing the prevention and recovery of women's health, in an organized way, assisting them in all phases of their lives. The Program, whose orientation sought a differentiated view on women's care in 2004, was transformed into a national policy, becoming the National Policy for Integral Attention to Women's Health (PNAISM), proposing a set of guidelines aimed at humanization and quality in women's health care.

In this sense, through a bibliographic and documentary study, the objective of this article is to present the trajectory of the constitution of the National Policy of Integral Attention to Women's Health, as well as to understand its effectiveness today, presenting the possibilities and challenges that are put to its implementation. To this end, this work was divided into three sections: in the first section we present the process of constitution of women's health as a public policy in Brazil; in the second section we present the National Policy for Integral Attention to Women's Health; and, in the third and final section of this article, we point out some possibilities and challenges of the implementation of PNAISM.

2 WOMEN'S HEALTH AS A PUBLIC POLICY IN BRAZIL

History shows us that the trajectory traveled by women in the search for health services is permeated by weaknesses, discriminations, insatisms and violations in their care. For this reason, the recognition of women's rights calls for the humanization of care, as well as the quality of care focusing on the promotion, observation and respect for human rights in the middle of an ethical framework that ensures the integral health and well-being of this public.

In Brazil, the process that incorporated women's health as a national policy occurred slowly, with some incipient expressions dating back to the beginning of the 20th century, such as programs aimed at the pregnancy-puerperal cycle and prevention of cervical cancer. During the 1930s to 1970s, maternal-infant programs conceived a restricted care for women, supported by their biological property and their social

function as mother and wife, entrusted with the creation, education and care of children and other family members (BRASIL, 2004). Thus,these programs prioritized interventions in the maternal and child context for the protection of risk groups that were in a greater situation of vulnerability, such as pregnant women and children and acted vertically and with no integration among the other actions proposed by the federal government, disregarding the specificities of the population's health, according to the territory in which it was inserted (BRASIL, 2004).

With this, these programs began to be strongly criticized by the feminist movement, due to their reductionist character in women's health care, which accessed only some health care during the pregnancy and puerperium period, leaving the care absent in the other phases of life. Through a relevant performance in the health area, the women's movement contributed to the participation of the issues that, until that period, were placed in the background because they were seen as something to be treated in the middle of private relations (BRASIL, 2004).

At that moment, the debate of the feminist movement increasingly highlighted the inequalities in relations between men and women, issues related to sexuality and reproduction, as well as frailty over the contraceptive and prevention of sexually transmitted infections, in addition to complications in women's health resulting from intense loads of domestic work and child rearing (BRASIL, 2004). In view of these notes, it was proposed that the elaboration, implementation and evaluation of women's health policies should consider such differentiations in social relations between men and women. With this, the organized movement of women complained about the recognition of the female public as subjects of rights that had needs beyond pregnancy and childbirth, demanding improvements to their health condition in all life cycles (BRASIL, 2004).

From the changes, advances and monitoring of the transformation of the role of women in society, in 1986, the Ministry of Health elaborated the Program of Integral Assistance to Women's Health (PAISM) which represented an important change in the concepts that guide the actions of care to this group. Based on concepts discussed by the Health Movement, the Program assumed as principles and guidelines the proposals of decentralization, regionalization of services and hierarchization, as well as equity and integrality of care. The process of construction of the Unified Health System had a strong influence on the implementation of PAISM, mainly through the characteristics of the new health policy, with its process of municipalization and reorganization of primary care through the Family Health Program strategy (BRASIL, 2004).

This new direction of women's health care indicated their gaze to all phases of life and consisted of educational, preventive, diagnostic, treatment and recovery actions, including assistance in gynecological clinics, family planning, the approach to Sexually Transmitted Infections (STIs), in addition to other needs signaled by the female population profile (BRAZIL, 2004).

However, the results of studies on the paism implementation process demonstrated difficulties in its implementation, such as discontinuity in the program advisory process, even though such analyses did not

verified the reality of all Brazilian municipalities (BRASIL, 2004). Thus, in the search to address these problems, the Ministry of Health organized, in 2001, the Operational Standard of Health Care (NOAS), which in its text brought the expansion of the responsibilities of municipalities in Primary Care, defined the process of regionalization of care, created strategies for consolidating the management of the SUS and requalified the criteria of local and state qualification. On women's health, more specifically, NOAS had about ensuring basic minimum actions such as prenatal and puerperium, as well as practices that permeate women's health, such as health promotion and disease prevention, and the follow-up of people with chronic diseases of high prevalence, among other responsibilities to municipal (NOAS, 2001).

However, according to Correa and Piola (2003), although the objective of expanding comprehensive care to women's health has been preserved, with the progression and rupture with the limited strategies of the past, broad care for women's health was not yet guaranteed, besides not having effected transversality on issues of race and gender, absences with regard to climacteric and menopause, gaps in gynecological complaints, infertility and assisted reproduction, as well as weaknesses in women's mental health, chronic-degenerative diseases and adolescent health.

In 2003, the Technical Area of Women's Health of the Ministry of Health observed the lack of articulation with other technical areas and the need for suggestions for new actions aimed at the care of women in the field, women with disabilities, black, indigenous, deprived of liberty, lesbians and also about the debates and strategies about the relationship between women's health and the environment (BRAZIL, 2004).

Thus, in 2004, PAISM became the National Policy for Integral Attention to Women's Health (PNAISM), defining its priorities through the situational diagnosis of the health of Brazilian women, built in conjunction with diverse social actors. The Ministry of Health, in partnership with different sectors of society, especially the women's movement, the organization of rural workers, the black movement, with researchers, scholars in the area, health managers, among others, elaborated the document "National Policy of Integral Care for Women's Health - Principles and Guidelines", reflecting the commitment to the implementation of actions that corroborate d'justice for the effectiveness of women's human rights and the reduction of morbidity and mortality from predictable and preventable causes (BRASIL, 2004).

Acting from a gender perspective, PNAISM has its guiding principles in integrality and health promotion, seeking to strengthen advances in the sphere of sexual and reproductive rights and aiming at improving obstetric care, family planning, care about abortion, combating domestic and sexual violence, comprehensive care for women with HIV/AIDS, prevention and care for users with chronic non-communicable diseases and gynecological cancer. Moreover, the policy aims to expand specific strategies for groups that, historically, are on the margins of public policies (BRASIL, 2004).[1]

[1] Gender identity is a concept that reflects the social and historical construction of male and female. While the female and male sexes are linked to biology and are determined by the genitals or chromosomes, gender is constructed through self-perception, that is, the way the person expresses himself socially. Gender, therefore, is a personal and social classification of individuals, guiding roles and expressions of female or male, regardless of gender and sexual orientation (JESUS, 2012).

Characterized by its transversality, The PNAISM is a proposal of joint construction that emphasizes respect for the autonomy of the fundamental partners for the implementation of the policy, fostering the female protagonism over their bodies and emphasizing the empowerment of women and their participation in the spaces of social control (BRASIL, 2004).

Based on the National Policy of Integral Care for Women's Health, the State continued to develop public policies aimed at guaranteeing women's rights in relation to their needs. Topics such as sexual and reproductive health, prevention and combating violence against women, the health of lesbian, bisexual and trans women, pregnancy and the puerperium, care for women in deprivation of liberty, among others, are presented over time through programs, policies and plans aimed at guide the approach of these debates, as we can see through the table below.

Table 1 - Some actions of attention to women in Brazil since 2004

Name	Year
National Sexual and Reproductive Rights Policy	2005
Maria da Penha Law	2006
National Pact to Combat Violence Against Women	2007
National LGBT Comprehensive Health Policy	2011
Stork Network	2011
National Policy Plan for Women	2013
National Policy for The Care of Women in Situations of Deprivation of Liberty and Prison Egressas	2014

Source: Prepared by the authors from Brazil (2005), Brazil (2006), Brazil (2011b), Brazil (2011c), Brazil (2011d), Brazil (2013) and Brazil (2014).

In view of the above, it is perceived that after The PNAISM, the public administration of Brazilian federated entities, under tension and participation of civil society, have sought to enable and implement actions that respond to the longings and demands arising from women under diverse realities and their specificities.

3 THE NATIONAL POLICY OF INTEGRAL CARE FOR WOMEN'S HEALTH

The National Policy for Integral Care for Women's Health incorporates in its structure integrality and health promotion as its guiding principles aimed at consolidating sexual and reproductive rights and focusing its actions on improving obstetric care, assisting safe abortion, family planning strategies, the debate on domestic and sexual violence, in the prevention and treatment of women with HIV/AIDS and other sexually transmitted infections, chronic diseases, as well as gynecological cancer, seeking to expand access to health.

Considering the specificities of the various territories at the national level, which are characterized by different levels of organization and local development, the PNAISM is placed as a proposal of articulated construction, observing and respecting the autonomy of the subjects involved in its scope, characters that are fundamental in the process of implementing policies, under the emphasis on the empowerment of women users of the SUS and their insertion in the spaces of social control.

To this end, the general objectives of PNAISM include the promotion of the improvement of women's living and health conditions through the realization of legally constituted rights, by expanding access to promotion, prevention, recovery and assistance services at the national level, aiming also to contribute to the reduction of women's morbidity and mortality, mainly because of avoidable causes, observing the different life cycles and different population groups, expanding, humanizing and qualifying attention in the Sphere of the SUS (BRASIL, 2004).

Health encompasses multiple aspects of everyday life, such as food, housing, work, income, leisure, the relationship with the environment, and in the case of women, the lack of access and quality of these aspects tend to worsen in the face of discrimination in the relationships they experience. Factors such as ethnicity, race, gender and economic vulnerability contribute deeply to the widening of disparities.

Although women live longer than men, they get sick more often and this situation of greater vulnerability is more associated with the process of social discrimination than with biological characteristics and factors. Therefore, The PNAISM exposes the issue of the gender relationship and its inequalities as a crucial point for the analysis of the epidemiological profile and for the planning of health actions aimed at promoting the improvement of living conditions, equality and citizenship rights of the female public, understanding that these relationships, associated with the reality of the double and triple working hours experienced by them, increase the possibility of illness (BRASIL, 2004).[2]

As stated by politics, social, economic and cultural inequalities are based on the process of illness and death in societies and in each individual in their particularity in different ways. Thus, considering the differences in power between men and women, historically constituted, it is noted that these disparities have a strong impact on the health condition of the female public and this should be considered as motivating in the formulation of public policies.

Therefore, the National Policy of Integral Care for Women's Health seeks to understand the heterogeneity present throughout the country, reflecting on the economic, social, cultural conditions and access to available health actions and services, considering these characteristics to enable a performance closer to the territory and its reality aiming at more qualified results.

Thus, the practice of the objectives explained occurs mainly from primary care (AB) given its ordering function of the health network and its characteristic as the preferred gateway. Care for women in

[2] According to the IBGE publication in 2019, on Social Statistics, life expectancy for women in 2018 was 79.9 years, while for men it was 72.8 years. Available in: <https://agenciadenoticias.ibge.gov.br/agencia-sala-de-imprensa/2013-agencia-de-noticias/releases/26104-em-2018-expectativa-de-vida-era-de-76-3-anos>. Access in 25/01/2023

this context dialogues with the pnaism proposal considering gender issues, integrality and health promotion as privileged understandings, also taking into account advances in the field of sexual and reproductive rights, from the perspective of the different dimensions of human rights and issues related to citizenship (BRASIL, 2016). In addition, the commitment to the performance of health actions in the SPACE of AB aims to reduce morbidity and mortality due to predictable and avoidable causes, based on good professional practices, focusing on the family and the community, in addition to women's health. (BRAZIL, 2016).

In the daily life of health services in AB, integrality is translated through the health care of users, based on the expanded clinic, not reducing their condition of illness. However, this also incorporates the provision of more comprehensive care, ranging from the promotion, prevention, screening and early identification of diseases, to the curative perspective, rehabilitation, palliative care, in addition to the observance of the prevention of unnecessary interventions and damages (BRASIL, 2016).

Regarding the specificities that interfere in women's health, PNAISM brings, for example, abortion and mortality associated with the pregnancy and puerperium cycle, since pregnancy is not a disease, but a chronic condition that requires differentiated care and is related to female sexuality. Thus, the National Policy considers the causes of maternal death as possible to be avoided because they are linked to low level of information and schooling, social and economic conditions, family dynamics in which violence is inserted and difficulty in accessing good quality health services (BRASIL, 2004).

In view of the above, the obtaining of prenatal care in the first three months of pregnancy has been incorporated as an indicator in the evaluation of quality in primary care. Capturing pregnant women to start prenatal care in a timely manner helps in the early identification of changes and in carrying out appropriate interventions on the conditions that make women's and children's health vulnerable, through strategies of education and health care seeking the well-being of both, including the father, partner or partner, when there is and is of interest to the woman. Moreover, pregnant women should also be oriented about their sexual and reproductive rights, as well as those that refer to labor guarantees, and in the case of unwanted pregnancy, interdisciplinary follow-up should be guaranteed, leading the user in a welcoming, integral way and considering their specificities (BRASIL, 2016).

On the puerperium, The PNAISM observes the need to consolidate health care in this phase, as well as a concern that the puerperal consultation is not only intended to evaluate and vaccinate the newborn, but to fully monitor the woman and child. Then, her return to the health service after delivery is encouraged, and this feasibility can be achieved by scheduling the first care before discharge from the maternity ward, the performance of a home visit in the first week after the baby's discharge and the scheduling of the late postpartum consultation (42 days after delivery) (BRAZIL, 2016).

Considering that the postpartum is bordered by peculiarities experienced by the woman, from child care, physical and emotional changes, in addition to the subjectivities specific to daily life and the social relationships in which she is inserted, the National Policy draws attention to shared care, referring the

puerperal woman, when necessary, to specialized services in mental health if there is a perception of severe mental suffering, also offering support to the family and articulating the support network (BRASIL, 2016).

The National Policy for Integral Attention to Women's Health also addresses family planning, aiming to stimulate the implementation and implementation of this action for men and women, in adulthood and adolescence. Family planning refers to a set of actions to regulate fertility, assisting men and women in preparing for the conception and birth of children, as well as adolescents, with or without stable partners, for sexually active life. (BRAZIL, 2016).[3]

It is also important to point out that reproductive planning actions also touch the health of lesbian and bisexual women, since for this group, the right and interest in motherhood need to be guaranteed, through the provision of assisted reproduction techniques, such as artificial insemination and in vitro fertilization provided by SUS (BRASIL, 2016).

Regarding the performance of PNAISM on cancer, the policy aims to reduce morbidity and mortality in the female population for this cause, in order to enable actions for women to be cared for, observing all aspects related to the disease ensuring them access to strategies for promotion, prevention and treatment of their gynecological health, including symbolic effects, such as the reflexes of mutilation from breast cancer (BRASIL, 2004).

Cancer is the main public health problem worldwide and is among the leading causes of death in the population aged up to 70 years. In women, according to the 2018 world estimate, the highest incidences were breast cancer (24.2%), colon and rectum (9.5%), followed by lung (8.4%) and cervical cancer (6.6%). Breast cancer has predominant incidence rates worldwide, regardless of the Human Development Index (HDI) (BRASIL, 2019).

Nationwide, according to the annual estimate for the period 2020 to 2022, the most frequent categories of cancers in women will be breast cancer with 66,280 new cases, corresponding to an expected risk of 61.61 cases per 100,000 women; colon and rectum cancers with a calculation of 20,470 new occurrences, equivalent to 19.03 per 100,000 women; cervical cancer represented by 16,590 new cases, 15.43 of them per 100,000 women; that of presumed lung in 12,440 and a risk of 11.56 per 100,000 women and; thyroid cancer estimated at 11,950 new events, 11.15 per 100,000 females (BRASIL, 2019).

With regard to cervical cancer, achieving high coverage in the screening of women inserted in the target audience is the element of greatest relevance to obtain considerable reduction in incidence and mortality from this malignant neoplasm. The cytopathological examination offered mainly in AB is the main screening strategy for cervical cancer and its lesions (BRASIL, 2016).

In the case of lesbian women, they demand attention from health teams, because this group may be more vulnerable to cervical cancer, due to the mistaken belief of them and health professionals about the absence of the possibility of infections in sexual intercourse between females. Therefore, the offer and

[3] Family planning or reproductive planning and its actions are defined in regulations regulated by Law No. 9,263 of 1996, which provides other measures and establishes penalties.

collection of prevention tests should be offered aiming at the opportunity of early diagnosis (BRASIL, 2016).

In reference to breast cancer, this is the one that most affects women in the world, thus being the largest cause of cancer death in developing countries, and in Brazil, it is among one of the ones that most affect the female population (BRASIL, 2016). As a strategy to face this issue and based on the objective of the PNAISM on this topic, screening, that is, the performance of tests or tests with the purpose of early identification to reduce the morbidity and mortality of the disease, enables the identification of women who already have breast cancer, however, still have no symptoms. To this end, at the national level, the recommended strategy is to perform mammography in women between 50 and 69 years of age, every two years (BRASIL, 2016).

Implementing, implementing and promoting women's health care in climacteric and old age also permeates the objectives of The PNAISM, with the expansion of access and qualification of care in the Sphere of the SUS as a strategy. Some women go through the climacteric period without relevant complaints, however, others may present diversified symptoms and intensities, which reinforces the need to emphasize that these situations can interfere in the quality of female life in their psychosocial and affective environment, so it is necessary a humanized approach through a qualified listening reception to identify for which reasons the user seeks the health service and direct it to other points and services of the health network (BRASIL, 2016).

Another important object incorporated by the National Policy of Integral Attention to Women's Health is the search for the consolidation of the fight against sexual and domestic violence to which women are victims, since this problem affects the female public of different sexual orientations, classes, origins, schooling, territories, races/ethnicities, subjected to unequal relations of power, may occur from childhood to old age, in work spaces, religious, community and cultural relationships among other contexts (BRASIL, 2016).

Worldwide, violence against women is a serious public health problem because it is among the main causes of female morbidity and mortality. PNAISM brings the proposal to promote care for women and adolescents who are under sexual and domestic violence, through the organization of the integrated network of care for women victims of these violations, the articulation of actions for the prevention of sexually transmitted infections and HIV/AIDS, and the promotion of preventive practices against violence (BRAZIL, 2004).

In the area of health, organizations committed to the care of people victims of sexual violence, for example, must ensure comprehensive care, performing the necessary steps, including preventive measures, emergency, follow-up, rehabilitation, treatment of injuries and the consequent impacts of violence on mental and physical health, in addition to access to legal abortion, when requested by the adult or adolescent woman, according to relevant legislation on these cases (BRASIL, 2016). In Primary Care, health units play a fundamental role in the fight against violence in all its forms and cause illness. Actions

to produce health care should be developed in an effort to guarantee women's autonomy over their bodies and enabling access to sexual rights (BRASIL, 2016).[4]

Thus, in addition to the qualification of the reception and care of health professionals, PNAISM aims to formulate national policies so that attention and surveillance of violence against women are a priority in the field of health care so that all access points are attentive to the abusive processes experienced by the female public since much of the suffering and maternal deaths may be associated with the mistreatment and violations experienced by they. In this sense, the National Policy of Integral Care for Women's Health comes to defend the life and rights of women, especially with regard to sexual and reproductive rights, to train health services for a citizen approach that can consider women as subjects of guarantees and pay attention to the situations of the different vulnerabilities present.

In view of the above, in the field of women's health care provided for by politics, in dialogue with services, with professionals and devices, it is observed that women, whether disabled, bisexual, transsexual, lesbian, black, indigenous, women in the countryside, forests, waters, roma, sex workers, women in street situations, women in the prison system or in deprivation of liberty, require adjustments of the actions offered to guarantee and facilitate access to services, since cultural, environmental, architectural or aitudinal barriers can distance them, causing more violations of rights (BRASIL, 2016).

4 THE CHALLENGES FOR THE IMPLEMENTATION OF WOMEN's HEALTH CARE POLICY

There are difficulties in the implementation of the actions foreseen by the PNAISM given the still existing objections to the consolidation of the Unified Health System and its weaknesses in attention to the population in general, which directly snares in the execution of the purposes of the women's health care policy.

The challenges to operate and provide quality in women's health care are also intersectoral, that is, it is essential to articulate with other sectors in order to overcome the determinants that act on the well-being and integrity of women, such as the issue of social, racial, ethnic class, sexuality, gender inequality, distance between residence and health services, lack of awareness and organization of the network, among others.

Broadly speaking, the difficulties of implementing the PNAISM are mainly materialized, due to the need to maximize health services so that there is the necessary support that meets in a qualified way the demands related to sexual violence and abortion situations in order to overcome religious and moralistic arguments; to increase universal access to health considering social groups and their specificities as young

[4] It stands out Law No. 12,845/2013, which provides for the mandatory comprehensive care of persons victims of sexual violence, Decree No. 7,958, also from 2013, which establishes for public security professionals and the SUS service guidelines victims of violence, and the Technical Standard For the Prevention and Treatment of Injuries Resulting from Sexual Violence Against Women and Adolescents of 2012, of the Ministry of Health. Together, there is Ordinance No. 204/2011 that universalized notification in cases of domestic, sexual violence, among others, and in 2014 this ordinance was replaced by Ordinance No. 1,271, which also established the immediate notification of cases of sexual violence in the municipal sphere.

women, older women, LGBTQI+, women under vulnerable circumstances, among others; to improve the reach to sexual health services, such as prevention, diagnosis and treatment of Sexually Transmitted Infections and AIDS; to expand and promote the participation of men in the health care of women and children (COELHO et al., 2017).

There are also other points that also require attention, such as the production and guarantee of access to health information, giving visibility to issues of gender, ethnicity and race inequalities mentioned above; the strengthening of actions in the scope of reproductive planning in the field of Primary Care, with special focus on non-hormonal methods, such as the Intrauterine Device (IUD); reducing maternal mortality; promoting women's economic autonomy; the consolidation of education for citizenship and equality; to give visibility to the problems arising from the work overload that women have when in multiple working hours, and maintenance, and expansion of the financing of health policy, which has been constantly suffering neoliberal attacks (BRASIL, 2004).

Together with the previous challenges, it is observed more approximately to daily life and to the territory, equally important problems to be faced, divided into three main dimensions: challenges related to women, related to health professionals and the structure and disposition of health services.

On the objections that refer to women, one can point to the feeling of not belonging to the SUS and because they are deeply inserted in an experience of exclusion and prejudice, which hinders access to services; there is the question of the exposure of the body and its doubts to professionals, which refers to shame or embarrassment; the ease of seeking information in media such as TV, social networks, websites, magazines, among others, considering that the reasons that lead them to this attitude are the delay in accessing the services, the difficulty in moving to services or the cost of medicines that are not offered free of charge, among others and; responsibilities and commitments such as the organization of family routine, with working hours, with the care of children, the elderly and sick, which are assumed as priorities to the detriment of their own health (COELHO et al., 2017).

As regards health workers, they sometimes contribute negatively to women's access to services. Practices of judgment and blaming cases, for example, of an unwanted pregnancy, of the search for abortion, of the development of diseases such as diabetes and of the difficulty of breastfeeding, distance women from the services; the lack of empathy in the absence of the transmission of confidence from the professional to the user, especially with the use of a language that makes it difficult to understand what is being spoken and; the service that does not transmit availability for a dialogue and for the joint proposition of treatment alternatives (COELHO et al., 2017).

Finally, the obstacles related to health services, such as the hours of care that coincide with the working hours of many women and the scheduling system that require the presence of the user for their performance and referrals to specialized services that occur slowly, in general, becoming another difficulty to be faced (COELHO et al., 2017).

5 CONCLUSION

In view of what was exposed, the present study did not claim to exhaust the debate on the complexity and reflection that women's health care demands, however, after the route performed, it was possible to apprehend the meaning of the National Policy of Integral Attention to Women's Health as a result of social tensions and as a reflection of the movement that seeks to bring the female public to the center of the production of their health.

The PNAISM is, in particular, an achievement of the feminist movement that for decades has been dissatisfied with the ways in which interventions on women's health were carried out, as well as with the invisibility that was had about the differences that permeate and that concern the living conditions of women.

Thus, the PNAISM as a response strategy that the State gives to the female demands constituted socially and historically, brings in its scope clear objectives about its purpose of intervention, but that do not materialize in its entirety because they are under the condition of unsatisfactory investments by that same State, as well as other social policies.

However, even in the face of all the difficulties presented, the demands in the daily routine of the services continue to be placed by women who demand health equipment and who need care that perceives its specificities. This reality requires, especially from professionals working in the health network, to develop actions to produce care and to guarantee women's rights by fostering their autonomy and co-responsibility in the care process of their health, through the capacity of mediation between the fragility condition of The PNAISM and the SUS and the requests exposed by the female public.

It is essential that professionals provide comprehensive and humanized care since most women in the territories in which attention is paid are under one or more conditions of rights violations. These agents should be sensitive to the difficulties that women express verbally and nonverbally.

Primary Care, because it is inserted in the territories and closer to the users, has substantial relevance in the identification of female needs in the health sphere and beyond, through approaches that propose attention and access to relevant information in each situation in order to support them in their decisions.

Finally, the practices proposed here aim to serve not to fall into a fatalistic conception that devalues and weakens the process of struggle of yore, which resulted in the inclusion of women's demands in the public agenda. At the time, The PNAISM requires health workers to become aware of the various factors that affect women's health, and that they can qualify their actions and direct them to the feminine well-being, with a view to the realization of rights and the search for resistance to the processes of scrapping health policy in its entirety.

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