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PERFORMANCE OF PSYCHOLOGIST IN WOMEN'S HEALTH IN PRIMARY CARE

ATUAÇÃO DO PSICÓLOGO EM SAÚDE DA MULHER NA ATENÇÃO PRIMÁRIA

ACTUACIÓN DEL PSICÓLOGO EN LA SALUD DE LA MUJER EN LA ATENCIÓN PRIMARIA

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ABSTRACT
The present study is an experience report on the role of a psychologist in carrying out individual and collective actions in women's health in Primary Health Care (PHC). The participants in this experience were women, users of three family health reference teams in a municipality in Ceará, to which the psychologist was linked, in the period from 2014 to 2016. The techniques for data collection consisted of simple observation, field diary, and recording of actions using instruments and reports. The Holliday model was adopted to promote the systematization of the experience and the analysis of the results. The interventions were divided into four axes: prevention and health promotion, health care, matrix support, and intersectoral articulation. It was observed that the psychologist presents himself as a strategic professional in PHC, as he has the technical preparation to address gender and mental health issues.
Keywords: *Primary Health Care; Women's Health; Practice Psychological; Health Promotion; Comprehensive Health Care.*

RESUMO
O presente estudo trata-se de um relato de experiência sobre a atuação de uma psicóloga na realização de ações individuais e coletivas em saúde da mulher na Atenção Primária à Saúde (APS). As participantes dessa experiência foram as mulheres, usuárias de três equipes de referência em saúde da família de um município do Ceará, às quais, a psicóloga estava vinculada, no período de 2014 a 2016. As técnicas para coleta de dados consistiram em observação simples, diário de campo e registro das ações por meio de instrumentais e relatórios. Adotou-se o modelo de Holliday para promover a sistematização da experiência e a análise dos resultados. As intervenções foram divididas em quatro eixos: prevenção e promoção da saúde, assistência à saúde, apoio matricial e articulação intersetorial. Observou-se que o psicólogo se apresenta como um profissional estratégico na APS, por ter o preparo técnico para abordar questões de gênero e saúde mental.
Descritores: *Atenção Primária à Saúde; Saúde da Mulher; Prática Psicológica; Promoção da Saúde. Assistência Integral à Saúde*.

RESUMEN
Este estudio es un relato de experiencia sobre el trabajo de una psicóloga en la realización de acciones individuales y colectivas en salud de la mujer en Atención Primaria de Salud (APS). Las participantes de esta experiencia fueron mujeres usuarias de tres equipos de referencia en salud familiar de un municipio del estado de Ceará, a los que la psicóloga estaba adscrita, entre 2014 y 2016. Las técnicas para la recolección de datos consistieron en observación simple, diario de campo y registro de acciones mediante instrumentos e informes. Se utilizó el modelo de Holliday para sistematizar la experiencia y analizar los resultados. Las intervenciones se dividieron en cuatro ejes: prevención y promoción de la salud, atención a la salud, apoyo a la matriz y coordinación intersectorial. Se observó que los psicólogos son profesionales estratégicos en la APS, ya que tienen formación técnica para tratar cuestiones de género y salud mental.
Descriptores: *Atención Primaria de Salud; Salud de la Mujer; Práctica Psicológica; Promoción de la Salud. Atención Integral de Salud.*

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INTRODUCTION

Primary Health Care (PHC) is a basic component of national health systems, which seeks to intervene in the main health and social problems of the population through care, prevention, and health promotion actions.[1] In Brazil, the main PHC model is the Family Health Strategy (FHS).[1]

To promote primary health care, the FHS relies on Family Health Reference Teams (FHTs), composed of physicians, nurses, dental surgeons, nursing technicians, community health agents, oral health assistants and oral health technicians, who work in delimited territories and have sanitary responsibility for an enrolled population.[1]

In order to promote the expansion of the scope and problem-solving capacity of the actions carried out by the FHTs, the Ministry of Health (MS), through Ordinance GM No. 154/2008, created the Family Health Support Centers (NASF).[2] These centers were composed of health professionals from various professional categories, such as psychologists, social workers, and physiotherapists, among others, with the function of supporting FHTs and qualifying the care provided by PHC.[2] The NASF operated from 2009 to 2019 and triggered significant advances in expanding the population's access to various PHC care strategies.[2]

In 2017, the NASF was renamed the Expanded Center for Family Health and Primary Care (NASF-AB), according to the new National Primary Care Policy (PNAB).[3] This revision of the PNAB was seen as a setback in relation to PHC policies, as it introduced changes that prioritized the traditional Primary Care model to the detriment of the FHS. In addition, since this new PNAB and the publication of Constitutional Amendment No. 95/2016, there has been a limitation on public investments in health.[3] This restriction was aggravated in 2019 by Previne Brasil, which eliminated discretionary funding for NASF teams.[3] As a result, there has been a significant disaccreditation of these teams across the country.[3]

To reverse this scenario, in 2023, Ordinance No. 635 of May 22 was launched, which instituted the federal financial incentive for the implementation and funding of Multiprofessional Teams in Primary Health Care (eMulti), a substitute arrangement for NASF.[3] Composed of health professionals from different categories or specialties, the eMulti work in an integrated manner with PHC teams.[3] This new proposal is based on the strengthening of interprofessional actions and the incorporation of technologies and innovations in health.[3] The activities of the eMulti may include individual, group, or home care, the provision of health actions at a distance, the joint development of therapeutic projects, interventions in the territory, and intersectoral practices, among others.[3] This study was also carried out in the context of the NASF, but its reflections are important to build an interprofessional performance in accordance with the health needs of the population in the eMulti.

It was in this context of the creation of these multidisciplinary teams, together with the health residencies, that the insertion of the psychologist in PHC became viable.[4] Historically, psychology has evolved, marked by restricted interventions that are disconnected from the needs of Brazilian public health, as it presents academic training and professional practices mostly centered on individual, private, and elitist clinical practice.[4] In this case, public health is understood as services offered by the State to deal

with the population's health problems, unlike collective health, which refers to an interdisciplinary field of theoretical and practical knowledge. Emerged in Brazil in the 1970s as a critique of the traditional public health model, collective health has a broader and more integrated focus on the health-disease-care process.[5] Because of this, the term collective health will be preferred in the rest of the text.

Thus, when the psychologist was inserted in PHC, he initially presented difficulties in adapting to work processes focused on collective and interprofessional interventions. According to the Federal Council of Psychology[4] the work of the Psychologist in PHC should be at the service of the principles and guidelines of the SUS, with the objective of promoting work aimed at changing the living conditions of the population and that articulates the promotion of health and citizenship.

This article aims to report experiences of psychologists working in women's health care in PHC, according to the perspectives of gender, comprehensiveness, extended clinic and interprofessional practices.

METHODS

This is an experience report on the role of a psychologist, a multi-professional resident in family and community health, in carrying out individual and collective actions in women's health in PHC. The participants in this experience were women, users of three FHTs in a municipality in Ceará, to which the psychologist was linked, in the period from 2014 to 2016.

For the systematization of the experiences, the Holliday model was used,[6] which is structured in five stages: the starting point, the initial questions, the recovery of the lived process, the deep reflection, and the conclusions. Data collection was carried out by means of a field diary and simple observation, in addition to other important sources, such as photographs, videos, and instruments to record the activities of the residents., Holliday's model was also used to interpret and analyze the experiences, which is based on the dialectical methodological conception, which understands social reality as historical, in constant movement, and as a product of the transforming activity of human beings.[6] The data were also discussed in light of the scientific literature on the subject.

RESULTS

The starting point for constructing the reported experiences was the process of territorializing the areas of three Family Health Teams (FTH), conducted by the residents. Through this activity, it was identified that the reality of these territories included significant social problems and health issues affecting women, such as domestic violence, social, emotional, and economic vulnerability, a notable occurrence of mental disorders—particularly depression and anxiety; and concerning use of psychotropic substances, which made the female population more vulnerable to morbidity and mortality situations.

Subsequently, the psychologist and resident sought to include actions aimed at women's health in her work agenda, based on the premise of questioning: how can the primary healthcare psychologist act effectively in women's health care? It was recognized that there was a need to coordinate core and field interventions in health[7], as well as intersectoral actions addressing women and their particularities. Thus, actions in the field

of women's health were organized into four axes: health prevention and promotion, health care, matrix support, and intersectoral coordination.

These actions focused on multidisciplinary and interdisciplinary team work, where the psychologist contributed to a broader understanding of health issues and applied her core and field knowledge, with mental health being her primary area of expertise. The division of actions into four axes was centered on the support vectors of Oliveira, Pequeno, and Ribeiro,[8] which are: matrix support, institutional support, care support, and community support. These vectors are proposed as a way to organize the everyday care work of the psychologist in primary health care, encompassing interdisciplinary, intersectoral, intra-institutional, and core actions.[8]

The health prevention and promotion axis involved actions to prevent diseases and promote the quality of life for women through the dissemination of reliable information, encouragement of healthy lifestyles, and reduction of health risks. Actions included: the "As Poderosas" health promotion group, workshops on women's rights and domestic violence, and activities related to Pink October and International Women's Day.

The "As Poderosas" women's health promotion group aimed to promote health, citizenship, and the empowerment of participants in their health and illness processes through discussions on relevant women's health topics and the organization of art and dance workshops. Workshops on women's rights, domestic violence, and activities related to Pink October and International Women's Day were conducted within the women's group, other health promotion groups, waiting rooms, schools, and community meetings.

The health care axis covered specific psychological care for women with mental health needs. Actions included: a therapeutic mental health group, individual psychological support, mental health and domestic violence victim care, as well as support for these women and their families, and assistance for women in their last trimester of pregnancy.

In the territories of the three FTH, there was a strong relationship between women's health and mental health issues, with women being the primary group reporting mental health complaints, particularly depression and anxiety. Most of these women had recent or current histories of domestic violence, indicating that this context is a determinant in the development of mental disorders.

The frequent complaints from women about mental disorders in one team's area led to the need for the following interventions: mental health support and a therapeutic group. The support was provided in an elementary school located in front of the Family Health Unit (UBS). The FTH was advised to invite women with mental health complaints from the area to this session. It was conducted in conjunction with the Psychosocial Care Center (CAPS) team to promote case sharing and ensure and facilitate access to specialized care for severe and persistent cases.

Through this support, services were organized according to the actual health needs of the population, which allowed the establishment of a therapeutic mental health group for women. The group's meetings were held in the UBS auditorium, as it was spacious and accessible to community women. This intervention aimed to create a space for shared and community mental health care, where participants shared their daily lives, joys, and sorrows, had fun, created art, told stories, were listened to, and strengthened their self-

esteem and confidence, relaxed, and discussed their rights.

Individual psychological support was available for the three FTH and was provided in the UBS, users' homes, or community spaces. This psychological support was a resource for cases requiring individualized care and aimed to intervene in episodes of intense or moderate mental suffering through brief and focused psychotherapy.

Support for domestic violence victims and their families involved listening to the cases, which were often associated with mental health complaints. During this support, efforts were made to restore the women's self-esteem, provide guidance on their rights, and strengthen them to report the violence. Care for domestic violence cases was shared with the rest of the primary health care team. During the residency period, a matrix support meeting was held with the Specialized Social Assistance Reference Center (CREAS) team to discuss the topic and case studies.

Support for women in the last trimester of pregnancy aimed to provide qualified listening, facilitate the experience and learning of relaxation techniques, and offer guidance on natural childbirth. The psychologist conducted psychological and emotional support interventions to promote a broader view of prenatal care and pregnancy.

The third axis, matrix support, consisted of creating pedagogical and care spaces for interprofessional collaboration among the FTH. Actions included: case discussions, shared care and joint visits, construction of Singular Therapeutic Projects (PTS), matrix support in mental health, and the psychologist's involvement in prenatal, childcare, and gynecological prevention consultations.

In this axis, matrix support in mental health and shared care with nurses in prenatal, childcare, and gynecological prevention consultations stood out. Matrix support was conducted through meetings between the CAPS and primary health care teams, discussing relevant mental health topics, case discussions, PTS construction, and shared care.

The psychologist's role in prenatal, childcare, and gynecological prevention consultations involved shared care with nurses. These consultations, typically conducted by nurses and doctors, focused on standard clinical procedures that often overlooked other health issues, such as psychological and social demands.

The intersectoral coordination axis involved shared interventions between the FTH, health sector, and one or more public policy sectors. Actions in this context were primarily conducted with schools through health education practices, and with the Social Assistance Reference Center (CRAS) and CREAS.

Significant difficulties in implementing the actions included a lack of communication among the Health Care Network (RAS) points, hindering integrated interventions, limiting practices related to women's health in the FTH, and rigid work processes within the FTH, resulting in resistance from some professionals to innovative practices and a limited perception of the psychologist's role in the FTH. Teamwork difficulties among residents were also an issue, initially marked by conflicts and lack of academic preparation for interprofessional work. Overcoming these obstacles involved creating communication channels and holding therapeutic meetings among health professionals from both the municipality and the residency program.

DISCUSSION

Despite the difficulties faced, it is evident that with the implementation of women's health actions structured around four main axes, the role of the psychologist in Primary Health Care (PHC) in the municipality was significantly strengthened. This is due to the interventions being developed based on the territorialization process, the four vectors model of the support tool[9], and the guidelines of eMulti[3]. Thus, these actions went beyond traditional psychological intervention practices. Additionally, it is important to highlight that this experience allowed for the construction of both theoretical and practical knowledge regarding the psychologist's role in PHC in women's health. This knowledge can serve as a model for professionals in this category to organize their work processes in PHC, aligned with gender perspectives, comprehensiveness, expanded clinical practices, and interprofessional work.

The first axis encompassed the implementation of preventive and health promotion actions, which form the basis of the work of FTH, operating from a perspective of comprehensive health that relates health production to the expansion of citizenship[1]. The main action of this axis was the creation of the women's health promotion group "As Poderosas." Health promotion groups in PHC are collective and interdisciplinary interventions aimed at promoting autonomy and continuously improving the health and living conditions of populations.[10] Actions in these groups are typically facilitated through active methodologies that encourage the protagonism of their members and foster the shared exchange and construction of health knowledge.[10]

Another action within this axis was the psychologist's involvement in Pink October campaign activities. This campaign takes place worldwide to raise awareness about the prevention and treatment of breast cancer and cervical cancer. However, in municipalities, this event is often conducted in a campaign-like model, separated from PHC activities. From this perspective, the decision to work on this theme aimed to enhance Pink October activities by critiquing this model and creating proposals that sought to promote comprehensive and continuous care for women diagnosed with cancer, contextualized with PHC activities and other health policies.

The health care axis involved offering individual or group support to women with mental health care needs, victims of domestic violence, and/or those in their last trimester of pregnancy. Regarding individual psychological support, it is important to note that individual and clinical consultations conducted by eMulti professionals should only occur in specific cases and based on agreements with the FTH and users.[3]

The main complaints presented by women served by this axis were related to symptoms of depression and anxiety, which are the most common mental disorders in PHC and have higher prevalence among women.[11] Many of these complaints were associated with domestic violence, coinciding with another action offered by this axis, which was support for women victims of this violence. Psychologists, being professionals trained to provide qualified and non-punitive listening, become strategic in PHC for supporting victims of domestic violence and for preventing and mitigating the impacts of this severe form of rights violation.

Other important actions within the health care axis included mental health support and the provision of a therapeutic group. This support is defined as a service organization

strategy that breaks the logic of free and scheduled demand and creates communication channels between users and health professionals.[12] Offering a therapeutic group in PHC is an important strategy to strengthen the Brazilian psychiatric reform, as it allows for the expansion and qualification of care for people with mental disorders within their own living territories.[10,12]

The third axis involved matrix support actions, which refer to a health work strategy providing technical support to reference teams by specialized teams.[7] In this organizational arrangement, these teams share the care provided to users and their families through case studies, shared consultations and home visits, construction of Singular Therapeutic Projects (PTS), health projects in the territory, as well as supervision and training.[7] This shared responsibility for cases eliminates the logic of referral and counter-referral, generating comprehensive care and the ability to resolve health problems.[7]

The main activities within this axis were the implementation of matrix support in mental health and shared consultations with nurses in prenatal, childcare, and gynecological prevention consultations. Matrix support in mental health is a new way of producing health, where two or more teams, in a process of shared construction, create a pedagogical-therapeutic intervention proposal.[12] In shared consultations, the inclusion of the psychologist allowed for the qualification of care by strengthening the practice of expanded and person-centered clinical practices through the approach of psychological and emotional aspects. Addressing these aspects requires the articulation and inclusion of different perspectives and disciplines, made possible through team and interdisciplinary work practices.

Finally, regarding the intersectoral coordination axis, it is worth noting that conducting shared actions with other public policy sectors enables the effective and efficient resolution of social and health problems that the health sector alone could not address, as well as creating communicative spaces between public policies ensuring population rights.[8]

CONCLUSÃO

In view of the above, the following potentialities of the reported experience were identified: the work of the PHC psychologist contextualized to the health needs of the population and the implementation of innovative interventions of an interprofessional nature with emphasis on preventive and health promotion practices. However, as difficulties to be overcome, the following were noted: lack of communication between the points of the health care network, limiting practices in relation to women's health in the FHS, stiffening of the work processes of the FHTs, and the difficulty of teamwork among residents.

In general, the psychologist presented himself as a strategic professional in PHC to expand and qualify women's health actions. The consolidation of a new professional practice of the psychologist in PHC, which is in accordance with the principles of the SUS, is a great challenge, as cultural and academic transformations still need to occur for this situation to be effective. However, significant changes are already being observed in

the training and performance of psychologists in public health, resulting from the various innovative experiences that have become a reality throughout the country.

Although the possibilities of action presented in this experience report are consistent, they do not constitute rules and norms for the practice of psychologists in PHC in the field of women's health and, therefore, it is emphasized that there is a need for other studies and research that deal with this theme, with the objective of transforming and improving the actions of this professional in the field of PHC. In addition, it is essential that psychology professionals unite to establish their role within public health policies through the sharing of experiences and the defense of the SUS, becoming both technical and political leaders.

It is worth noting that the implementation of these actions was only possible due to the insertion of the psychologist in the context of the multi-professional residency at the School of Public Health of Ceará, which provided the broadening of this professional's view about social and health issues, in addition to promoting learning concerning the theoretical and practical aspects of the field of PHC, and, mainly, the context of health production and interprofessional care practices. This experience demonstrates how multi-professional residency is a transformative and effective continuing education strategy for the legitimacy of the SUS and the FHS.

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