

Women's health in primary care: challenges in nursing practice

Saúde da mulher na atenção primária: desafios na atuação do enfermeiro

Salud de la mujer en la atención primaria: desafíos en la actuación del enfermero

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Abstract

Objective: to analyze the challenges faced by nurses in women's primary health care. **Method:** a qualitative study conducted between November 2022 and May 2023 with four nurses from a municipality in the interior of Rio Grande do Sul, using semi-structured interviews and a focus group. Analysis was performed using the thematic content analysis technique. **Results:** three main challenges were identified: the invisibility of nursing consultations and cultural resistance among female patients; limited professional autonomy, exacerbated by the absence of municipal protocols; and work overload resulting from staff shortages and turnover. These factors negatively affect the continuity of care and the bond with patients. **Conclusion:** it is necessary to strengthen nursing consultations, implement specific protocols, and value the role of nurses in women's health care. Collaboration between professionals and management, characterized by attentive listening and institutional support, can enhance autonomy and improve the quality of care.

Descriptors: Primary Health Care; Women's Health; Nursing; Nursing Care; Professional Autonomy

Resumo

Objetivo: analisar os desafios da atuação do enfermeiro na Atenção Primária à Saúde da mulher. **Método:** estudo qualitativo, desenvolvido entre novembro de 2022 a maio de 2023, com quatro enfermeiras de um município do interior do Rio Grande do Sul, utilizando entrevistas semiestruturadas e grupo focal. A análise foi realizada por meio da técnica de conteúdo temática. **Resultados:** identificaram-se três principais desafios: invisibilidade da consulta de enfermagem e resistência cultural das usuárias; limitação da autonomia profissional, agravada pela ausência de protocolos municipais; e sobrecarga de trabalho, decorrente da escassez e rotatividade de profissionais. Esses fatores impactam negativamente a continuidade do cuidado e o vínculo com as usuárias. **Conclusão:** é necessário fortalecer a consulta de enfermagem, implementar protocolos específicos e valorizar a atuação do enfermeiro no cuidado à saúde da

mulher. A articulação entre profissionais e gestão, com escuta qualificada e apoio institucional, pode ampliar a autonomia e qualificar a assistência.

Descritores: Atenção Primária à Saúde; Saúde da Mulher; Enfermagem; Cuidados de Enfermagem; Autonomia Profissional

Resumen

Objetivo: Analizar los desafíos que enfrentan las enfermeras en la atención primaria de salud de la mujer. **Método:** Se realizó un estudio cualitativo entre noviembre de 2022 y mayo de 2023 con cuatro enfermeras de un municipio del interior de Rio Grande do Sul, utilizando entrevistas semiestructuradas y un grupo focal. El análisis se realizó mediante análisis temático de contenido. **Resultados:** Se identificaron tres desafíos principales: la invisibilidad de las consultas de enfermería y la resistencia cultural de las usuarias; la limitada autonomía profesional, agravada por la ausencia de protocolos municipales; y la sobrecarga de trabajo resultante de la escasez y rotación de profesionales. Estos factores impactan negativamente la continuidad de la atención y el vínculo con las usuarias. **Conclusión:** Es necesario fortalecer las consultas de enfermería, implementar protocolos específicos y valorar el rol de las enfermeras en la atención de la salud de la mujer. La articulación entre profesionales y administración, con escucha activa y apoyo institucional, puede aumentar la autonomía y mejorar la calidad de la atención.

Descriptor: Atención Primaria de Salud; Salud de la Mujer; Enfermería; Atención de Enfermeira; Autonomía Profesional

Introduction

Primary Health Care (PHC) is recognized as a benchmark for organizing health systems in many countries. Since the International Conference on PHC held in Alma-Ata in 1978, this model has been guided by the principles of universality, comprehensiveness, and equity, proposing a holistic approach to care that moves beyond the traditional medical-centric model.¹

Guided by person-centered care, PHC seeks to ensure comprehensive care through health promotion, disease prevention, health surveillance, and continuous care.² It is primarily implemented through the Family Health Strategy (FHS), which consists of multidisciplinary teams; within these teams, nurses play a strategic role by engaging in management, direct care, and strengthening bonds with service users.³ However, studies indicate that the accumulation of clinical, administrative, and managerial duties can compromise the execution of clinical activities and the quality of care provided.⁴

In the context of women's health, nurses carry out essential actions to promote health and protect the female population.⁵ Key responsibilities include prenatal nursing consultations, performing cytopathological exams, managing sexually transmitted

infections via the syndromic approach, conducting clinical breast examinations, and ordering mammograms, as well as activities related to reproductive planning and postpartum follow-up.⁶

In recent years, international organizations and nursing regulatory bodies have advocated for expanding the scope of nursing practice as a strategy to strengthen PHC and increase access to health services. The World Health Organization highlights that ordering tests and prescribing medications, when supported by clinical protocols, contribute to increasing the problem-solving capacity of services and fostering the achievement of universal health coverage.⁷ In Brazil, these responsibilities are recognized by the Federal Nursing Council and professional legislation, provided they are grounded in public health programs and institutionally established protocols.⁸ However, the implementation of these competencies varies across municipalities, particularly in small-scale settings, where organizational and institutional limitations may restrict professional autonomy and compromise the effectiveness of care.⁸⁻¹⁰

Furthermore, the period of health service reorganization following the acute phase of the COVID-19 pandemic imposed new challenges on Primary Health Care (PHC). The backlog of programmatic actions focused on women's health, including cytopathological exams, mammograms, and preventive follow-ups, increased the demand for care in subsequent years, thereby raising nurses' workloads and necessitating a reorganization of care processes.¹¹⁻¹²

Although the role of the nurse is strategic for expanding access to and the comprehensiveness of women's health care, challenges persist regarding professional autonomy, work organization, and the social recognition of the nursing profession. In small municipalities, these challenges can be exacerbated by human resource shortages, staff turnover, a lack of clinical protocols, and reliance on local management arrangements. Such factors can compromise the implementation of the women's health care pathway, affecting access, continuity of care, and the effectiveness of actions carried out within PHC.^{10,13-14}

Studies indicate that the structural characteristics of Primary Health Care (PHC) services, such as limited professional availability, unstable employment arrangements, and the specificities of local management, directly affect nursing professional autonomy

and the implementation of the women's health care pathway, particularly outside major urban centers.^{5,9} Despite these findings, there remains a need to deepen the understanding of how these factors play out in the daily operations of small municipalities. The objective was to analyze the challenges faced by nurses working in women's primary health care.

Method

This was a descriptive, exploratory study with a qualitative approach, conducted between November 2022 and May 2023. It took place in a small municipality in the interior of the state of Rio Grande do Sul, which had two Family Health Strategy (FHS) units and one outpatient clinic, serving an estimated population of 7,312 inhabitants.¹⁵

All nurses working in these services were invited to participate in the study, totaling nine nurses. Data collection was divided into two stages. In the first stage, semi-structured interviews were conducted to characterize the participants, and in the second stage, a focus group technique was employed.

The Inclusion criteria for participation were: nurses employed by the FHS units or the outpatient clinic who provided care to female patients. There were no exclusion criteria.

The lead researcher contacted the participants via the messaging app WhatsApp to present the research project and the Informed Consent Form. Four nurses agreed to participate; they were identified by the letter "N" (Nurse) followed by a number to preserve their anonymity. The other professionals showed no interest and provided no reason for not participating in the study.

The first stage of data collection was scheduled with the participants and took place virtually via Google Meet. This stage utilized the individual semi-structured interview technique; sessions were audio-recorded and lasted between fifteen and thirty minutes. Only the researcher and the interviewee were present during data collection.

After completing the first stage, the researcher scheduled the first and second focus group (FG) meetings with the participants.¹⁶ These meetings were audio-recorded, and each lasted an average of one and a half hours. The principal researcher, an assistant researcher, and the participants were present at the focus group meetings.

This article discusses the results of the first focus group, which was guided by the questions: “How do you perceive the role of nurses in women's health?” and “How do you perceive the role of nurses in women's health within the municipality?” Subsequently, the data were gathered, examined, and processed using the thematic content analysis technique.¹⁷

Initially, there was a pre-analysis through a preliminary and exhaustive reading of the interview and focus group transcripts, aiming to familiarize the researchers with the empirical material and identify units of meaning. During the material exploration phase, excerpts deemed relevant were coded and grouped based on content similarity. Afterward, the results were processed and the data interpreted to identify core meanings and relationships among the participants' statements. From this process, a central thematic category and its respective themes were constructed, expressing the challenges associated with the nursing role in women's health within Primary Health Care (PHC).

All standards and guidelines established in Resolution N. 466/12 were strictly observed. The research project was approved by the Research Ethics Committee, holding the Certificate of Presentation for Ethical Appreciation (CAAE) number 63010222.8.0000.5323 and opinion number 5.766.366. The Consolidated Criteria for Reporting Qualitative Research (COREQ) were taken into account during the preparation of this article.

Results

The participants were female and aged between 29 and 47. One served as the coordinator of the municipality's nursing teams, while the others worked in coordination and direct care roles within the Family Health Strategy (FHS) or outpatient clinics. Their experience in the nursing field ranged from one year and five months to eleven years.

Notably, three of them held a specialization in Nursing and Public Health, and none held a specialization in women's health.

Challenges in Nursing Practice in Women's Health

Data analysis revealed a central thematic category and three themes related to the challenges faced by nurses in the field of women's health. Participants cited the population's difficulty in accepting nursing consultations, highlighting the low regard for this professional category. They also mentioned a lack of nursing autonomy regarding the prescription of certain medications, linked to the absence of municipal protocols and resistance from physicians. They reported a lack of time to organize management and care activities within Primary Health Care (PHC) and, finally, identified the frequent turnover of professionals within multidisciplinary teams as an additional challenge.

Nursing Consultations in Women's Health: Invisibility and Professional Recognition

Although the nursing consultation in women's health is regulated and legitimized as a nursing responsibility, it still faces significant obstacles regarding acceptance and recognition by both female patients and the multidisciplinary team. This lack of visibility is particularly evident in small municipalities, where a culture prevails that prioritizes physicians over the role of nursing professionals, as evidenced by the nurses' accounts.

One of the main barriers reported by the participants is public resistance to care provided by nursing professionals, such as the performance of technical procedures (including cytopathological exams), mammography counseling, and skilled listening. This resistance is attributed to deeply rooted cultural aspects that associate gynecological care exclusively with physicians. According to the participants, patients express insecurity when care is not provided by a doctor:

We hand over the screening test results and explain everything, yet we still hear the same thing: "I don't feel confident; I'm going to make an appointment with the doctor." (N2)

No matter how much attention we give, how well we conduct the nursing consultation, or how actively we listen, we still face this hurdle of resistance [...] they still need to hear it from the doctor [...] it is a deeply ingrained cultural issue. (N4)

Another factor identified is the lack of adequate information regarding the exclusive duties and legal scope of practice of nurses. This lack of awareness among the general public and segments of the healthcare team contributes to the undervaluing of nursing consultations and gives rise to situations of mistrust, dissatisfaction, and even negative public exposure for the profession:

They don't just show up and say, "I want a consultation with the nurse" [...] it's as if we lack credibility. They only want a consultation with a doctor. (N3)
We offer guidance, but they don't accept it; they even take to social media [...] a while back, a city councilor questioned some of the care provided by nurses [...] which just goes to show the lack of information regarding the duties nurses are authorized to perform. (N2)

Faced with the challenges cited by the nurses, they highlight the need to strengthen nursing consultations in women's health in PHC. According to them, overcoming professional invisibility necessarily involves valuing nurses as protagonists in care, expanding health education strategies aimed at the population.

Challenges related to autonomy in nursing practice in Primary Health Care

The participants emphasized autonomy, identifying it as a challenge within Primary Health Care (PHC) practice. According to their accounts, nurses lack the autonomy to fully carry out all their duties, which hinders the continuity of care.

They also noted that the absence of a municipal protocol to support nursing care actions in women's health leads to patients being shuffled around within the service; this occurs because nurses, who are the first to make contact and identify health issues, lack the autonomy to prescribe the medications needed for treatment. Consequently, patients require referrals for medical consultations, subject to appointment availability or the urgency of the situation.

We don't have much autonomy to make certain decisions or to prescribe medications. (N4)
If we notice an abnormality, some discharge, or a complaint they report, we don't have the autonomy to prescribe treatment [...] we don't have a municipal protocol that allows us to write prescriptions [...] we end up having to ask the doctor for the prescription so we can give it to the patient. I see this as a major downside, because we've assessed the patient and heard the complaint, yet we have to go to another room to make the request; if there were an internal protocol, we could resolve the issue ourselves. (N2)

There is a law and a decree regulating this, but it needs to be implemented at the municipal level—there has to be a protocol in place for us to have more autonomy, especially regarding medication [...] it would make things much easier [...] I've referred patients several times—when a doctor wasn't available, or during a preventive screening when a patient complained of discharge [...] I would seek out the outpatient doctor so the patient wouldn't be left without care [...] but having that protocol is really important. It represents greater autonomy for us. (N3)

Resistance from doctors was also identified as a challenge regarding women's healthcare. According to one of the participants, this reluctance to participate in developing a municipal protocol hinders the expansion of care to address other important needs, such as providing guidance to girls beginning their sexual lives or to women going through the menopausal transition. The lack of clear protocols to guide nursing practice impedes the development of nursing autonomy within Primary Health Care. Furthermore, the high demand for prenatal care places a heavy burden on the service.

[...] one of the difficulties we face here in implementing the protocol is the need for a doctor willing to participate in it, but it is something we have to try to do [...] [Doctor's Name] is quite resistant in certain situations [...] we haven't managed to fully take prenatal care off her hands yet. The nurses conduct consultations jointly with her; she sees the pregnant woman from the very beginning of the pregnancy. And that was something we wanted to change so we could address other women's health needs that sometimes go unmet [...] for example, if a young woman who is becoming sexually active wants to start taking the pill, we can provide guidance, but we can't prescribe it. Then she goes to see [Doctor's Name], and he doesn't give it the proper attention [...] The same applies to women in the climacteric or menopausal stages. We ought to give them more attention but can't, because the prenatal schedule is always packed. I don't know to what extent she [the doctor] would agree if we were to prescribe. (N1)

Nurses indicate that their autonomy in Primary Health Care (PHC), particularly regarding women's health, is constrained by institutional, legal, and cultural barriers. The lack of clear, formalized municipal protocols limits the full exercise of nursing competencies, necessitating constant coordination with the medical team; this results in care delays, fragmented service delivery, and a sense of professional powerlessness. Furthermore, resistance from some physicians to sharing responsibilities and establishing collaborative workflows exacerbates these limitations on nursing autonomy, thereby compromising service effectiveness and hindering expanded access to care for other significant women's health needs.

Between Overload and Instability: Organizational Challenges in Nursing Work

Work overload also emerged as a challenge that hinders the performance of management and care activities in Primary Health Care (PHC). It was noted that the high workload faced by nurses in PHC stems from a combination of factors, including numerous health programs, public policies, and targets set by managers, alongside limited staffing within the teams.

The nurses in the Family Health Strategy (ESF) teams are increasingly overwhelmed by the sheer number of programs involved; since we have minimal staffing at the outpatient clinic—the Basic Health Unit (UBS)—there is a shortage of personnel in the ESF teams [...] Nurses need to be valued more, because every demand falls to the nurse to organize and coordinate within the team. Here, the coordinators are the nurses [...] whenever a task is assigned to a nurse—take the current issues with dengue, COVID-19, and the flu vaccine, for instance, plus the need to handle child health monitoring, women's health consultations, and prenatal care—it's a lot for too few people [...] and, for example, the mayor is never going to think, "It would be good to hire another nurse to improve care." They just don't think that way. I don't think that will ever happen. (N1)

The workload in the ESF is very stressful because you have just one nursing technician and one nurse—there's no dedicated vaccinator, so you get involved with vaccinations and triage as well. You can't handle it all. It's very stressful trying to organize everything. (N3)

The participants also noted that frequent changes in the professionals making up the multidisciplinary teams interfere with the continuity of care. There is staff turnover within Primary Health Care due to short-term employment contracts, which hinders contact and the establishment of bonds with the local population.

Most nurses are hired on a contract basis. There is a set term; when that contract ends, a new one is drawn up. Then new professionals come in, and just as they start adapting to the reality and getting to know the area, the contract expires and a new professional arrives [...] there is also a lack of permanent teams. There is almost constant rotation of both nursing technicians and nurses. That really hinders things, too. (N4)

I agree with the other ladies about the staffing shortage [...] I think there are only two tenured nurses; the rest are all on contracts [...] it's that same cycle. Just when you start getting used to things and adapting, everything changes. The nursing staff situation is really difficult. (N3)

Consequently, the nurse faces difficulties in understanding and identifying the users' needs and demands. It is evident that this relationship requires ongoing follow-up and the establishment of a bond.

I struggled quite a bit during the first year, especially since I don't live in the municipality. I didn't know anyone, but I've since formed a strong bond—partly because the users who seek out the ESF are almost always the same people; they come in quite frequently. You end up building that connection with them, but establishing that bond was really difficult for me during that first year. (N2)

The testimonies reveal that excessive workloads and team instability pose obstacles to the effectiveness of nursing interventions in PHC. The combination of clinical and managerial responsibilities, along with staff shortages and constant turnover resulting from precarious employment arrangements, compromises the continuity of care, weakens the bond with service users, and leads to physical and emotional exhaustion among professionals.

Discussion

Nursing consultations in women's health remain an undervalued and under-recognized practice, especially in small municipalities. This invisibility has been attributed to the public's lack of knowledge regarding the legal scope of nursing practice and the prevalence of a biomedical culture that associates gynecological care exclusively with physicians. This finding aligns with existing literature highlighting the challenge of integrating nursing consultations into a care model that remains physician-centered.¹⁸⁻¹⁹

The nursing consultation is a practice exclusive to nurses; grounded in technical-scientific knowledge, it contributes to identifying health- and disease-related situations. The activity aims to detect health issues and develop care strategies that foster disease prevention and health promotion through appropriate interventions and guidance.²⁰

The term "nursing consultation" emerged in 1968 at the Oswaldo Cruz Foundation's National School of Public Health. It has been used in PHC since the 1970s to define the comprehensive and individualized care provided by nurses to patients.⁶ Moreover, the nurse's role in this area is recognized by the National Primary Care Policy, which authorizes nurses to conduct consultations, provide group-based care and educational activities, perform procedures, order diagnostic tests, prescribe medications, and make referrals to other services.²

This practice has gained popularity among users and professionals alike, as the consultations are recognized for their welcoming and educational nature, aimed at improving quality of life and fostering patient autonomy. Nursing consultations provide a safe space for active listening, thereby strengthening the bond between the patient, the professional, the multidisciplinary team, and the health facility. Furthermore, they allow for the assessment of physical, mental, and emotional health, as well as the identification of specific needs, social context, and family dynamics; this facilitates the organization and implementation of priority practices regarding health promotion, protection, recovery, rehabilitation, and care.¹⁸

However, according to the study participants, cultural resistance acts as a limiting factor for the development of nursing consultations. The users' preference for medical care over consultations with nurses reflects a perspective deeply rooted in the biomedical model, which prioritizes treating disease over promoting health. This reality results in low adherence to nursing guidance and the underutilization of nurses' technical capabilities.¹⁸⁻¹⁹

However, the results of this study suggest that the preference of female users for medical care cannot be interpreted solely as an expression of a biomedical culture or a lack of knowledge regarding nursing competencies. Participant accounts indicate that women recognize nurses' technical ability to identify health problems but experience a context in which these professionals often lack the institutional backing to finalize certain clinical courses of action, particularly due to the absence of municipal protocols authorizing medication prescriptions and the ordering of specific interventions. From this perspective, seeking medical care may represent a rational strategy for users to obtain a faster resolution to their needs, avoiding multiple referrals and the "healthcare odyssey" of moving between different professionals and services.

The literature also identifies this aspect as a challenge in nursing practice. A national mixed-methods study highlights a tendency to seek only medical consultations, leading to the underutilization of nursing consultations in the daily routine of PHC.¹⁸ This is a cultural issue rooted in the biomedical model. Furthermore, users often show resistance to guidance provided by nurses, evidenced by low adherence to health promotion practices recommended by these professionals.¹⁹

Nursing is a profession regulated by law, supported by a code of ethics, and essential to society. Nevertheless, despite technical and scientific advancements, it still faces challenges in gaining greater social visibility. A common misconception persists that nursing is a merely technical activity subordinate to medical practice, contributing to a limited understanding of the profession's complexity and scope.¹³

This distorted understanding of the profession is even more evident in small municipalities, where cultural resistance is also reflected in the dynamics of the multidisciplinary team. In these contexts, medical hegemony dominates health practices, hindering the recognition of nurses' autonomy and active role.¹⁰⁻¹¹ Compounding this are the fragility of public policies aimed at valuing the nursing profession and the progressive dismantling of Unified Health System (UHS) structures, which further limits nurses' practice, particularly in women's healthcare.²¹ These findings underscore the need for strategies that promote recognition and appreciation of nursing consultations in women's health, especially in settings where a medical-centric culture prevails and the role of the nurse lacks visibility.

Another noteworthy aspect concerns the prescribing of medications by nurses. It is important to emphasize that this is a legally established competency within PHC, supported by Ministry of Health protocols or internal protocols authorized by municipalities. The use of these protocols gives nurses the confidence to manage pharmaceutical care. It also fosters the standardization of care practices and enhances autonomy in the work process.^{9,18}

Nursing practice legislation recognizes that nurses have the legal authority to prescribe medications included in public health programs and institutionally approved protocols. Although this practice is widely acknowledged, some resistance persists among physicians regarding medication prescribing and diagnosis formulation by other health professionals. However, recognizing nursing as a prescribing profession contributes to the quality of care, particularly in low-complexity cases, by optimizing care workflows and allowing physicians to focus on medium- and high-complexity situations.²²

The accounts reveal that limited professional autonomy is a recurring obstacle. The lack of specific institutional protocols, combined with physician resistance to sharing responsibilities, prevents nurses from fully managing patient care, especially regarding medication prescribing.

This limitation leads to care discontinuity, professional frustration, and patients having to navigate multiple points within the health system. Furthermore, it compromises the effectiveness of women's health care by hindering PHC's ability to resolve common issues such as sexually transmitted infections, reproductive planning, the climacteric, and menopause. In such cases, the need for additional referrals to physicians can prolong service response times, fragment care, and reduce PHC's capacity to act as the coordinator of care.

From this perspective, professional autonomy should not be understood merely as a professional prerogative of nursing, but as an essential component of the problem-solving capacity of PHC. When institutional structures limit nurses' clinical practice, the effects extend beyond the professional realm and directly affect the experience of service users, resulting in care delays, fragmentation of care, and increased reliance on medical consultations. Thus, the limitation of professional autonomy observed in this study affects not only nursing work processes but also influences how the population perceives the effectiveness of different professionals and accesses health services.

An international qualitative study conducted in Brazil and Germany demonstrated that expanding nursing practices in PHC requires a reconfiguration of the relationships between nurses and physicians, favoring more horizontal models of interprofessional collaboration. Expanding nursing autonomy often faces barriers related to disputes over professional scope of practice, yet it can also strengthen team integration when accompanied by clear role definitions, shared protocols, and institutional support.²³ In this sense, the resistance observed among the study participants is not an isolated reality but part of a phenomenon discussed internationally within the context of expanding advanced nursing practices.

This highlights the importance of protocols that ensure greater professional autonomy.^{9,24} These findings align with the present study, in which participants emphasized the need to develop a municipal protocol capable of addressing the specificities of women's health care.

The challenges associated with expanding the scope of nursing practice observed in this study have also been described in various international contexts. Evidence from North America, Europe, and Latin America demonstrates that expanding nurses' clinical competencies in PHC often occurs in settings marked by disputes over jurisdictional boundaries between professions, particularly regarding medication prescribing, ordering diagnostic tests, and monitoring clinical conditions. Although several countries have formally expanded nursing autonomy, institutional, regulatory, and cultural barriers persist that hinder the full utilization of these competencies.^{7,25-26}

A recent report by the Organization for Economic Co-operation and Development (OECD) highlights that the implementation of advanced nursing practices in PHC remains uneven across countries, often constrained by resistance from professional groups, traditional service organization models, and regulatory restrictions imposed by various professions.²⁵ Such disputes go beyond the definition of technical duties; they reflect historical power dynamics that influence the distribution of responsibilities in healthcare delivery. In this context, the resistance observed among participants regarding the development of municipal protocols and the sharing of clinical tasks with physicians mirrors a global phenomenon of negotiating and redefining professional boundaries within PHC.²⁵

These discussions take on even greater significance in rural and remote areas. International studies show that expanding nurse autonomy helps reduce access barriers, improve service effectiveness, and strengthen continuity of care in regions facing physician shortages.^{7,26} However, even in these settings, implementing more collaborative models often faces obstacles linked to institutional acceptance and persistent hierarchical views regarding health professions.^{7,25-26}

International evidence indicates that strengthening nursing autonomy depends not only on regulatory frameworks but also on fostering collaborative environments between nurses and doctors. A research has identified that interprofessional

relationships grounded in mutual trust, recognition of professional competencies, and clearly defined roles facilitate the expansion of clinical nursing practices and improve population access to health services. Thus, developing care protocols and strengthening interprofessional collaboration can simultaneously enhance the professional standing of nursing and improve the quality of women's healthcare in PHC.²³

This would enable nurses to initiate and complete patient care more effectively, referring patients to medical specialists only when appropriate. However, it is understood that it is essential for the municipal manager to be familiar with the activities performed by nurses in PHC, thereby enabling them to support and approve the development and implementation of protocols tailored to the specific population, needs, and care pathways of each municipality.¹⁸

Another crucial point, as reported by the participants, concerns the heavy workload faced by nurses in Primary Health Care (PHC). The multiplicity of programs, the shortage of human resources, and staff turnover hinder the planning and continuity of activities. These factors, also described in other studies, weaken the bond with service users and compromise the quality of care.¹²⁻¹³ In this sense, it is known that within PHC, nurses are responsible for carrying out management, administrative, and clinical care activities to organize and improve the quality of care provided to the population.⁹

In the context of women's health, these factors can directly affect the continuity of longitudinal care, hindering prevention, screening, health education, and the monitoring of specific conditions throughout the female life cycle. In small municipalities, where teams tend to be smaller and healthcare resources more limited, the disruption of professional relationships tends to have an even greater impact on care coordination.^{10,13-14}

Challenges related to heavy workloads and staff shortages have also been widely discussed internationally. The World Health Organization's State of the World's Nursing 2025 report highlights that the global shortage of nurses remains a major obstacle to strengthening health systems, particularly in PHC. The document emphasizes that poor working conditions, limited career advancement, and a lack of recognition for the nursing profession contribute to workforce retention issues and compromise the continuity of care. These aspects align directly with the participants' accounts regarding

staff turnover and heavy workloads observed in the study setting.⁷

It is worth noting that the interpretation of these findings must take into account the timeframe in which the data were collected. The data collection period, spanning 2022 and 2023, coincided with the post-COVID-19 pandemic transition phase, a time marked by the resumption of previously deferred programmatic activities, intensified immunization campaigns, and the reorganization of health services. In this context, PHC nurses played a pivotal role in coordinating multiple care-related and managerial demands, a factor that likely contributed to the heightened sense of workload burden reported by the participants. Although some of these challenges persist today, the findings must be interpreted in light of this specific period of health service reorganization, offering an opportunity to reflect on how pre-existing vulnerabilities were exacerbated within the context of health system recovery.

Furthermore, it is acknowledged that the work process can also be hampered by a lack of material and human resources. Compounding this are administrative, managerial, and structural demands, a lack of recognition for the activities performed by nurses, and high staff turnover within the services. All these aspects can lead to the disruption of planned activities.^{13,27}

In this context, nurses indicated that the municipality in question experiences frequent turnover among professionals in the PHC multidisciplinary team. As noted by the nurses and confirmed by the literature, constant staff changes disrupt the bond with the population, hindering dialogue and the implementation of health initiatives.¹⁴

Moreover, turnover impedes a professional's adaptation to the local context, as well as their ability to get to know the population and build relationships within the team. This situation may stem from temporary employment contracts, a lack of team interaction, limited autonomy, poor remuneration, exhausting routines, and heavy workloads.^{14,28} Such conditions can lead to job dissatisfaction and stress, directly affecting nurses' occupational health and compromising both their well-being and the quality of care provided to the population.²⁹

Given this scenario, there is an urgent need for integrated measures that promote the value of nursing consultations in women's health, particularly in settings characterized by a biomedical hegemony and resource scarcity. Establishing a leading role for nurses requires the implementation of specific municipal protocols, the strengthening of professional autonomy, and institutional and social recognition of their strategic role in PHC.

Furthermore, it is essential to invest in public policies that ensure better working conditions, reduce turnover, and foster the integration of multidisciplinary teams, thereby supporting continuity of care and the building of strong bonds with the population. In this way, it will be possible to overcome cultural and structural barriers, expanding women's access to comprehensive, humanized, and high-quality care, ensured by the technical and ethical competence of nurses.

The challenges identified in this study transcend the specific local setting investigated and reflect structural tensions inherent in the organization of PHC. Although the findings emerged from a small municipality, issues such as the invisibility of nursing consultations, limitations on professional autonomy, and excessive workloads reflect phenomena observed in various national and international contexts, phenomena linked to the persistence of the biomedical model, disputes regarding the scope of nursing practice, and challenges in managing the health workforce. However, in small municipalities, these issues may be exacerbated by a limited pool of professionals, reliance on local institutional arrangements, and heightened vulnerability to staff turnover.

Consequently, the results should not be viewed merely as individual difficulties faced by the participants, but rather as manifestations of organizational, political, and cultural factors that shape PHC's capacity to deliver comprehensive and effective women's health care. These factors directly affect the implementation of women's health care, particularly in small municipalities, where reliance on local resources and a limited workforce make the consequences of organizational weaknesses for access, continuity, and quality of care more apparent.

This study has certain limitations, notably the small number of participants, as only four of the nine eligible nurses agreed to take part. While all professionals working in the studied services were invited, the participation of fewer than half of those eligible may have limited the range of experiences and perspectives captured in the analysis. Furthermore, the lack of systematic data on reasons for non-participation makes it difficult to pinpoint the factors behind the refusals. Nevertheless, given the study context, characterized by small teams, heavy workloads, and a small-town setting, one cannot rule out the possibility that factors such as professional burnout, lack of time, or fear of exposure in a close-knit institutional environment influenced participation rates.

Despite these limitations, the intended analytical depth was achieved using various data collection strategies, including semi-structured interviews and focus groups, which enabled an in-depth exploration of the participants' experiences. Furthermore, the participating nurses held diverse roles within the municipality's health services, encompassing both clinical care and coordination activities; this facilitated the gathering of complementary perspectives on the challenges of working in women's health within primary health care.

Conclusion

The practice of these professionals is influenced by organizational, institutional, and cultural factors that affect the provision of care to women and the execution of their duties in PHC. The main challenges identified were the low value placed on nursing consultations, manifested by resistance from female patients and limited recognition of the nurse's role; constraints on professional autonomy linked to the lack of municipal protocols supporting clinical practices; and excessive workloads resulting from staff shortages and turnover, which impact work process organization and the continuity of care.

The findings underscore the need to strengthen nursing consultations in women's health, expand institutional support for nursing practice through the implementation of clinical protocols, and invest in organizational conditions that foster continuity of care in PHC. These measures can help improve the quality of women's healthcare and strengthen the nurse's role at this level of care.

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Funding / Acknowledgement: *Programa Institucional de Iniciação Científica e Tecnológica (PRO-IC) - Women in Sciences Modality.*

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Editor in Chief: Cristiane Cardoso de Paula

Associate Editor: Ana Paula de Assis Sales

How to cite this article

Cruz MDR, Pilger CH, Gonçalves AR, Gomes BCF, Santos EO, Prates LA. Women's health in primary care: challenges in nursing practice. Rev. Enferm. UFSM. 2026 [Access at: Year Month Day]; vol.16, e18:1-22. DOI: <https://doi.org/10.5902/2179769293022>