

Manifestations of institutional violence in the context of health care for women in situations of sexual violence¹


Manifestações de violência institucional no contexto da atenção em saúde às mulheres em situação de violência sexual

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Abstract

The study analyzed the manifestations of institutional violence in health care for women in situations of sexual violence. This is a qualitative research based on semi-structured interviews with 68 professionals and 15 managers working in nine municipal health services in Fortaleza, Ceará, Brazil. The analysis was organized into four themes: invisibility of sexual violence; violence in welcoming women; structural, drug and supply limitations; and action concerning legal abortion. The results revealed non-recognition of sexual violence as an object of intervention in the health sector and a welcome to women marked by omissions, lack of privacy, and discriminatory attitudes. Structural conditions and scarcity of drugs and supplies were mentioned as limiting for the service. Legal abortion involved cultural, managerial and institutional conflicts that favored the violation of rights. It is concluded that institutional violence in the context of care for women in situations of sexual violence goes beyond subjective issues and health professional training. And offering comprehensive care that can overcome institutional violence requires management to rethink the configuration of care network services and be close to the actors involved.

Keywords: Violence; Sexual Violence; Health Services; Women's Health; Legal Abortion.

1 Source of funding: Conselho Nacional de Desenvolvimento Científico e Tecnológico (CNPq) through Public Notice MCTI/CNPq/SPM-PR/MDA No. 32/2012 - Relações de Gênero, Mulheres e Feminismos.

Resumo

O estudo analisou as manifestações de violência institucional na atenção em saúde às mulheres em situação de violência sexual. Pesquisa qualitativa baseada em entrevistas semiestruturadas com 68 profissionais e 15 gestores atuantes em nove serviços da rede municipal de saúde em Fortaleza, Ceará, Brasil. A análise foi organizada em quatro temáticas: invisibilidade da violência sexual; violência no acolhimento à mulher; limitações estruturais, de medicamentos e de insumos; e atuação frente ao aborto legal. Os resultados revelaram o não reconhecimento da violência sexual como objeto de intervenção no setor saúde e um acolhimento à mulher marcado por omissões, falta de privacidade e atitudes discriminatórias. As condições estruturais e a escassez de medicamentos e insumos foram colocadas como limitantes para o atendimento. O aborto legal envolveu conflitos culturais, gerenciais e institucionais que favoreceram a violação de direitos. Conclui-se que a violência institucional no contexto da atenção às mulheres em situação de violência sexual extrapola questões de ordem subjetiva e de formação dos profissionais de saúde. E a oferta de uma atenção integral capaz de transpor a violência institucional requer que a gestão repense a configuração dos serviços da rede de atendimento e esteja próxima dos atores envolvidos.

Palavras-chave: Violência; Violência Sexual; Serviços de Saúde; Saúde da Mulher; Aborto Legal.

Introduction

The epistemic and operational principles of the Brazilian health system advocate equitable health care, reiterating universality and integrality of care (Paim et al., 2011). Brazil goes further by decreeing that this attention should be organized in an articulated, qualified and effective network, legalizing normative documents and holding managers accountable for complying with the law in the organization of health care networks (Brasil, 2011).

Despite the normative advances for establishing reference services in the care of women in situations of sexual violence (SV), the institutionalization of humanized practices still faces the reproduction of gender stereotypes and the lack of care flows that prevent the violation of rights (Alcaraz et al., 2014; Cavalcanti et al., 2015). Thus, it is clear that in these services, institutional violence (IV) is widespread and takes on formats that deny the advances in this complex field of action.

IV is understood as that practiced in institutions that provide public and/or private services perpetrated by agents who should protect women in situations of violence, guaranteeing them a humanized, preventive and damage-reparative attention (Mury, 2004). Santos et al. (2011) define it as that exercised in health services by omission or commission. The former aspect includes the total or partial denial of health actions and the latter refers to unnecessary and/or undesirable procedures.

The debate on the subject in the theoretical and practical field is related to the interdisciplinary character of professional training in Human Rights appropriate to the changes in society and the needs of the population, that is, training in the defense and expansion of Human Rights (Tosi, 2006).

Investigations of IV in different settings have focused on state apparatuses, organizational structures, work processes, denial of autonomy, and the rights of women seeking care (Aguiar; D'Oliveira; Schraiber, 2013; Azeredo; Schraiber, 2017; Bento; Moreira, 2017). Contradictorily, there is a scarcity of literature analyzing IV in contexts of care for female victims of SV, in which gender inequality is constitutive of the demand met, since research mostly refers to the pregnancy and

puerperal cycle (Aguiar; D'Oliveira; Schraiber, 2013; Martins; Barros, 2016) and incarcerated women (Ferreira et al., 2017).

It is understood that IV manifestations in care services to women in SV situations require investigations in different scenarios, even if they present similarities. It is important to mention that the Brazilian scenario that clouds the health sector and many others demands monitoring by the instituent (Carvalho; Gastaldo, 2008) so that it does not conform to the instituted, which denies women's rights and autonomy.

In this logic, the study analyzes the manifestations of institutional violence in health care to women in situations of sexual violence.

Method

This article is an excerpt from the research "Analysis of health services in the care of women in situations of sexual violence: a comparative study in two Brazilian capitals (Rio de Janeiro and Fortaleza)" and focuses on the manifestations of IV in health care to women in situations of SV in Fortaleza, Ceará, Brazil. This municipality has a high rate (10.4 per 100,000 inhabitants) of homicides of women, occupying the 4th position among the capitals of the country (Waiselfisz, 2015).

This is a qualitative study, undertaken in secondary and tertiary level health services linked to the municipal health network of Fortaleza. The municipality has a network of ten hospitals, of which nine were research fields, signaled by the Municipal Health Department (SMS) at the time of data collection as reference services in the care of women in situations of SV.

Higher-level management and care professionals who worked in these services participated in the study, ensuring the participation of different professional categories (doctors, nurses, social workers, psychologists, educators). In all, the survey involved 68 healthcare professionals and 15 managers.

For data production, we used semi-structured interviews with questions about identification, professional training, institutional placing, and health care in cases of SV. Participants were

selected by recommendation of team professionals experienced in the issue in focus. The interviews took place between August and December 2013 with written authorization, individually and privately, in days and times agreed with the institutions and professionals.

The recordings had an average of 30 minutes per interview, later fully transcribed and coded with the abbreviations M (manager), numbered from 1 to 15; and D (doctor), N (nurse), SW (social worker), P (psychologist) and E (educator), numbered 1 to 68, so as to preserve anonymity. The empirical material was organized according to the research questions.

For data analysis, we adopted the content analysis technique in the thematic modality, guided by the analytical trajectory proposed by Gomes (2013). After an exhaustive reading of the reports and initial classification, meaning cores were assigned in each class of the classification scheme and the material was regrouped into four themes: **invisibility of sexual violence; violence in welcoming women; structural, drug and supply limitations; and action concerning legal abortion.**

The study was approved by the Research Ethics Committee of the Municipal Department of Health and Civil Defense of Rio de Janeiro, under Opinion No. 45A/2013.

Results and discussion

Participants

The data portrayed a similar number of male and female managers, with a slight majority of men. As for professionals, women predominated. The age of most participants in both groups ranged from 40 to 59 years. The participants considered united (by formal or common-law marriage) and that declared themselves Catholics predominated in both groups.

Regarding the professional profile, medical training stood out among managers, and social workers and nurses among professionals. In both groups, most have a degree in a public university. Regarding the time of graduation, most managers graduated over 25 years ago and professionals ranged from 11 to 20 years since graduation.

In both groups, participants with graduate studies prevailed, with more *lato sensu* specialization courses. As for working time in the health institution, an equal number of managers were working in the unit for less than 5 years and for 11 to 20 years; among professionals, most had less than 5 years of experience. Managers and professionals hired by a state selection process predominated, although many did not mention their type of employment. Participants' short working time in the unit, despite the age and time since graduation, may be related to the high turnover of professionals in services, especially in management positions, which almost always change with each new administration.

Invisibility of sexual violence

The invisibility of SV in health services is demonstrated by the difficulty of professionals to recognize its manifestations as an object of intervention of institutional care proposals, not including them as a part of the services: *I have never had the opportunity to attend women with this kind of demand. It was a surprise to know that the hospital is a reference, because I was never told that* (P7).

An insignificant number of respondents incorporated SV into their statements as a problem to be faced and assisted by the health sector. For some, the issue is a "police case", exclusively of the public security and justice sectors, reducing the phenomenon to a criminal act.

In contrast, participants are linked to institutions indicated by the Municipal Department of Policies for Women as a reference in the care of women in situations of SV. This fact brings us to the existing gap between what is advocated and disseminated in the media and the actual implementation of these practices in services. The lack of knowledge of this function by professionals with years of experience alludes to articulations and decisions agreed upon in central management that do not reach the professionals responsible for the operationalization of actions, highlighting the fragmentation in the process.

In the service we had never really instituted this situation, to be conducted here. [...] We were not

told that we would treat patients with sexual violence. As there was no such communication, the team remained that way, unaware that this service exists. (D11)

It is inconvenient to hold health professionals liable for impromptu and inappropriate attention, given that these actors are displaced from the covenant process and without ongoing education that includes training and supervision on appropriate intervention. Intervening on SV requires understanding it as a demand and knowing how to position oneself towards building a network that enables effective coping.

Testimonials reiterated non-identification of situations of SV against women in professional practice. Others pointed out that this difficulty is linked to the fact that explicit demand is considered low. Veiled cases manifest themselves as invisible demands that impose obstacles to their recognition.

We had a case where the woman came six times and said she had a sore throat and pain. The doctor could not visualize, was not sensitized to identify that this could be a case of sexual violence. (M6)

In some situations this violence goes unnoticed because she comes for another reason. If the host professional does not have a keen eye, it may go unnoticed. (SW10)

These notions explain that SV often does not present itself as a main complaint and the act does not manifest itself in visible body marks through injuries and trauma resulting from aggression. The manager's words corroborate the professionals' difficulty in addressing the social determinants of health (Warmling et al., 2018) and the difficulty in recognizing and managing cases. The context in which emergency care is delivered does not allow qualified listening to the demand by professionals, focusing on vital parameters, with a tenuous bond, and preventing the detection of SV situations.

Externalizing the problem becomes more delicate when violence is chronic, most often perpetrated by the intimate partner in the domestic or intrafamilial context. In secondary and tertiary care, explicit

cases of SV are often perpetrated by strangers. The literature reaffirms the invisibility of violence against women in health care (Almeida; Silva; Machado, 2014).

This weakness in services is largely due to the absence of interdisciplinary spaces in health education that can dialogue on complex topics such as violence (Cortes; Padoin, 2016), and the little investment in qualification and professional support. Also the clinical conduct based on the biomedical model and the organization of the work process itself do not favor the execution of an expanded clinic that enables the development of integral care to the individual (Guedes; Nogueira; Camargo Júnior, 2009; Pedrosa; Spink, 2011).

In the first contact with professionals, women voice other complaints that could only be addressed if there were, during professional training, an approach on how to deal with cases of violence against women. The verbalization of experienced violence demands conditions of accessibility, privacy and empathetic listening by the professional, in order to guarantee the integrality of care.

Disregarding SV as a health problem and institutional function, coupled to the barriers that impede its identification, contribute to the production of IV, such as omission in health services (Santos et al., 2011). That is, this type of violence is expressed in women's relationships with health units and health professionals, configured mainly by lack of access and poor quality of service delivery.

Violence in welcoming women

Women's first contact with health services is often marked by lack of privacy, exposure of violence to others, discriminatory attitudes, and value judgments. Testimonials point to criticism of care without privacy and employees who expose women to embarrassment. This is compounded by disorganized work processes and discriminatory acts that confirm IV in the health care of these women: *Often, she gets very exposed. There are those who stand around, wondering about the situation she has experienced. Women are welcomed, but exposed (N63); She is a victim of violence out there and suffers more violence here when she is inadequately*

approached by the professional. She is assaulted twice as she comes here (N36)

This IV is a serious problem, usually silenced, invisible and naturalized in the daily routine of health units. It has been pointed out as a result of the precariousness of the health system and the personal conduct of professional disrespect towards women. These forms are present in rude, disrespectful, discriminatory speech and inattention to women's health needs.

Discriminatory attitudes with moralistic statements about women's personal lives and behavior, as well as authoritarian discourse, reproduce prejudice and sexist attitudes in social relations between the sexes, corroborating the hegemonic gender matrix. This reinforces the emotional experience of vulnerability in women who have experienced violence, generating a vicious circle between interpersonal violence and institutional violence, and prevents institutions from fulfilling the role of disrupting the problem's production chain (Villela et al., 2011). Health care, which should fulfill its social function of empowering and generating autonomy for women, ends up oppressing and reinforcing gender inequalities (Carvalho; Gastaldo, 2008; Pedrosa; Spink, 2011).

Aguiar, D'Oliveira and Schraiber (2013) argue that, in the field of relations between professionals and users, the situations of IV are difficult to be perceived as such by the subjects involved, even if they imply annulment of autonomy and class, race or gender discrimination. For the authors, IV manifestations are naturalized in the institutional culture, favoring its conditions of existence and perpetuation.

It is worth adding that attending to physical trauma, while recognizing the importance, should not be the main focus of attention. This inhuman and inefficient route reversal also reproduces IV by distancing women from fundamental rights. The inability to deal with sensitive complaints reinforces the hospital's view as a space where power operates through the desubjectivation of the other (Guedes; Nogueira; Camargo Júnior, 2009; Villela et al., 2011). These flaws, which are present in the depersonalization of women and in the substitution of a dialogic relationship by examinations and

technical procedures, transform the health sector into a producer of institutional violence.

When it comes to SV situations, welcoming presupposes receiving women with respect and solidarity, understanding demands and expectations. People in situations of violence experience fear, anxiety, shame, guilt and hopelessness. To minimize suffering, professionals who welcome these users should demonstrate empathy, sensitivity, and judgment-free attitudes, as well as the ability to put themselves in the shoes of others; postures not identified in the reports presented, contrary to the guidelines of the Technical Standard (Brasil, 2012).

It is worth adding that welcoming these women still depends on the professionals' conception of the meaning of the phenomenon and the impact that this act can also have on workers themselves, who, in turn, need to reflect and evaluate their own feelings and prejudices, aiming to avoid distortions in communication with women (Barros et al., 2015).

Structural, drug and supply limitations

Regarding physical structure, even with different institutional vocations and modes of operation, the absence of a specific place to care for women in SV situation was identified in all units investigated: *There is no specific location. It is a situation in which the woman is very exposed, embarrassed. And when she stays in the hallway it is even worse, because she's exposed to everyone, she is left there, helpless* (N63).

Nevertheless, managers and professionals mention the concern to deliver care in offices/rooms of social workers, doctors and psychologists, i.e. places with more privacy. Some recognized the need for such care to take place outside the emergency environment to ensure privacy and confidentiality during the interview and exams. On the other hand, in trauma services, women are seen in emergencies, hallways or wards, exposing them to embarrassment.

Possibly, the limited physical area of some hospitals or the number of women who seek these services as a result of SV does not justify having a specific room for this type of care. On the other hand, if there is no institutional organization including a

suitable place and a staff prepared for this purpose, this demand will remain low, as the lack of privacy at the place of reception is also a reason for users not to seek the service and not to report SV.

The lack of privacy makes it difficult to approach sensitive experiences, which renders the woman's first contact with the service impersonal and makes it unfeasible to follow her up, appearing to imply that this is not a place for meeting subjective needs (Villela et al., 2011).

It is noteworthy that the dimensions of comfort, privacy and resolution are referred to as conditions of the practice of reception that must be held in SUS units, being essential to qualified listening of demand and guarantee of integrality of care (Brasil, 2014). Decree No. 7.958/2013 ensures the principles of respect for the dignity of the person, non-discrimination, confidentiality and privacy, and services should have a qualified listening space with privacy, in order to provide an environment of trust and respect (Brasil, 2013).

As for the technical procedures in caring for women after SV, these include a set of interventions to prevent unwanted pregnancy and sexually transmitted infections (STI). These actions are time sensitive, and it is recommended that care be performed within 72 hours after aggression due to the greater effectiveness of prophylactic measures (Brasil, 2012).

IV is also identified because of limitations in drug supply and the necessary supplies for these interventions. The organizational structure of the municipal hospital network in Fortaleza does not adequately meet the needs of women in SV situations, considering that only one service was prepared to carry out STI prophylaxis and emergency contraception. This scenario contradicts the recommendations of official regulations (Brasil, 2012), which postulate that institutions with gynecology and obstetrics services must be structured to address these cases.

The concentration of actions in only one location of the network causes excessive demand, which may overload this institution and impair attention to cases, as human and material resources may not be sufficient to meet the entire set of requests from the municipality.

Action concerning legal abortion

Pregnancy stands out among the consequences of SV due to the complexity of psychological and social reactions, being conceived by women as a second violence. The Technical Standard, in all its versions, guides services and health professionals in the conduct of these situations (Brasil, 2012), in which women have the right to legal abortion guaranteed since 1940 (Brasil, 1940).

In this research, professional performance in relation to pregnancy due to a SV in the municipal network hospitals of Fortaleza was restricted to a single health unit. This shortcoming - the municipality has only one unit that performs legal abortion - is compounded by the fact that this procedure is restricted to a single day of the week. It is noteworthy that this service used to receive, in addition to referrals from other institutions in Fortaleza, users from other municipalities in the state.

We do not find it easy for doctors to do a legal abortion, because within the law, ethics, they may not want to perform it. As there is only one, we always schedule it for Wednesday when he is on duty [...] the psychologist in charge of these cases contributes to this dialogue, but the other professionals, nurse, social worker and physician on-duty do not form a bond with that. (P19)

The reduced number of health services that perform legal abortion is a reality in the Brazilian territory (Madeiro; Diniz, 2016). Madeiro and Diniz (2016) did a survey on legal abortion services in Brazil and found that of the 68 services listed by the Ministry of Health and the State Health Departments as in operation, only 37 actually performed the procedure.

The termination of pregnancy provided for by the law involves cultural, managerial, institutional and personal conflict that favors women's peregrination through the health network or the delay in access to abortion, often exceeding the expected time to perform the act. This fact implies non-guarantee of the right, besides emotional and physical disorders.

The organization of the work process concentrating the legal termination of pregnancy

on a single team and on a single day of the week, as verified in this research, hurts the legal prerogatives, the rights guaranteed and the guidelines of the Ministry of Health (Brasil, 2012). The low availability of professionals, especially doctors, to perform abortion is one of the main challenges for the effective fulfillment of legal abortion.

The composition of the multiprofessional team is still an obstacle for most services that provide this type of care in Brazil (Madeiro; Diniz, 2016). Thus, performing legal abortion runs into administrative and personal obstacles for health workers. Although the attention to women in SV situation has brought, with more emphasis, abortion to the daily life of health institutions, this theme is still taboo for many professionals.

For this study's participants, the refusals to this type of care were based on religious, moral, individual right to conscientious objection, technical unpreparedness, ignorance of the laws, stigma involved in the act, and emotional suffering of the team.

Termination of pregnancy is also conditioned by the medical staff's position regarding the right to conscientious objection, as provided for in the code of medical ethics. Montoya-Vacadiez (2014) asserts that conscientious objection can be understood as an act opposed to a legal mandate to the detriment of clashes with moral, philosophical or religious convictions, leading to conflict between obedience to the law and obedience to the judgment of consciousness.

It is worth clarifying that the right to conscientious objection not to perform legal abortion must be respected. In contrast, it is the institutional duty to inform women about their rights and to ensure timely attention to abortion by another professional or service. Management of health institutions that provide this service should use strategies to ensure the right to legal abortion, for example by implementing working schedules without objecting professionals and non-participation of objecting professionals in practices contrary to their consciences (Diniz, 2013).

Healthcare for SV victims is a priority and the unfounded and unjustified refusal to deliver it can be ethically and legally characterized as malpractice or negligence.

In the other institutions surveyed here, despite the different characteristics of each service, most managers and health professionals are unaware of the legal guidance, technical procedures and referrals that should be undertaken in cases of pregnancy resulting from sexual violence. As a result, the guidance given to women is not always appropriate; referral to the places that perform legal abortion is not guaranteed, evidencing the inexistence of an intrasectoral flow for this care in the municipality.

In a unit that was formulated with the objective of fully assisting the female public, including attention to violence situations, one professional indicates that, although the hospital has an adequate physical structure, the health team is not trained for this type of action, making it unfeasible:

We have a physical structure, but we have no staff and the system itself is not structured, for the hospital's own financial reasons. The hospital was supposed to have been opened with everything ready. It's like you are in a great house but it doesn't work. (P48)

The analysis shows the need to structure the units to enable legal abortion and to train the team on the theoretical and practical domains about the issue, because even if the institution does not perform this procedure, professionals should be able to provide guidance and refer users to other network services.

It is also noteworthy that, for some interviewees, the woman must still confirm that the pregnancy was the result of SV by placing a police report (BO), an expert report or judicial authorization to only then have access to legal abortion.

First thing, she has to go to the woman's police station to make the complaint. Then she goes to the Forensic Medicine Institute for the exam to prove that she was actually raped. There, she takes the pregnancy test to check if she is pregnant or not. After these legal procedures, legal abortion will be allowed. (D39)

From the professional's words, it is clear that the woman who proposes abortion has to **prove** she was

sexually abused, as it is understood that she could simulate violence just to perform the procedure. This confirms that the truth of the woman's report is disputed, and her statement is not sufficient to guarantee termination of pregnancy. This position stems from the lack of knowledge about public health policies, the professionals' fear of committing a crime, and the persistence of moral judgment about the veracity of SV to perform legal abortion (Diniz et al., 2014; Farias; Cavalcanti, 2012).

Diniz et al. (2014) argue that, in general, the truth of SV is built on the encounter between the truth tests about the occurrence of the event and the reading about the woman's subjectivity. The location of the SV scene is also a modulating factor for the truth test - if the act involved greater cruelty, the pros are more likely to realize that the woman is telling the truth; however, if violence occurred in the marital context, for example, the woman's text may be placed under suspicion due to the socio-cultural issues that naturalize this act in these relationships (Diniz et al., 2014).

From this perspective, the testimony of women is not enough for access to legal abortion services. She will need to pass the health team's veridiction tests in order to have her right legitimized and be recognized as a "victim." She will have to tell a story that presents a causal relationship between violence and pregnancy and, in addition, subjective traces of victimization and the description of a place that social imagination regards as conducive to the occurrence of violence (Diniz et al., 2014).

This stand, identified in the testimonies of some participants in this study, contributes to making it difficult for users to access legal abortion and is rejected by the Technical Standard (Brasil, 2012), which exempts women from presenting a BO, expert report or any other document attesting to sexual violence. The woman or her legal representative's consent should be sufficient to obtain access to the procedure in health services. The only document required for termination of pregnancy due to rape is the woman's written consent (Brasil, 2012).

Refusal to terminate pregnancy due to sexual violence constitutes institutional violence, bringing consequences for women's sexual and reproductive self-determination. This violence can lead women

to seek this procedure in unsafe conditions, which constitutes an even greater public health problem, with serious repercussions for their health. When legal abortion is not granted by health services, many women resort to clandestine abortion, a procedure that carries health risks and unnecessarily exposes them to serious complications and death.

In Latin American countries, the impediments imposed on women who choose to terminate their pregnancies generate more than four million illegal abortions each year, with very high maternal mortality due to clandestine abortion, especially in less developed countries (Sigal, 2015). In Brazil, abortion is among the four leading causes of maternal mortality, with unacceptably high rates by international standards (McCallum; Menezes; Reis, 2016).

Scholars argue that a woman completing an abortion in the hospital means plunging into an environment in which an institutional culture is rooted through everyday processes and dynamics that impact caregiving (McCallum; Menezes; Reis, 2016). The moralizing and prejudiced view manifested in demonstrations of intolerance or hostility towards women who resort to legal abortion is imbricated in professional practice and institutional arrangements (structure, organization, culture), making humanized attention unfeasible and restricting access to the procedure safely.

Final considerations

The interviewees' testimonies signaled the complex network of challenges facing the health care of women in situations of sexual violence. The path taken by women in search of possibilities for coping with the problem shows the need to overcome overlaps of violence. In this sense, it is essential to articulate the manifestations of institutional violence to the dimensions of structural violence experienced by society as a whole.

Thus, the analysis of the manifestations of IV in health care to women in SV situation reveals that the problem goes beyond subjective and professional training issues. It is evident that the lack of institutional support culminates in the removal of

health professionals from this type of attention and the consequent violation of human rights.

Delivering care as provided in technical documents and the law implies the participation of actors involved both in the production of knowledge about the policies and standards that guide the action in the health sector and the construction of best practices.

In order to confront institutional violence in the daily routine of health units, management should rethink the configuration of services and care network for women who suffer sexual violence, in order to expand and decentralize the provision of this type of care. Moreover, local management should be close to the actors involved, directing them in accordance with the public policies that guide health actions, and enabling integral attention to women through the provision of welcoming environments aimed at ensuring of rights.

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Authors' contribution

Moreira and Vieira participated in all stages of the preparation of the manuscript. Cavalcanti coordinated the research and, with Silva and Feitoza, critically reviewed the article. All of the authors contributed to the writing of the manuscript and approved the final version to be published.

Received: 09/15/2018

Approved: 11/03/2019