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Review Article

Women's Experiences of Gynaecological Consultations – Uncovering Its Technological Toolboxes: Challenges in a Brazilian context

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Abstract

Historically, the medical definition of women as an object of biomedical knowledge has restricted the way by which gynecology is understood. In Brazil's Unified Health System (Sistema Unificado de Saúde – SUS, in Portuguese), it is the responsibility of gynaecological care services to identify, diagnose and treat reproductive related conditions. However, gynaecological consultations are based predominantly on a medicalised model of diagnosis, treatment and disease management which often fails to address the wider determinants of women's reproductive health and its impact on their general health and life chances. This paper is focused on the way the Brazilian health system has responded to women's health needs in gynaecological consultations, given its central role in maintaining and promoting women's health. it explores variations between "what should be" and "what is" offered to Brazilian women in gynaecological consultations. The authors argue that while gynaecological consultations in Brazil (and elsewhere) are currently restricted to programmatic targets, complaints and symptoms associated with sexual and reproductive functions; consultations could be used to respond to women's needs, using a broader life course approach if a combination of health technologies 'toolboxes' are employed. Implementation of care services utilising a 'toolbox' approach provides an opportunity to truly follow the principle of 'integrality', one of the doctrinal principles of the Brazilian health system, which furthermore could have application in women's health care services elsewhere.

Keywords: *Gynaecology, women's health, integrality, health toolboxes*

Introduction

Over the last three decades demographic changes, lifestyle and environmental factors have brought about profound changes in morbidity and mortality profiles worldwide. This epidemiological transition has been marked by a decrease in the rates of infectious diseases and a raise in the occurrence of non-comunicable diseases. In such a scenario, scientific developments and associated increases in the availability of diagnosis tools and treatment have not been able to completely eradicate the global burden non-communicable diseases such as cancer, which remains among the most common cause of death, especially in low and middle-income countries [1]. The WHO report that cancer is the second leading cause of death globally, and was responsible for 8. 8 million deaths in 2015. Globally, with approximately 70% of deaths from cancer occuring in low- and middle-income countries (World Health Organization 2018).

In relation to women's cancers population-based interventions can be largely effective in reducing the impact of cervical and breast cancer on women`s morbidity and mortality, however, rates have continued to rise in the past 30 years [2]. Globally, breast cancer is the most frequently diagnosed cancer and the leading cause of cancer death among women, accounting for 23% of the total cancer cases and 14% of the cancer deaths [3]. With approximately 530 000 new cases per year worldwide, cervical cancer is the fourth most common type of cancer among women, being responsible for the death of 265 thousand women per year [2].

Women`s health is a Brazilian government priority [4]. Breast and cervical cancer, together with contraception, sexually transmitted diseases and AIDS, maternal health, abortion, chronic diseases, domestic violence, are all categorized in the Brazilian public health agenda as concerning to "women`s health" [5]. Even though there is recognition of the importance of this range of problems, programmatic actions are focused on reproduction with interventions across the 'reproductive cycle' from gynaecological to maternal care. Gynaecological services in Brazil are the only part of the system specifically directed towards responding to women's health needs as maternal care includes also care for the baby. It is therefore, in gynaecological services, which are identified as the main provision, responsible for providing health care to women, that they should find responses to their needs.

The term "gynecology", has its origin in the Greek roots "gyneco" meaning "woman", and "logia" meaning "study", so gynecology literally is the study of women. Despite the broaden scope of its literal

meaning, historically, the medical definition of women as an object of biomedical knowledge has restricted the way by which gynecology is understood as something strictly concerning reproductive related conditions [6].

In Brazil's Unified Health System (Sistema Unificado de Saúde – SUS, in Portuguese), it is the responsibility of gynaecological care services to identify, diagnose and treat reproductive related conditions, like cervical and breast cancer and sexually transmitted diseases, as well as provide guidance on reproductive planning [7–9]. To meet these aims the system relies on gynaecological consultations delivered by primary care services based predominantly on a medicalised model of diagnosis, treatment and disease management. This approach often fails to address the wider determinants of women's reproductive health and its impact on their general health and life chances. There is the need therefore, as stressed by The WHO, to address women's health comprehensively in order to extend the agenda beyond reproduction and provide care to new women's health related problems, like the chronic diseases. The approach to be taken would be one that considered women's health as a continuum during her life course with lifechances and health impacted by social determinants as well as availability of medical care [2].

This paper is focused on the way the Brazilian health system has responded to women's health needs in gynaecological consultations, given its central role in maintaining and promoting women's health. Exploring how gynaecological care has been delivered in Brazil, this paper will contribute to analyses of variations between "what should be" and "what is" offered to Brazilian women in gynaecological consultations.

The authors argue that while currently gynaecological consultations in Brazil are restricted to programmatic targets, complaints and symptoms associated with sexual and reproductive functions; they still have potential to respond comprehensively to women's needs, depending on the combination of health technologies being employed. We point out that such potential could be achieved through implementation of care services that truly follow the principle of 'integrality', one of the doctrinal principles of the Brazilian health system.

The paper begins by describing the Brazilian context, with regard to the organization of the health system and epidemiological data. It goes on to present the discussion standpoints taking into account the proposal of an enlargement of the boundaries of the healthcare offered in gynaecological consultations. Health as a positive resource, rather than simply treatment of illness is the theoretical standpoint which underpins this paper. The relevance of this to the practice of health professionals, in particular of nurses is used as a reference point to explore the issues raised.

Overview of the Brazilian Health System and Primary Care Services

Brazil is the fifth largest country in the world with a population of over 200 million people in 2016 (www. statistica. com 2018). Despite the challenges represented by regional diversities and social inequalities Brazil has experienced increasing economic development, [10, 11] In addition, the past ten years has seen changes in the country's demographic profile with an age range weighted more towards adults and elderly rather than children [12]. In Brazil, as elsewhere, economic growth has been accompanied by a reduction in the rates of infectious diseases and a need to prioritize the care for non-communicable diseases in an ageing population [12].

The last few decades have seen important improvements in the health status of the Brazilian population, which can be ascribed to initiatives resulting in positive changes in the social determinants of health. A radical institutional change in the Brazilian health system with the offering of universal and free access to health care services was one of the changes associated with those improvements [13, 14]. Although the public services can be accessed by everyone, it is mostly used by people on lower [13].

In 1988, after a period of nearly 20 years of military dictatorship, a new federal constitution was promulgated, starting a period of redemocratisation of the country. For the first time in Brazilian history a constitution established that health was a citizen's right and a governments' duty. In 1989, a national health system funded by taxes and social contributions - unique in Latin America - was established, guaranteeing equal and free access to health care at primary, secondary and tertiary level [14]. Since then, the SUS has represented a landmark in the overcoming of health inequities, although the old public health problems have not been eliminated yet and new ones, like the rise of non-communicable diseases, have been adding pressure to the system [13, 14].

The system is organized on the basis of the following doctrinal principles: universality, integrality, equity and social control. It foresees the delivery of healthcare according to levels of complexity (primary, secondary and tertiary), through a network of integrated services coordinated by federal, state and municipal government. It works on the basis of decentralization and regionalization processes, with priority given to prevention [4, 13]. The National Policy of Basic Attention (in Portuguese, Política Nacional de Atenção Básica), which establishes the guidelines for actions in primary care, highlights its importance as the main gateway and communication center with the whole healthcare network. The Policy stresses that it is therefore essential to take universality, integrality of attention, equity and social participation as the actions orienting principles [15].

Primary care has been key to the expansion of access to health services. It is the entry level of the Health System. It is responsible for providing universal and comprehensive care and coordinates the flow and continuity of care by referring service users to other levels of care, like specialist services and hospital care [11]. It has also been important in the implementation of intersectorial actions for health promotion and disease prevention [10].

The Brazilian primary care network is constituted by two principal sets of services: Basic Health Units and Family Health Clinics. Although both work with overlapping care offers, much attention has been given to the expansion of the Family Health Program (in Portuguese, Programa de Saúde da Família - PSF) coverage. The Program was created to organize the decentralization process from federal to municipal healthcare management. The relevance of the

PSF to the system lies on its importance for the restructuration of municipal health systems and reorganization of primary care. It is focused on family and community health, targets to be met by the work of family care teams composed by a minimum of one doctor, one nurse, one auxiliary nurse, oral health professionals and community health agents (who live in the same community of the service users) [15] . Each team works in a specific geographic area and with its respective population, which facilitates the effectiveness of the actions and the potential of the services to understand and respond to the users` needs.

Women's Health in the Brazilian Context

In 1989, a health reform introduced new goals to the Brazilian context of women's healthcare, taking into account a broadening perspective of women's health with the intent of overcoming the traditional focus on reproduction. New health policies were created such as the National Program of Comprehensive Care to Women's Health (Programa Nacional de Atenção Integral à Saúde da Mulher, PNAISM, in Portuguese). Despite the declared intentions and the development of some coherent actions, the definition of women as reproductive beings remains significantly influential in the care women receive. In addition, the restriction of women's health to reproduction has not always included consideration of their general well-being [16].

The care offered to women in Brazil is commonly associated with the competence of women's bodies to produce and maintain healthy babies [17, 18]. Pre-natal and post-natal care, breastfeeding check-outs and education are amongst the services provided. In this arena other issues, concerning women's health and well-being, such as those associated with the menopause (post reproductive years) or conditions commonly experienced post menopausally like urinary incontinence, high blood pressure and cardiovascular diseases, remain neglected [2, 19].

As previously mentioned, in Brazil, the areas of focus for women's health care are closely related to governmental programmatic goals which are aligned with epidemiological measures of incidence and prevalence. However, this emphasis raises a problem with regards to women's health as not everything concerning the impact of health, womanhood and gynaecological conditions can be identified solely on the basis of objective and measurable data. Women's health, reproductive system and gynaecological needs retain their close association with the cultural, sociological and psychological situation in which health and wellbeing are experienced and understood by the women themselves. It therefore follows that in a data driven, medically orientated environment, such as Brazilian health contexts, it would be unsurprising to find situations that impact on women's health which would remain hidden.

For example, despite the universal and free access to health care and the government initiatives to promote preventive consciousness, the percentage of smear test beneficiaries is still very low, considering a coverage that does not exceed 8% of women aged over 20 years. This percentage is far short of the recommendations of the WHO, which recommends coverage of 85% of the female population at (World Health Organization 2015). Also, it has been observed that the majority of women undergoing a smear test are less than 35 years, suggesting that their access to prevention is related to their attendance at the health clinics in order to receive care for birth control [4, 20] .

The consequences of this situation in the Brazilian context can be seen in the case of cervical cancer. In 2012, the disease was the third highest cause of death from cancer among Brazilian women, representing a mortality rate adjusted to the world population of 4. 72 deaths for every 100 thousand women [20]. In the year 2014, 15. 590 new cases of cervical cancer were predicted, with an estimated risk of 15. 33 cases per 100. 000 women [20]. The estimated cervical cancer incidence rates and mortality in Brazil are in the 'intermediate' range compared to other countries with a similar GDP, but are high when compared to high-income countries with early detection well-structured programs [20]. This suggests that health and life chances in cervical cancer are not simply a question of the disease itself as a physical entity. This is further borne out by the fact that cervical cancer rates are highest in the poorest Brazilian regions, like the Northern territories where the incidence is 23. 6 cases per 100. 000 inhabitants compared with 10. 15 cases in the Southeast [20].

Early diagnosis and treatment has shown to be key strategies in the fight against the burden women's cancers such as breast and cervical cancer (World Health Organization 2015). In both cases, the success of the interventions depends not only on the quality of specific primary care offers - screening and first access to treatment - but also on the competence of the health system to intervene in the social and cultural determinants of health which are largely linked to equity and social justice [2, 12, 13, 21].

Breast and cervical screening and treatments are provided through gynaecological services, part of the primary care services in Brazil. In relation to breast cancer; self-examination, clinical breast examination and mammography screening are the main strategies used to reduce breast cancer mortality rates [21, 22]. While for cervical cancer, reduction in mortality and morbidity follows the WHO recommendations (World Health Organization 2015) in providing periodical cytological screening, cervix examination after applying acetic acid, vaccination of girls against the Human Papilloma Virus (HPV) infection and treatment for precancerous lesions or invasive cancer. These actions are among the interventions that have been currently put in place by the Ministry of Health.

The highly medicalised approach used in both breast and cervical cancer care illustrates how the prioritized intervention strategies for women's health in Brazil, rely on scientific and technological knowledge to provide for all care needs. The services provided are therefore based on two assumptions; the professionals' competence to make use of the available technical tools to identify and 'treat' women's conditions and the government's commitment to provide the services necessary for those needed conditions [23, 24].

Meeting the Challenge of Women's Health Integrality in Gynaecological Consultations

We propose a broader interpretation of "gynaecological consultations" in Brazil, beyond the focus on pathology and its

biomedical origins. This interpretation puts forward a notion that gynaecological consultation should encompass more than a pathological focus and related issues, such as clinical diagnosis and treatment. Instead, we propose an expansion of its traditional conceptualization in Brazil to include cultural, social and personal aspects of care. This proposed concept is anchored in an amplified notion of health (taking into account social, religious, economic, racial and gender issues, etc.), in line with the assumptions of health promotion and the meanings of integral health. Those assumptions are also highlighted in the National Program of Comprehensive Care to Women's Health [4]. By going beyond the usual, predominantly focused on women's diseases and the biology of the reproductive system, this new conceptualization of gynaecological consultation allows for the opening of other possibilities to meet women's needs.

Adopting this perspective we define "gynaecological consultation" as an interactive encounter between at least one health professional and one woman, which is carried out with the aim of understanding and meeting this woman's health care needs. Such needs are to be assessed not only considering the demands posed by health policies and programs but also by valuing more personal demands that can possibly be hidden behind usual programmatic priorities.

In addition to physical examination, medical history and conducting smear tests, there are other components that should equally constitute gynaecological consultations. These components include listening, dialogue, and bond development, discussion to promote ways of addressing problems, etc. These act as key health practices as well as products of the caring relationship. Adopting this approach requires a change in the Brazilian tradition of predetermined medicalized definitions to establish in advance of consultations, the actions and expected outcomes of each gynaecological consultation.

Integrality, rights and responsibilities

Our argument for a change on the way women's health needs are addressed in gynecological consultations is based on two theoretical constructs. The first is *integrality*, a central principle of the Brazilian health system. Although it has been pointed out in the literature that "integrality" cannot be defined absolutely, mainly because it can incorporate multiple meanings, some authors have argued that it can be seen as an ethical value [25, 26, 27].

Considered as a value, integrality embodies the idea of health as a right and health needs as marked by a high level of subjectivity, unpredictability and complexity (Pinheiro *et al.* 2012). The right is not only envisioned in the right of access to health services, but also refers to a person's set of rights as a whole. Taking into account its legitimacy as constituent of the operational logic of the Brazilian health system, integrality shall be the orienting line for all the actions undertaken in health services. In that sense, health policies/programs and the derived actions should be aimed at guaranteeing the rights of people living with certain diseases to the assistance they need as well as the rights of those without the disease, to benefit from preventative actions [26]. As a driving force of the system, integrality requires that healthcare includes more than simply actions to reduce the burden of diseases in terms of suffering, risk of death or possible complications. Healthcare integrality demands the broadening of the assistance response by providing a broad range of support for the people so that, despite the disease, they can have the best life possible.

Integrality is taken here as an image-aim or an idea-force, as something to fight for. It is not the same as utopia, which in essence describes an ideal that may never be reached. Integrality, in contrast, encompasses a goal believed to become real in the future. It is personally and contextually determined within the 'lived experience' of the individual. In that sense, to propose an image-aim implies to make a distinction of what one wants to achieve from what already exists, based on a critique of the present reality [26].

The link between integrality and prevention is similar. One cannot prevent a disease by simply measuring and investigating it as an entity in isolation from human experience. There are a number of issues to be taken into consideration in the planning and implementation of diseases preventive strategies. These are not necessarily limited to the disease itself, but may impact on an individual's ability to take advantage of the preventative or assistance actions available (Oliveira 2011, Victora *et al* 2011, Rossetto & Oliveira 2013, Blanchard *et al.* 2013, [16] . For example; a Brazilian housewife with a diagnosis of a lump in her breast was referred to a specialist service to undergo a mammography. The service was located far away from the place she lived and as the local services did not have mammography equipment she would need to travel to another city taking with her three children. The health professional who diagnosed the lump did not ask if she had any difficulty to attend the mammography appointment. He focused only on the physical breast examination and completion of the paperwork. In the end, the woman could not take up the referral in order to benefit from the care offered, risking her life, hence the well-being of herself and possibly future welfare of her children.

In order to make the most of the care available in gynecological consultations, the encounter between the professional and the service user must be guided by what we call an "amplified hearing" (Pinheiro *et al.* 2012). This requires the caregiver to facilitate within the consultation an environment which supports open dialogue with the woman, integrating the physical diagnosis and possible treatment or management options within the context of her wider needs.

It is important to highlight that, in such perspective; women should not be treated as a group but as individuals, a position that may have the potential to reconfigure their relation (as users) with the system, in the sense of defining the healthcare trajectory in particular terms. The care offers available to women in primary care settings are, usually, formatted according to specific programmatic goals limiting the practice to a restricted frame of morbidity and restricting the assistance to women's health needs.

One cannot dispute the value of public health policies and programs focused on the control of certain epidemiologically relevant diseases, like cervix and breast cancers. The critique is that little attention has been given by them to women's singularities, either in preventive or clinical assistance. The importance of epidemiology for the definition of public health targets has led women to be valued less for its unique demands and most particularly by its representation as a group with a certain "epidemiological profile" [16, 28].

Good quality relationship user-professional is essential for integrality oriented actions (Pinheiro *et al.* 2012) missed. Gynecological consultations guided by open conversations, can give woman the opportunity to express concerns or difficulties regarding sexual life, which are not necessarily definably as a clinical issue but may be equally a health need. Integrality in a gynecological consultation may illuminate situations of gender power imbalance, domestic and sexual violence, infertility, sexual pleasure or unpleasant sexual relations, reproductive rights, for example. Integrality opens a space to discuss a woman's unique requirements, challenging the practice of configuring in advance the limits of the care to be offered.

'technologies', toolboxes and women's health

The second construct which supports our discussion is the notion of 'health technologies' based on the work of Emerson Merhy and colleagues [29]. The authors draw on Marx's theorization about "living and dead labor" and the understanding that labor is configured not only in terms of its operative dimension (as an activity), but as a praxis, which in its turn gives meaning to the work [30]. Human production activities are therefore undertaken through a mental construction of the product to be made, which precedes the work process itself. All products used in the production process, which are results of a previous human work, are called dead labor. Living labor is a process that makes use of the products of dead labor in a creative work, which ends up in the manufacture of a new product [29, 30].

'Health technologies' here does not only refer to the equipment or instruments needed in the delivery of particular health services, like in gynaecological consultations. It also encompasses technological knowledge, professional experience and components of the work process which combine to inform professional decision making [31]. The notion of "health technologies" has at its center a critique of the objectification of the healthcare subject – the transformation of the person into an object of the clinic -, which may be viewed as a product of the fragmentation and medicalization of the biological body [31, 32] . Life and its experiences are not only the result of the functioning of body parts, either taken individually or as a certain biological system. There are other elements and interactions involved in the processes of life production. As pointed out before, many of them have been neglected in gynaecological consultations when it comes to prevention or treatment of what may initially be seen as a physiological problem, reducing the actions potential to optimise women's health and wellbeing.

Health technologies are constituents of technological toolboxes, which are brought by health professionals to their encounters with service users. At least three toolboxes are present in such context: toolbox of "*hard technologies*", of "*soft-hard technologies*" and of "*soft technologies*" [29, 31]. Next, following the ideas of Merhy *et al.* (1997) and Merhy and Feuerwerker [29, 31], we take the notion of "technological toolbox" as applied to the care model of traditional gynaecological consultation undertaken in Brazilian primary care services.

The toolbox constituted by "*hard technologies*" allows for the health professional to make use of machines or equipments to carry out physical, laboratorial and imaging examination. In traditional gynaecological consultations this toolbox would include the speculum, the microscope, or other equipments used to examine, access physical information, perform laboratorial and imaging examination. Those tools made possible the development of a clinical reasoning and, in certain cases, to define therapeutical interventions. Such processes consume the dead labor (of the machines) and the living labor of their operators.

The second toolbox is based on the particular professional role of the caregiver, in the traditional gynecological consultations offered in primary care services, a position assumed by doctors or nurses. Such role guides the health professional's way of understanding and approaching the woman's gynaecological needs. While it may be based on professional knowledge about what are those needs and how to respond to them, there may always be a degree of tension generated by the professional's uncertainty in the definition of "what to do". It is through professional experience in clinical situations that the professional begins to develop the links between these first two boxes. Toolbox two therefore combines 'hard' tools and reflexive exercises through which the caregiver develops a professional reasoning. It is therefore conceptualized as constituted by "*soft-hard technologies*" [29, 31].

The third toolbox is constituted by tools that allow the professional to get a more accurate perception of the particular situation of the woman to be cared for. Her social and cultural context, experiences and values, support network, are all important aspects to be accessed in order to understand her singularities. To do that, interactive tools are to be used, like listening, developing a bond, getting to know the woman's expectations and requests, familiarization with possible impacts of a certain condition and treatment regime to her life, are some tools that may facilitate the dialogue with that person and with her needs. These 'tools' enrich and broaden the professional's clinical reasoning and, at the same time, increase the opportunities for the woman to be an active participant in such encounter. Those tools contained in toolboxes three are called "*soft-technologies*" [29, 31].

The configuration of models of health care depends on the way those three kinds of technologies are combined [31]. During the gynecological consultation, for example, the health professional embarks on a mediation process between approved procedures/test related to the symptoms presented in each case, their professional knowledge and the singularity of each woman's experiences before deciding the best approach to take.

Final Reflections

This paper presents a reflexive standpoint to help guide thinking about how women's health needs could be addressed in Brazil. The decision to develop this reflexive paper arises from our belief that there is much to be gained from examining health technologies' potential for integrality in gynaecological consultations in Brazil, where women's individual needs are not commonly considered, is problematic. In addition, while focused on the Brazilian context, gynaecological consultations are not unique to this country and exist in some form in most countries. The concept of integrality and the use

of 'toolboxes' in gynaecological consultations therefore has potential benefits to improving the effectiveness of such consultations for women in other countries.

In the way we conceptualize it, a gynaecological consultation should be guided by an integrated approach combining what are known as 'soft' and 'hard' technologies. This requires an acceptance of the importance of a range of skills involving more than the prioritized use of equipment and procedures. From this standpoint, any professional decision in relation to gynaecological care will acquire a degree of individualised meaning and negotiated management, actions that make sense in the particular situation of each woman.

To expand the definition of Brazilian gynaecological consultations in such a way would require consideration of the possibility of expanding its structural limits, e. g. , to accept that it may include actions and procedures of different professionals, depending on the nature of the woman`s health needs. In such perspective the healthcare offered by gynaecological consultations to Brazilian women will be the result of the articulation of a network of health services on a continuous basis, considered the needs expressed by each woman`s request to the services. It will be set by particular therapeutic projects, and therefore will count on a health services network that has flexible configurations and is centred on the needs of the women requiring care.

The WHO classical definition of health puts forward a positive view of health as a state of well-being, not merely an absence of disease [33]. This infers that even when services are focused on treating illness, promoting future health cannot be achieved by limiting care to pathology identification, diagnosis and treatment [34–37]. In addition, as care is also delivered during consultative interactions between women and their health caregiver, it is unlikely that, considering only technical knowledge of health care professionals will be sufficient to also address the subjective and diverse needs of the women involved.

In the current Brazilian context gynaecological consultations do not usually have the necessary scope for the promotion of women's health, with priority given to complaints and symptoms associated with sexual and reproductive functions. In such context other possible health needs are disregarded, such as the ones related to contextual factors (social, relational and affective, for example) that impact upon their health. Along with smear test procedures, breast examination and the diagnosis of sexually transmitted infections, for example, gynaecological consultations should take into consideration other important health related issues like access to health care offers, the possibility to exercise self-care and make informed decisions related to personal health, and so on. These are all aspects of women's health that should be valued in such encounters [23].

In addition to their diagnostic purposes, the smear test and breast examination may provide opportunities for establishing dialogue, connection and affirmation of women's sexual and reproductive rights. By taking into account social determinants of health, gender perspectives and valuing women's decisions regarding sexual and reproductive health, the health professional may optimise the health promotion potential of each consultation. This has the potential to bring about important changes in the way women's healthcare is provided in Brazilian primary health care settings. This in turn could contribute to maximizing women's wellbeing while contributing to a reduction in women's morbidity and mortality.

Even when the theoretical background suggests that this possibility exists (and we believe that), to actual see that potential in Brazil; will depend on professionals' capacity to be open to other ways of configuring healthcare. To successfully engage with possibilities of change in women's services, Brazilian health professionals and service providers need to be supported to overcome "taken for granted' assumptions of how health care, in this case gynaecological consultations, are provided. This paper is the first stage in challenging those assumptions of what is "natural" in such consultations. Without presenting this 'alternative' view of reality of women's healthcare in Brazil there will be little chance of successfully achieving our aim of identifying and exploring factors that may facilitate changes in policy or processes to support the practice of integrality. The reflections developed here, may help health professionals to begin to visualize a more individualized approach to women's health and the associated combinations of health technologies that make up the toolboxes used in the consultations.

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Conflict of interest

No conflict of interest has been declared by the authors.

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