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Original Article

The profile of women attended in gynaecological nursing consultations in primary health care

O perfil da mulher atendida em consulta de enfermagem ginecológica na atenção primária à saúde

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ABSTRACT

Objective: to evaluate the profile of women attended in gynaecological nursing consultations within the context of primary health care. **Methods:** this cross-sectional, analytical study conducted through the analysis of 135 medical records of women aged 25-64 years who underwent gynaecological nursing consultations. A validated instrument was used for data collection. Data were analysed using descriptive and inferential approaches. **Results:** adult, married women with low educational levels predominated, mostly engaged in domestic work and with income considered sufficient. Chronic diseases, family conflicts, frequent religious practice, and high adherence to contraceptive methods were identified, contrasting with low use of dual protection and limited knowledge about cervical cancer screening. Considerable gaps in the records of family and sexual violence, as well as a high proportion of incomplete data, were observed. **Conclusion:** the identified profile reveals social and health vulnerabilities that impact women's care and highlights the need for educational strategies, sensitive care, and a comprehensive approach. **Contributions to practice:** the study supports improvements in care processes, enhances the use of standardised instruments, and strengthens the role of nurses in promoting comprehensive, equitable, women-centred care based on their real needs.
Descriptors: Women's Health; Primary Health Care; Uterine Cervical Neoplasms; Office Nursing.

RESUMO

Objetivo: avaliar o perfil das mulheres atendidas em consulta de enfermagem ginecológica no contexto da Atenção Primária à Saúde. **Métodos:** estudo transversal e analítico realizado por meio da análise de 135 prontuários de mulheres de 25 a 64 anos de idade que realizaram consulta de enfermagem ginecológica. Utilizou-se um instrumento validado para coleta de dados. Os dados foram analisados de forma descritiva e inferencial. **Resultados:** predominaram mulheres adultas, casadas, com baixa escolaridade, dedicadas ao trabalho doméstico e com renda considerada suficiente. Identificaram-se doenças crônicas, conflitos familiares, prática religiosa frequente, além de elevada adesão aos métodos contraceptivos, contrastando com a baixa utilização da dupla proteção e o conhecimento limitado acerca do exame preventivo do câncer do colo do útero. Observou-se considerável ausência de registros sobre violência familiar e sexual e elevado número de informações incompletas. **Conclusão:** o perfil encontrado evidencia vulnerabilidades sociais e de saúde que impactam o cuidado feminino e reforçam a necessidade de estratégias educativas, acolhimento sensível e abordagem integral. **Contribuições para a prática:** o estudo subsidia melhorias nos processos assistenciais, qualifica o uso de instrumentos padronizados e fortalece a atuação do enfermeiro na promoção do cuidado integral, equitativo e centrado nas necessidades reais das mulheres.
Descritores: Saúde da Mulher; Atenção Primária à Saúde; Neoplasias do Colo do Útero; Enfermagem Ambulatorial.

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Introduction

Primary health care (PHC) is configured as the entry point to the health system and sustains the essential attributes of first contact, longitudinality, comprehensiveness, coordination, family and community orientation, and cultural competence. In addition, it plays a decisive role in the control of cervical cancer (CC), ensuring access, quality, and effectiveness in actions related to health promotion, prevention, diagnosis, treatment, and rehabilitation[1].

Health promotion, grounded in educational strategies appropriate to the sociocultural context and the social determinants of the health-disease process, constitutes an indispensable tool to encourage protective practices and expand self-care[1-2]. Within the CC care pathway, these actions are mainly concentrated in PHC, including health education activities, for example, during consultations[3].

In educational actions, emphasis is placed on the dissemination of knowledge regarding the pathophysiology of CC, risk factors related to human papillomavirus (HPV) infection, the importance of consistent condom use, the recommended periodicity for screening for CC, and the need to return to receive results and initiate timely treatment when indicated[3].

Cervical cancer is one of the leading causes of mortality among women worldwide. It continues to affect a high number of women annually and accounts for a significant proportion of cancer-related deaths. In several countries, this type of neoplasm is among the most frequently diagnosed in the female population; in others, it constitutes the leading cause of cancer-related death, thereby representing a serious public health problem and affecting the quality of life and wellbeing of affected women[4].

Risk factors encompass socioeconomic, behavioural, and access-related aspects. These include smoking, negative self-perception of health, low educational level and income, early initiation of sexual activity, lack of condom use, multiparity, low adherence to screening, single marital status, and barriers to accessing care[5].

Nurses assume a central role by operationalising care through the nursing process, as established by the Brazilian Federal Nursing Council Resolution No. 736/2024, which regulates its implementation throughout the national territory and guides the organisation and documentation of gynaecological nursing consultations[6]. The systematised analysis of gynaecological nursing consultations, particularly in addressing CC, enables the qualification of clinical practices, supports care models, and strengthens the training of professionals and students[7].

The relevance of this study lies in its contribution to advancing knowledge on the profile of women attended in gynaecological nursing consultations, with an emphasis on CC, in PHC, generating evidence applicable to professional practice and health planning. Socially, its results may support more effective prevention and early detection strategies, with potential impact on reducing the incidence and mortality of cervical cancer.

Thus, this study aims to evaluate the profile of women attended in gynaecological nursing consultations within the context of primary health care.

Métodos

Type of study and study setting

This is a cross-sectional, analytical study conducted in three Family Health Strategy (FHS) units in a city in the south of the state of Minas Gerais, Brazil, using a review of medical records of women within the coverage area who underwent gynaecological nursing consultations with screening for CC between 2022 and 2024.

Sample

Sample consisted of 135 medical records of women aged 25-64 years who underwent PCC in the last 3 years, using a validated tool[8]. Inclusion criteria were cisgender women who underwent PCC between 2022 and 2024 and who, during the gynaecological

nursing consultation, had the "Gynaecological Nursing Consultation Instrument in Primary Health Care" applied. Exclusion criteria were puerperal women, women who had undergone total hysterectomy, and transgender men.

To support the analysis, municipal data were collected from the current system. This revealed that 21,230 women were in the target age group, 3,679 of whom had undergone screening for CC in the last 3 years. In January 2024, 166 tests were performed in the 21 health units where the study was conducted. Considering a 5% significance level and a 3% margin of error, the sample size calculation indicated the need for 222 medical records. However, during the data collection process, 25 records were lost due to changes in coverage territory by some users and 62 records were lost due to the validated instrument not being used for part of the consultations. This resulted in a final sample of 135 eligible records for analysis.

Data collection

Following municipal authorisation and ethical approval, data were collected between June and August 2024 by reviewing the medical records of women who attended nursing consultations in three FHS units and for whom the validated instrument was used to conduct gynaecological nursing consultations[8]. Based on Wanda de Aguiar Horta's Theory of Basic Human Needs, this instrument guides the systematisation of the nursing consultation and structures the recording of clinical information into different sections. For this study, data were extracted directly from the standardised fields of the instrument that were available in the medical records.

Women's profiles were the set of information recorded in the collection data tool. This included identification data and sociodemographic characteristics (e.g. age, education, marital status, occupation, and income), family history and health conditions, gynaecological and obstetric history, aspects related to sexuality and contraceptive method use as well as information from the clinical assessment and physical and gynaecological examinations performed during the nursing consultation. Thus, using this tool enabled the data collected from the records to be systematised and the profile of women attending for screening for CC to be characterised.

Researchers conducted data collection in contact with the nurses of the units, consulted screening for CC registers, and individually analysed the medical records. Data were entered into Excel spreadsheets and organised into a database developed jointly with a statistician.

Data analysis

A descriptive analysis was performed using absolute and relative frequencies. For the inferential analysis, the Chi-square goodness-of-fit test was applied to verify whether the distribution of the categories of each variable differed from a theoretical uniform distribution. The null hypothesis considered the equality of proportions among the valid categories of each variable in the data collection tool, given the absence of established population parameters. The "no response" categories were only included in the descriptive analysis. The test was applied to each variable individually in Tables 1, 2 and 3, considering their respective degrees of freedom. A significance level of 5% ($p < 0.05$) was adopted. All analyses were conducted using R software, version 4.4.2.

Ethical considerations

During access to medical records, privacy, confidentiality, and the rights of the women were ensured in accordance with Resolution No. 466/2012, using only sequential numbering for identification. Waiver of informed consent forms were signed, as well as a declaration of commitment by the principal researcher. The study, involving human beings and using data from public health units, was submitted to the Municipal Health Secretariat for authorisation, accompanied by the Institutional Consent Form and the Data Use Commitment Form. Subsequently, the pro-

ject was submitted to the Research Ethics Committee of the *Universidade Federal de Alfenas*, evaluated and approved under Certificate of Ethical Appraisal Submission No. 78514324.2.0000.5142 and Opinion No. 6,816,315/2024.

Results

A total of 135 medical records of cisgender women attended in gynaecological nursing consultations between 2022 and 2024 were analysed. Regarding sociodemographic characteristics, most women were concentrated in the 36-45-year age group (n = 40, 29.6%), with a statistically significant distribution among categories (p < 0.001). Concerning marital status, married women predominated (n = 64, 47.4%), also with a statistically significant difference (p < 0.001).

With regard to education, the "no response" category was the most common (n = 125, 92.6%), which highlights an important gap in the records and significant differences between the categories (p < 0.001). In terms of occupation, women engaged in various professional activities predominated (n = 87, 64.4%), with a statistically significant distribution (p < 0.001).

With respect to sufficient family income, most records did not present this information (n = 93, 68.9%), constituting the most frequent category and statistically different from the others (p < 0.001). Finally, a marked predominance of women with religious beliefs was observed (n = 113, 83.8%), with a statistically significant difference among the analysed categories (p < 0.001) (Table 1).

Table 1 – Sociodemographic characteristics of women attended in gynaecological nursing consultations (n=135). Alfenas, MG, Brazil, 2024

Variable	n (%)	Df*	p-value†
Age group (years)			
16-25	4 (2.9)		
26-35	24 (17.7)		
36-45	40 (29.6)	5	< 0.001
46-55	31 (22.9)		
56-65	34 (25.1)		
No response	2 (1.4)		

(The Table 1 continue...)

Variable	n (%)	Df*	p-value†
Married	64 (47.4)		
Other categories	20 (14.8)	2	< 0.001
No response	51 (37.7)		
Education			
Incomplete primary education	5 (3.7)		
Other education levels	5 (3.7)	2	< 0.001
No response	125 (92.6)		
Profession/occupation			
Homemaker	16 (11.8)		
Various	87 (64.4)	2	< 0.001
No response	32 (23.8)		
Sufficient family income			
Yes	30 (22.2)		
No	12 (8.9)	2	< 0.001
No response	93 (68.9)		
Religious belief			
Yes	113 (83.8)		
No	4 (2.9)	2	< 0.001
No response	18 (13.3)		

*Df: Degrees of freedom; †Chi-square test for categorical distribution

With regard to sexual and reproductive health, a higher frequency of women using contraceptives was observed (n = 52, 38.5%), although without a statistically significant difference between categories (p = 0.281). Among those using contraceptive methods, hormonal contraceptives predominated (n = 30, 57.7%), with no statistically significant difference compared to other methods (p = 0.267).

Sexual activity was the most frequent category (n = 85, 62.9%), showing a statistically significant difference among the analysed categories (p < 0.001). Regarding age at first sexual intercourse (coitarche), the "no response" category stood out (n = 93, 68.9%), with a statistically significant distribution (p<0.001). In relation to having a steady sexual partner, most women reported having one (n = 82, 60.7%), with a statistically significant difference between categories (p = 0.012).

Regarding sexual desire, the most frequent category was "no response" (85.2%), with a statistically significant difference (p < 0.001). Concerning sexual pleasure, there was also a predominance of the "no response" category (n = 115, 85.9%), with a statistically significant difference (p < 0.001). With respect to discomfort during sexual intercourse, the most frequent category was again "no response" (n = 90, 66.7%), with a statistically significant distribution (p < 0.001).

Regarding knowledge about screening for CC, a large proportion of records did not include this information (n = 127, 94.0%), constituting the most frequent category and statistically different from the others (p < 0.001). Finally, concerning history of violence, the "no response" category predominated (n = 109, 80.8%), with a statistically significant difference among the analysed categories (p<0.001) (Table 2).

Table 2 – Sexual and reproductive health aspects among women attended in gynaecological nursing consultations (n = 135). Alfenas, MG, Brazil, 2024

Variables	n (%)	Df*	p-value†
Use of contraceptives			
Yes	52 (38.5)		
No	46 (34.0)	2	0.281
No response	37 (27.5)		
Type of contraceptive‡			
Hormonal	30 (57.7)	1	0.267
Others	22 (42.3)		
Sexually active			
Yes	85 (62.9)		
No	34 (25.2)	2	< 0.001
No response	16 (11.9)		
Coitarche, years			
Before 15	5 (3.7)		
15-20	28 (20.7)		
21-25	7 (5.2)	4	< 0.001
After 25	2 (1.5)		
No response	93 (68.9)		
Steady sexual partner			
Yes	82 (60.7)	1	0.012
No response	53 (39.3)		
Sexual desire			
Yes	10 (7.4)		
No	10 (7.4)	2	< 0.001
No response	115 (85.2)		
Pleasure during sexual intercourse			
Yes	4 (2.9)		
No	15 (11.2)	2	< 0.001
No response	116 (85.9)		
Discomfort during sexual intercourse			
Yes	24 (17.7)		
No	21 (15.6)	2	< 0.001
No response	90 (66.7)		
Knowledge about screening for cervical cancer			
Yes	6 (4.5)		
No	2 (1.5)	2	< 0.001
No response	127 (94.0)		
History of violence			
Yes	7 (5.1)		
No	19 (14.1)	2	< 0.001
No response	109 (80.8)		

*Df: Degrees of freedom; †Chi-square test for categorical distribution; ‡Only women using contraceptive methods

Most women did not report family conflicts (n = 70, 51.8%), with a statistically significant difference among the analysed categories (p < 0.001). Regarding health conditions, 79 (58.5%) of the records indicated the presence of at least one condition, showing a statistically significant distribution (p < 0.001). Among women with health conditions, hypertension was the most frequent condition (n = 31, 39.3%), with a statistically significant difference in the distribution of categories (p < 0.001).

In relation to lifestyle habits, a higher frequency of women who did not consume alcohol (n = 66, 48.9%) and who did not use tobacco (n = 101, 74.8%) was observed, both variables showing statistically significant differences among categories (p < 0.001) (Table 3).

Table 3 – Characteristics related to family conflicts, health conditions, and lifestyle habits among women attended in gynaecological nursing consultations (n = 135). Alfenas, MG, Brazil, 2024

Variables	n (%)	Df*	p-value†
Family conflicts			
Yes	13 (9.6)		
No	70 (51.8)	2	< 0.001
No response	52 (38.6)		
Health conditions			
Yes	79 (58.5)		
No	17 (12.6)	2	< 0.001
No response	39 (28.9)		
Type of condition‡			
Hypertension	31 (39.3)		
Diabetes	23 (29.1)	2	< 0.001
Hypothyroidism	20 (25.3)		
Others	5 (6.3)		
Uso de álcool			
Yes	55 (40.8)		
No	66 (48.9)	2	< 0.001
No response	14 (10.3)		
Uso de tabaco			
Yes	19 (14.0)		
No	101 (74.8)	2	< 0.001
No response	15 (11.2)		

*Df: Degrees of freedom; †Chi-square test for categorical distribution; ‡Only women using contraceptive methods

Many variables showed a high rate of missing information, with no recorded entries, which directly impacts the completeness and depth of the records available in the analysed medical files.

Discussion

Gynaecological nursing consultations, conducted by trained nurses, constitute a fundamental tool for expanding women's access to sexual and reproductive health services and ensuring comprehensive, humanised practices within PHC[9]. The findings of this study reveal a sociodemographic profile predominantly composed of adult, homemaker, married women with low educational levels, a pattern also observed in other investigations conducted in Brazilian public services[10]. This predominance may reflect a set of family and occupational responsibilities placed on adult women, especially those who reconcile domestic care and work, reducing the time available for self-care and regular use of health services[11-12].

The psychosocial conditions identified in this study reinforce the impact of social inequalities on women's health. The presence of informal occupations, the high number of women dedicated exclusively to domestic work, and reports of family conflicts point to vulnerabilities that may compromise autonomy and access to health services[13]. On the other hand, religiosity, frequently recorded in medical records, may constitute an important source of emotional support[14], particularly in contexts marked by family tensions and caregiving burden.

Within the domain of sexual and reproductive health, data indicate that most women reported being sexually active, and a large proportion used contraceptive methods, a finding consistent with studies that indicate adherence to protective methods and a predominance of hormonal contraceptive use among those who use any method[15-16]. Reports of discomfort during sexual intercourse by some women reinforce the importance of qualified listening and the establishment of a bond between nurse and user, which are essential elements for women to feel welcomed and safe during gynaecological nursing consultations[17-18].

Another critical point observed was the low amount of data regarding knowledge of screening for CC, corroborating studies that associate limited understanding of the test with lack of knowledge about HPV, negative perceptions of the procedure, and ineffective communication between professionals and users[4,19-20]. Evidence shows that many women seek health services only when experiencing gynaecological signs and symptoms, reinforcing the need to intensify educational and counselling actions during consultations[21-22].

Data on self-reported health conditions also reveal a scenario consistent with the epidemiological profile of adult women attended in PHC, with emphasis on hypertension, diabetes, and hypothyroidism, chronic conditions that require continuous follow-up. The data collected from the medical records of women from FHS units in this study are also consistent with studies associating personal habits with increased risk of gynaecological infections and chronic and neoplastic diseases[23-25]. These findings reinforce gynaecological nursing consultations as a privileged space for the integrated management of health conditions[7,26], especially when recognising the centrality of PHC in longitudinal care.

Family or domestic violence, recognised worldwide as a social determinant with a profound impact on women's health, was reported by some women, although probably underreported due to the sensitive nature of the topic and the lack of records on this issue in medical files[27]. Furthermore, trust relationships established with nurses may facilitate the identification of such situations and expand the possibility of safe and timely referrals[26]. In this study, the absence of records on this topic in a large proportion of medical files reinforces the need for greater sensitivity and systematisation in addressing this issue during gynaecological nursing consultations.

Finally, the considerable amount of missing data observed in essential variables such as education, income, psychosocial aspects, sexual history, and violence reveals a structural weakness in the care, recording, and documentation process, a finding also identified in other studies[28]. Incompleteness compromises continuity of care, hinders situational as-

sessment of the territory, and limits epidemiological analyses capable of supporting health planning. The appropriate use of validated instruments, such as the one adopted in this study, may contribute to reducing these gaps, provided that it is accompanied by continuous team training.

Thus, the results of this study reaffirm the strategic relevance of gynaecological nursing consultations in PHC, both for the promotion of sexual and reproductive health and for addressing the inequalities that permeate women's lives. The set of findings reinforces the need for integrated and humanised actions, centred on qualified listening and expanded care, which are fundamental elements for nursing practice in PHC.

Study limitations

This study has limitations related to its retrospective design and the exclusive use of secondary data recorded in medical records, which resulted in a high proportion of missing information in some variables. In addition, the lack of control over the quality of professional records may have led to underestimation of relevant aspects, such as contraceptive practices, sexual complaints, psychosocial vulnerabilities, and situations of violence. It should also be noted that limitations related to the availability and completeness of records may have affected the sample selection process, resulting in a final number lower than that estimated in the sample size calculation. Furthermore, the length of the instrument may have constituted a barrier.

Contributions to practice

The results provide important contributions to clinical practice, highlighting the need for continuous training of nursing staff regarding the use of validated instruments, strengthening qualified listening and comprehensive approaches during gynaecological nursing consultations, and reinforcing the importance of educational actions aimed at self-care, contraceptive use, and understanding the purpose of screening for CC. These findings may guide improvements in care protocols, support clinical decision-making, and contribute to the enhancement of care strategies in PHC focused on women's real needs.

Conclusion

A set of social, clinical, and informational vulnerabilities was identified, requiring strategic and integrated responses from health services. The predominance of adult women with low educational levels, dedicated to domestic work, rarely questioned about their knowledge of screening for CC, low adherence to dual contraceptive protection, presence of chronic diseases, and reports of family conflicts indicate the urgent need to strengthen health education actions, qualified reception, and intersectoral interventions that go beyond the collection of CC screening. The marked absence of records on family and sexual violence suggests underreporting and points to a gap in addressing sensitive topics by the team.

Author contributions

Conception and design or analysis and interpretation of data: **Tavares TR, Dias A, Franco APMML, Freitas PS.** Manuscript drafting or critical revision of important intellectual content; Agreement to be accountable for all aspects of the manuscript related to the accuracy or integrity of any part of the work to be appropriately investigated and resolved: **Tavares TR, Dias A, Ribeiro PM, Calheiros CAP, Franco APMML, Freitas PS.** Final approval of the version to be published: **Tavares TR, Dias A, Ribeiro PM, Calheiros CAP, Franco APMML, Freitas PS**.

Data availability

The authors declare that the entire dataset supporting the results is available within the body of the article.

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