

ORIGINAL ARTICLE

## PERCEPTIONS OF FAMILY HEALTH TEAMS ON CONTRACEPTION CARE\*

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### ABSTRACT

**Objective:** To identify the perceptions of Family Health teams on contraceptive care.

**Method:** A qualitative research, of the exploratory-descriptive type. Data collection was conducted by means of semi-structured interviews, totaling 55 participants active in the Family Health Strategy in a capital of southern Brazil. For the organization and coding of the data, the resources of the webQDA software were used and, for data analysis, the four generic processes were followed: apprehension, synthesis, theorization, and transfer.

**Results:** Four categories emerged, namely: perceptions on contraceptive care; contraceptive care actions; characteristics of the people who demand contraceptive care; and sensations experienced by the teams when working in contraceptive care.

**Conclusion:** The arguments and counterarguments raised by the participants need to be widely discussed during the work process of the teams, with the aim to improve contraception care, thus contributing to the reduction of unplanned pregnancies and their implications.

**DESCRIPTORS:** Qualitative Research; Primary Health Care; Family Health; Family planning; Contraception.


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## PERCEPÇÕES DE EQUIPES DE SAÚDE DA FAMÍLIA SOBRE A ATENÇÃO EM ANTICONCEPÇÃO

### RESUMO

*Objetivo:* identificar as percepções de equipes de Saúde da Família sobre a atenção em anticoncepção.

*Método:* pesquisa qualitativa, do tipo exploratório-descritiva. Coleta de dados por meio de entrevistas semiestruturadas, totalizando 55 participantes atuantes na Estratégia Saúde da Família de uma capital do Sul do Brasil. Para organização e codificação dos dados, utilizaram-se os recursos do software webQDA e, para análise dos dados, seguiram-se os quatro processos genéricos: apreensão, síntese, teorização e transferência.

*Resultados:* emergiram quatro categorias: percepções sobre a atenção em anticoncepção; ações da atenção em anticoncepção; características das pessoas que demandam atenção em anticoncepção; e sensações vivenciadas pelas equipes ao atuarem na atenção em anticoncepção.

*Conclusão:* os pontos e contrapontos levantados pelos participantes precisam ser amplamente discutidos durante o processo de trabalho das equipes, tendo em vista o aperfeiçoamento da atenção em anticoncepção, contribuindo, dessa maneira, para a redução das gravidezes não planejadas e suas implicações.

**DESCRITORES:** Pesquisa Qualitativa; Atenção Primária à Saúde; Saúde da Família; Planejamento Familiar; Anticoncepção.

## PERCEPCIONES DE EQUIPOS DE SALUD FAMILIAR SOBRE LA ATENCIÓN EN MATERIA DE ANTICONCEPCIÓN

### RESUMEN:

*Objetivo:* identificar las percepciones de los Equipos de Salud Familiar sobre la atención anticonceptiva.

*Método:* investigación cualitativa, exploratoria-descriptiva. Recopilación de datos a través de entrevistas semiestructuradas, con un total de 55 participantes activos en la Estrategia de Salud Familiar en una capital del sur de Brasil. Para la organización y codificación de datos, se utilizaron los recursos del software webQDA y, para el análisis de datos, se siguieron los cuatro procesos genéricos: aprehensión, síntesis, teorización y transferencia.

*Resultados:* surgieron cuatro categorías: percepciones sobre la atención en materia de anticoncepción; acciones de cuidado anticonceptivo; características de las personas que demandan atención anticonceptiva; y sensaciones que experimentan los equipos cuando se desempeñan en la atención anticonceptiva.

*Conclusión:* los puntos y contrapuntos planteados por los participantes deben ser ampliamente discutidos durante el proceso de trabajo de los equipos, con miras a mejorar la atención en la anticoncepción, a fin de contribuir en la reducción de embarazos no planificados y sus implicaciones.

**DESCRIPTORES:** Investigación Cualitativa; Primeros Auxilios; Salud Familiar; Planificación Familiar; Anticoncepción.

## INTRODUCTION

It is estimated that 41% of the annual pregnancies on a global scale are unplanned. The use of contraceptives corroborates the decrease in this percentage. However, it is estimated that 33 million women/year, who use contraceptive methods, become pregnant accidentally. Of this total, a portion results in abortions; and another in unplanned babies. The consequences of abortion practices are well studied, being a worldwide issue for coping, since it affects a mean of 22 million women/year, culminating in the death of 47 thousand women/year. The consequences of the second choice (option for the birth of unplanned babies) are not adequately addressed in the studies<sup>(1-2)</sup>.

At the national level, the results of the *Nascer no Brasil* (Being born in Brazil) survey<sup>(3)</sup> indicate that, in order to contribute to better maternal and neonatal outcomes, it is necessary to expand reproductive planning so as to guarantee women the right to decide if and when they want to become pregnant. Considering the expanded sample of the research in question, the results indicate that 2% of the interviewees (corresponding to more than 50 thousand women) stated that they had tried to interrupt their current pregnancies. In addition, the report of negative or ambivalent feelings in relation to the current pregnancy was signaled by one third of the participants, that is, more than half of the women did not plan to become pregnant at that time. Women with unplanned pregnancies had less prenatal coverage and later onset of prenatal care, according to the researchers' analysis<sup>(3)</sup>.

Such situations —unplanned pregnancies, abortion and its consequences, and unfavorable maternal and neonatal outcomes— point to the emergence of the agenda related to contraceptive care. With this understanding and considering Primary Health Care (PHC) as a privileged locus for health care<sup>(4-5)</sup>, this research was developed with the objective to identify the perceptions of Family Health teams (FHTs) on contraceptive care.

## METHOD

A qualitative research, of the exploratory-descriptive type. The exploratory design provides a general recognition of the phenomenon and, in turn, the descriptive sphere focuses on describing the characteristics of this phenomenon<sup>(6)</sup>. The results of research studies of this nature provide opportunities for new investigations and, above all, have the potential to change the researched reality<sup>(6)</sup>.

Nationally, the Family Health Strategy (FHS) emerged to reorganize PHC through monitoring and coordination of the care provided by Family Health teams (FHTs) in a given territory<sup>(5)</sup>. In the municipality chosen to carry out this study, a capital of southern Brazil, PHC is the main guiding principle of the Municipal Health Secretariat (*Secretaria Municipal de Saúde*, SMS). At the time of data collection, the city had 128 FHTs, and it was the first capital in Brazil to achieve, in 2015, 100% FHS coverage<sup>(7-8)</sup>.

For this study, five Health Centers (HCs) were chosen, one of each Health District (HD) in the municipality. The research participants were members of the FHTs linked to the selected HCs: 23 Community Health Agents (CHAs), nine nursing technicians, 14 nurses, and nine physicians. The data collection period, referring to the interviews, took place between June and July 2015. To record the semi-structured interviews, a voice recording resource was used, with the authorization of the participants after reading and signing the Free and Informed Consent Form (FICF).

The organization and coding of the data was supported by the resources of the webQDA software<sup>(9)</sup>. For data analysis, the four generic processes were used, namely: apprehension, synthesis, theorization, and transfer, with the following meanings: collection of all the information and beginning of the analysis; association and variations of the

information obtained; formulation of assumptions and questions regarding the information found; and socialization of the research results<sup>(10-11)</sup>.

The CEP/CONEP System approved this research through Opinion No. 1,076,501, on May 25<sup>th</sup>, 2015, after evaluating that it is guided by the terms of Resolution No. 466/2012 of the National Health Council<sup>(12)</sup>.

## RESULTS

The results obtained with the analysis of the 55 semi-structured interviews are represented by four categories and their respective subcategories (Chart 1), with emphasis on the description of the arguments and counterarguments that the FHTs pointed out about contraception care.

Chart 1 - Categories and subcategories referring to the Perceptions of Family Health teams on contraceptive care: arguments and counterarguments. Florianópolis, SC, Brazil, 2016

CATEGORIES	SUBCATEGORIES
I – Perceptions on contraceptive care	<ul style="list-style-type: none"> <li>· Perceptions related to contraceptive methods to prevent pregnancy/ not having children.</li> <li>· Family planning and birth control as a synonym for contraceptive care.</li> <li>· Perceptions related to Sexually Transmitted Infections (STIs), sexuality, professional services, sexual and reproductive rights, women's autonomy, and economic and social conditions.</li> <li>· Difficulty in understanding the term "contraception".</li> </ul>
II – Contraception care actions	<ul style="list-style-type: none"> <li>· Essence of the actions (information, guidance, counseling, and surveillance).</li> <li>· Types of actions (appointments, educational groups, procedures and/ or techniques, home visits, school activities, team meetings, and case discussions).</li> <li>· Types of access (receiving spontaneous demand and scheduling appointments).</li> <li>· Does not act or perceives limits in the performance.</li> </ul>
III – Characteristics of the people who demand contraceptive care	<ul style="list-style-type: none"> <li>· Most common characteristics (young women, adolescents, low purchasing power, low schooling, nulliparous or multiparous).</li> <li>· Uncommon characteristic (male gender).</li> </ul>
IV – Sensations experienced by the FHTs when working in contraceptive care	<ul style="list-style-type: none"> <li>· Positive feelings (well-being, partnership, accomplishment, pleasure, security).</li> <li>· Negative feelings (insecurity, frustration, inability, discomfort).</li> </ul>

Source: The authors.

The excerpts from the participants' speeches help to illustrate and support the understanding of the results.

### Category I – Perceptions on contraceptive care

*I relate it to family planning and the prevention of possible pregnancies, especially during adolescence, at times considered, in theory, inadequate (E24 – Physician)*

*I relate to it STDs, because I have the habit of prescribing contraceptives with the use of the disease prevention method, which is the use of condoms. So I don't discard it [...] I always make it very clear to the patient (E7 – Nurse)*

## **Category II – Contraceptive care actions**

*More at the office level, totally at the office level, it comes from the person. She says: "I want to take the contraceptive." We perform the consultation and prescribe it. (E48 – Nurse)*

*Before, we used to make the group. The group wasn't working very well, I don't know if it was because of the schedule (E6 – Nurse)*

## **Category III – Characteristics of the people who demand contraceptive care**

*Girls who are very early in their active sex lives [...] our concern is with teenagers, but also with other mothers, with other women who already have children and are careless (E10 – CHA)*

*Men don't usually look for it, so I think it becomes very much the woman's responsibility (E32 – Physician)*

## **Category IV – Sensations experienced by the teams when working in contraceptive care**

*Very comfortable. I think I feel very comfortable. It's very rare something going wrong, trying to put an IUD and failing. [...] or, when the person doesn't adapt, I feel secure to offer other methods, other options. I feel very secure about it (E17 – Physician)*

*I feel really, really bad. It's frustration. Watch the girls lose. Imagine the fifteen-year-old-girl, with two or three children, what is she going to do? It's complicated. To study and acquire something later and raise these children. It's difficult (E3 – Nursing Technician)*

## **DISCUSSION**

Predominantly, the FHTs have "perceptions related to contraceptive methods to prevent pregnancy/not having children". The focus given to the contraceptive methods and the indication of their basic purpose to avoid pregnancy/not having children denotes an objective view of contraceptive care, focused on physiological aspects, which is commonly presented to the FHTs through the Ministry of Health (MoH) manuals and books related to the theme<sup>(13-14)</sup>.

In the statements from the interviewees it was possible to observe the current use of the terms "family planning" and "birth control" as synonyms for contraceptive care. The term "family planning", although commonly adopted, even to name the law that regulates it in the country (Law No. 9,263/96)<sup>(15)</sup>, has been questioned, as it is considered that planning can be idealized even without the intention of establishing a family. With this understanding, the MoH suggests replacing the term "family planning" with "reproductive planning". It is about the adequacy of the nomenclature, although the concept is the same: a set of actions to regulate fertility with guaranteed sexual and reproductive rights<sup>(14-15)</sup>.

In turn, the term “birth control” is associated with the imposition of laws and state policies on people’s reproductive life, for the purpose of demographic control. In Brazil, it is a crime to act in this direction<sup>(14-15)</sup>. The conceptual confusion does not seem to be a random one: perhaps it is because of what is in the imagination of the participants. A study that analyzes the theme in the national context states that, in Brazil, reproductive planning actions were “[...] a clear birth control policy disguised under the euphemism of family planning, thus being a maneuver [...]”<sup>(16:129)</sup>.

There are also reports of complaints about the high number of sterilizations, aimed at poor and black Brazilian women, carried out inadequately by assistance institutions financed by foreign capital<sup>(17)</sup>. This was found by the National Demography and Health Survey (Pesquisa Nacional de Demografia e Saúde, PNDS), carried out in 2006, when it showed the persistence of social inequalities related to reproductive planning: the risk of a woman residing in the Northeast region being sterilized is 52% higher than that of a woman from the South region<sup>(18)</sup>.

On the other hand, some participants presented “perceptions related to STIs, sexuality, professional services, sexual and reproductive rights, women’s autonomy, and economic and social conditions”, linking the concept of contraceptive care with other spheres that permeate the theme. It is extremely important to note that the members of the FHTs draw this parallel between sexual health issues, especially those related to the prevention of STIs, including HIV, and contraception care. Due to the feminization, youth, and pauperization of the AIDS epidemic, the Ministry of Health promotes that the actions are worked on together<sup>(14)</sup>.

It is known that the contraceptive methods with the lowest failure rate for pregnancy are those that least protect against STIs; therefore, the perception of risk for STIs affects the choice of the contraceptive method<sup>(19)</sup>. A very widespread concept is that of double protection, that is, contraceptive methods that simultaneously promote protection against STIs and against pregnancy. Stimulating the use of condoms (male or female), associated with the use of another contraceptive method, seems to be the most adequate option, mainly considering the implications of an unplanned pregnancy and the incidence of STIs/HIV<sup>(19)</sup>.

In relation to sexuality: talking about sexuality is still considered a taboo. Many professionals experience difficulties in addressing this theme during the consultations<sup>(14)</sup>. It should be noted that, dealing with contraceptive aspects allows, to a certain extent, accessing issues related to sexuality (and vice versa).

With little predominance, however with depth, some speeches were related to sexual and reproductive rights. Understanding contraceptive care from the perspective of sexual and reproductive rights is one of the most comprehensive views, as it considers that people have the right to decide whether or not they want to have children freely and responsibly, as well as the right to freely live and express their sexuality<sup>(14)</sup>.

At the 1994 International Conference on Population and Development (ICPD) held in Cairo, and at the IV World Conference on Women of 1995 held in Beijing, the notions of sexual and reproductive rights, as well as the concept of women’s empowerment, entered the agenda<sup>(20-21)</sup>. Despite this, in the context of sexual and reproductive health, it is common to identify rights being restrained<sup>(17)</sup>. For this reason, all these expanded and related perceptions to themes that permeate contraception care, signaled by the participants of this research, have the potential to provide opportunities for the improvement of the care offered.

An example of this are the findings of the “essence of the actions” subcategory, which has understood the issue of information, guidance, advice, and surveillance. In essence, it is advice in different measures. According to the MoH,

[...] contraceptive care presupposes the provision of information, counseling, clinical follow-up, and a range of contraceptive methods and techniques scientifically

accepted that do not endanger people's lives and health, for men, women, adults and adolescents, in a context of free and informed choice<sup>(14:111)</sup>.

And it recommends the consideration of some points during counseling in contraceptive care: the preference of the woman, the man or the couple; the characteristics of the methods (effectiveness, side effects, acceptability, availability, ease of use, reversibility, protection against STI/HIV); the individual factors and the context of life related to the users, such as economic conditions, health status, personality characteristics of the individual, stage of life, sexual behavior pattern, reproductive aspirations, cultural and religious factors, as well as other factors such as fear, doubt, and shame<sup>(14)</sup>. It is noticed that there are many and varied considerations when advising on contraceptive methods and techniques, as well as that the types of the actions offered are varied.

In the "types of actions" subcategory, individual consultation was the predominant model. Many speeches point to the conduction of educational groups as a possibility; however, they bring reservations regarding this action strategy. There were also a few statements related to activities in schools, as well as to educational groups. School activities were identified as a possibility for improving contraceptive care.

The different ways of acting in contraceptive care (appointments, educational groups, procedures and/or techniques, home visits, school activities, team meetings, and case discussions) show that there are numerous strategies to implement this care in PHC. In addition, these different modes of action provide opportunities for all members of the FHts, within their responsibilities, to continuously contribute to the improvement of contraception care. And, when relating the speeches, it is noticed that a link is established among the ways of acting, that is, there is a strong connection between the actions of all members of the FHts and, as a consequence, depending on how they act, there is repercussion in the chain of actions offered and carried out in relation to contraceptive care.

Here is one of the fundamentals of PHC, which promotes teamwork so that not only actions are shared, but also that the care capacity of the entire team is expanded<sup>(5)</sup>. The reservations made by the participants in relation to the activities in the schools show that the promotion and prevention actions that articulate training, education and health practices, especially the sexual and reproductive health education advocated through the Health at School Program (*Programa Saúde na Escola, PSE*), are not being carried out systematically by the FHts<sup>(5)</sup>.

When mentioning the different types of actions, "types of access" also emerged, with a significant predominance of receiving spontaneous demand. A lot has been discussed about the concept and ways of receiving demands. However, for the MoH<sup>(22)</sup>, receiving demands is revealed in concrete practices and care relationships in addition to the discourse. In essence, receiving spontaneous demand enables, among other things, the most basic element that can be offered to the users of the health services: access.

This universal access is one of the PHC guidelines, the preferred "gateway" of the Health Care Network (*Rede de Atenção à Saúde, RAS*), with the capacity to receive, link, account for, and resolve issues in health care<sup>(5)</sup>; consequently, and when pertinent, also for issues of contraceptive care.

In turn, in the "does not act or perceive limits in the performance" subcategory, it appears that some members of the FHts do not perceive themselves as agents of action in contraceptive care. However, the ways of acting are numerous and have the potential to involve the entire team. The National Policy for Primary Care (*Política Nacional da Atenção Básica, PNAB*) lists 18 attributions common to all PHC professionals, among which is the guarantee of health care by means of health promotion, protection, and recovery actions and prevention of injuries with a view to integrality, guarantee of meeting spontaneous demand, carrying out programmatic, collective, and health surveillance actions<sup>(5)</sup> and, among these attributions, it is appropriate to include contraception care.

When considering the perceptions that the FHts have on contraceptive care, as well as the actions performed, the participants described that the contraceptive care offered is predominantly demanded by young women, especially adolescents, with variation among nulliparous or multiparous women, of low purchasing power and low schooling (“most common characteristics” subcategory).

The “uncommon characteristic” subcategory has the most punctuated speech in the male figure. Regarding the woman/man relationship, it is questioned why the topic of contraception is still an almost exclusive attribution of women. This discussion will be based on the political-legal context of the Brazilian scenario. At the beginning of the 1980s, there was the Comprehensive Women’s Health Care Program (*Programa de Atenção Integral à Saúde da Mulher*, PAISM) and the feminist movement as precursors in the struggle for women’s health care focused on sexual and reproductive health<sup>(17)</sup>, that is, movements of women who, with legitimate acts, called for the responsibility and control of their bodies.

On the other hand, despite these efforts, until the 1988 Constitution, there was a perverse social way of paternity: the illegal one, which corresponded to children born out of marriage. The law did not require recognition of bastard children. Pure and simple denial of paternity was allowed if the man wished so<sup>(23)</sup>. With these divergences, it is imagined that the same generation would make the following reading: women are calling responsibility for the issue of contraception, while men are still protected by a law that exempts them from any responsibility on the subject.

Discussions deepen over time and, to some extent, there is an improvement in laws that protect children<sup>(24)</sup>. Then, under the new rules and understandings, there are adjustments in public policies, for example the National Policy for Comprehensive Care for Women’s Health (*Política Nacional de Atenção Integral à Saúde da Mulher*, PNAISM)<sup>(25)</sup> and the National Policy for Comprehensive Care for Men’s Health (*Política Nacional de Atenção Integral à Saúde do Homem*, PNAISH)<sup>(26)</sup>.

The first appeared in 2004 and, among other points, has as one of its objectives fostering the implantation and implementation of what is called assistance in family planning. It is interesting to note that this is the only objective, among the others of this policy, which encourages the participation of men and women, adults, and adolescents in actions concerning the theme<sup>(25)</sup>. In this same perspective, four years later, PNAISH comes to guarantee men the right to participate in what is now called reproductive planning, and the same policy dictates that there is an urgent need to overcome the exclusively female responsibility over the contraceptive practices<sup>(26)</sup>.

Despite the driving force of the policies, little is reflected on the practice of the health services, as observed in a study<sup>(27)</sup> which explores this (dis)articulation between the care provided to men and women in PHC services. It was concluded that there are inequities and a polarization of woman-reproduction versus man-sexuality in the organizational structure of the health services. In order to overcome this logic, they bet on the integrality of the services to (re)articulate the issues of sexuality and reproduction for men and women<sup>(27)</sup>.

From another study<sup>(28)</sup>, which explores the nurses’ perception of the family planning service aimed at the male population, results emerged showing that shame, prejudice, and fear of feeling vulnerable are the possible reasons for the male patients distancing from the health services and, consequently, from sexual and reproductive health actions. In relation to the demand for sterilization (vasectomy), the biggest obstacles are the preconceived and mistaken ideas that men still have on the topic<sup>(28)</sup>.

Finally, on the “sensations experienced by the FHts” when working in contraceptive care, it was observed that the statements illustrate feelings of well-being, duty fulfilled, pleasure, and security. But some members of the FHts, depending on the situations experienced, point out that they feel insecurity, frustration, impotence, and discomfort. It is known that the therapeutic relationship between the health professional and the user is very important for conducting the health process. And from this relationship, feelings emerge, sometimes not favorable for the establishment of the bond, which is so necessary



for the maintenance of this relationship.

Therefore, identifying these sensations on the part of the members of the FHTs when acting in contraceptive care will allow considering all these feelings for understanding and not judging the dynamics of the users' lives<sup>(14)</sup>.

When (re)visiting the sensations, whether positive or negative, that emerge when acting in contraceptive care, the FHTs can improve this care, in a constant movement of change. This is because, when they feel secure, experiencing a sense of accomplishment and happiness with their performance, the FHTs will be able to maintain and improve the standard of care offered. In the opposite sense, when they feel frustration, impotence or insecurity, they can mobilize in search of new alternatives to improve this care, thus overcoming a simplistic and deterministic logic on the theme, to articulate with contraception care issues such as sexuality, gender relations, and responsibility of the subjects<sup>(29)</sup>, in search of reproductive autonomy<sup>(30)</sup>.

It is noteworthy that this study was limited to identifying the perceptions of FHTs about contraceptive care in a capital in the South of Brazil, with considerable prominence in the national scenario; therefore, it is not appropriate to attribute generalizations to the results described.

## CONCLUSION

The arguments and counterarguments presented regarding contraceptive care and its related topics have the potential to be widely discussed, deepened and applied by the FHTs during the work process, aiming at improving this care.

It is noteworthy that this study contributes to the construction of knowledge, not only for Nursing, but for the entire context of the FHS, mainly because it recognizes that contraception care must and can be offered by the entire FHT in a shared way, on a permanent basis and with constant balance.

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