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Do you get pregnant only if you want to? Educational practices in reproductive planning actions

Só engravida quem quer? Práticas educativas nas ações de planejamento reprodutivo

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ABSTRACT
This scientific paper aimed to understand the weaknesses and potentialities in reproductive planning actions in the health care network, with an emphasis on educational practices with users. This research is qualitative and was carried out in Primary and Secondary Health Care Units, located in a city in the Metropolitan Region, in the countryside of the Brazilian Northeast, from February to March 2015. This study had 20 participants: four nurses, twelve users and four key informants, who are professionals who work in the units under study. Semi-structured interviews and systematic observation were used for data collection and hermeneutic-dialectic analysis for organization. In the daily life of services, health education is restricted to lectures and the preventive theme of conception. Users expressed little information and understanding about reproductive planning and use of methods. It is considered that educational practice requires dialogical strategies to recognize special demands and needs in the search for guaranteeing sexual and reproductive rights in comprehensive health care.

Keywords: Delivery of health care. Family planning. Sexual and reproductive health. Unified health system.

RESUMO
O estudo objetivou compreender as fragilidades e potencialidades nas ações de planejamento reprodutivo na rede de atenção à saúde, com ênfase nas práticas educativas junto às usuárias. A pesquisa é do tipo qualitativa e foi realizada em Unidades de Saúde da Atenção Primária e Secundária, localizadas em um município da Região Metropolitana, no interior do nordeste brasileiro, nos meses de fevereiro a março de 2015. O estudo contou com 20 participantes: quatro enfermeiras, 12 usuárias e quatro informantes-chaves, que são profissionais que atuam nas unidades em estudo. Utilizou-se entrevista semiestruturada e observação sistemática para coleta de dados e análise hermenêutica-dialética para sua organização. No cotidiano dos serviços, a educação em saúde se restringe às palestras e à temática preventiva da concepção. As usuárias expressaram pouca informação e compreensão sobre planejamento reprodutivo e uso dos métodos. Considera-se que a prática educativa requisita estratégias dialógicas para o reconhecimento de demandas e necessidades singulares na busca da garantia dos direitos sexuais e reprodutivos na atenção integral à saúde.

Palavras-chave: Assistência à saúde. Planejamento familiar. Saúde sexual e reprodutiva. Sistema Único de Saúde.

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INTRODUCTION

Family Planning (FP) comprises a set of basic actions in the provision of sexual and reproductive health care. In its operation, it must offer services, medicines and input that enable people to make a free and spontaneous decision whether or not to have children, as well as the number of children and the desired birth spacing. To this end, resources must be provided for conception, contraception and prevention of unplanned pregnancy, guaranteeing the freedom to choose the most appropriate method.[1]

The decision of whether or not to have children or when and how many children people or couples decide to have can directly impact the fertility levels of the world and the structuring of families with minors or without children. It is also worth noting that there is a worldwide difficulty in making reproductive rights excellence for people, given the frustration with the search for reproductive rights in health systems, both in essential services and in the supply of contraceptives. Other factors also influence FP, such as gender inequality, economic barriers, low quality of employment, remuneration and the absence of daycare centers.[2]

Fertility is related to social practices and people's power to make choices about the number of children, intervals of pregnancy or non-pregnancy are attitudes observed by the policies that accompany economic development, as well as sustainability and well-being for people. High fertility creates challenges for countries in providing quality education to children, medical care, employment opportunities for young people, high rates of maternal and child mortality and reduced human capital. The higher the fertility rate, the greater the disorderly growth of the population. Low fertility is associated with an increase in social security and social security networks, resulting from populations of older people.[3]

Since the 1960s, there has been a global movement on reproductive rights aimed at accessing the information and means necessary to make decisions about people's FP. During this period, the average number of births per woman was 4.8 children, compared to 2.9 in 1994 and 2.5 today. In Latin America, the fertility rate was 5.4 children in 1969; three in 1994 and currently two children. In Brazil, the rate was 5.2 children per woman in 1960; 2.6 in 1994 and 1.7 in 2017. However, the percentage of women with some type of stable union between the ages of 15 and 49 who are not using any contraceptive method is 7% for Brazil, 10% for Latin America and the Caribbean and 12% worldwide.[4]

In recent years, the FP has made progress in countries with lower world income. In 69 countries, 314 million women and adolescents, out of a total of 926 million of childbearing age, are using modern contraceptive methods such as condoms, pills and implants, with 53 million new users in the last seven years and 9 million in 2019. Of the surveyed countries, 41 are in Africa, 21 in Asia and Oceania, four are in Latin America and the Caribbean and three in the Middle East.[5]

In addition to the high fertility rate providing poor prognosis for populations, unplanned pregnancy is another important factor resulting from the absence of FP. This situation usually occurs during adolescence due to the couple's inexperience or is related to marital infidelity. The absence of goals and strategies for sexual education in school settings, for example, would open space for individual and collective reflection on responsibilities involving sexuality, contraceptive methods, pregnancy, abortion and sexually transmitted infections (STIs).[6]

Thus, healthcare services must offer quality care, either individually, to couples and/or in groups, in order to promote access to the necessary information with counseling, educational activities and clinical activities, which can guarantee the free and appropriate choice of method. For this, adequate

infrastructure in the healthcare network is necessary, with sufficient material, technological resources, equipment and input to develop the planned actions.[7]

For the person to freely and informedly choose the desired method, the right to information that provides autonomy and decision-making power must be guaranteed. It is recommended to consider the current and past clinical history, personal and family pathological history, and age.[8]

It is claimed that FP programs have expanded approaches to human reproduction, which go beyond the performance only in contraception. For this, it is assumed that their actions comprise an educational process integrated with people in their needs and demands on fertility, sexuality and pregnancy. It is necessary that people have the opportunity to decide about their offspring and sexual life, through health education. Through dialogues in health care, it is possible to strengthen the subjects' autonomy by recognizing their unique and behavioral conditions.[9]

In the FP offered in healthcare services, users' autonomy must be a major factor in reproductive health, in the sense of recognizing the relevance of fundamental rights - sexual, reproductive and contraceptive methods. The conduct of clinical and care practices must be in an ethical and professional relationship, promoting shared decisions, with adequate information and multiple options.[10]

In this context, individual or collective educational practice has been shown to be relevant in preventing pregnancy, reducing abortion and planning the children of users who seek FP; this practice must always respect people's autonomy, the free choice of the method and elaboration of its planning according to each one's uniqueness.[11]

The choice of contraceptive method must take into account aspects such as the method's effectiveness, side effects, acceptability, availability, ease of use, reversibility, protection against sexually transmitted diseases and HIV infection, in addition to individual factors, such as economic conditions, health status, the personality characteristics of the woman and/or man, the stage of life, the pattern of sexual behavior, reproductive aspirations and cultural and religious factors.[7]

The Brazilian Unified Health System (SUS) provides, free of charge, eight types of reversible contraceptive methods, among them, female and male condoms, oral pill, mini pill, monthly injectable, quarterly injectable, intrauterine device (IUD), emergency contraceptive pill, diaphragm and vaginal rings. In addition to these, there are the definitive methods, tubal ligation and vasectomy, which are procedures performed through surgical interventions.[12]

It is noteworthy that, even with the availability of contraceptive methods guaranteed by public policies, there are still aspects related to the insufficiency of this distribution, but also related to the correct use of the methods in accordance with medical prescriptions.[13] In this context, how access to information on sexual and reproductive health occurs to SUS users, as well as the lack of prioritization of FP actions in health care networks, are questioned.

Assistance to reproductive life planning (RLP) consists mainly of health promotion, prevention, information and education actions.[9] This is the most appropriate term to address issues related to FP, since it is based on respect for sexual and reproductive health and rights (SRHR), which imply the expansion of actions directed only to the offer of methods and techniques for conception and contraception, contributing to the change of the controlling approach of the offered assistance, rooted in the operationalization of the FP.[7] Given the above, the objective of this study is to understand the weaknesses and potentialities in reproductive planning actions in the health carenetwork with an emphasis on educational practices with users.

METHODOLOGY

It is a qualitative research with a hermeneutic-dialectic approach.[14] The scenario was made up of health units in a municipality based in the Metropolitan Region in the countryside of the northeast of Brazil. The consolidated criteria for reporting qualitative research (COREQ) were followed.[15]

The municipality has 54 health establishments affiliated with SUS, and has 27 Family Health Strategy (FHS) teams. Of these, three Basic Health Units (UBS) were selected for the study, located in the urban area, chosen by criteria of areas with higher population density and service, as well as their representative location in the territory of the municipality's headquarters. It also included the Center of Excellence in Reproductive and Sexual Health (CEMEAR) - specialized care service and reference for the municipal primary care network -, chosen due to the fact that it also assists FP users.

Twenty people participated in the research, being 12 users, four nurses and four key informants, who are employees of the chosen Health Units and the specialized service, acting in the supply of input and general care. As inclusion criteria, nurses were selected for participating in the care for users in RLP. Users were chosen if they participated in the nursing consultation. The key informants were defined during the development of the research as they comprise activities related to comprehensive care, dispensing medications and scheduling tests and/or procedures. In the development of the research, the final sample was defined when the information about the study covered the multiple dimensions of interpretation[14].

Data collection was carried out from February to March 2015, using two techniques: semi-structured interviews and systematic observation. The collection was conducted by a nurse, master's student in nursing, with no experience in any of the research locations.

The interviews took place after the nursing consultation individually at different times from one user to another, in a room that was not being used at the time, to protect the privacy of the research participants. After collecting the users' information, when there was no demand in the program, the nurses and informants were interviewed in the nursing room, at a time established before or after the daily care. The interviews lasted 15 minutes on average.

The interview was based on questions about access, contraceptive methods and educational practices. For users, the questions were: 1) Have you ever visited the Health Center to get the pill or contraceptive method?; 2) Were you assisted when you sought the service ?; 3) Did you obtain information about the method before or during the consultation ?; and 4) Was this information sufficient to answer your questions? For nurses, the questions were 1) Do users understand the importance of using contraceptive methods?; 2) Does the guidance cover all existing methods ?; and 3) Is there an educational practice addressing the theme of family planning? And for the informants, these were the questions: 1) Is there any educational practice regarding family planning? and 2) Do women report questions about any method?

The reception of health professionals to clients and the exposure of clear and understood information by users were systematically observed. The observation time was carried out according to the day of family planning of each service, an average of 4 hours, that is, a daily shift, for one month.

The information was recorded in audio with a digital recorder, with the literal transcription of the interviews in an electronic text document, being organized in files identified with codes, in addition to the notes observed and recorded in a field diary.

For data analysis, the qualitative material technique was chosen from the hermeneutics-dialectics[14] approach. The data were analyzed by the nurse who collected them, by the supervising professor and members of the research group where they were all inserted. In this analytical process,

deep and critical understanding of reality were emphasized, considering daily changes, dialogues and subjective relationships between people, carried out in three stages:[14] the ordering and clarification of data, with exhaustive reading of the material, transversal interpretation of information and the final and deep analysis of the findings.

The ordering of the data occurred through the set of interview material, which included: transcription of the statements, re-reading of the material, ordering the reports, assuming a start of classification; and organization of observation surveys, respecting an order according to the analytical proposal. Subsequently, each unit of meaning was classified with a horizontal mapping. The convergent, divergent and complementary aspects of each group of statements that were related to the study question were extracted. In the last stage, cross-sectional understanding was interpreted through the meanings and critical and reflective categorization and argumentation.

As for ethical aspects, the study complied with the precepts that involve research with human beings, in accordance with resolution no. 466/2012, of the National Health Council.[16] The interviewees were identified by the letters U (User), E (Nurse) and I (Key Informant), followed by Arabic numerals. Observations were identified without coding. The research was approved by the Human Research Ethics Committee of the Regional University of Cariri (URCA), under no. 953,800/2015 and CAAE 40830414.0.0000.5055.

RESULTS AND DISCUSSION

From the analysis of the statements of all the participants and records of the observations in the context of primary and secondary care, it was evident that the RLP actions are directed to aspects restricted to female contraception. This way, the description of the mentioned practice is presented to the users, addressing the informative and educational dimensions, focused on assistance.

In the daily routine of UBS services, health education initiatives for this theme are still restricted to lectures, with participation linked to the offer of snacks or gifts, almost always afforded by nurses.

> *Because people here do not give much value to the educational activity, they come if they're given a treat. It is so much that we brought things here, that we bought. A treat, afforded by ourselves to bring treats [...] and the snack, otherwise they won't come. They won't* (E2).
> *The nurse takes out of a bag several baby hygiene kits, diaper packs and souvenirs that will be raffled for pregnant women who attend the lecture on breastfeeding. [...] in the baby's week [...]* (OBSERVATION).

According to the reports, it was noticed that the professionals expressed a complaining and unmotivated speech, believing that the users participate in the lectures in search of exchanging for something material and, still, that few women feel encouraged to attend. This situation was observed regarding the formation of groups, as maintaining them frequently, quantity of participants and quality, becomes a challenge for the nurse's work.

There are difficulties related to insufficient training for professionals within the educational practices on reproductive planning, and it is complemented by the lack of interest in clarifying and encouraging the user to use different or more appropriate methods. Such situation results in limited direction to the use of conventional methods, the resistance of users to participate in educational activities and the continuity of the univocal perspective of contraception, as the only option offered by healthcare services.[17]

Studies demonstrate that some factors can

directly and negatively interfere with adherence to health education actions, and professionals need to create positive situations that do not allow demotivation to interfere in the professional-user relationship, in order to maintain positive reception and the bond,[18] because if these professionals have a reductionist conception about SRHR they will end up passing on information inconsistent with the appropriate recommendations, harming the population's right to access.

The literature argues that educational actions, even using different strategies, with more effectiveness for participation, remain focused on guidelines on contraceptive methods, when they should address aspects related to sexual and reproductive health - such as information about human sexuality, sexually transmitted infections or even maternity and paternity.[19]

Another aspect worth mentioning is the approach to sexual and reproductive education, which is increasingly accepted by the community in the school context, being reinforced by an informant who reiterates the insertion of these contents in school environments, as intervention spaces.

> *I mean, nowadays, you only get pregnant if you want to. At school it's taught, there are lectures, no more innocent people. No! Because people start to learn at a young age, at school, in the science book the third, fourth grade boys already have the little boy naked and the little girl naked and they learn about it. At school it's taught that there are condoms, medicine, that there are many options. And it's all free. Why do they get pregnant? Carelessness* (I3).

> *The informant shows an amount of 10 requests for HCG exams during the week, reporting that the majority of users are teenagers* (OBSERVATION).

The perception of educational actions and their sufficiency for knowledge about protection practices in the sexual act, prevention of unplanned pregnancy and in relation to sexuality itself are clear and justified because they happen from the school environment, aimed at students from nine years old, when the dialogue on these topics starts. The Health in School Program (PSE)[20] seeks mainly to prevent STIs and early pregnancy, and other aspects of adolescents' SRHR must also be addressed, since they are also citizens with rights.

The moment when children and adolescents are experiencing in the school period provide the acquisition of new knowledge and, in search of answering questions about themselves, they become information multipliers. Thus, the orientations directed to their life and sexuality projects are important to avoid early or unplanned pregnancies and communicable diseases.[21]

On the other hand, thinking about adolescent health means thinking about the different ways of living adolescence and living life. However, it implies a movement to rethink health education practices that focus on this significant portion of society.[22] The lack of significant approaches to the theme in the school environment leaves adolescents, especially those who do not have dialogue in the family environment, unassisted about knowing ways to prevent pregnancy.[23]

Thus, health education, depending on who and how it is practiced, can both enable the construction of autonomous subjects in their analysis and choice processes, and can contribute to the reproduction of a population unable to reflect critically on the realities surrounding them.[24] It is necessary to understand human relationships, such as the formation of bonds, autonomy and welcoming in the encounter between the professional and the user.

In this scenario, another aspect evident in the educational practices developed occurs in the presence of undergraduates in the UBS, bringing some accommodation on the part of the professionals who justify lack of time.

> *No, it's not done! Mainly because we don't have much time for lecturing. And [...] the lectures are sometimes held when there are students, when there are students from Higher Education Institutions they guide with lectures* (I4).

> *Not in my routine, I did it a long time ago. I think there is a certain melancholy, a certain professional strain. I think, I don't know, because that has been going on for some time. Before I did more, in the meeting room I felt more like meeting women and doing an educational activity, showing all the methods, you know* (E2).

It is evident, then, the comfort of the professionals in the face of the situations found in their own work routine, who often prefer individual service to the collective one, probably due to the constant presence of undergraduates at UBS leaving them in comfortable situations regarding educational practices.

It is emphasized that educational actions, regardless of the methodology adopted, must maintain a participatory character, with an exchange of information and experiences, based on the experiences of each individual.[25] Relationships that promote collaboration and communication are also assumed in order to contribute to the development of work, based on dialogical and horizontal relations.

In this way, health education actions with non-vertical information, constructed as a group based on the users' demands, contemplating their future perspectives, expand the understanding regarding reproductive planning and reproductive health.[26]

From the interviewees' statements, the need to discuss and implement a strategy to guarantee reproductive health rights is evident. The context of Primary Care should make it possible to do health in other ways, integrating feeling, thinking and acting, imbued by the process of changes in care practice and the expansion of care for integrality.

According to the statements and observation that follow, there is the formation of a group with the use of the flipchart and dynamic language to arouse the users' attention in the context of secondary care. However, small space, scarce time, absence of educational material and high demand are difficulties for the FP.

> *It was necessary to have our own space, a material, so that we could expose, so that we could have a bigger discussion, where the patient could also express herself, ask questions and also learn. According to the procedure with what is necessary, what step, she will follow. So, you know, we don't have much material for us to make this group. The group schedule does not provide this either. Because the group time is a time before medical care* (E4).

> *In the specialized service surveyed, it is noticed the permanence and continuity of educational lectures, and despite the difficulties mentioned, the educational practice happens, weekly, by a multiprofessional team.* (OBSERVATION).

There are some situations that hinder health education actions, which absorb issues related to users, healthcare professionals and management. Among others[27]: limited supply of contraceptive methods, the inadequate physical space of healthcare services to provide guidance and the lack of professional training on contraception. Respondents also recognize[28] obstacles regarding the lack of continuing education actions; existence of personal difficulties, concerning knowledge sharing; and the excessive demand for work.

Thus, for the full implementation of RLP actions, managers must guarantee the necessary infrastructure for the functioning of healthcare services, providing them with material resources, appropriate technologies, equipment, ambience and sufficient inputs for the set of actions proposed to support the processes of permanent education and

structure the reference network beyond the scope of Primary Care, at other levels of health care.[29]

The informative focus of communication practices between users and the healthcare team surround contraception and are noticeable under the central aspect of reproductive planning.

> *More or less, I was afraid to have the IUD inserted, because I no longer menstruate, I only menstruate very little. Then I said, no, I'm not going to, what if don't menstruate at all, then I get more disturbed (laughs)* (U1).

> *I took all the time until I got it [pregnant]. Taking the pill. Yeah. That's why, after I got pregnant with her, I preferred the injection. And ... I was just a little bit like that after I had the girl* (U2).

Although the lack of information on female sexuality, understanding of contraceptive methods, motherhood, among others, are recognized, the most strategic way should be to seek a dialogue with these women, so that healthcare actions that can meet their real needs and interests are built.

In this context, it is emphasized that healthcare professionals must act by doing healthcare education individually and/or in groups, discussing what the RLP is, what is its importance in the life of the woman, man or couple, which contraceptive methods made available by the Ministry of Health are, how to use them and what are the possible side effects and/or complications of each, always taking into account the users' personal desire for contraception.[30]

In this way, the possibilities of autonomy are extended to the subjects who share it through the relationship driven by dialogue, strengthening the bonds and having greater understanding and communication with team members and with users inserted in spaces that provide learning of useful tools for the service and enable the client to exercise their rights, recognizing contraceptive methods and making choices freely.[31]

The dialogue provides a care relationship and creates a bond of trust in the communication exposed between the parties involved. Therefore, empathetic behavior with attitudes is necessary, expressing reciprocity and welcoming attention on the part of professionals.

When the relationship established in health care is weakened, in its potential to welcome, listen or give a more adequate response, users will seek information about contraceptive methods in other closer meetings.

> *No. I was always looking, as I was studying nursing, for my teacher. I would reach out to her, "Teacher, I have questions about this here, that ...". I used to take everything from college, because, as I already told you, they do not give you the understanding you need at the health care centers, due to the great demand of people, right?* (U5).

> *More about friendship, television, those things, I guess. At school, right? Everywhere, because today information is everywhere. I think that's it* (U6).

> *Then, I tell my boss, because she is a Nurse too, that I think I have been wanting to take it for many years. And now, [Name of daughter, breastfeeding] is already stopping breastfeeding and menstruation is about to start, right?* (U11).

The need for health care practices that meet the specificities and uniqueness of users requires establishing bonds and spaces for interaction. The relationships allow to organize work and produce health care, as the practices depend on this relational dynamics between healthcare professionals and users, articulated with the organizational/managerial processes.[24,31]

The creation of effective bonds between healthcare professionals and users establishes relationships of exchange and trust, contributing significantly to autonomy, the expansion of co-

responsibility and the guarantee in the follow-up of care based on education.

Under this focus, the bond starts to be considered as a landmark of great importance and relevance in the SUS, through the conceptual change of the relationship between the professional and the user of a healthcare service.[24] For the RLP, it is necessary to constitute a learning space that overcomes biological reductionism, promotes dialogical spaces with the exchange of experiences on sexuality and reproduction and strengthens the subjects' autonomy for their reproductive choices.[9]

For the proper functioning of the program, it is essential that the Health Units make the different contraceptive methods available, and in an amount compatible with the local reality, so that the assistance and educational actions are developed in an integrated way, to bring the service closer to the community and meet different needs.[8]

In the health services under study, RLP actions should be directed towards a new look with users, seeking to overcome a practice performed by isolated actions that, at times, are limited only to meet the demands of contraception. It is necessary to overcome these gaps, expanding the look at health care from the perspective of comprehensiveness, which are fundamental in the process of care in this area.

When working from the perspective of the interrelationships between care and education, inseparable, the existence of a reflective process is revealed, with autonomy and co-responsibility in health care. In attitudes still restricted to instructional health education in the form of lectures or groups, as well as individual consultation, the need for information and communication is revealed. Thus, the relationships of/between users in the RLP, permeated by articulated practices and approached in a libertarian sense and committed to the other, unleash possibilities that promote change, making them protagonists and with an attitude to say: you only get pregnant if you want to!

FINAL CONSIDERATIONS

Nurses approach the RLP with educational practices and guidelines aimed at passing on information about the various contraceptive methods. However, the lack of information on methods and understanding of proper use are recurrent among users. It is also evident that there is a need to expand the possibilities of building autonomy and co-responsibility for women, driven by horizontal education for the exercise of conscious decisions.

In this sense, healthcare professionals working in this scenario should favor the development of more welcoming and humanized practices, guided by qualified listening, valuing the subjectivity of the subjects involved in the care process.

It is noteworthy, then, that the services bring potentialities to the assistance to the RLP when they provide guidance, scope of care and sharing of contraceptive methods. However, they are limited to the use of more directive technologies associated with health care, such as lectures and individual guidance, which may make it unfeasible or limit some potentialities, such as dialogue, as well as the integrality of nursing care.

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