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The role of family planning in primary health care: mixed methods of data analysis

Papel do planejamento familiar na atenção primária à saúde: métodos mistos de análise de dados

Papel de la planificación familiar en la atención primaria de salud: métodos mixtos de análisis de datos

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Abstract

Introduction: Family planning within the scope of primary health care comprises an essential set of actions capable of guaranteeing the right to reproductive health for patients of the Brazilian Unified Health System. However, several obstacles prevent its full implementation, causing many citizens not to access this service. **Objective:** To analyze the role of family planning in the construction of parenting from the perspective of users of primary health care services in Fortaleza (state of Ceará, Brazil). **Methods:** Cross-sectional mixed methods study with concurrent data triangulation, according to Creswell and Clack. For the quantitative phase, 60 parents were selected to respond to a structured questionnaire, of whom 12 participated in the qualitative phase through semi-structured interviews. **Results:** Regarding the responses to the questionnaire, most participants had their first child between the ages of 17 and 20 years, currently have two children, and remain with the same partner as when they had their first child. The interviews showed lack of knowledge of family planning, attributed to the scarcity of assistance, lack of acceptance by healthcare professionals, inefficiency of policies, and lack of interest on the part of the population. The triangulation of methods showed complementation and corroboration between quantitative and qualitative data. Data integration enabled us to observe an appeal to the population's co-responsibility in relation to family planning and the need for more training and awareness of the topic among healthcare professionals. **Conclusions:** It is necessary to advance the family planning approach in the context of primary health care, in such a way that it can become an actual place of care, exchange, and development of effective and affective parenting.

Keywords: Family development planning; Family relations; Data analysis; Primary health care.

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Resumo

Introdução: A assistência ao planejamento familiar no âmbito da atenção primária compreende um importante conjunto de ações capazes de garantir o direito à saúde reprodutiva aos usuários do Sistema Único de Saúde brasileiro. Entretanto vários obstáculos impedem sua implementação plena, fazendo com que muitos usuários não tenham acesso a esse serviço. **Objetivo:** Analisar o papel do planejamento familiar na construção da parentalidade sob a ótica de usuários de serviços de atenção primária à saúde em Fortaleza (CE). **Métodos:** Estudo transversal de métodos mistos, com triangulação concomitante de dados, de acordo com Creswell e Clack. Para a fase quantitativa, selecionaram-se 60 pessoas em exercício da parentalidade para responder a um questionário estruturado, das quais 12 participaram da fase qualitativa através de entrevistas semiestruturadas. **Resultados:** Em relação às respostas ao questionário, a maioria dos participantes teve o primeiro filho entre 17 e 20 anos, atualmente possui dois filhos e permanece com a mesma parceria da época do primogênito. As entrevistas evidenciaram o desconhecimento sobre o planejamento familiar, atribuído a escassez da assistência, falta de acolhimento pelos profissionais de saúde, ineficiência de políticas e desinteresse da população. A triangulação de métodos evidenciou complementação e corroboração entre os dados quantitativos e qualitativos. A integração de dados permitiu observar um apelo à corresponsabilidade da população em relação ao planejamento familiar, além da necessidade de mais treinamento e sensibilização dos profissionais de saúde quanto ao tema. **Conclusões:** É necessário avançar na abordagem do planejamento familiar no contexto da atenção primária à saúde para que este possa se tornar de fato um espaço de cuidado, troca e desenvolvimento da parentalidade efetiva e afetiva.

Palavras-chave: Planejamento familiar; Relações familiares; Análise de dados; Atenção primária à saúde.

Resumen

Introducción: La asistencia a la planificación familiar en el ámbito de la atención primaria comprende un importante conjunto de acciones capaces de garantizar el derecho a la salud reproductiva de los usuarios del Sistema Único de Salud brasileño. Sin embargo, varios obstáculos impiden su plena implementación, provocando que muchos ciudadanos no accedan a este servicio. **Objetivo:** Analizar el papel de la planificación familiar en la construcción de la paternidad desde la perspectiva de los usuarios de los servicios de atención primaria de salud en Fortaleza (CE). **Métodos:** Estudio transversal de métodos mixtos con triangulación concomitante de datos, según Creswell y Clack. Para la fase cuantitativa se seleccionó a 60 personas en ejercicio de la paternidad para responder a un cuestionario estructurado, de los cuales 12 participaron en la fase cualitativa a través de entrevistas semiestructuradas. **Resultados:** En cuanto a las respuestas al cuestionario, la mayoría de los participantes tuvo su primer hijo entre los 17 y 20 años, actualmente tiene dos hijos y permanece con la misma pareja que cuando tuvo su primer hijo. Las entrevistas evidenciaron un desconocimiento sobre planificación familiar, atribuido a la escasez de asistencia, la falta de aceptación de los profesionales de salud, la ineficiencia de las políticas y el desinterés de la población. La triangulación de métodos mostró complementación y corroboración entre datos cuantitativos y cualitativos. La integración de los datos permitió observar un llamado a la corresponsabilidad de la población con relación a la planificación familiar y la necesidad de mayor capacitación y sensibilización de los profesionales de la salud sobre el tema. **Conclusión:** Es necesario avanzar en el abordaje de la planificación familiar en el contexto de la atención primaria de salud para que se convierta en un lugar real de cuidado, intercambio y desarrollo de una paternidad efectiva y afectiva.

Palabras-clave: Planificación familiar; Relaciones familiares; Análisis de datos; Atención primaria de salud.

INTRODUCTION

The family can be described as a representation of the current social construction, capable of apprehending perceptions about the functioning of the social fabric of an era.[1] Nowadays, there is a tendency to choose to delay parenting to meet the social, professional, and personal demands of a couple.[2] Even so, a portion of the population is excluded from this possibility. No wonder, between 2010 and 2015, Brazil had a rate of 68.4 births per one thousand women aged between 15 and 19 years, which is higher than the South American average, 66 births per one thousand women in the same age group.[3]

One of the main factors for the occurrence of teenage pregnancy is the lack of information about sexual and reproductive rights.[4] Other factors include clinical, social, emotional, and familial aspects.[5] In this context, actions carried out in the Brazilian Unified Health System (*Sistema Único de Saúde* – SUS) with the purpose of promoting the stability of families since their constitution have the assistance from family planning (FP), which is predominantly the responsibility of the Family Health Strategy (FHS) teams, the main model of primary health care (PHC) in Brazil. FP consists of a "set of actions of fertility regulation that guarantee equal rights to establish, limit, or increase the number of children per women, men, or couples."[6] Among the several FHS professionals, nurses usually perform FP actions.[7,8]

The Brazilian Ministry of Health (*Ministério da Saúde* – MS) advises that FP activities should involve educational actions, counseling, and clinical activities, in an integrated way, to guarantee access to the basic right to either have children or not. Educational activities, collective and individual, aim to provide knowledge of contraception and sexuality. Counseling involves managing demands, assessing individual's and couples' risk for sexually transmitted infections, and recognizing the importance of joint action between professionals and users. Clinical activities involve anamnesis, physical examination, complementary preventive or diagnostic tests, in addition to treatments and the choice of contraceptive method.[9]

FP still has many challenges in its implementation, especially when used with a controlling bias, placing greater emphasis on contraception rather than guaranteeing conditions conducive to pregnancy.[10] Thus, due to the importance of a broad perspective on sexual and reproductive rights, encompassing women, men, heterosexual and homosexual couples, in addition to the desire to start a family, the term FP has been replaced with reproductive planning.[11]

Internationally, universal access to reproductive health is considered by the United Nations as a fundamental human right. Among the Sustainable Development Goals, a global agenda consisting of 17 goals and 169 targets, the targets 3.7 and 5.6 — of ensuring "universal access to sexual and reproductive healthcare services, including for family planning" and "universal access to sexual and reproductive health and reproductive rights" by 2030, respectively — stand out.[12,13]

In Fortaleza, the capital of the state of Ceará (CE), Brazil, reproductive planning actions carried out by the Municipal Health Department are still traditionally referred to as FP.[14] Both in small cities of Ceará and in Fortaleza, studies indicate that the provision of FP practice is often marked by inconsistencies with the guidelines recommended by the MS.[6,9] There is a lack of care for adolescents, respecting their autonomy and right to safe sexual practices, lack of information, difficulty accessing contraceptive methods and their inappropriate use, circumstances that are also highlighted in the present study.[15,16] In addition, most of the studies, sometimes quantitative, sometimes qualitative, involve only young pregnant women, without the participation of their partners, or are studies on the FP from the perspective of healthcare professionals.[15-19]

In the present study, in an innovative way, by using mixed methods, we aim to bridge the knowledge gaps regarding the role of FP in the construction of parenting from the perspective of users of primary health care services in Fortaleza, Brazil.

METHODS

This is a cross-sectional study using mixed methods with concurrent triangulation of data, according to the framework proposed by Creswell and Clack[20] and Santos et al.[21] This approach was chosen to provide a study capable of contemplating the subject in multiple ways and to avoid leaving gaps in the universe under analysis. The guiding questions of the research were:

1. What is the FP users' perception of parenting?
2. What is the users' perception of the role of the FP?
3. Are there failures in FP actions?
4. Is it possible to develop problem-solving methods capable of tackling such failures?

Qualitative and quantitative data had equal weight attribution and were mixed using integration (Quan + Qual).[20] The survey-type quantitative step was guided by the Strobe (Strengthening the Reporting of Observational Studies in Epidemiology) tool,[22] while the exploratory-descriptive qualitative step was guided by

the Coreq (Consolidated Criteria for Reporting Qualitative Research) tool.[23] The study was conducted in six primary health care units (PHCU), each belonging to a Regional Executive Secretariat (*Secretaria Executiva Regional* – SER) in the city of Fortaleza, chosen by simple random sampling during the period of January 2020.

The research population consisted of users of FP actions, of both sexes and sexually active. The sample from each PHCU was calculated proportionally to the number of users in each SER. A total of 60 individuals agreed to participate in the research. Considering all units, 15 people denied the invite for participation. Participants were personally invited by researchers at the PHCU and selected by convenience. They were individually approached, the research was explained in detail, and then they were asked about the desire for collaboration. When there were doubts, they were promptly clarified. The 60 individuals participated in the first stage, consisting of responding a questionnaire prepared by the authors, of 12 multiple-choice, self-applicable questions, based on literature on the study topic. Of the 60 participants, 12 participated in the second qualitative stage with semi-structured interviews. In this second stage, those who were users of the FP and were pregnant at the time of the performance of the study were included, seeking to assess perceptions of the development of fatherhood and motherhood.

To collect quantitative data for the first stage, the authors prepared a questionnaire containing 12 self-applicable multiple-choice questions, based on literature on the study topic.[24]

During the interview stage, a semi-structured script developed by the authors, with open-ended questions, was used in order to characterize the FP in the construction of parenting, containing the following questions:

1. What was it like when you found out you were pregnant (your partner was pregnant)?
2. How was your quality of life before having children? And how is it like now? What have changed?
3. How did you learn about the FP strategy? How did you start using it?
4. What is your opinion about people's sex education? What do you think should be done about this?
5. If you could go back in time, would you do it differently?

The interviews took place in a private environment, always conducted by the same interviewer, who is one of the authors of the study, without the presence of observers, after the FP consultation, and were recorded on a digital audio device. After each interview, the content of the recordings was fully transcribed. The average duration of the interview was 40 minutes.

The R software[25] was used to analyze quantitative variables, age at the birth of the first child, number of children, and distribution of questionnaire responses. A descriptive analysis was performed regarding the characteristics of the participants and the answers to the questionnaire. For the analysis of questions whose answer options were "No," "Yes," "Sometimes," "Occasionally," and "I don't know," the options "Sometimes" and "Occasionally" were considered as "Yes," whereas the "I don't know" answers were considered as "No." To estimate the measures of position and dispersion for the number of children, "More than 5" was considered as a value equal to 6. Seeking to answer to hypotheses about possible relations between the answers to the questionnaire, 2×2 contingency tables were compiled and the chi-square statistical test, Fisher's exact test, Student's t-test, and Wilcoxon-Mann-Whitney test were applied as well as Kendall's and Spearman's correlations. A significance level of 5% was adopted. Unanswered questions were withdrawn from the analysis.

Regarding the qualitative analysis, thematic analysis was used,[26] which was systematized in the following phases: pre-analysis — skimming of the content of the interviews based on the principles of exhaustiveness, representativeness, homogeneity, and relevance —; investigation of the material — construction of operations for coding keywords and related topics, with subsequent aggregation of information into thematic categories —; interpretation — processing of results, inference and interpretation based on the theoretical framework.

Finally, qualitative and quantitative data were integrated by concurrent triangulation aimed at determining convergences and divergences.[20]

The study was approved by the Research Ethics Committee of Universidade de Fortaleza (Opinion No. 3.661.667). The participants signed an informed consent form before becoming involved in any part during the study. Participants' statements were identified as "Interviewee" followed by a sequential number. The authors decided not to share study data and codes used in the analyses.

RESULTS

Quantitative data

A total of 60 users participated in the research, 12 men (20%) and 48 women (80%), 25 of whom were pregnant (62.5% of women). Regarding the age at which the interviewee had their first child, the minority (6.7%, n=4) became a mother/father between 14 and 16 years old, while the vast majority of the interviewees had children between 17 and 20 years old (Table 1). The highest proportion of women had children between 17 and 25 years old (69% of women, n=33), while men were 26 years of age or older (58% of men, n=7). Regarding marital union, 31 participants (51.7%) remain together with the same partner with which they had their first child. Conversely, 16.6% (n=10) of individuals are single, widowed, or divorced and 31.7% (n=19) have a different partner. On average, the interviewees had two children (median 2; mean 2.133; variance 1.3718; standard deviation [SD]: 1.1712) (Table 1).

Table 1. Distribution of the research participants' characteristics. Fortaleza (CE), Brazil, 2020.

Participants' characteristics	n (total=60)	% of the total
Sex		
Woman	48	80
Man	12	20
Age group at the birth of the first child		
14 to 16 years	4	6.7
17 to 20 years	20	33.3
21 to 25 years	18	30
26 years or older	18	30
Number of children		
1	20	33.3
2	22	36.7
3	13	21.7
4	2	3.3
5	1	1.7
More than 5	2	3.3
Marital union		
With the same partner with whom they had the first child	31	51.7
With a partner other than the one with whom they had the first child	19	31.7
Divorced	2	3.3
Widowed	3	5.0
Single	5	8.3

Among the 35 participants who did not plan their first child, most (37%, n=13) aged between 17 and 20 years when the child was born. Conversely, among the 25 interviewees who planned their first child, most aged between 26 and 30 years (36%, n=9).

The correlation between the interviewee's age at the birth of the first child and their current number of children was measured using the Spearman's and Kendall's coefficients. The results were -0.4611 and -0.3865, respectively. We observed an inversely proportional correlation, although not so high, showing that, to some extent, the interviewees who had children at an older age currently have fewer children, and the interviewees who had their first child earlier currently have more children.

Most participants (n=41; 68.3%) did not know the FP before the birth of their first child. Table 2 shows the distribution of the frequency of "No" and "Yes" answers to other questions in the questionnaire. Most participants answered that, at the birth of their first child, they had sufficient information about how conception occurred (71.75%, n=43).

Table 2. Distribution of "No" and "Yes" answers to questions of the survey questionnaire. Fortaleza (CE), Brazil, 2020.

Question	No		Yes	
	n	%	n	%
Did you have sufficient information about how conception occurred at the time your first child was born?	17	28.3	43	71.3
Was your first child's pregnancy planned?	35	58.3	25	41.7
Did you consider yourself fit for becoming a mother/father at the time your first child was born?	31	51.7	29	48.3
At the time your first child was born, did you/your partner make use of any contraceptive method when you found out the pregnancy?	45	75	15	25
Currently, do you/your partner use any contraceptive method?	31	52.5	28	47.5
Do you think that you are currently a responsible mother/father?	1	1.7	59	98.3

The Wilcoxon test and the t-test were performed for comparing the difference in the median and mean number of children in relation to interviewees who remained with the same partner and interviewees who did not remain with the same partner. The p-value results were 0.0508 and 0.0278, respectively. Likewise, tests were applied regarding the number of children for interviewees who planned to have their first child compared with those who did not plan it. The p-value results were 0.2361 and 0.4639, respectively.

Contingency tables referring to the questions in the questionnaire were compiled in pairs to highlight possible relations between the answers and to perform the chi-square test and Fisher's exact test. Both tests showed no significant difference for either association. Thus, we did not find sufficient evidence to state that there is a statistically significant relationship between planned pregnancy and currently having the same partner, or between knowledge of conception and planning the first pregnancy. FP knowledge had no influence on the use of contraceptive methods when finding out the first pregnancy. The current use of a contraceptive method is independent of the use of contraceptive when finding out the first pregnancy. Currently being a responsible mother/father proved to be a variable regardless of whether individuals considered themselves fit for being a responsible mother/father at the time of conception of the first child.

Qualitative data

A total of 12 interviewees participated in this stage, eight women aged between 14 and 25 years, mostly; and four men, two aged over 25 years. There was a predominance of individuals with only two

children, who are still with the same partner, and who became parents without planning. By analyzing the material collected during the interviews, three categories were identified:

1. Access to FP;
2. Health education and FP;
3. Perceptions of pregnancy and the development of motherhood and fatherhood.

In category 1, "Access to FP," participants reported the deficiency of FP actions, due to the inefficiency of public policies and public management; the difficulty of services in promoting health, especially to the most vulnerable population, through health education; and the lack of interest in FP on the part of users themselves.

> *I think that the health center leaves much to be desired in this aspect. There should be more lectures, especially for younger girls (adolescents). (Interviewee 1)*
> *The truth is people don't wanna be enlightened, they don't wanna learn about a subject that is so important to us. The government also invests very little. (Interviewee 12)*

Interviewees also mentioned that healthcare services do not manage demands related to sex education, which must go beyond the delivery of contraceptives, requiring patience and empathy on the part of healthcare professionals.

> *First of all, the people who are going to provide this type of service should be a little more patient, 'cause there are lay people who don't even know what it's about, you know? (Interviewee 8)*

In category 2, "Health Education and FP," the statements point to users' ignorance about the FP program, especially among men.

> *I'm not familiar with this family planning! (Interviewee 4)*
> *I've just known about it as I speak to you. I think it could have helped, 'cause we would be informed, we would think, and we would be careful, so to speak, right? If I were careful, I wouldn't be such a young father, but it happened, right, it was as God wanted it to be. (Interviewee 9)*

The study indicates that knowledge of contraceptives is acquired from the family, in an empirical way. Many reports also indicated knowledge acquired from the community health agent, but in a scarce and discontinuous way.

> *[...] it was with the health agent. Now, she's not going [to the health center] anymore, but there used to be the follow-up. (Interviewee 8)*
> *I learned from my parents, 'cause they were always very strict in this aspect. (Interviewee 12)*

Regarding category 3, "Perceptions of pregnancy and the development of motherhood and fatherhood," we verified that, when asked how they found out the pregnancy, ambivalent feelings emerged, affecting parenthood. The following feelings were mentioned: fear, insecurity, lack of preparation, rejection and regret, but also happiness and contemplation for generating another life.

I was desperate, I just wanted to die. I wanted to die, and I rejected him almost until the end of my pregnancy. (Interviewee 6)
For me, it was a surprise, 'cause I wasn't expecting it and I made use of the contraceptive, so it was a surprise. I wasn't prepared, but I had to accept it in good faith. (Interviewee 8)
I didn't like it very much, you know? I wasn't prepared yet at the time, not at the time, I had no job, I had no education... I wasn't expecting it, you know? (Interviewee 9)
It was good, a happy time. I felt good. (Interviewee 10)

Some interviewees reported that parenting changed financial conditions, professional and academic careers, and that, given their experience, they would have prepared themselves psychologically and financially to become fathers and mothers.

I would have finished my studies. In my mind, I couldn't even think about being a father back then. I really wanted to have finished my studies and have a better future than what I have now, today. (Interviewee 9)
I would have planned to have this child with better conditions. (Interviewee 11)

Triangulation of methods

Most (33.3%) of the study participants were between 17 and 20 years old at the time of their first conception (Table 1), period of entry into the labor market and professionalization. In addition, the majority (51.7%) did not consider themselves fit for becoming a parent (Table 2). These quantitative findings corroborate and may explain the reported demand for financial organization before starting their own family trajectory, illustrated by converging statements from category 3 of qualitative data (Interviewees 9 and 11).

In Table 2 we can observe that, at the birth of their first child, 75% of the respondents did not use contraceptive methods and 51.7% did not consider themselves fit for parenting, although 71.3% had information about conception. The chi-square test and Fisher's exact test showed no evidence between knowledge of conception and planning the first pregnancy. Thus, these quantitative data alone are insufficient to understand the context of the first pregnancy. Qualitative data using categories 1 and 2 allow this understanding, complementing quantitative data, as illustrated by the interviewees' converging statements (Interviewees 4 and 12).

By the integration between quantitative and qualitative data, we can observe a demand for co-responsibility of the population with regard to FP, while, for this purpose, the acceptance and sensitization of healthcare professionals to deal with such actions is necessary. This fact is evidenced by the high percentage of interviewees who claimed to have information about conception associated with the statements mentioned in categories 1 and 2.

There were no differences between quantitative and qualitative data.

DISCUSSION

The fact that the majority of study participants (80%, n=48) are women can be interpreted from the perspective of cultural gender relations established in Brazil. Traditional masculinity values create a view of men who are distant from practices deemed feminine, and the need for care is associated with fragility or submission.[27] Thus, the responsibility for contraception, in general terms, falls mainly on women, focusing

on methods related to the female body.[28,29] Such conceptions were perceived in the statements of the male study participants, who pointed out that they did not frequently use the services of PHCU, were unaware of the FP, and associated it with consultations directed at women to avoid pregnancy. These conceptions are in accordance with another qualitative study conducted with men in a small city of Ceará and with data from literature review.[30,31]

Teenage pregnancy is considered to be a pregnancy that occurs up to 21 years of age. The literature shows that adolescent pregnancy reaches high numbers, accounting for up to 25% of all pregnancies.[32] In the evaluated sample, we found an even higher percentage (40%, Table 1).

Overall, pregnant adolescents are more subject to adverse situations due to physiological and psychological characteristics of this age group.[33,34] In social terms, risks are presented through several facets such as low level of education, low income, conflicting family relations, drug use, and emotional deprivation.[35,36] Contraception, combined with education and health care, may reduce these risks, as confirmed by a study carried out with 258 pregnant adolescents in the FHS in Teresina, state of Piauí (Brazil), where low knowledge of contraceptive practices increased the chances of unintended pregnancy by 4.5%.[37]

A study conducted with women aged 15 to 18 years at a family health unit in Ribeirão Preto (state of São Paulo, Brazil) showed that the main sources of information on reproductive health for young women were families, schools, and health professionals.[38] However, it is not possible to guarantee the quality of this information, due to the particularities of the families, the lack of a comprehensive educational policy, and obstacles to the practice of health professionals, sometimes marked by prejudice. This reflection is corroborated by several studies. One of them analyzed the knowledge of sexuality and contraceptive methods among individuals at a public school. The results showed that 66.67% discussed the subject with friends; 59.65% stated that the school does not provide information about sexuality; and of the 31.58% who had already have intercourse, only 55.56% used contraceptive methods.[39] Ratifying these results, in our study, we observed that 48.3% of the participants did not have sufficient information about conception during the first pregnancy.

Some studies show that sexual activity among young people is still marked by the incorrect and inconstant use of contraceptive methods.[38,40] Corroborating these data, in this study, unintended pregnancy occurred both among those who did not have contraception knowledge and among those who had it. Results such as these are sometimes used to justify the recommendation, or coercion, by healthcare professionals and services of specific contraception methods, especially long-term ones, for adolescents or other groups of women in social vulnerability, arguing that they would not be able to choose or to use other methods appropriately.[41]

In the present study, 58.3% of the participants did not plan their first child and 70% were up to 25 years old at the time of the birth of their first child. The data reflect the Brazilian reality, in which most pregnancies are unintended. Of the Brazilian women planning their pregnancies, the majority are white, with higher level of education, over 35 years of age, and in a stable relationship.[28]

Having children during adolescence does not only affect women, but also men.[42] Research on adolescent paternity emphasized the occurrence of school dropout among young low-income parents, as the work to support the family is often irreconcilable with studies, directing them to autonomy and the informal market, without labor guarantees, and, in some cases, to crime.[43] In our research, we verified the impact of early parenting, interfering with financial organization and with the change of professional perspective.

The results of the interviews showed difficulties in implementing the FP in health services due to the lack of government actions and the lack of professionals qualified for the function. Supporting this view, a study conducted in the state of Santa Catarina (Brazil) demonstrated that the FP is considered by some healthcare professionals as a strictly medical practice whose purpose is to distribute condoms and provide guidance on the use of contraceptives. Furthermore, in the same study, many professionals emphasized that they were not aware of the National Policy on FP.[44]

The statement of one of the interviewees highlighted the lack of government investment as an obstacle to access FP actions. This situation is sometimes evidenced by the unavailability of different contraceptive methods in health centers. A study that evaluated the physical availability of supplies for FP in health centers throughout Brazil that joined the National Program for Access and Quality Improvement in Primary Care (*Programa Nacional de Melhoria do Acesso e da Qualidade da Atenção Básica* – PMAQ-AB) from 2012 to 2018 showed that the most available methods were oral contraception and male condom combined, while the IUD was the least available.[45]

It should be noted that it is essential to promote criticism when it comes to conservative policies that oppose access and comprehensive sexual and reproductive health care, particularly for adolescents.[46,47] This aspect is corroborated by a narrative review conducted with 5,530 publications from 1990 to 2015, which identified interventions in the work practices of healthcare professionals addressing person-centered care as more effective in improving perceptions of quality and knowledge of the FP among their users.[48]

Collective health promotion initiatives constitute a useful strategy with regard to adolescents' educational purpose. An example was proposed in the city of Alfenas, state of Minas Gerais (Brazil), which provided for continuing education and training of healthcare professionals, the implementation of the FP, the provision of contraceptive methods, and the awareness of the attended public, especially young people and women of childbearing age.[49] The use of new educational strategies based on creative, artistic, and playful approaches are effective in increasing the participation of adolescents in FP activities.[47] In the present study, during the interviews, there was no report of a playful approach to the subject of FP, nor involving a multidisciplinary team for this purpose. There was no mention of which professional was considered a reference to approach the FP, despite the outstanding role of nursing with regard to educational and care activities.[7,8]

The person-centered approach, with a real focus on the comprehensive care of women, men, young people, and adults, contextualized by social determinants, constitutes an important tool in the context of PHC to promote reproductive justice.[10,41] Data from the 2013 National Survey of Health show that sexual and reproductive health in Brazil is marked by socioeconomic inequities. Black and mixed-race women from the North region and with low level of education undergo more sterilization surgeries, while white women, with higher level of education, and from the South and Southeast regions use more oral contraceptives and double protection as a contraceptive method.[28]

In the present study, 48.3% of the participants had a partner other than the one with which they had their first child, evidencing the establishment of new family relationships between stepfather or stepmother and stepchild, and the FHS team may mediate these new relationships and care for the child from the first relationship.[50,51]

The research has limitations specific to its design, with low potential for generalization, in addition to convenience sampling. Interviewing users after the FP consultation is also a limitation due to courtesy bias. Other limitations were the noninclusion of participants without children; the failure to address aspects related to a more inclusive definition of family and parenting beyond the heteronormative model. Finally, there was no characterization of the participants regarding income, level of education, and skin color;

however, during the interviews, socioeconomic aspects were present in the participants' statements, which highlights their determining influence on the study topic.

CONCLUSION

The results show that, from the perspective of the participating users, the FP is not well-explored in the context of public health in Fortaleza, considering that most of the participants were unaware of the program. Most of the people who contacted the FP did so after the birth of their first child, which shows a failure to achieve the sex education measures proposed by local health actions. Furthermore, the prevalence of adolescent pregnancy and its impacts, such as school dropout and early insertion into the labor market, were highlighted.

The presented data are relevant to improve the planning and implementation of public policies and work practices of FHS professionals focused on reproductive health, mainly related to adolescents.

It is recommended that health services and professionals, especially in PHC, when implementing public FP policies, pay attention to the rights of users, with respect to autonomy, privacy, and freedom, without discrimination and coercion. It is essential to expand the supply and the universal availability of contraceptive methods. In addition, every visit by a user to the health service is an opportunity for educational actions, not only regarding contraception, but also for a comprehensive approach to sexual and reproductive health. Especially for the FHS, the interaction of members of the health teams is paramount, so that everyone can contribute to the success of the FP according to their professional skills.

CONFLICT OF INTERESTS

Nothing to declare.

AUTHORS' CONTRIBUTIONS

GBMR: Conceptualization, Data curation, Writing – original draft, Resources. LBC: Project administration, Formal analysis, Conceptualization, Data curation, Writing – review & editing, Investigation, Methodology, Funding acquisition, Resources, Software, Supervision, Validation, Visualization. MTR: Data curation, Writing – original draft, Resources. ICR: Data curation, Writing – original draft, Resources. FOP: Data curation, Writing – original draft, Resources. MPNF: Data Curation, Writing – review & editing, Investigation, Methodology, Resources. CRSSN: Data Curation, Writing – review & editing, Investigation, Methodology, Resources.

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