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# ATTENTION ON CONTRACEPTION BY FAMILY HEALTH TEAMS: CONVERGENCE OF EDUCATIONAL AND INVESTIGATIONAL PRACTICES

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## ABSTRACT

**Objective:** to build health actions in conjunction with Family Health teams to improve contraceptive care.
**Method:** a qualitative research, in the convergent care modality, with theoretical and methodological support from the Paideia Support. Data collection was performed through semi-structured interviews and convergence groups. The research participants belonged to five Health Centers in the city of Florianópolis, Brazil. The empirical material was organized and coded through the webQDA software. Data analysis followed the four generic processes: apprehension, synthesis, theorization and transference.
**Results:** the analysis of the semi-structured interviews allowed the elaboration of proposals to improve contraceptive care and the convergence groups provided opportunities for education and awareness on the theme of contraceptive care. The first strategy used in the convergence groups was the presentation of inserts with the proposed actions to improve contraceptive care, allowing the participants of the groups to validate the actions (or not). The second strategy used Therapeutic Dolls to create scenes that contextualize contraceptive care in the daily services, allowing the recognition of two categories for analysis: the vulnerability profile of the users who demand contraceptive care; and the possibilities for perfecting this attention.
**Conclusion:** the Family Health teams are betting on actions aimed at guaranteeing the access of users, especially adolescents, to sexual and reproductive health services.

**DESCRIPTORS:** Contraception. Health education. Family health. Methodology. Qualitative research.

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## ATENÇÃO EM ANTICONCEPÇÃO PELAS EQUIPES DE SAÚDE DA FAMÍLIA: CONVERGÊNCIA DE PRÁTICAS EDUCATIVAS E INVESTIGATIVAS

### RESUMO

**Objetivo:** construir ações de saúde em conjunto com equipes de Saúde da Família para aperfeiçoar a atenção em anticoncepção.
**Método:** pesquisa qualitativa, na modalidade convergente-assistencial, com suporte teórico-metodológico do Apoio Paideia. Coleta de dados por meio de entrevistas semiestruturadas e grupos de convergência. Participantes da pesquisa pertenciam a cinco Centros de Saúde do município de Florianópolis, Brasil. O material empírico foi organizado e codificado por meio do *software* webQDA. A análise de dados seguiu os quatro processos genéricos: apreensão, síntese, teorização e transferência.
**Resultados:** as análises das entrevistas semiestruturadas permitiram a elaboração de propostas para aperfeiçoar a atenção em anticoncepção e os grupos de convergência oportunizaram dinâmicas de educação e sensibilização sobre o tema da atenção em anticoncepção. A primeira estratégia utilizada nos grupos de convergência foi a apresentação de encartes com as ações propostas para aperfeiçoar a atenção em anticoncepção, permitindo aos participantes dos grupos validarem (ou não) as ações. A segunda estratégia utilizou Bonecos Terapêuticos para criação de cenas que contextualizam a atenção em anticoncepção no cotidiano dos serviços, oportunizando o reconhecimento de duas categorias para análise: o perfil de vulnerabilidade dos usuários que demandam por atenção em anticoncepção; e as possibilidades para o aperfeiçoamento desta atenção.
**Conclusão:** as equipes de Saúde da Família apostam em ações voltadas para garantia do acesso dos usuários, especialmente dos adolescentes, aos serviços de saúde sexual e reprodutiva.



**DESCRITORES:** Anticoncepção. Educação em saúde. Saúde da família. Metodologia. Pesquisa qualitativa.



## ATENCIÓN ANTICONCEPTIVA POR PARTE DE EQUIPOS DE SALUD DE LA FAMILIA: CONVERGENCIA DE PRÁCTICAS EDUCATIVAS Y DE INVESTIGACIÓN

### RESUMEN

**Objetivo:** elaborar acciones de salud en conjunto con equipos de Salud de la Familia para perfeccionar la atención en materia de anticoncepción.
**Método:** investigación cualitativa, en la modalidad convergente-asistencial, con el soporte teórico-metodológico del Apoyo Paideia. Los datos se recopilaron por medio de entrevistas semiestructuradas y grupos de convergencia. Los participantes de la investigación pertenecían a cinco Centros de Salud del municipio de Florianópolis, Brasil. El material empírico se organizó y codificó por medio del *software* webQDA. El análisis de los datos siguió los cuatro procesos genéricos: aprehensión, síntesis, teorización y transferencia.
**Resultados:** los análisis de las entrevistas semiestructuradas permitieron elaborar propuestas para perfeccionar la atención en materia de anticoncepción, y los grupos de convergencia hicieron posible que se establecieran dinámicas de educación y sensibilización sobre el tema de la atención anticonceptiva. La primera estrategia que se utilizó en los grupos de convergencia fue la presentación de insertos con las acciones propuestas para perfeccionar la atención anticonceptiva, lo que permitió que los participantes de los grupos validaran (o no) las acciones. La segunda estrategia empleó Muñecas Terapéuticas para crear escenas que contextualizan la atención anticonceptiva en las actividades diarias de los servicios, con lo que se hizo posible reconocer dos categorías para el análisis: el perfil de vulnerabilidad de los usuarios que requieren atención anticonceptiva y las posibilidades para perfeccionar dicha atención.
**Conclusión:** los equipos de Salud de la Familia apuestan por acciones dirigidas a garantizar el acceso de los usuarios, especialmente de los adolescentes, a los servicios de salud sexual y reproductiva.



**DESCRIPTORES:** Anticoncepción. Educación en salud. Salud de la familia. Metodología. Investigación cualitativa.

## INTRODUCTION

In the national context, Family Health (FH) is the strategy of reorientation of the care model in Primary Health Care (PHC). Since 1994, the Family Health teams (FHts), based on the PHC fundamentals, such as decentralization, capillarity, resoluteness, coordination and ordering of networked care,[1–2] include sexual and reproductive health actions in their range of services, including contraceptive care.

Care is understood as the provision of information, counseling, clinical follow-up and contraceptive methods and techniques to people of reproductive age, which is part of the framework of sexual and reproductive rights.[3] In view of this, public policies direct the actions on sexual and reproductive health of the Brazilian population, articulating the guarantee of these rights by the State through the work of health professionals, especially those of PHC,[4] so that they need to be constantly sensitized and able to act effectively in this direction, i.e., it is necessary that the professionals are able to perform counseling and prescription of contraceptives, for example. And, this only becomes possible from the acquisition of technical-scientific knowledge.[5]

However, there are few studies on educational practices, in the context of contraceptive care, aimed at the PHC health professionals. The Brazilian Ministry of Health (MoH) itself points out that the PHC health professionals do not feel able to develop reproductive planning actions and that contraceptive attention is not yet perceived as a basic health action by these professionals.[3] Therefore, it is concluded that the issue of contraceptive care is still incipient in PHC and this, in a way, justifies the development of this study.

In this confrontation, we seek for a broader view of the health-disease-intervention process. For this, it is necessary to foster the continuing education of the professionals of the Unified Health System (*Sistema Único de Saúde*, SUS), qualifying them to understand the clinical practice as an interrelational practice,[6] as well as understanding the health education device.[7] Therefore, the objectives of this study are the following: to build health actions in conjunction with FHts to improve contraception care and to develop educational and awareness-raising practices on contraceptive care with the FHC members, in the light of the Paideia Support.

## METHOD

From a qualitative nature, this study found in the Convergent Care Research (*Pesquisa Convergente Assistencial*, PCA) a design that unites doing and thinking in Health-Nursing care practice in search of a provocative design of changes in health practices.[8–9] According to the authors of the PCA, this research modality is committed to creating alternatives to minimize or solve adverse situations by fostering the relationship between research and care.[8–9]

As a theoretical and methodological support for the development of the research, it was decided to use some resources from the Paideia Support, in an attempt to expand people's ability to analyze and intervene on the world, operating on the logic that change is inevitable.[10–11]

This research was conducted with the Municipal Health Secretariat (*Secretaria Municipal de Saúde*, SMS) of Florianópolis, Santa Catarina (SC), which is the first Brazilian capital with 100% coverage by the Family Health Strategy (FHS),[12] more specifically in five Health Centers (HCs), with the members of the FHts. Data collection took place through semi-structured interviews and convergence groups.

The participants' inclusion criteria were three items: having at least one year of experience in PHC; having a professional employment relationship with the SMS; and performance linked to an FHt. The exclusion criteria were the following: being away or on vacation during the data collection period.

The invitation to potential research participants occurred only after the authorization of the SMS, and the approach was individual and carried out in the respective HCs. This strategy allowed for the presentation of the research objectives, as well as for detailing its development. There was no definition of any specific number of each professional category for the semi-structured interviews, as well as for the participation in the convergence groups. What prevailed was the interest and availability to participate in the different stages of the research.

As for the semi-structured interviews,23 Community Health Agents (CHA), 9 nursing technicians, 14 nurses and 9 doctors participated. The data collection period (semi-structured interviews) took place between June and July 2015. The interviews were conceived in the physical space of the HCs, during the opening hours of the service. To record the interviews, the voice recording feature through the SONY ICD-PX240 IC Recorder was used after reading the Informed Consent Form (ICF) and after obtaining the authorization from the participant. Two and a half days was the mean time spent in each HC to conduct the interviews, and all the interviews were fully conducted and transcribed by the field researcher. On average, the interviews lasted 20 minutes. We sought to raise the perceptions of the FHts on the theme of contraceptive care, namely: the profile of the people who demanded this care; the characteristics of the actions performed by the teams; the potentialities and difficulties in the development of the respective actions; as well as survey of actions/proposals to improve contraceptive care.

Two months after the semi-structured interviews, time necessary for developing the analysis of the data that emerged from the interviews, as well as for the elaboration of the inserts with the actions/proposals to improve contraceptive care, the second stage of the research was initiated: the convergence groups.

For the convergence groups, which have the purpose of simultaneously developing research and social and personal growth,[13] five convergence groups (one in each HC surveyed) from all the Sanitary Districts (SDs) of the municipality were gathered. The convergence groups were comprised of 15 CHAs, 2 nursing technicians, 8 nurses and 4 doctors. They were divided into Group (G) as follows: in G1 there were 5 CHAs and 2 nurses; in G2, 2 nurses; in G3,5 CHAs, 1 nursing technician, 2 nurses and 2 doctors; in G4,1 CHA, 1 nursing technician, 1 nurse and 1 doctor; and in G5,4 CHAs, 1 nurse and 1 doctor.

With the participants' permission, during the convergence groups, the SONY ICD-PX240 IC Recorder was kept on and six of the seven scenes presented were filmed with the CANON Power Shot SX 400 IS camera, this due to the fact that, in one of the scenes, the participants were not allowed to do the shooting, which was readily respected by the field researcher. The mean duration of each convergence group was 1 h 30 min. The invitation to participate in this stage of the research occurred at the phase of the semi-structured interviews and/or in a new approach with other members of the FHts.

In the convergence groups, the Paideia Effect was sought, which aims to expand possibilities of acting on the relationships, in which individuals, through a social and subjective process, expand the capacity to understand the context, others and themselves.[10–11] Considering the limits of this study, it is weighted that some resources of the Paideia Support were used during the convergence groups: wheel creation; co-production; supporter role; and the observation of the power-knowledge-affection triad during the relationships.[10–11]

The strategies used in the convergence groups were the following: presentation of inserts (Figure 1) with the actions proposed by the FHts to improve contraceptive care, whose objective was to validate (or not) the actions proposed by the members of the FHts; and presentation/use of the Therapeutic Dolls (TDs) tools (Figure 2), for creating scenes/characters that represent the context of contraceptive care, as well as inserting (in the scene) one of the proposed actions to improve the type of contraceptive care chosen, by the group after reading the inserts.

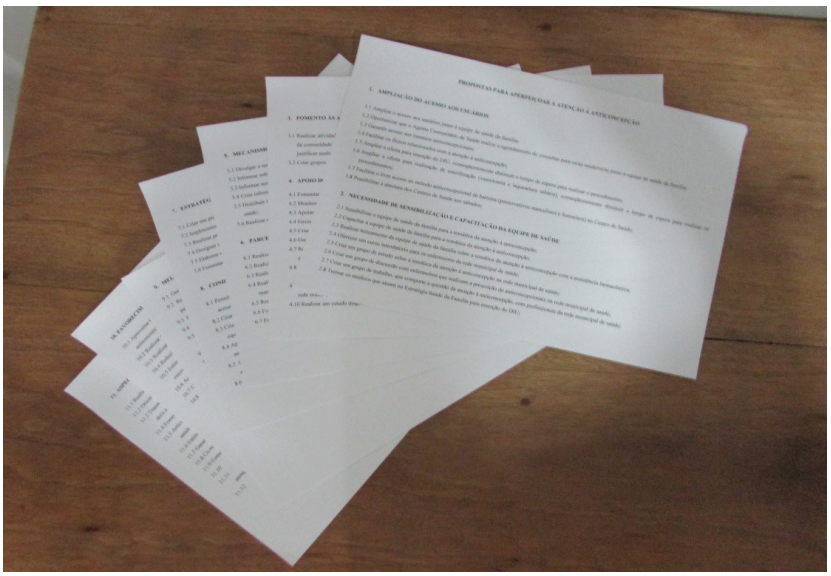

**Figure 1** – Inserts with the proposed actions to improve contraceptive care.

**Figure 2 –** Therapeutic Dolls, tools to work the contextualization of contraceptive care.

To analyze the data from the two phases of data collection (semi-structured interviews and convergence groups), the empirical materials used were the transcripts of the 55 semi-structured interviews and the descriptions of the group moments, in particular, the description of the seven scenes and the characters therein represented. Data was organized and coded with the support of the resources of the webQDA software.[14] The apprehension and synthesis of the findings of the convergence groups, in particular, were facilitated by the immersion of the field researcher in the care practice, through the groups, with educational purpose and awareness regarding the theme of contraceptive care. In addition, the detailed description of the dynamics/scenes performed in the convergence groups enabled to unveil the phenomenon to improve contraceptive care by the FHts. Here, in the convergence groups, the “surprise” was found that the PCA reserves the experience of convergence for those interested in this type of research.[8–9] After this finding, we proceeded with the last two phases of the analysis process: theorization and transference.[8]

## RESULTS

The results emerged from the reflections made through the semi-structured interviews and the convergence groups. In the phase of the semi-structured interviews, 55 members of FHts participated, while in that of the convergence groups, 29.

The first strategy, carried out in the five convergence groups, was the presentation of inserts with the actions proposed by the FHts to improve contraceptive care. For illustration purposes, the results of this first part will be presented through the actions that had the most positive reinforcements (characterized by speeches, during the convergence group, which highlighted the importance of the action and/or the possibility of the action to improve contraceptive care) by the participants of each convergence group, as well as the actions that had the most negative reinforcements (characterized by speeches, during the convergence group, which did not realize, in the proposed action, the potential for improving contraceptive care and/or the perceived impossibility of effectiveness). Here, it is emphasized that the speeches are from the group, that is, the prevalence of the group will be presented.

It is noteworthy that the proposed actions were co-produced between the members of the FHts, who participated in the semi-structured interviews, and the field researcher. The construction of the proposals was based on the answers to the last two interview questions: What are the key points for effective contraceptive care to happen? And, taking into account the fundamentals cited, propose actions to improve contraceptive care. This resulted in a list of actions distributed in 11 core themes, presented below.

The actions included in the central theme – Expansion of access to users – that received positive reinforcements during the convergence groups were the following: to increase the access to users to the FHt (G2 and G3) and to facilitate the flows related to contraceptive care (G2 and G4). The action was the following: to provide the opportunity for the CHA to schedule appointments for the users with the FHt validated by G1, but was weighted by G3 and not approved by G4. Still, the action of enabling the opening of the HCs on Saturdays was not approved in G2, G4 and G5.

The actions of the central theme – Need for awareness and training of the Family Health team – obtained only positive reinforcements during the convergence groups (G1, G2, G4 and G5). While the following actions: sensitizing and enabling the FHt on the theme of contraceptive care; offering introductory courses for nurses in the municipal health network; creating discussion group with nurses who prescribe contraceptives in the municipal health network; and training the doctors who work at the FHS to insert the Intrauterine Device (IUD) were the actions, inserted in this central theme, that received the most positive reinforcements by the participants of the referred convergence groups.

The following actions: conducting group educational activities on contraceptive care for women, men and couples in HCs and/or other community devices, offering different day and time alternatives, as well as ensuring justification for users' absence from work for group participation; and creating groups of adolescents in the HC that make up the central theme – Encouraging group activities – received negative reinforcements from participants in all convergence groups. However, some participants from G1 and G3 mentioned that the first action of this theme could contribute to the improvement of contraceptive care, but they believe it is difficult to accomplish, especially regarding the adherence of the users and the logistics for the accomplishment of the group.

All actions under the central theme – Support from the central level – received positive reinforcement from the participants in the convergence groups, with emphasis on the following actions: ensuring the necessary inputs to provide contraceptive care, in particular the hormonal, barrier and IUD contraceptive methods; conducting a study with the pharmaceutical assistance on modern contraceptive methods (including low-dose hormonal contraceptive methods) and verifying

the possibility of offering these methods by the municipal health network; updating the Protocol for Integral Attention to Women's Health in the city, seeking the units of actions related to contraceptive care throughout the municipal health network; and conducting a diagnostic/survey study on the quality of contraceptive care in the municipality.

On the central theme – Dissemination mechanisms – all the proposed actions received positive reinforcement by the participants of the convergence groups, examples: creating informative (leaflets, *folders*, inserts) on the subject of contraceptive attention, using simple and youthful language; distribute informational (leaflets, *folders*, inserts) on the topic of contraceptive care during home visits by the CHAs. However, the action of conducting campaigns and/or thematic weeks on the topic of contraceptive care received a caveat made by the participants of G2, as they consider that actions related to contraceptive care should be daily and not watertight for periods of campaigns and/or thematic weeks, for example.

The following actions: carrying out educational actions on sexual and reproductive health in the schools through the School Health Program (*Programa Saúde na Escola*, PSE), in a systematic and planned manner; performing educational actions on sexual and reproductive health in the early grades, adapting the content and approach according to age group; performing educational actions on sexual and reproductive health in a playful and interactive way, overcoming the logic of the lectures; and involving the students' parents in educational activities on sexual and reproductive health; were those of the central theme – Partnership with schools – that received many positive reinforcements from the participants in all the convergence groups. It should be noted that this central theme stood out over the other central themes presented in the booklet of the actions proposed by the validations scored in all five convergence groups.

On the central theme – Strategies for the creation of policies and/or programs – no considerations were obtained regarding the actions proposed in this item, whose example as proposed actions is the following: creating a municipal program that addresses the theme of contraceptive care and implementing the program in the municipal health network.

Already some actions of the central theme – Infrastructure conditions and material resources – stood out for receiving several negative reinforcements from the participants of the convergence groups, namely: creating a reference center that includes contraceptive care services (G2, G3 and G4); promoting the delivery of hormonal contraceptives, in special cases (for women who prove the difficulty of collecting the supply or for postpartum women) through the Home Remedy Program (G2, G3, G4 and G5); and offering "vouchers" so that women can apply monthly and quarterly injectable contraceptives to the Pharmacy Popular networks (G3 and G4).

On the central theme – Improvement of the work process –, practically all the actions were validated, examples: generating and/or working with indicators/markers that support the issue of contraception care; performing health surveillance in the context of contraceptive care, particularly in special cases (women with difficulty adhering to the chosen/prescribed contraceptive method; risk situations for unplanned/unwanted pregnancy); and fostering interdisciplinarity in the actions of the health team regarding contraceptive care. However, the action of expanding the vacancies in the schedules of the medical professionals and nurses for care that includes contraceptive attention, with an extended time option when consulting for IUD insertion, obtained negative reinforcements by the participants of the G2 and G4 convergence groups.

As a central theme – Favoring the bond – in some of its actions, it had several negative reinforcements from the members of the convergence groups. The actions that were not validated were the following: home visits for pregnant and postpartum women, with an approach focused on sexual and reproductive health (G3 and G4); conducting home visits for adolescents with an approach to sexual and reproductive health (G2, G3, G4 and G5); reducing the duration of hormonal contraceptive

prescription from one year to six months (G2, G4 and G5); and avoiding turnover among the FHts' professionals (G1, G3 and G4).

Finally, the actions of the central theme – Philosophical, Sociocultural and Educational Aspects – received positive reinforcement by the participants of the convergence groups, with emphasis on the following actions: clearly and objectively transmitting the information related to the theme of contraceptive attention, seeking to certify understanding of the user (G5); fostering a sense of co-responsibility (men/women) of the results or not of responsible contraception/parenting (G5); fostering men's co-responsibility in sexual and reproductive health issues, as well as in specific actions that support contraceptive attention (G4 and G5); and paying attention to the sexual and reproductive health demands of the individuals with special needs (G4).

The second dynamic of the convergence groups was the presentation of the tools of the TDs to the FHts, the resource of the TDs being understood as a possibility to work in groups themes like sexuality, reproductive planning, and family relationships, among others. And the elaboration of scenes with the TDs, in order to represent the context of the health services focused on contraceptive care, with the choice and insertion of one of the proposed actions, contained in the inserts, to improve this attention. This second dynamic was performed in three convergence groups (G1, G3 and G5), resulting in seven scenes. The description of the scenes served as empirical material for data analysis, resulting in two main categories: the vulnerability profile of the users who demand contraception care by the FHts, with a focus on adolescents; and possibilities for the improvement of contraceptive care by the FHts, with emphasis on actions aimed at ensuring the users' access to the health services.

As for the context created in the scenes, the vulnerability profile of the users who demand contraception care by the FHTs was shown in the following: in G1 – Scene A, the issue of the concern of a grandmother with her 14-year-old granddaughter was portrayed. She did not complete school and is in a relationship with a young man who is underworked and has little financial resources; in G1 – Scene B, the scene about the character of a pregnant woman, without prenatal care, who says she is in her sixth pregnancy and no longer wants children; in G3 – Scene A, the participants introduced a teenager with many doubts and concerns; in G3 – Scene B, they presented the story of a postpartum woman with cognitive problems, with reports of various pregnancies and abortions, with a husband who does not cooperate with the care of her children and a mother who is overwhelmed with this situation; in G3 – Scene C, the character of a teacher showed apprehension about the behavior related to the sexual demands of his teenage students, especially some students with disabilities; in G5 – Scene A, a young couple who claimed to be a drug user demanded contraception care; and in G5 – Scene B, a 14-year-old postpartum woman with her newborn son was accompanied by her 12-year-old sister and her mother, who was very distressed by her daughter's situation, to welcome the spontaneous demand made by a nurse.

In developing the scenes, the members of the FHts (re)signify the daily activities of their health actions focused on contraceptive care and insert in the scene an action proposed to improve contraceptive attention. With this, they envision possibilities for the improvement of contraceptive care by the FHts. The chosen proposed actions that were inserted in the scenes are predominantly aimed at providing access to the health services, for example: in G1 – Scene A and G1 – Scene B, the proposed action chosen was to enable the CHA to schedule consultations for the users with the FHt. In G3 – Scene A, albeit indirectly, they also deal with access to foster the creation of a special room in the HC, so that the adolescents have free access to the room and to the health professionals to answer any questions regarding sexual and reproductive health, as well as contraception; in G3 – Scene B, they provide the opportunity to represent the ease of access to insert the IUD in the HC within seven days; in G3 – Scene C, they represent access, intermediated via activity at school, when an FHt doctor will carry out an educational activity on sexual and reproductive health with

the students, in addition to ensuring individual care at the HC, if necessary; in G5 – Scene A, they represent access through consultation with a young couple who demand counseling for contraception, which even receives an offer for serological tests; and in G5 – Scene B, there is a representation of extended access for the whole family, showing the nurse welcoming the demand of the postpartum woman and the family that accompanies her.

## DISCUSSION

The validation (or not) of the actions proposed by the FHts to improve contraceptive care, although not performed with a specific instrument for this, took place through the positive and negative reinforcements of the groups' participants under the proposed actions presented. The actions included in the following central themes: increased access to users; need for awareness and training of the health team; central level support; dissemination mechanisms; partnership with schools; improvement of the work process; and philosophical, sociocultural and educational aspects, were the ones that received the most positive reinforcements, which means that it was in line with PHC principles.

Already the actions contained in the following central themes: promotion of activities in groups; strategies for creating policies or programs; infrastructure conditions and material resources; and favoring the bond, received some caveats or negative reinforcements from the members of the convergence groups, and most of the actions that were not validated are those that break, in essence, with what is advocated by PHC.

In the convergence groups, the proposed actions, as well as their validations (or not) by the members of the FHts, denote the multidimensional character of contraceptive care. This can also be verified through the results of a study that points out that the health professionals perceive information; the provision of contraceptive methods; the effectiveness of the method; the prompt delivery of the male condom; counseling on the repercussions of an unplanned pregnancy; sexuality detached from pregnancy; the inclusion of the sexual partner in family planning decisions; and conducting group orientation for adolescents, women and couples, as important factors for the quality of contraceptive care, but point out that the FH units are not a place for training the health professionals on issues related to sexual and reproductive health.[15]

In addition to these factors, other studies add that the perceptions and knowledge of the health workers, especially the knowledge deficits of PHC workers regarding the theme of contraception,[16–20] by far determine the quality of care offered, example: there is the non-prescription of Emergency Contraception (EC) by some professionals, with the simple justification that the use of EC will not become a routine.[20]

Also, considering the note that PHC workers make the precariousness of sexual and reproductive health care to adolescents and men, and the latter, in particular, are said to be clients who hardly seek PHC to address sexual and reproductive health issues, and the biggest perceived obstacles are misconceptions and preconceptions, especially those related to vasectomy.[21]

Also, considering that the examples that showed misperceptions that directly interfere with the quality of care are not rare, namely: participants of a study realized their limitations in the management of some methods, making them underused;[22] others underestimated the prevalence of unwanted pregnancies and also the failure rates of the typical contraceptive use available as oral contraceptives, condoms and injectable contraceptives, for example.[23]

Not to mention, the fact of the health workers' personal experiences and beliefs regarding the contraceptive methods, which may also have an impact on the care offered, as shown by the study that sought to verify whether or not the personal experience with a particular method would influence the promotion of this method among the clientele assisted by these professionals.[24]

In view of the above, multiple factors are revealed that interfere with the quality of the contraceptive care offered, so for the preparation of the scenes it was necessary to elaborate, in an improvised way, a script and, consequently, to decide for the creation of the characters, working, thus, the device of health education that encourages inventing and experimenting in an attempt to circumvent the fixed and pre-organized methods.[7]

In this same direction, the Paideia method was applied by establishing dialog in the co-production and validation (or not) of the proposed actions to improve contraceptive care. Since the various actions proposed signal the desire for change in an attempt to seek the articulation of knowledge and practices; in the articulated and simultaneous conjugation of power, knowledge and affection; and in expanding the conception of the object of knowledge and intervention in the health field. And this, to some extent, typifies the Paideia Effect, which consists in expanding one's autonomy, that is, one's ability to understand and act on the world and on oneself.[10–11]

It is interesting to note that all seven scenes punctuate aspects of vulnerability of the characters that represent the users, especially the adolescent figure, which was represented in four of the seven scenes created. The explicit or veiled demands of the adolescents from the health services need to be understood so that this audience is met, in all its uniqueness, also integrally in contraceptive care.

A study, which evaluated the participation of adolescents in the FHS, based on the framework of the theoretical-methodological framework of an enabling participation,[25] helps scale the complexity of serving these customers through the FHts. It was found that the participation of adolescents was predominantly focused on the first level of the reference that indicates the normative participation in which the user is only able to take care of themselves. The study participants who worked at the FHS observed that adolescents sought the team in search of aspects related to the disease, when they demanded consultations, for example. It was also identified that adolescents demanded care related to prenatal care and related to reproductive planning. In the present study, the second level of the referential indicates normative participation plus independence, as it is a moment characterized not only by taking care of oneself, but also expanding to care in the family. Although the activities developed in the schools were incipient in the studied context, when the adolescents presented a participatory process in the health education activities, they enabled the third level of the referential: emancipatory participation. The ideal of a transformative participation that goes beyond taking care of oneself to social control and is represented in the fourth level of the reference was not observed through the results of the study.[25]

Enabling participation occurs at the intersection of the second (normative participation plus independence) and the third level (emancipatory participation) of the referential, through the health education process.[25] A challenge is presented here: it is not enough to offer the adolescent (or any other user) contraceptive care actions, it is urgent to promote the protagonism of this user through educational processes in health that promote participation beyond what is put.[7]

Several studies indicate that the care for adolescents, in the context of sexual and reproductive health, is precarious and not specific,[26] some also consider that the way the professionals perceive teenage pregnancy is what will influence their attitude toward prescribing contraceptive methods for adolescents;[27] others believe that increasing adolescents' access to the health services requires a reduction in formalities, besides perceiving promoting characteristics for health actions in the school.[19]

For the outcome of the scenes, there was the insertion of the proposed action chosen. With slight variations, it was observed that the efforts of the FHts to effectively perform and improve contraceptive care were aimed at ensuring the users' access to the health services. A recent integrative literature review study, which aimed to analyze the scientific production about the evidence, potentialities, challenges and perspectives of PHC in the coordination of the Health Care Networks (HCBs) shows, among other aspects, that the discussions about access, among the review studies, move between

the weaknesses of PHC, when the reception is incipient in the FHS; among the potentialities, when considering the increase of PHC supply with reduction of access barriers; and the challenges for strengthening the FHS as a gateway to the health system.[28]

It is known that the set of health actions that encourage health promotion, disease prevention, diagnosis, treatment, rehabilitation, harm reduction and maintenance of health in the individual and collective sphere is called PHC. And that universal access, commonly known as a "gateway" to the health services, has one of its basic foundations. However, access is not the only foundation of PHC, since it has in the territory, in the development of bonding and accountability relationships between the teams and the population, in the longitudinality of care, the coordination of care, the completeness, the expansion of the autonomy of the users and communities and the stimulus for user participation, challenges to be overcome.[1–2]

However, the actions proposed and validated by the FHts and the representations made through the scenes with the TDs in the convergence groups by the members of the FHts show access as a first order potentiality for the improvement of contraceptive care.

To ensure the users' access to the health services, especially in the context of contraceptive care, the improvement of the services offered, the improvement of communication, the promotion of contraceptive methods, the implementation of actions at the managerial and network level, are encouraged, especially with schools.[19,24,29] Some researchers are making efforts to study the differential of the CHA in contraceptive care, as well as the potential of the CHA to broaden the users' access to sexual and reproductive health services.[18,30] It is also observed that, for the most part, this is not very sophisticated: simple interventions can make a difference in the quality of the contraceptive care offered.[31] Research studies evaluating the contraceptive care services shows that in certain contexts the services offered fall far short of what is advocated. In others, although considered adequate, the results indicated that they need constant improvements.[15,32]

The fact that the results are not generalizable is recognized as a limitation of this research; however, it is expected that this study, through this theoretical and methodological approach, will contribute to sowing a change in the intentionality of the FHts that act in contraceptive care. In addition, it encourages other researchers, especially those focused on practical research/living research, to venture into the list of actions proposed by the FHts to improve contraceptive care by applying and researching (or researching and applying) these actions in their care practices.

## CONCLUSION

The convergence groups carried out in the light of the Paideia Support contributed to the development of educational and awareness-raising practices (in groups) on contraceptive care with members of FHts. The maximum convergence of the PCA was experienced. The insertion strategies with the actions proposed by the FHts to improve contraceptive care and the TDs, in particular, contributed to an exercise of (re)signifying the context of contraceptive care in PHC.

The results, based on the validations of the actions proposed by FHts to improve contraceptive Care and obtained through positive reinforcements to the actions approved by the participants of the convergence groups, expose the numerous contributions and possibilities of contraceptive care in this context, namely: expanding access to the users; the need for awareness and capacity building of the FHts; central level support; the dissemination mechanisms; the partnership with the schools; the infrastructure conditions and material resources; the improvement of the work process; and the fostering of the philosophical, sociocultural and educational aspects. It should be noted that the proposed actions related to the partnership with the schools were the ones that received numerous positive validations by the members of the FHts that participated in the convergence groups – which

shows that the theme of sexual and reproductive health should be worked towards intersectorality between health and education.

The scenes with the TDs emphasized the representation of actions aimed at the users' access to the health services – which shows the potentiality of this PHC foundation as of first order, in the view of the members of the FHts, to improve contraceptive care.

The focus given to the adolescent character, inserted in contexts of vulnerability, demonstrates the reality faced by the FHts in the daily services and, at the same time, a strong direction for the improvement of contraceptive care for this public.

The principles of the Paideia Support permeated the convergence groups, from the preparation of the meetings to their realization. The creation of wheels, the co-production, the role of supporter and the observation of the power-knowledge-affection triad, present in the relationships, provided opportunities for group co-living (social process) and in the group (subjective process), reaching, to some extent, the Paideia Effect, which culminated in the unveiling of the phenomenon for the improvement of contraceptive care in PHC by the members of the FHts.

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## NOTES

### ORIGIN OF THE ARTICLE

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### CONTRIBUTION OF AUTHORITY

Study design: Maus LCS, Santos EKA.
Data collection: Maus LCS.
Analysis and interpretation of data: Maus LCS, Santos EKA.
Discussion of the results: Maus LCS, Santos EKA.
Writing and/or critical review of content: Maus LCS, Santos EKA, Backes MTS.
Review and final approval of the final version: Maus LCS, Santos EKA, Backes MTS, Gregório VRP, Borck M.

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### ETHICS COMMITTEE IN RESEARCH

The study was approved by the Research Ethics Committee of the *Universidade Federal de Santa Catarina*, opinion No.1,076,501. CAAE 43381415.4.0000.0121.

### CONFLICT OF INTEREST

No any conflict of interest.

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