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Childbearing assistance in primary health care

Assistência à concepção na atenção primária em saúde

Asistencia a la concepción en la atención primaria de salud

ABSTRACT

Objective: To identify the actions of childbearing assistance in Primary Health Care. **Method:** Qualitative study, conducted with 30 physicians and 50 nurses from family health strategy teams. The data were interpreted according to content analysis and in the light of the specialized literature. **Results:** The following stand out among the guidelines offered to the public: identification of the fertile period, recommendations on the frequency of sexual practices, prescription of preventive folic acid and anamnesis limited to the woman's sexual life history. In more complex cases, referral to another level of health care is performed, for example, the specialized gynecology consultation, due to the lack of a reference service for infertility. **Conclusion:** The incipient actions taken by professionals in the clinical approach and management of services do not meet the recommendation of ministerial documents.

Keywords: Health Care; Sexual and reproductive rights; Reproductive health; Reproduction; Primary Health Care.

RESUMO

Objetivo: Identificar as ações de assistência à concepção naAtenção Primária à Saúde. **Método:** Estudo qualitativo, realizado com 30 médicos e 50 enfermeiros de equipes da estratégia de saúde da família. Os dados foram interpretados segundo a análise de conteúdo e à luz da literatura especializada. **Resultados:** Destacam-se entre as orientações oferecidas ao público: a identificação do período fértil, recomendações sobre a frequência de práticas sexuais, prescrição de ácido fólico preventivo e anamnese limitada à história de vida sexual da mulher. Em casos mais complexos, é realizado o encaminhamento para outro nível de atenção à saúde, por exemplo, a consulta especializada de ginecologia, por falta de serviço de referência para infertilidade. **Conclusão:** as ações incipientes realizadas pelos profissionais na abordagem clínica e na gestão dos serviços não vão ao encontro da recomendação de documentos ministeriais.

Descritores: Atenção à Saúde; Direitos sexuais e reprodutivos; Saúde reprodutiva; Reprodução; Atenção Primária à Saúde.

RESUMEN

Objetivo: Identificar acciones de asistencia a la concepción en la Atención Primaria de Salud. **Método:** Estudio cualitativo, realizado con 30 médicos y 50 enfermeros de equipos de estrategia de salud de la familia. Los datos fueron interpretados de acuerdo con el análisis de contenido ya la luz de la literatura especializada. **Resultados:** Entre las orientaciones ofrecidas al público, se destacan: la identificación del período fértil, recomendaciones sobre la frecuencia de las prácticas sexuales, prescripción preventiva de ácido fólico y anamnesis limitada a la historia de vida sexual de la mujer. En casos más complejos, se derivan a otro nivel de atención de la salud, por ejemplo, una consulta especializada de ginecología, debido a la falta de un servicio de referencia para la infertilidad. **Conclusión:** las incipientes actuaciones realizadas por los profesionales en el abordaje clínico y en la gestión de los servicios no se ajustan a las recomendaciones de los documentos ministeriales.

Descriptores: Atención a la salud; Derechos sexuales y reproductivos; Salud reproductiva; Reproducción; Atención Primaria de Salud.

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INTRODUCTION

From the 1970s, the feminist movement in Brazil made history in the struggle to guarantee the rights considered basic to a dignified life, supported by the Declaration of Human Rights, calling for universal and quality health care that covered the entire life cycle of women and not only the biological and reproductive(1,2).

In this sense, we highlight the implementation of the Comprehensive Women's Health Care Program (PAISM) in 1983, which boosted the achievement of the Unified Health System (SUS); the enactment, in 1996, of Law number 9,263, which deals with Family Planning, recognizing it as a set of actions to regulate fertility that guarantees equal rights of constitution, limitation or increase of offspring by women, men or couples, including, therefore, assistance in conception and contraception(1,3). The program became a National Policy in 2004 and, in 2005, the National Policy on Sexual and Reproductive Rights began to highlight reproductive health as a right and sexual health as a fundamental element, considering the subjects in the physical and social aspects and in their uniqueness(7). Therefore, it is recommended to use the term reproductive planning in recognition of a greater scope, eliminating the idea of a purely economic-demographic approach, becoming the basis for a deeper debate on sexual and reproductive health (4,5,6).

Sexual health and reproductive health have thus become permanently part of the government agenda and, over the last few years, have been reinforced with the publications in 2005 of Ordinance number 426/GM(8), which instituted, within the scope of the SUS, the National Policy for Comprehensive Care in Assisted Human Reproduction (PNRHA); and in 2012 of Ordinance number 3.149(9), which established the allocation of financial resources to health establishments that perform procedures for assisted human reproduction care, within the scope of the SUS.

To provide services and professionals, in 2016, the Ministry of Health, in partnership with the Syrian-Lebanese Institute of Education and Research, published the Basic Care Protocol: Women's Health, reaffirming that reproductive planning actions would be aimed at strengthening the sexual and reproductive rights of individuals and would be structured in clinical, preventive, educational actions, offering information and the means, methods and techniques to regulate fertility(10). This ministerial document directs that the actions contemplate, mainly, three types of activities: counseling, educational activities and clinical assistance, developed in an integrated, multi and interdisciplinary way.

Theoretical recommendations consider counseling and practical educational activities to be fundamental, based on a dialogue of trust, which should, in this way, encourage the practice of safe sex, emphasizing the experience of sexuality without constraints and favoring the evaluation of the particular vulnerabilities of users, both regarding voluntary motherhood and self-decided contraception(4,11).

To guarantee reproductive rights, it is relevant to identify the life context of the person/couple and their ideas; desire or not to have children; perform a proactive approach favoring questions about sexual activity; assess the vulnerabilities of subjects and/or couple to HIV infection and other Sexually Transmitted Infections

(STIs); and understand that the success to be achieved depends on the joint and supportive action of health professionals with stakeholders(5,12).

The global report Infertility Prevalence Estimates (1990-2021), published by the World Health Organization (WHO), showed that one in six adults worldwide suffers from infertility, equivalent to 17.5% of the adult population(13). According to the Brazilian Society of Assisted Reproduction, eight million individuals may face difficulty in generating a child(14), with the main causes of infertility being the woman's reproductive age, anatomical problems in the male and female reproductive systems, hormonal imbalances, endometriosis and STIs(15,16). Thus recognizing, on the one hand, a repressed demand for these services and, on the other, a timid, costly and selective reproductive assistance in the national scenario. After all, advances in the area of medical technology have unquestionably benefited human reproduction, but they have not become effectively accessible to SUS users, revealing that the service offered by the State distances itself from the constitutional precept(17,18).

In this sense, to guarantee reproductive rights and stimulate decision-making that reduces the pilgrimage of people with fertility problems in health services, considering the relationships between the context, variations in the implementation of an intervention and the process of producing these effects, this study aims to identify the actions of childbearing assistance in Primary Health Care (PHC). It is believed that approaches to the phenomenon will reproduce different logics of understanding, revealing that the organizational, political, cultural and social context impacted the implementation of the effective process of the reproductive planning assistance policy in the country.

METHODS

This is an excerpt from a final paper of the Nursing course of the State University of Paraíba (UEPB), developed and presented in 2018 and 2019, respectively, after being approved by the Research Ethics Committee of the State University of Paraíba, CAEE number: 69239717.4.0000.5187, as it complies with the recommendations of Resolution number 466/2012.

A qualitative, exploratory, descriptive, retrospective study was chosen to better fit the objective of this study, since the research involves people's lives, their experiences, feelings, emotions and behaviors, in addition to studying cultural phenomena, social movements, interaction between individuals and organizational functioning. This investigation was conducted and structured with reference to the Consolidation Criteria for Qualitative Research Reports (Coreq).

The study was carried out in 80 Basic Family Health Units (BHU), located in eight health districts, in the urban and rural areas, in the municipality of Campina Grande - PB. This municipality is considered, by the Ministry of Health (MH), a pioneer in the institutionalization of the Family Health Program (FHP), in the 1990s, as a strategy for reorganizing primary care, adopting the logic of health surveillance, with a conception centered on the promotion of quality of life.

The research participants were

physicians and nurses from the Basic Family Health Units (BHU) who met the following criteria: working on the strategy for at least six months and routinely performing family planning care as an assignment in the work process, excluding professionals who were on vacation or sick leave during the collection period. At the end, 80 professionals, 30 physicians and 50 nurses participated in the study, considering the technique of theoretical saturation of the speeches.

Data collection took place from September 2018 to December 2019, through a questionnaire to characterize the sample and semi-structured interviews, prepared by the researchers of this research with questions directed to the target population, individually audio-recorded, with guarantee of privacy, in the respective health units.

Subjects were previously identified and invited to participate in the research after explaining the objectives and collection procedure. Those who met the established inclusion criteria were interviewed after signing the Informed Consent Form (ICF), at a convenient time, considering the dynamics of the service. The term mentioned that the answers could be changed, with the inclusion or deletion of excerpts, at the end of the interview and/or after listening to the audios.

The interviews were transcribed manually, maintaining the reliability of the information relevant to the analysis, soon after they were carried out. In order to safeguard the identification of professionals and health units, an alphanumeric system was used to encode them, with S being the order of the professionals' speeches (S1, S2, S3...), and the letters P (for physician) and N (for nurse), followed by a number in the sequential order of the interviews (P1, P2, N1, N2...).

Bardin's content analysis was the technique used for data analysis, performing the reading, the choice of documents, the formulation of hypotheses/objectives, the elaboration of indicators and the systematization of initial ideas. In the material exploration phase, the category (coding system) and the registration/context units were defined to enable interpretations and inferences. In the last phase, the results were treated, condensing and highlighting the information for analysis, culminating in interpretations based on reflective and critical analysis.

RESULTS

Characterization of participants

Eighty professionals from the Family Health Strategy (FHS) participated in the research, 50 nursing professionals and 30 medical professionals, with a mean age of 40 years (ranging from 30 to 50 years). Of the total, 20 were male and 60 were female; of these, 45 were nurses. Twelve professionals had a master's degree in the area of public health and/or related areas, 48 had a specialization/residency in Family Health and 22 had an undergraduate degree only.

REPRODUCTION ASSISTANCE ACTIONS

A priori, the professionals were asked about family planning actions that they carried out, with the objective of assistingconception, intheroutine health

care of women or couples who could not get pregnant. The speeches revealed that they received qualified listening, educational activities, guidance related to the fertile period, sexual frequency, healthy habits, referrals, requested complementary tests, identified risk factors and pre-existing diseases or conditions, prescribed folic acid and, when necessary, vaccinated patients:

"Women who are unable to get pregnant, we make the guidelines, regarding the fertile period, sexual frequency and healthy habits. They seek individualized care even for the shame of recognizing themselves as "incapable". After the guidance stage and the woman returning unsuccessfully, I can only refer to the physician to request all hormones, ultrasound, investigate pre-existing diseases. If nothing is clear, before we refer the patient to the women's health service or specialized consultation with gynecology, we ask for the spermogram" (S5N2).

"First action is to notice the difficulty of getting pregnant. We do this after the anamnesis. Then we set out to identify risk factors, diseases or conditions that prevent conception. In any case, we recommend the use of folic acid and we also guide on the necessary vaccinations that should be done before conception. I request laboratory tests, but objectively, I do not recognize any action of mine in primary care that can be mentioned as sufficiently resolutive that characterizes reproductive assistance" (S4P1).

"Here we host, qualified listening, educational activities. If pregnancy does not occur, we start asking for exams, researching the hormonal issue to analyze the biological part, but we get stuck in the difficulty of exams and the lack of a service for referrals. Our actions are limited and without monitoring, not to say totally non-existent for reproductive health" (S14N2).

"Here in primary care, from a clinical point of view, we can only request exams and refer. And, being aware that basic exams are insufficient to guarantee reproductive health care, we attest that in practice the SUS does not cover reproduction treatment and that private services do not believe in SUS exams. So, sometimes, I think the best clinical action would be to simply refer. And spare the woman from taking and redoing exams. The assistance action is limited to referral" (S8P2).

The welcoming described in the professionals' statements reveals the exercise of serving the users from the perspective of care as an integral action, respecting diversity and uniqueness, understanding the needs, curiosities, doubts, concerns, fears and anxieties related to issues of sexual rights and reproductive planning. However, for reproductive health practice, it is important to provide the subjects involved with care with a proposal that also addresses: identification of the life context of the person or couple and their ideas; desire or not to have children; proactive approach favoring questions about sexual activity; assessment of individual or couple vulnerabilities to HIV infection and other STIs; and understanding that the success to be achieved depends on the joint and supportive action of health professionals

with the person or couple.

The textual analysis of the responses shows that health professionals describe limited actions. It is assumed, therefore, that they are not aware of ministerial protocols, which, due to the fact that the municipality relegates clinical conduct to professional initiative/experience, disregarding the necessary structuring for the line of care, ends up compromising reproductive care.

When asked if the basic health care protocol for women or couples planning pregnancy and conception assistance is already implemented in the municipality, they stated that they did not have access and/or knowledge on the subject:

"There is no effective action to assist conception in SUS. Or if there is, I don't know any protocol from the Ministry or the State or Municipal Health Department. But I keep thinking that if there is no way to solve it in primary care, would the protocol only be to recommend referral? What can be done for conception in primary care? Human reproduction is related to medical technology that is not justified in primary care or financed in SUS" (S2P2).

"The secretariat never presented or recommended the adoption of a protocol to approach the woman who wants to become pregnant. Just check where there are data about this audience or related to this demand. Nothing was passed on to physicians, to the family health strategy teams as a goal, priority, recommendation, protocol or anything that counts. The fact is that whether there is demand is totally unknown. It certainly reflects the prejudice that only the rich can use human reproduction" (S14P3).

In the specific case of nursing professionals, the speeches reveal the adoption of a protocol with indication of actions based on the recommendations of protocols of the Ministry of Health and the Regional Nursing Council (COREN) to work in the state of Paraíba, but without any mention for family planning, with regard to conception:

"We use the nurse's protocol in the council's family health strategy. But there is no action for conception. I have 15 years of profession working in primary care and I do not know of anything official that recommends action for conception. Our focus always follows this way for the poor to avoid children. For the rich, yes, human reproduction. Therefore, I am unaware of any action or service for family planning in SUS" (S11N1).

"Look, we only have the protocol of the Family Health Strategy, which brings together all the recommendations on almost all clinical situations. It talks about family planning, but not about coping with infertility in primary care. This is not attribution of this level of complexity" (S4N1).

When asked about the actions taken to clarify the difficulty in becoming pregnant, the testimonies of the professionals expressed that the diagnoses are often not closed, being limited to a dialogue about the individual case, exams and referral to more complex services:

"We request tests in an attempt to clarify, but sometimes we simply cannot explain why, because we also only do the

most basic tests. We are primary care providers. Many times my explanation focuses on saying that it is necessary to go to a specialist or relax, forget about it and maybe the patient will get pregnant. But this is not clinical or therapeutic, I recognize. But we do not have any educational actions in the services, I do not know if there is demand for it". (S4P2).

It is observed that the lack of understanding of the rights to reproduction can be summarized to the lack of training of professionals to act in the aid to reproduction as a basic action in primary care of reproductive planning and in the express non-adoption of the protocol by the coordination of women's health care in the municipality.

"Talking about childbearing assistance in primary care seems impossible to me. I never received any training or qualification. And my area is general practice" (S8P1).

"I believe childbearing assistance is not on the list of priorities of the municipality, state and Ministry. If conception was, we would have had training by now. Everything that is a priority is preceded by training and then they continue to demand goals. We have never had any specific action on reproductive health. I could not say, in my area, any information about this demand" (S8N2).

Despite the reality found, clinics specialized in attesting that couples with difficulty in becoming pregnant are infertile are only available in isolated and disjointed assistance from the network. For this reason, professionals are awaiting evaluation of a more complex outpatient/hospital service or specialized professionals from the private network:

"I do all the research. Sometimes, we end up stopping at a certain test, for example, the hysterosalpingography, which is a more complicated test to get through the SUS, so you end up not getting it, but, as far as I remember, here in the area there are two cases of oligozoospermia or azoospermia, the absence of sperm in the semen collection, and two patients who had hormonal changes. I spent months following the patient, just listening, until she received the hysterosalpingography result and it confirmed that the fallopian tubes were obstructed. But it is a terrible wait for us, for the result and for the users, for an explanation that does not explain and that moves away from social conditions" (S4P2).

"The responsibility for classifying, diagnosing and solving is not ours, of primary care. That's why we referenced it. But I refer to the gynecologist specialty. There is no reference service in the network as there is for high-risk pregnant women, heart problems, diabetes, tuberculosis" (S9N9).

"I send it to the federal service, which was where I knew I had the right assisted reproduction. Or rather, a physician who understands the subject. But that I don't even know how this is actually happening. I was sending there and they also did not return to say if they could not get care. There is no number of users who want it. Nor quantitative among those who wished and how many became pregnant and was funded by SUS" (S5N2).

To overcome this situation, the need for a municipal flowchart becomes evident, given that the testimonies of professionals show that many do not know exactly what the reference service in the municipality is and mention federal and municipal public health institutions, as well as a school clinic of a private college, such as specialized establishments in the area of women's health and urology that can assist in reproduction, but not necessarily articulated in a specific care network and/or agreed to guarantee due care.

DISCUSSION

The National Policy on Primary Care (PNAB) and the National Policy on Integral Attention to Women's Health (PNAISM) prioritize health promotion actions for the prevention and rapid identification of diseases in the field of sexual and reproductive health, being considered one of the responsibilities of the actors involved in this scenario, especially in the municipal context(1,19).

Recent research points out gaps between what was proposed by the policy guidelines and what is being offered in the practice of services, revealing that a large part of the educational activities on this theme refer to contraception and STIs, omitting themes related to sexuality, gender issues, methods for conceiving a baby, which are part of reality and are necessary for users who seek the service(19).

Therefore, according to the reality found in the health units studied, there is an urgent need to review the approach to educational actions, including topics such as human reproduction and conception in Primary Health Care, since the public that seeks the service is varied and has different needs, in order to promote equal rights related to sexual and reproductive health today and respecting the individual as a subject with an active voice in relation to his/her own body, being free to make choices(20).

The work of professionals must consider the uniqueness of the patient and the clinical examination of the user/couple so that the care is performed effectively. That said, anamnesis is an important stage for health professionals to obtain information about sexual and reproductive life, menstrual cycle, pathologies of the reproductive system, current and previous history, physical examination, existence of chronic diseases and/or other factors that may interfere with the conception process (5).

At this moment, the health professionals must still identify the life context of the person or couple, evaluating nutritional aspects, use of medications, working conditions, control of pre-existing clinical conditions, occurrence of gestational interruptions, in addition to requesting laboratory, hormonal, spermogram, hysterosalpingography, among others, when the specialized service is not easily accessible.

Recently, the Ministry of Health published a flowchart helping professionals to approach the woman or couple planning the pregnancy, which includes everything from welcoming with qualified listening to the need for referral to a specialized service in infertility, to fulfill the other stages of initial evaluation and diagnosis(9). However, im-

plementing it in Primary Care is a huge challenge, given the existing prejudice, which constitutes barriers and impairs the care of users(4).

For the Ministry of Health, professionals working in Primary Health Care have the technical competence to identify the woman's fertile period, provide guidance on the period favorable to conception, as well as make an anamnesis in order to rule out pathologies and/or factors that prevent or hinder conception, in addition to recommending vaccination against rubella and preventive administration of folic acid and requesting complementary tests such as cytology and oncotic colpocytology collection, anti-HIV serologies, hepatitis B, hepatitis C, syphilis (VDRL), IgG toxoplasmosis, fasting blood glucose and spermogram(5).

Both physicians and nurses working in primary care should be able to perform preconceptional assessment and guidance within this level of care. Thus, only in specific cases should the patient be referred to a specialized service, namely: a woman under 30 years of age, with more than two years of active sexual life, without contraception; a woman aged 30 to 39 years and with more than one year of active sexual life, without contraception; a woman aged 40 to 49 years, with more than six months of active sexual life, without contraception; spouses in active sexual life, without the use of contraceptives that have a factor that prevents conception, regardless of the time of union(10). Women who tend to seek the service voluntarily for physiological reasons usually have conditions such as endometriosis, polycystic ovaries, fibroids, polyps, among others(20,22).

It is noteworthy that attention should be paid not only to the health conditions of women, but also those of their partners, when applicable. In 2018, the Ministry of Health published a document on men's sexual and reproductive health, which included some of the various sexual and reproductive dysfunctions that can affect the male sex, including infertility, which can be motivated by several factors: mumps, diabetes, some types of STIs, antisperm antibodies, use of exogenous anabolic hormones without medical recommendation, anatomical problems, genetic causes that produce sperm DNA defects and cancers, in addition to occurrences without apparent causes diagnosed in 15-20% of cases(23,24).

It should be noted that the distancing of men from health services is a very common fact caused by several factors, including the current FHS model, which predominantly favors the health of women and children, making these subjects not feel an integral part of this model. Thus, there is a need for professional training to integrate men in the guidelines and conduct of the couple's reproductive health care, creating strategies that bring users closer to the services offered(25,26,27).

Despite being actions recommended in the protocol of the Ministry of Health, the professionals from Campina Grande attested in their speeches that they did not receive any training to work in this area of care. In this sense, it is necessary for the State to provide the subjects involved with care with an ed-

ucational proposal that ensures sexual and reproductive rights, as these, when required, directly affect the work processes of health professionals, directly influencing the conduct of care to users(4).

The testimonies also revealed obstacles in the referral and counter-referral system in place in the municipality, an aspect that has now been overcome, from a technical point of view, with the implementation of the regulatory system in January 2018. However, what is seen in practice does not match what is recommended, since consultations are only carried out upon spontaneous demand, that is, when in most cases, the woman suspects her fertile condition and seeks the service in search of answers. When this occurs, the nurse begins the investigation and refers her to the doctor, who, in turn, due to the difficulties of what can be done, refers her to the gynecologist/obstetrician in the service network, since in the Northeast only Pernambuco (Instituto de Medicina Integral Prof. Fernando Figueira – Imip) and Rio Grande do Norte (Maternidade Escola Januário Cicco) have this service.

FINAL CONSIDERATIONS

It was possible to verify that the lack of definition of the municipal and state network for attention to reproduction and the lack of knowledge of professionals about the legal provision within the scope of the SUS, of the National Policy for Comprehensive Care in Assisted Human Reproduction, favors the discrediting of the potentialities and responsibilities of the public service to assist reproduction, reinforcing national geopolitical inequalities.

It is suggested as improvements to the reality found the construction of permanent education actions focused on the theme in question, training the PHC team to adequately treat infertility, in addition to the elaboration of local protocols with the objective of improving the reference and counter-reference of these cases.

The non-inclusion of all family health units and the restriction to medical professionals and nurses, not including users and other team members, such as psychologists and social workers, may have limited the reflections of the study, and therefore it is not possible to generalize the results.

The theme of the study is relevant today, as it reinforces the urgency of making society aware to debate the difficulties of human reproduction profusely, breaking labels that involve social prejudices, strengthening the urgency of improving care for users who seek conception aid, thus being a reference for other studies.

REFERÊNCIAS

1. Brasil. Ministério da Saúde. Política Nacional de Atenção Integral à Saúde da Mulher: princípios e diretrizes. Brasília: Ministério da Saúde, 2004 [Citado 28 set 2022]. Disponível em: http://bvsms.saude.gov.br/bvs/publicacoes/politica_nac_atencao_mulher.pdf.

2. Carloto CM, Damião NA. Direitos reprodutivos, aborto e Serviço Social. Serv soc soc. 2018;(132):306-25. DOI: https://doi.org/10.1590/0101-6628.143.

3. Brasil. Presidência da República. Lei n. 9.263, de 12 de janeiro de 1996. Regula o § 7º do art. 226 da Constituição Federal, que trata de planejamento familiar, estabelece penalidades e dá outras providências. Brasília: Diário Oficial da República Federal do Brasil, 1996 [Citado 28 set 2022]. Disponível em: http://www.planalto.gov.br/ccivil_03/leis/l9263.htm.

4. Telo SV, Witt RR. Sexual and reproductive health: team competences in Primary Health Care services. Ciênc Saúde Colet. 2018 [Citado 28 set 2022];23(11):3481-90. DOI: https://doi.org/10.1590/1413-812320182311.20962016.

5. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Atenção Básica. Cadernos da Atenção Básica n. 26: Saúde sexual e reprodutiva. Brasília: Ministério da Saúde, 2013 [Citado 28 set 2022]. Disponível em: http://bvsms.saude.gov.br/bvs/publicacoes/saude_sexual_saude_reprodutiva.pdf.

6. Mozzaquatro CO, Arpini DM. Planejamento familiar e papéis parentais: o tradicional, a mudança e os novos desafios. Psicol ciênc prof. 2017 [Citado 28 set 2022];37(4):923-38. DOI: https://doi.org/10.1590/1982-3703001242016.

7. Brasil. Ministério da Saúde. Política Nacional de Direitos Sexuais e Reprodutivos [Internet]. Brasília (DF): Ministério da Saúde, 2005 [Citado 28 set 2022]. Disponível em: http://bvsms.saude.gov.br/bvs/publicacoes/cartilha_direitos_sexuais_reprodutivos.pdf.

8. Brasil. Ministério da Saúde. Portaria n. 426/GM, de 22 de março de 2005. Institui, no âmbito do SUS, a Política Nacional de Atenção Integral em Reprodução Humana Assistida e dá outras providências. Brasília: Ministério da Saúde, 2005 [Citado 28 set 2022]. Disponível em: http://bvsms.saude.gov.br/bvs/publicacoes/portaria_426_ac.htm.

9. Brasil. Ministério da Saúde. Portaria n. 3.149, de 28 de dezembro de 2012. Fica destinados recursos financeiros aos estabelecimentos de saúde que realizam procedimentos de atenção à Reprodução Humana Assistida, no âmbito do SUS, incluindo fertilização in vitro e/ou injeção intracitoplasmática de espermatozoides. Brasília: Ministério da Saúde, 2012 [Citado 28 set 2022]. Disponível em: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2012/prt3149_28_12_2012.html.

10. Brasil. Ministério da Saúde. Instituto Sírio-Libanês de Ensino e Pesquisa. Protocolos da Atenção Básica: Saúde das Mulheres [Internet]. Brasília: Ministério da Saúde, 2016 [Citado 28 set 2022]. Disponível em: http://bvsms.saude.gov.br/bvs/publicacoes/protocolos_atencao_basica_saude_mulheres.pdf.

11. Lélis B, Eulálio V, Silva A, Bernardes N. Planejamento familiar: perspectiva de ações a serem implementadas na Estratégia de Saúde da Família – ESF. Rev psicol. 2019 [Citado 28 set 2022];13(45):1103-13. DOI: https://doi.org/10.14295/idonline.v13i45.1729.

12. Bezerra INM, Monteiro VCM, Nascimento JL do, Vieira NRS, Silva RPC da, Alcântara BDC de, Gonzaga MCA, Lima JCS, Machado FC. Ações de educação em saúde e o planejamento familiar: um relato de experiência. Rev Ciênc Plur. 2019 [Citado 28 set 2022];4(3):82-90. DOI: https://doi.org/10.21680/2446-7286.2018v4n3ID17293.

13. World Health Organization. Infertility prevalence estimates, 1990-2021. Geneva, 2023 [Citado 10 out 2023]. Disponível em: https://iris.who.int/bitstream/handle/10665/366700/9789240068315-eng.pdf.

14. Malavé-Malavé M. Infertilidade: o que pode ser feito? 2022 In: Fundação Oswaldo Cruz, Ministério da Saúde. Instituto Nacional de Saúde da Mulher, da Criança e do Adolescente Fernandes Figueira [Internet]. Rio de Janeiro: IFF/Fiocruz. 2022 [Citado 10 out 2023]. Disponível em: https://www.iff.fiocruz.br/index.

15. Vieira MFC, Oliveira MLC. Protocolo de Atendimento Psicológico em um Serviço de Reprodução Humana Assistida do Sistema Único de Saúde - SUS. Psicol teor pesqui. 2018 [Citado 28 set 2022];34:e3449. DOI: https://doi.org/10.1590/0102.3772e3449.

16. Conceição TLC, Silva TV da, Cordovil DC, Carvalho T dos S, Pacheco JO, Cruz Neto MS da, Santana MSS, Miranda SO da S, Almeida BB, Vieira FN. Desvelando a reprodução assistida pelo Sistema Único de Saúde. Res Soc Dev. 2022 [Citado 28 set 2022];11(9):e18711931694. DOI: https://doi.org/10.33448/rsd-v11i9.31694.

17. Marques PP, Morais NA de. A vivência de casais inférteis diante de tentativas inexitosas de reprodução assistida. Av psicol latinoam. 2018 [Citado 28 set 2022];36(2):299-314. DOI: http://dx.doi.org/10.12804/revistas.urosario.edu.co/apl/a.4315.

18. Souza ÂM, Cenci CMB, Luz SK, Patias ND. Casais inférteis e a busca pela parentalidade biológica: uma compreensão das experiências envolvidas. Pensando fam. 2017 [Citado 28 set 2022]. 21(2):76-88. Disponível em: http://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S1679-494X2017000200007&lng=pt&nrm=iso.

19. Brasil. Ministério da Saúde. Portaria n. 2.436, de 21 de setembro de 2017. Aprova a Política Nacional de Atenção Básica, estabelecendo a revisão de diretrizes para a organização da Atenção Básica, no âmbito do Sistema Único de Saúde (SUS). Brasília: Diário Oficial da União, 2017 [Citado 28 set 2022]. Disponível em: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2017/prt2436_22_09_2017.html.

20. Nasser MA, NemesII MIB, AndradeIII MC,

Prado RR do, Castanheira ERL. Assessment in the primarycare ofthe State of São Paulo, Brazil: incipient actions in sexual and reproductive health. Rev Saúde Pública. 2017 [Citado 28 set 2022];51:77. DOI: https://doi.org/10.11606/s1518-8787.2017051006711.

21. Paiva CCN, Caetano R. Evaluation of the implementation of sexual and reproductive health actions in Primary Care: scope review. Esc Anna Nery Rev Enferm. 2020 [Citado 28 set 2022];24(1):e20190142. DOI: https://doi.org/10.1590/2177-9465-EAN-2019-0142.

22. Grangeiro YA, Feitosa PWG, Cruz PHMG, Matosa SP, Almeida BS. Reprodução humana assistida no Brasil: uma análise epidemiológica. Rev Interfaces. 2020 [Citado 28 set 2022];8(1):437-44. DOI: https://doi.org/10.16891/717.

23. Thable A, Duff E, Dika C. Infertility management in primary care. Nurse Pract. 2020 [Citado 28 set 2022];45(5):48-54. DOI: https://doi.org/10.1097/01.NPR.0000660356.18430.0a.

24. Brasil. Ministério da Saúde. Saúde sexual e saúde reprodutiva: os homens como sujeitos de cuidado. Brasília (DF): Ministério da Saúde, 2018 [Citado 28 set 2022]. Disponível em: https://bvsms.saude.gov.br/bvs/publicacoes/saude_sexual_reprodutiva_homens_cuidado.pdf.

25. da Silva DJ, Santana BP de, Santos AL. Infertilidade: umproblemadesaúdepública. Rev Uningá. 2021 [Citado 28 set 2022];58:eUJ3044. DOI: https://doi.org/10.46311/2318-0579.58.eUJ3044.

26. Dias MG, Santos JS, Almeida DR, Rocha FC, Andrade Neto GR, Andrade DLB. Participação masculina no planejamento familiar. HU rev. 2017 [Citado 28 set 2022];43(4):349-54. DOI: https://doi.org/10.34019/1982-8047.2017.v43.13866.

27. Queiroz ABA, Mohamed RPS, Moura MAV, Souza IEO, Carvalho MCMP, Vieira BDG. Nursing work in assisted human reproduction: between technology and humanization. Rev bras enferm. 2020 [Citado 28 set 2022];73(3):e20170919. DOI: http://dx.doi.org/10.1590/0034-7167-2017-0919.

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