Professional competence and contraceptive care

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Abstract

Objective
To evaluate the technical competence of professionals carrying out activities related to contraceptive care.
Methods
Evaluative research in the field of health was conducted in eight districts of the State of Ceara from July to September 2003. Data was collected by means of interviews with 29 nurses working in the Family Health Care Program within these districts and 50 people being attended by this program. Observations of the Family Health Care Units were a complementary source of data within this study.
Results
The majority of nurses had received some form of training regarding contraception and the technical norms regulating their use. However, professional barriers were reported by the nurses and others were identified by lay persons being attended by the program, that indicate the need to provide better training for professionals engaged in this area of care. The nurses recognized they had deficits in information and communication skills as well as technical deficits in dealing with contraception.
Conclusions
There are gaps in professional competence with regard to contraceptive care that, when associated to the lack of systematization of team work, generates distortions in the quality of care. Team work was characterized by the lack of definition of team members' specific attributions and tasks.

INTRODUCTION

Professional competence in the field of contraception should include up-to-date technical, scientific and cultural knowledge, directed towards attending to the sexual health and reproductive needs of clients. This includes skill in counseling, informing and communicating adequately, participating in the decision-making process with respect to contraceptive methods (CM) and lending support to the client respectfully. With this respect, the Brazilian Ministry of Health[7] also suggests that professionals should be prepared to deal with the myths, preconceived notions and erroneous perceptions that individuals accumulate with respect to CM, sexuality, reproductive health, follow-up of their children, among other things.

The role of health professionals in the field of family planning is upheld by article 226, paragraph 7th of the Federal Constitution, that recommends that assistance should be based on the principle of responsible parenthood and on individuals' and/or couples' right to free choice.[7] Therefore, the actions geared towards contraception are based on the premise that all CM approved in Brazil will be provided, thus guaranteeing women's, men's and cou-

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ple's freedom of choice. CM currently available and authorized in Brazil include behavioral methods, masculine and feminine condoms, diaphragms, spermicides, IUDs, oral and injectable hormones, tubal ligation and vasectomy.[8]

Certain elements were established with respect to contraceptive health care in family planning so as to assure that good quality assistance be offered to the population. These elements include offering choice of methods; information given to clients; interpersonal relations; professional competence, follow-up and continuity mechanisms; and the availability of the appropriate network of services.[2] However, professional competence is one of the most difficult aspects to evaluate, for clients tend to evaluate this aspect of care according to the time spent with them and the support they receive more than to their technical knowledge and professional skills. According to the same author, clinical incompetence is rarely reported for the documentation concerning clinical procedures and their consequences was poor and scarce. An exception was a detailed study on death due to sterilizations in Bangladesh, resulting from non-sanitary physical circumstances, precarious conditions of asepsis, gross technical errors or the application of inappropriate medical standards. One of the reasons for the scarcity of studies may be political in character, for serious technical problems may not be published, in light of the breach in collaboration of that professional in the improvement of his/her performance. The *status* bestowed upon physicians in particular may be another reason, since clinicians have been protected by the majority of public reports.[2]

Considering the above mentioned issues, the following questions arise: Are Family Healthcare teams sufficiently trained to offer contraceptive care? Do they have access to manuals and technical norms that may guide assistance? What are the difficulties or obstacles that arise in dealing with contraception? How do people seeking care perceive the performance of health teams with respect to contraceptive care?

Therefore, the objective of this study was to evaluate the technical competence of professionals engaged in contraceptive care.

METHODS

Asserting the significance of analyzing professional competence is complemented by Garcia-Nunez's claim [5] that an evaluation reveals what is functioning and what is not, what should be maintained and what shouldn't be, constituting itself in an instrument in the decision-making process.

This study was conducted in eight districts of Northeastern Brazil (Aratuba, Aracoiaba, Baturité, Capistrano, Guaramiranga, Itapiúna, Mulungu and Pacoti), from July to September 2003, and included both urban and rural zones. At the time, 30,116 families were registered in the Family Health Program (FHP), corresponding to 87.8% of the population in this area.[10]

Subjects were selected according to the following criteria of inclusion: a) nurses: were involved in contraceptive care as members of the FHP team and b) lay persons: women or men participating in or who wished to participate in the FHP. Twenty-nine (90.6%) nurses from the region and 50 of the people attending the FHP were interviewed. Saturation of the replies was the criteria adopted for delimiting the number of interviews conducted with people attending the service, that is, data was collected without previously determining the number of interviews and as new events became depleted, the sample was considered satisfactory. [12]

Interviews were conducted according to two itineraries, one directed towards the nurses and the other towards the lay persons, containing both open and closed questions that were pretested in two Family Health Care Units (FHU).

The results were organized with reference to the Technique of Category Analysis of the Method of Content Analysis.[1] Events were codified and enumerated so as to facilitate the process of quantification. The itineraries of the interviews with lay persons were enumerated from one to 50 and those of the nurses were enumerated from one to 29. Information provided by nurses was codified with the letter "E", while data provided by lay persons was codified with the letter "U" for users. Fragmented reading of all the material was conducted, with the intent of dividing it into units of convergent and divergent meaning, resulting in four analytical categories: access to and quality of training in contraceptive care; access to updated manuals and technical norms concerning contraceptive care; Professional competence in contraception in the nurses' discourse and according to the experiences of those attending the services.

Research subjects were guaranteed anonymity, privacy, that their image would be safeguarded, non-stigmatization, and that information would not be used in a manner that could be detrimental to people or to the communities, so as to respect the ethical aspects of research.

RESULTS AND DISCUSSION

Access to and quality of training in contraceptive care

Twenty-one (72.4%) of the nurses interviewed had participated in some form of training in contraceptive care. The rest of the nurses, 8 (27.6%) that had no such training recognized the fact as a deficiency and expressed interest in acquiring this training.

Despite the fact that the majority of nurses had already had access to courses concerning this theme, almost all of them affirmed they had some sort of deficit in performing activities related to contraceptive care. Training is one of the ways of improving technical competence, however it is not a synonym for quality. The kind of training proposed[2] is based on competencies being monitored in service periodically. In this kind of training, the instructor evaluates the level of comprehension and assimilation of the participant's training in practice, rather than evaluating the time spent in training or the student's assimilation of information. Expanding this discussion, the fact that professionals are not apt is due, in part, to professional training that does not propitiate the development of competencies that can prepare them to enhance their problem-solving capacities in order to confront everyday life situations in a creative way, giving due appreciation to learning to learn and to team work.[9] The same author emphasizes that training should be continuous, institutionalized, multi-professional, centered on the work process and directed towards improving the quality of services, including the effective participation of the population attending these services.

Indeed, the methodology that has been employed in family planning/ contraceptive care training (1993 to 1995) is quite positivist, characterized by the predominance of the theoretical component and employing a process of evaluation centered on the knowledge assimilated by the participant during the classes. Certainly this kind of training did not generate significant improvements with respect to technical performance, for neither the field of action of these professionals, nor their working conditions or the continuous process of training in service was taken into consideration. However, Ceara now disposes of *"Instrumentos de Melhoria da Qualidade em Atenção Primária à Saúde"* [Instruments for the Improvement of the Quality of Primary Health Care"] that comprehends the area of family planning/contraception. These instruments were created by means of a collective process involving the participation of experts, professionals attending laypersons seeking family planning and contraceptive care, laypersons attending these services, and consultants from three international cooperation agencies Program for International Education in Reproductive Health (JHPIEGO), Management Sciences for Health (MSH) and Center for Communication on Programs (CCP). These are self-applicable instruments that are easy to use and that facilitate self-evaluation as well as the learning process within health teams, being a continuing education tool.[11] However, it is necessary to make these instruments available to the universe of health professionals that deal with this area of care, as a strategy to improve their technical performance.

Access to manuals and up-to-date technical norms for contraceptive care

Eighteen nurses (62.1%) stated they had access to this kind of material and presented the Ceara State Department of Health (14), the Ministry of Health (8), the *Sociedade Civil do Bem-Estar Familiar (BEMFAM)* [Family Welfare Civil Society] (5), the Panamerican Health Organization (PAHO)(3) and texts provided in the Specialization in Family Health Care Course as their main sources (2). However, several of these nurses claimed that they had no time for reading and for studying these manuals due to the activities involved in their daily routine. The other 11 (37.9%) nurses stated they did not have access to manuals and/or to technical norms.

Despite the considerable contingent of nurses that had access to instructional resources, this access should be universal. Managers must value and stimulate continuing education in services, mobilizing employees to form local study groups that function on a regular basis.

The norms regulating women's health activities constitute one of the programmatic areas of the Ministry of Health that distinguishes itself as a tool for the development of human resources, of health education and as a logistic support. It is an activity that is based on the supported of a broad spectrum of class organs, universities, and councils amongst others. When the *Programa de Assistência Integral à Saúde da Mulher (PAISM)* [Integral Health Assistance Program] was launched in 1984, technical manuals were sent to the state health departments, guiding the development of reproductive health activities, encompassing contraception. This initiative unleashed a wide spectrum of discussions and a learning process among professionals, students and other entities involved with women's health. However, a discontinuity in this process was detected and is corroborated by the affirmative that these norms are not well disseminated among physicians,[3] nor among the other

members of the health team, thus contributing towards the fact that certain conducts adopted by the services are out-to-date. These authors also state that the majority of schools of medicine and of nursing do not include family planning in their undergraduate programs and those that do include them, only discuss contraceptive methods, putting aside aspects such as reproductive and sexual rights and communication techniques, among others.

Throughout the period of fieldwork, the municipal departments of health received manuals of technical norms from the Ministry of Health directed towards professionals and managers that deal with contraception. The quantity of manuals proved to be insufficient, restricting the individual access of professionals to the material. Another aspect identified was the gap left by the Ministry of Health between the last version of the family planning manual[7] and the current revision,[8] that is, that is, from six to seven years, when new information should already have been incorporated into professional practice.

Professional competence in contraceptive care from the perspective of nurses and of people attended by the services.

Five nurses (17.2%) stated that they felt prepared

Table - Obstacles to Professional competence in contraceptive care and scientific evidence. Regional Health District of Ceará (Northeastern Brazil), July to September, 2003.

Professional obstacles	Scientific evidence
My uterus was irritated. The doctor said it was because of the pills [COC] and that I should stop taking them. (U14).	The Ministry of Health (MH) recommends the use of COC in cases of irritated uterus or cervical ectopia.[8]
When we reach the age of 35 they [doctors, nurses and nurse assistants] don't want to give us pills anymore [COC] (U17, U6). *I become insecure when it comes to determining at what age a woman should stop usisng the combined oral contraceptive...(E13).*	The MH recommends the use of COC until the age of 40 without restrictions; from that age on the indication is maintained, however with restrictions, since the risk of cardiovascular disease increases with age and may be greater for those taking the pill. However, if the person being attended is 35 or older and smokes more than 20 cigarettes daily, COC is counter indicated. [8]
It was not carelessness that led me to become pregnant of my second child. It was because the doctor told me I could not take the pill because I was breastfeeding. I was already menstruating. (U42). *When a woman who has concluded her third month of postpartum, is breastfeeding exclusively and is not menstruating, says she wants to take the pill,... I only offer it to her after she has undergone a pregnancy test (E24).* *I have doubts about when to initiate the combined oral contraceptive among patients who are breastfeeding: if the child is eating other foods is the mini pill still effective? After six months must the woman stop taking the mini pill? (E12)*	The pill and injectable contraceptives that are based exclusively on progestagen may be utilized among breastfeeding women six weeks after childbirth; the use of COC and combined injectable contraceptives may be initiated six months after childbirth, for they may reduce the quantity of milk and effect child development.[8] In the case of the client who had already begun to menstruate, it is probable that her child was no longer breastfeeding exclusively. Therefore, the combined hormones would also not be counter indicated. There is no need to ask for a pregnancy test if the patient is breastfeeding exclusively, for the chances of her being pregnant are practically null.
The nurse didn't give me my pills because I had just begun to menstruate two days before my consultation. She said it was for my own good, that if I began to take the pill I would become pregnant. (U19).	The pill may be taken initially any day of the menstrual cycle, if the professional prescribing it is reasonably sure that the client is not pregnant. In order to prescribe the pill, the professional needs to consider the following information: the menstrual cycle began less than seven days ago; the woman gave birth less than four weeks ago; the abortion took place less seven days ago; or the woman gave birth six months ago, is breastfeeding frequently and is not menstruating; or she did not have vaginal sexual intercourse since her last menstruation; or she used another CM correctly in her previous sexual activities.[6]
I wanted a tubal ligation, but the doctor Said I was too young (she was 24 years old) and that I had too few children (she had two children).	According to the Law no. 9.263/96, that is concerned with family planning, volunteer sterilization is permitted for men or women with full civil capacity and who are over 24 years of age or, have at least two live offsprings. [8]
You see 14 or 15 year old girls already taking hormones, that's not right (E2). Pills or injections are not the best methods for adolescents (E28).	The theoretical concern with the use of the pill in the beginning of adolescence has no scientific basis. Its use is recommended, without restrictions, from menarche onwards. Contraceptives based solely on progestagen, are recommended with restrictions from menarche to the age of 16 due to concern with respect to the hipoestrogenic effect.[8]
I recommend the suspension of the pill (COC) for six months when it has been used continuously for two years. I have attended women who have been using it continuously for up to five years, then I tell them to stop taking it for God's sake! (E22).	The Ministry of Health advises that there is no need to interrupt the use of the contraceptive method, for there is no scientific evidence that justifies this practice and it is a cause of undesired pregnancy.[8]
Before being referred for IUD insertion, we must undergo prevention (PAP'S Smear) because if we don't the doctor will not insert the IUD (E23).	There is no scientific evidence that justifies oncologic cytology as a pre-requisite for the insertion of the IUD. [3]

COC: Combined oral contraceptives

to deal with the issues involved in contraceptive care; 17 (58.6%) recognized they had technical difficulties in evaluating contraindications; 10 (34.5%) had difficulties in managing collateral effects and/or complications. Eight (27.6%) reported difficulties in informing lay persons about the correct way of using some of the CM, being that, for two of these, this was considered a technical issue and for the remaining nurses the difficulties were related to the lack of time associated to the large demand. Guaranteeing free choice with respect to contraceptive method was considered a challenge by 14 (48.3%) nurses, not because of the technical issues involved, but because of the small variety of CM available at the service.

The nurses that recognized they had difficulties in evaluating contra indications were referring exclusively to the hormonal contraceptives (pills and injections) and basically to the breastfeeding period. As to the management of collateral effects, the doubts expressed also referred to hormonal methods, including, predominantly, changes in the menstrual cycle.

Nurses' and laypersons' statements were consolidated in the Table, being classified as obstacles to professional competence in contraceptive care, and characterized as inappropriate conducts adopted by physicians and/or nurses and nurse assistants in the management of CM. Scientific evidence regarding these conducts are presented in conjunction with them.

This data confirms the need to implement continuing education among professionals working in this field. Technical lapses in professional activity lead, for example, to the professional's denial of patient's control over fertility due to extraneous criteria.[2] Another aspect of this issue is that clients are overburdened with the consequences of the use of inappropriate techniques, such as, for example, unnecessary pain, infections and other serious collateral effects; and, under certain circumstances, even death. The discourse of a woman who was attending the service and who had already experimented the IUD, confirms the above observations: "*I was always feeling the inflammation and, each six months I came back for a revision of the IUD and I always had something or other*" (U14). And, according to another woman who attempted to have an IUD inserted, but was not successful: "*I underwent preventive treatment to try to have an IUD inserted, but it wasn't possible. My uterus was perforated*" (U29).

As to the nurses that reported difficulties in informing clients with respect to the correct usage of contraceptive methods, one was referring specifically to the diaphragm and the other one was referring to injectable hormones. The fact that these methods were not easily available in the services and, therefore, had scarcely been managed was utilized by professionals as a justification for their lack of competence with respect to their correct usage. The statements below confirm this:

"*I don't feel secure about informing (clients) about IUDs and diaphragms; after all, these are methods that we scarcely mention, for they're never available here.*" (E6)

"*I find it difficult to teach (them) about the trimester injection, because it was available for a while, but it has now disappeared. We usually talk more about the methods that are available here.*" (E20 and E21)

These statements indicate the habit of informing clients only about CM that are available at the services. However, clients have the right to be informed about all existing methods, even those not available at the health care unit, for she/he may try to acquire them through other sources and there should be information regarding these sources available at the health care services in which he/she were first attended.

This study also indicates that the small variety of CM available and/or the irregularity of their supply at the health centers represents an obstacle to the management of counter indications and to the client's freedom of choice regarding contraceptive care, since the latter tend to take the risks related to those methods that are available. Thus the advice or decisions taken by professionals tend to be underestimated, threatening the effectiveness of technical criteria and conducts. The stories narrated by nurses explicit this finding:

"*Hypertensive women whose partners refuse to use condoms, I don't have any other method to offer them... do I offer them pills? Some of them say that if we don't give them pills, they will buy them. So it's better to offer them pills, at least they will be followed up by us*". (E28)

"*A hypertensive woman, for example, if I suspend the pill, she'll say that I'm "bad", she'll say that I "don't know anything"*. (E6, E16)

"*The population can't buy (CM), so they take what's available and this compromises our performance!*". (E20, E21, E24, E25 and E27)

Furthermore, nurses reported situations that confirmed physician's lack of preparation regarding contraceptive care. One of them stated: "*The doctors should become more involved. We refer a woman presenting complications regarding the use of the pill, and they send them*

back to us without having done anything for them" (E10). And another nurse reiterated: "*Frequently they (the doctors) are the ones who refer them (the women) to us. This happens with me, with (...) and I think it happens with other nurses as well"* (E8). Within the field of activity of the nurse E27, this kind of omission and lack of preparation on the part of physicians is so frequent that Within the field of activity of the nurse E27, this kind of omission and lack of preparation on the part of the physician is so frequent that the nurse took the initiative of assuming the full responsibility for contraceptive care and she emphasized: "Once, *I attended a woman who was over 40 years old, had sever hypertension and had a medical prescription for a combined pill. From this moment on I decided that within my sphere of action I would take on responsibility for all the family planning"* (E27). With respect to this issue it should be stressed that family healthcare is a proposal based on team work that should be carried out by the physician, the nurse, the nurse's assistant and community health agents that are co-responsible for the health of 1,000 families.

Therefore, the participation of each and all team members in the family planning activities so that the nurse isn't overburdened and her competence is not compromised is fully recognized. On the other hand, the statements of the two research subjects mentioned above brought the issue of professional competence on the part of doctors, nurses and nurse assistants (to a lesser degree) into discussion, for it seems to mark the centralization of the supply of contraceptive care among these three professional categories, particularly the doctor and the nurse. Regarding this theme, the concentration of activities and responsibilities on a single professional diminishes the technical competence with which some activities are undertaken.[3]

Follow-up consultations of women taking the pill, injectable contraceptives and IUD may be conducted by nurses or trained assistant nurses. Indeed, in some services, apparently, even IUD insertions may be carried out by nurses as well or even better than when they are inserted by doctors.[4]

In conclusion, the lack of systematic organization of team work, with tasks and attributions clearly defined was perceived in this study. Thus, the use of the Methodological Instrument for Quality Improvement as a tool utilized to lend support to the continuing education process in contraceptive care is suggested. Furthermore, future studies should be designed so as to discuss professional competence from the perspective of team work, which proposes the division of tasks and integrated assistance.

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