



Organizational barriers to the availability and insertion of intrauterine devices in Primary Health Care Services*

Barreiras organizacionais para disponibilização e inserção do dispositivo intrauterino nos serviços de atenção básica à saúde

Barreras organizativas para facilitación e implantación del dispositivo intrauterino en los servicios de atención básica de salud

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How to cite this article:

Gonzaga VAS, Borges ALV, Santos AO, Santa Rosa PLF, Gonçalves RFS. Organizational barriers to the availability and insertion of intrauterine devices in Primary Health Care Services. Rev Esc Enferm USP. 2017;51:e03270. DOI: <http://dx.doi.org/10.1590/S1980-220X2016046803270>

* Extracted from the dissertation “Barreiras organizacionais para disponibilização do dispositivo intrauterino nos serviços de atenção básica à saúde (macrorregião sul de Minas Gerais)”, Escola de Enfermagem, Universidade de São Paulo, 2016.

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ABSTRACT

Objective: To identify organizational barriers to IUD availability in Primary Health Care services from the perspective of women’s health coordinators. **Method:** This is a quantitative study carried out with women’s health officials from the municipalities of the southern macro region of Minas Gerais, Brazil, with an *on-line* completion of a structured instrument and a descriptive data analysis. **Results:** 79 technicians participated in the study. Among the municipalities, 15.2% do not provide IUDs and 8.3% do not refer women to other services, 53.7% do not provide IUDs at basic health units. Among those who provide the IUD, 68.7% do not have a specific protocol and 10.5% do not adopt pregnancy as a condition that makes it impossible to insert the IUD, and 80.6% adopt unnecessary conditions, such as vaginal infection. As a criterion for IUD access, 86.5% referred to a medical prescription, 71.6% required exams, 44.6% were over 18 years of age and 24.4% participation in groups, none based on scientific evidence. Only the doctor inserted the IUD. **Conclusion:** Problems in the access to the IUD were identified due to organizational barriers to its availability and insertion, such as the lack of availability of the method or the excess of unnecessary criteria to make it available.

DESCRIPTORS

Intrauterine Devices; Family Planning; Sexual and Reproductive Health; Primary Care Nursing; Women’s Health.

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Received: 01/11/2017
Approved: 07/20/2017

INTRODUCTION

Access to and use of contraceptive methods have positive effects on the sexual and reproductive health of women and men, as it prevents unplanned pregnancies and, consequently, reduces maternal morbidity and mortality and unsafe abortions⁽¹⁾. The Brazilian Unified Health System (SUS – *Sistema Único de Saúde*) provides several types of contraceptive methods, including long-term reversible ones, such as the copper Intrauterine Device (IUD). It is a safe, highly effective method with extremely low failure rates similar to those observed in female surgical sterilization (0.5%)⁽²⁻⁴⁾. It is the most widely used reversible method on the planet^(1,5) but remains underutilized in some regions of the world (North America, South Asia, Oceania, sub-Saharan Africa⁽⁶⁻⁷⁾ and Latin America)⁽⁸⁾.

In Brazil, IUD use is infrequent, only 1.5% of the women interviewed in the 2006 National Demographic and Health Survey reported its use⁽⁹⁾, probably due to the issues of access to and use of health services. Access to health services may be centered on the characteristics of individuals (those seeking care and those who conduct them within the health system); on the characteristics of the offer; in both characteristics; or in the relationship between them (individuals and offer)⁽¹⁰⁾. Thus, our assumption is that access to the use of health services can present different degrees of facilities or difficulties, depending on the organization of the health services, available resources (such as contraceptive methods) and the characteristics of the supply, determining the response to the health needs of a population, i.e., there are several organizational and individual barriers that permeate women's access to the IUD in the country.

Organizational barriers to IUD access are considered unnecessary criteria for their insertion, such as conditioning to participation in educational groups; the insufficient and discontinued supply of the method; inadequate knowledge of health professionals about their mechanisms of action; the lack of qualified professionals – added to the exclusivity of the medical professional for their insertion; and, finally, the absence of simplified protocols^(2,11-13).

On the other hand, among the individual barriers, the low level of knowledge of the women and the couples about the method stand out; myths and taboos about the IUD, such as belief in the possibility of causing cancer, cause abortions and being ineffective; fear of side effects, such as increased menstrual flow, both in number of days and in volume; and belief that it is not appropriate for nulliparous women, young or single women^(2,13-18).

Both barriers are experienced in Brazilian Primary Health Care (PHC)⁽¹²⁾ and prevent full access to the IUD, contributing to the low frequency of its use and constituting a barrier to the full exercise of sexual and reproductive rights⁽¹²⁾.

There are very few studies in Brazil that explore the organizational barriers faced by women to access contraceptive methods, including the IUD, according to their region of residence. Thus, our objective was to identify the barriers that women face to access PHC services for the introduction of the IUD, from the perspective of workers in the technical areas of the municipalities of a health macro-region.

METHOD

A quantitative, cross-sectional and descriptive study conducted with the coordinators of the technical area of women's health of the Municipal Health Secretaries of the Regional Health Superintendencies (RHS) of the southern macro region of Minas Gerais, and performed from March to May in 2016. The respondents were the coordinators of the technical area of women's health in each municipality, and were chosen by the criterion of being responsible for this technical area or, in the absence of these, the workers who could answer about the availability of the IUD.

Authorization to perform the research was requested by official letters which were sent to the regional health superintendents of the four regions. Although the answers regarding participation were positive, it was required that the researcher also make contact with the health managers of the municipalities, so that they could know the research and grant the authorization. The researcher requested authorization from all health managers in all municipalities (n=153): 86 of these authorized data collection (56.2%), 64 municipalities did not respond (41.8%) and 3 refused to participate (2.0%).

Upon receiving authorization, information was obtained on the coordinators in the Municipal Health Departments. They were contacted by telephone and the objectives and procedures of the study were explained. In addition, the electronic address and the authorization to send the questionnaire were requested. In addition to the questionnaire, an invitation and the Free and Informed Consent Term were also sent by e-mail for adherence and voluntary participation in the study.

Among the municipalities that authorized the survey, 80 responses were obtained, which corresponds to 93% of the total authorizations, and one response was excluded, because two responses were received from the same municipality (in this case, the response of the coordinator from the technical area of women's health in the municipality was considered). Thus, 79 responses (91.8% of authorizations) of workers (15 RHS municipalities from Alfenas, 11 RHS municipalities from Passos, 29 RHS municipalities from Pouso Alegre and 24 RHS municipalities from Varginha) were included.

Shortly after accepting their participation, study participants responded online to a semi-structured, self-filling questionnaire developed by the researcher herself using the Google forms application. The questionnaire was divided into five blocks: 1) information about RHS characteristics; 2) profile of the research participant; 3) women's health care activities related to the IUD; 4) educational activities in relation to family planning; and 5) respondents' considerations regarding the existence of difficulties and facilities for women to obtain the IUD.

The database was originated from *Google forms*. Statistical analysis was performed in three stages by Stata software, version 14.2. In step 1, the characteristics of the interviewed professionals were analyzed, by the variables: age, sex, educational level, type of specialization, profession and time of performance in the position. In stage 2, attention was focused on the availability/insertion of the IUD. For that,

the variables used were those related to IUD availability/insertion: IUD availability (no or yes); existence of a specific protocol for IUD availability (no or yes); conditions that may make it impossible for IUD insertion (anemia, HIV, vaginal infection, recent spontaneous or induced abortion, previous history of Pelvic Inflammatory Disease – PID, pregnancy, previous history of ectopic pregnancy, breastfeeding, diabetes, hypertension, working in jobs which require heavy lifting and others); professional who inserts the IUD (gynecologist/obstetrician, general practitioner, obstetrician, general nurse and other); scheduling for insertion of the IUD (no or yes); average waiting time for the woman, between the day of the first consultation, or the day she communicates her interest in using the IUD until insertion (less than 1 week, 1 to 4 weeks or more than 1 month); referral of the woman, in case the municipality does not provide the IUD (does not refer, refer to another municipality or other); location for the acquisition of the IUD (Primary Health Care Unit (*Unidade Básica de Saúde* – UBS)/Family Health Strategy (FHS), specialty outpatient clinic, central pharmacy, hospital, women's health sector, health department, other municipality and other); criteria for the woman to have access to the IUD (there are no criteria, to have prescription only from the gynecologist, to have prescription only from a physician, to have prescription only from a nurse, with prescription of gynecologist, physician or nurse, to perform exams, to be married, to be older than 18 years of age, previous participation in an educational group or other). The variables related to the respondents' considerations were analyzed in step 3: existence of difficulties for women to obtain the

IUD (no or yes); existence of facilities for women to obtain the IUD (no or yes).

The project was approved by the Research Ethics Committee of the Escola de Enfermagem of the Universidade de São Paulo (Opinion No. 1.212.779), in compliance with the determinations of Resolution 466/12 of the National Health Council, which regulates ethics in research involving human beings in Brazil.

RESULTS

The study involved 79 workers responsible for the technical area of Women's Health. The majority of respondents were between 24 and 34 years of age (50.6%), female (97.5%) and nurses (89.9%), with a period of 1 to 5 years working in their position (59.5%), with specialization (62.0%), masters (2.5%) or doctorates (1.3%). Only 26.9% of the postgraduates had obtained the degree in the area of Women's Health.

ORGANIZATIONAL BARRIERS RELATED TO IUD AVAILABILITY

The organizational barriers related to IUD availability are described in Figure 1. It was observed that some municipalities do not provide the method (15.2%). From these municipalities, 58.4% refer women to another municipality and 33.3% use other forms of referrals, such as a private network, a specialist, or the *Centro Viva Vida* (The Child and Maternal Mortality Reduction Program of the Government of Minas Gerais). It is interesting to note that 8.3% of the municipalities, in addition to not providing IUDs, do not refer women who are interested in using it. Among the municipalities that provide the IUDs (84.8%), the majority do not have a specific protocol for their availability (68.6%).

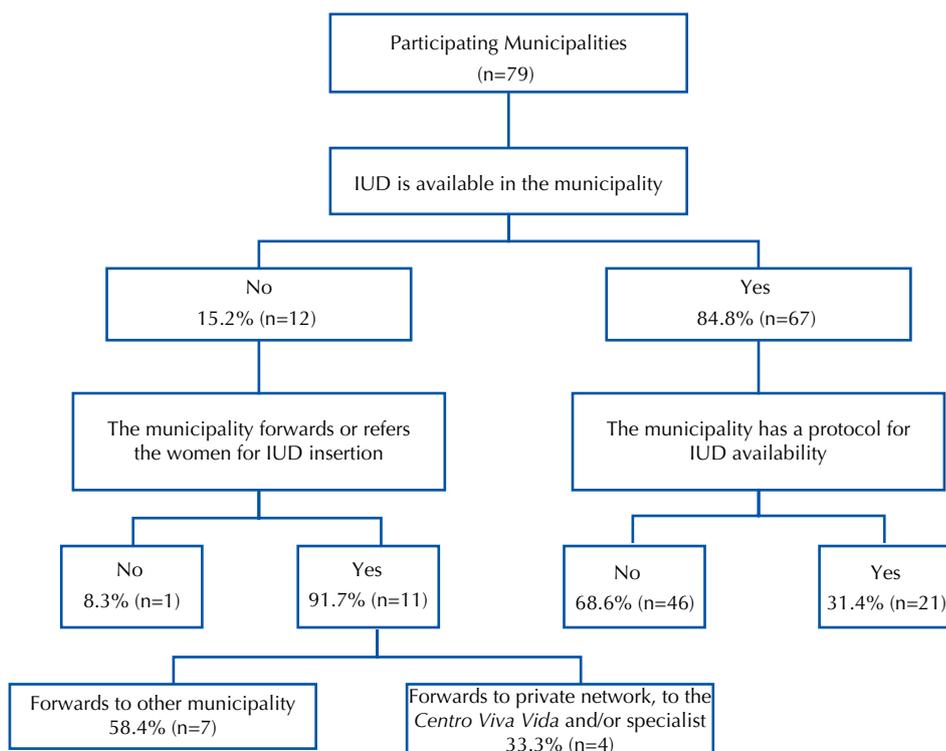
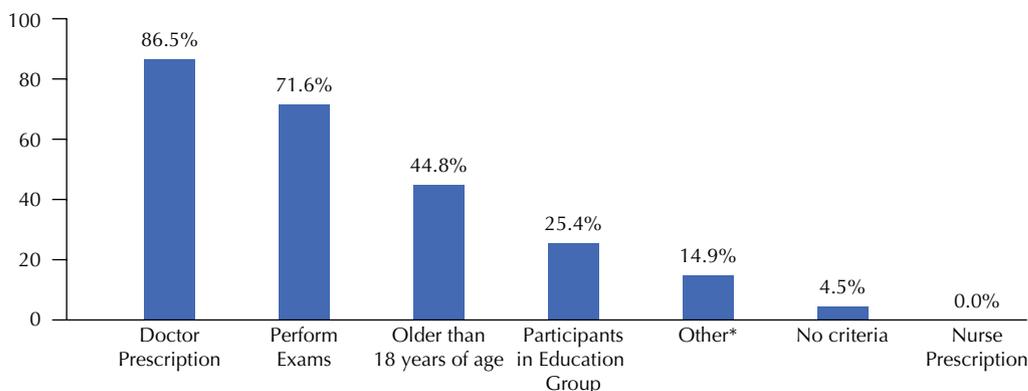


Figure 1 – Diagram of IUD availability – Southern Minas Gerais Macroregion, 2016.

Figure 2 shows the organizational barriers related to the criteria established by the health services to make the IUD available, with the majority of the municipalities making it available only through medical prescription (86.5%), exams (71.6%) and/or participation in an educational group (25.4%). In addition, almost half of the municipalities do not

provide IUDs for adolescents (44.8%). Another important barrier is that more than half of the municipalities reported not making the IUD available in the UBS/FHS (53.7%); 79.2% made the IUDs available in other health units, such as central pharmacy, Women's Health sector, specialty outpatient clinic, health secretariat and hospital.



*Be married, have at least one child, menstruating, currently using contraceptive for 6 months.

Figure 2 – Criteria established by the health services to make the IUD available, among the municipalities that make it available – Southern Minas Gerais Macroregion, 2016.

ORGANIZATIONAL BARRIERS ASSOCIATED WITH IUD INSERTION

Table 1 shows the barriers related to the routines for IUD insertion. It was observed that the insertion focuses on a single health professional, who is the physician. Another

barrier verified in almost all municipalities was the need for prior scheduling for IUD insertion. Another considered barrier is the average waiting time to have the IUD inserted which is 1 to 4 weeks (62.7%) – in almost one third of municipalities this waiting time exceeds one month.

Table 1 – IUD insertion routines, according to the availability protocol for the IUDs of the municipality – Southern Minas Gerais Macroregion, 2016.

Routines for IUD insertion	Total	
	n	%
Professional who inserts IUD		
Gynecologist and Obstetrician	65	97.0
General Medical Physician	02	3.0
Need to pre-schedule for insertion		
No	07	10.4
Yes	60	89.6
Waiting time for insertion		
1 to 4 weeks	42	62.7
More than 1 month	19	28.4
Less than 1 week	06	8.9

Most of the municipalities adopt clinical requirements that impede IUD insertion: vaginal infection (80.6%), previous history of PID (40.3%), recent spontaneous or induced abortion (40.3%), anemia and previous history of ectopic pregnancy

(29.8%), HIV (26.9%), breastfeeding and working in heavy physical labor positions (4.5%), diabetes and hypertension (3%). It is noteworthy that 10.5% of the municipalities do not adopt pregnancy as a condition that may impede IUD insertion.

Table 2 – Conditions that may impede IUD insertion, according to the IUD availability protocol – Southern Minas Gerais Macroregion, 2016.

Conditions that may impede IUD insertion	Presence of IUD availability protocol in the municipality				Total	
	Yes		No		n	%
	n	%	n	%		
Pregnancy	18	85.7	42	91.3	60	89.5
Vaginal Infection	20	95.2	34	73.9	54	80.6
Recent spontaneous or induced abortion	09	42.9	18	39.1	27	40.3
Previous history of PID	09	42.9	18	39.1	27	40.3
Anemia	08	38.1	12	26.1	20	29.8
Previous history of ectopic pregnancy	10	47.6	10	21.7	20	29.8
HIV	05	23.8	13	28.3	18	26.9
Other*	02	9.5	07	15.2	09	13.4
Currently breastfeeding	01	4.8	02	4.4	03	4.5
Performs heavy lifting activities	02	9.5	01	2.2	03	4.5
Diabetes	02	9.5	-	-	02	3.0
Hypertension	02	9.5	-	-	02	3.0

*Uterine malformation, excessive blood flow, vaginal bleeding without definite cause, uterine tumors, multiple partners, inverted cervix, nulliparity, endometrial thickening, presence or suspicion of cervical cancer and medical contraindication.

Participants were questioned about the existence of difficulties and facilities for women to obtain the IUD (Table 3). The majority reported no difficulties, but reported facilities for obtaining the IUD (86.1%). The rate of participants

who reported difficulties was higher among municipalities that did not provide the IUD (66.6%). The reverse is true of facilities; i.e., more facilities were reported among the municipalities that offer IUDs (94.0%).

Table 3 – Considerations of health workers responsible for the technical area of Women's Health who reported difficulties or facilities for women to obtain the IUD – Southern Minas Gerais Macroregion, 2016.

Considerations of the respondents about the existence of difficulties or facilities to obtain the IUD	The IUD is available in the municipality						
	No		Yes		TOTAL		
	n	%	n	%	n	%	
Difficulties	No	04	33.4	64	95.5	68	86.1
	Yes	08	66.6	03	4.5	11	13.9
Facilities	No	07	58.4	04	6.0	11	13.9
	Yes	05	41.6	63	94.0	68	86.1

DISCUSSION

ORGANIZATIONAL BARRIERS RELATED TO IUD AVAILABILITY

Only a small number of municipalities do not provide the IUD, and in some municipalities, besides not being available, there is no option for women to be referred to other services. The non-availability of the IUD and the non-referral for insertion, for whatever reason (bureaucratic, logistical or lack of decision of the municipality to make it available), is as an organizational barrier, often impassable by women. In both cases, a woman may not have access to the IUD, since she may face problems that make it impossible for her to go to other services or be deprived of the means to have her needs met. International studies show that, when the IUD is offered through appropriate contraceptive counseling, most women tend to opt for it⁽¹³⁾, which leads us to conclude that there are flaws in the implementation of women's sexual and reproductive rights, as contraception assistance provides the offer of all alternative contraceptive methods⁽¹⁹⁾, whose

financing, purchase and distribution is the responsibility of the Ministry of Health⁽²⁰⁾, guaranteeing women autonomy in controlling their fertility and choosing the method to which they are best suited^(3,12).

Another organizational barrier identified was related to the use of protocols, since it was evidenced that, among the municipalities that offer IUDs, most do not have a specific protocol to make the method available. The lack or non-use of a protocol with operational details may cause mismatched information and action variability among professionals or between health professionals and women, provoking a disorganized work process without legal support⁽²¹⁾ – which may signal that women who have an interest in using IUDs may be prevented from doing so.

CRITERIA FOR IUD AVAILABILITY

Regarding the IUD availability criteria, the findings of this study showed the existence of links between the access to the IUD to the consultation with a specialist, the conduct of examinations, which are often unnecessary, and the

participation in an educational group of reproductive planning, implying organizational barriers. Such findings are relevant as, in many municipalities, access to consultations, examinations and groups is not simple – and not fast. In addition, in relation to the criteria of the World Health Organization⁽¹⁷⁾ manuals and the Ministry of Health⁽³⁾, the IUD can be inserted by a trained and qualified health professional; can be used safely and effectively by most women, without any blood tests or preventive tests for cervical cancer, by simply using the Clinical Eligibility Criteria; and, in the impossibility of educational group participation, she can be individually oriented on the IUD^(3,17). The literature shows that difficulties and organizational setbacks, such as appointments, slowness in receiving the exam results and days and times of the groups, limit the access of women to the IUD, who may opt for another contraceptive method that does not meet their needs or face an unplanned or unwanted pregnancy⁽¹²⁾.

Another barrier identified is the fact that half of the municipalities do not provide IUDs for adolescents. A similar situation was observed in the city of São Paulo, where only one third of the UBS reported IUD placement in adolescents⁽²²⁾. Adolescents are vulnerable to unplanned and/or unwanted pregnancies and there is no contraindication to IUD use in this group, which is the basis for their indication in public health policy^(4,23).

Regarding the place/location of IUD availability, this study showed that most of the reported municipalities did not make it available in the UBS/FHS, with availability generally being centralized. The organization of contraceptive care should be given initially by the UBS – and the placement of the IUD is a fully practicable procedure at the primary level of care⁽³⁾. It must be acknowledged that its availability, when it occurs anywhere other than where is close to women's homes, can be a barrier to access, as distance and bureaucracy are considered as obstacles⁽²⁾.

ORGANIZATIONAL BARRIERS ASSOCIATED WITH IUD INSERTION

The limitation of the performance of other health professionals – other than the physician – in inserting the IUD may constitute barriers to the insertion of the IUD, as this professional is not always capable or available to insert the IUD⁽²²⁾. In Brazil, the insertion of the IUD can be performed by other trained health professionals^(3,17) and it is emphasized that trained and qualified nurses have legal competence to insert and remove the IUD⁽²⁴⁻²⁶⁾. Our findings showed that IUD insertion was only performed by the physician, which is not justified, mainly because there is evidence that there is no difference in the performance of nurses and midwives compared to the performance of physicians in this action⁽²⁷⁾.

Therefore, the use of specific protocols and the expansion of the performance of other trained health professionals in the IUD availability/insertion through *Task Shifting*⁽²⁶⁾ can represent effective and safe actions to reduce IUD barriers, improve access and prevent legal and ethical issues for the health professional⁽²⁸⁾.

Another important barrier of IUD insertion is the routine of prior scheduling, which makes us reflect on some

consequences, for example, unplanned or unwanted pregnancies and missed opportunities for IUD placement. It is important to note that until the date of the subsequent IUD insertion consultation, a woman may become pregnant or may encounter a number of difficulties that make it impossible for her to return. Studies have shown that insertion of the IUD should occur during the consultation itself, since several return visits to obtain the IUD may decrease the chances of adherence to the method⁽²⁾. In addition to prior scheduling, another important barrier that contributes to the difficulty of IUD insertion is the average waiting time for the woman to have the contraceptive inserted – which has exceeded 1 month in more than one third of the municipalities evaluated in the research. The CHOICE project, conducted in the United States, has shown that there is an association between reducing barriers and increasing IUD use. CHOICE broke some access barriers (waiting time and cost) and increased its use from 3% to 56%⁽¹³⁾ by immediately inserting the IUD soon after the woman states the desire to use it, at no cost to the woman. This work process, such as the immediate insertion of the IUD, is considered feasible in Brazil, due to the high coverage of the population by the FHS (64.6%)⁽²⁹⁾.

The adoption of certain clinical conditions by the woman as an impediment to the use of the IUD is undoubtedly a barrier to its insertion. Clinical conditions were cited by many of the municipalities as impediments to IUD insertion (vaginal infection, previous history of PID and spontaneous or recent induced abortion, HIV, and breastfeeding). The adoption of many of these clinical conditions is unfounded or unnecessary and hinders access to the method. Vaginal infection or breastfeeding, for example, do not in itself constitute limitations for insertion of the IUD, and a clinical evaluation is necessary before the woman is prevented from using the method^(3,17).

It is curious to note that, despite the numerous barriers to IUD access highlighted in the study, most interviewees considered that there were no difficulties for women. The opinion of these workers does not match our findings and shows another possible barrier: the non-recognition that the barriers exist. Adopting the perspective that there are no barriers prevent them from taking actions to remedy them, contributing to the low utilization of the method. It is therefore crucial to identify such barriers in PHC services to plan for increased access to the method and to make advances in the implementation of sexual and reproductive rights⁽²²⁾.

As a limitation of this study, it is worth noting that the sample is not representative, and it is not possible to generalize the findings of all Brazilian municipalities or the municipalities of the southern region of Minas Gerais. However, the results are similar to those obtained in the previously conducted national studies⁽¹¹⁻¹²⁾, which indicate that the weaknesses in the attention to contraception still persist in Brazil. Similar results are also found in other contexts, where access to the IUD is also permeated by organizational barriers^(2,13). As potentialities, our study allows the reflection and indirect evaluation of the services provided, which may lead to the improvement and expansion of women's health care in other Brazilian municipalities, guaranteeing the full exercise of their sexual and reproductive rights.

CONCLUSION

This study provides an overview of access to IUDs, and addresses the organizational barriers to its availability in PHC services, in relation to the method being offered and the criteria adopted to make it available. Organizational barriers related to the absence or non-use of protocols for IUD insertion were identified; organizational barriers such as not making the method available, excessive criteria regarding its availability established by the health services which is often unnecessary;

organizational barriers associated with IUD insertion, such as limiting the nurse's working field and prior scheduling for the procedure, and the adoption of certain clinical conditions of the woman that make it impossible to insert the IUD, conditions without support in the latest scientific evidence.

Organizational barriers are one of many reasons why women do not access the IUD. Therefore, more efforts must be undertaken to have these barriers removed and that the guidelines are respected and adhered to.

RESUMO

Objetivo: Identificar barreiras organizacionais para disponibilização do DIU nos serviços de Atenção Básica à Saúde na perspectiva dos coordenadores da área de saúde da mulher. **Método:** Estudo quantitativo realizado com responsáveis pela área técnica de Saúde da Mulher dos municípios da macrorregião Sul de Minas Gerais, com preenchimento *on-line* de instrumento estruturado e análise descritiva dos dados. **Resultados:** Participaram do estudo 79 trabalhadores responsáveis pela área técnica. Dentre os municípios, 15,2% não disponibilizam DIU e 8,3% não referenciam a mulher para outros serviços, 53,7% não disponibilizam o DIU nas unidades básicas de saúde. Dentre os que disponibilizam o DIU, 68,7% não possuem protocolo específico e 10,5% não adotam a gravidez como condição que impossibilita a inserção do DIU, e 80,6% adotam condições desnecessárias, como infecção vaginal. Como critério para acesso ao DIU, 86,5% referiram prescrição médica, 71,6% realização de exames, 44,6% idade acima de 18 anos e 24,4% participação em grupos, todos sem base em evidências científicas. Apenas o médico insere o DIU. **Conclusão:** Foram identificados problemas no acesso ao DIU, por meio de barreiras organizacionais para sua disponibilização e inserção, como a não disponibilização do método ou o excesso dos critérios desnecessários para disponibilizá-lo.

DESCRITORES

Dispositivos Intrauterinos; Planejamento Familiar; Saúde Sexual e Reprodutiva; Enfermagem de Atenção Primária; Saúde da Mulher.

RESUMEN

Objetivo: Identificar barreras organizativas para facilitación del DIU en los servicios de Atención Básica de Salud desde la perspectiva de los coordinadores del área de salud de la mujer. **Método:** Estudio cuantitativo realizado con responsables del área técnica de Salud de la Mujer de los municipios de la macrorregión Sur de Minas Gerais, con relleno en línea de instrumento estructurado y análisis descriptivo de los datos. **Resultados:** Participaron en el estudio 79 trabajadores responsables del área técnica. Entre los municipios, el 15,2% no facilitan el DIU y el 8,3% no derivan a la mujer a otros servicios, el 53,7% no facilitan el DIU en las unidades básicas de salud. Entre los que facilitan el DIU, el 68,7% no cuentan con protocolo específico y el 10,5% no adoptan el embarazo como condición que imposibilita la implantación del DIU, y el 80,6% adoptan condiciones innecesarias, como infección vaginal. Como criterio para acceso al DIU, el 86,5% relataron prescripción médica, el 71,6%, realización de exámenes, el 44,6%, edad superior a 18 años y el 24,4%, participación en grupos, todos sin base en evidencias científicas. Solamente el médico implantaba el DIU. **Conclusión:** Fueron identificados problemas en el acceso al DIU, por medio de barreras organizativas para su facilitación e implantación, como la no facilitación del método o el exceso de criterios innecesarios para facilitarlos.

DESCRIPTORES

Dispositivos Intrauterinos; Planificación Familiar; Salud Sexual y Reproductiva; Enfermería de Atención Primaria; Salud de la Mujer.

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