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Sexual and reproductive health: team competences in Primary Health Care services

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Abstract *Sexual and reproductive health rights were developed recently as a result from the movements held for Human Rights and citizenship. Delimitations of this subject have not been explored in Brazil yet, even though the importance of developing skills related to this subject is recognized. This paper aims to construct a Sexual and Reproductive health transversal skills framework based on specialists' point of view. A mix methods descriptive exploratory research with the use of the Delphi Technique was developed with 41 specialists in sexual and reproductive health and rights. Three rounds of data gathering were carried out. Of the 36 skills resulting from the qualitative analysis, 32 achieved a general consent and were classified in four domains: ethics and professional principles; leadership and management; community work, health and education, counseling and evaluation; and health care. Results corroborate skills content recommended by the international literature. These skills, which are transversal, may support the development of actions and practices of the health professionals concerning sexual and reproductive health care.*

Key words *Sexual and reproductive health, Sexual and reproductive rights, Professional competence, Primary health care*

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Introduction

Sexual and reproductive health and rights (SRHR) were recently acknowledged and are considered as historical achievement, resulting from the fight for citizenship and Human Rights[1]. They comprise the exercise of sexuality without constraints, of voluntary motherhood and self decided anticonception[2]. These rights should be noticed so that efficient government strategies are conceived, since meeting demands for care to sexual and reproductive health (SRH) associated to experiences of men and women should be a commitment in public policies in integrality perspective[3].

Actions in sexual and reproductive health have as legal framework the International Conference on Population and Development (ICPD), which defined them as essential to health, to sexual rights and to reproductive rights, abandoning the emphasis on the need of limiting population growth. They were also supported by the IV World Conference on Women, which presents advance in the definition of sexual and reproductive rights as Human Rights[4,1].

In Brazil, the National Policy for Integral Attention to Women's Health and, chiefly, the National Policy for Sexual and Reproductive Rights guide actions involving sexual and reproductive health[1].

The concept of reproductive right starts to be classified as a political act, pondering conversations and negotiations[2], however, this change in focus is complex and requires time, since it implies cultural transformations of society and must be focused on health education and protagonism of players involved with care, through dialogue, co-responsibilization and reflection on them[5].

The use of the term 'reproductive planning' instead of 'family planning' has supported the SRH in Brazil, including the defense that it is a more comprehensive conception, considering that the concepts of family planning, as well as birth control, have also an economic-demographic approach.

The consolidation of sexual rights only occurred during the 1990s and, today, one portion of feminist movements uses this terminology in the struggle against gender inequality[6]. The sexuality dimension arises as a polemic theme facing difficulties to advance due to taboos and prejudgments that permeate the discussion[7].

The way health institutions and practices are organized reproduces this context, offering a fragmented attention with low problem-solving capacity, with care oriented to clinical complaints and directed to the female public[5], whose services still present predominant healing characteristics, and few actions for prevention and promotion in Sexual and Reproductive Health[8]. The concrete exercise of sexual and reproductive rights demands public policies to guarantee sexual and reproductive health with primary healthcare as one of their major fields of action. Therefore, the requirement that the State must guarantee these rights is directly stated in work processes of health professionals, so that, depending on their attitude while serving users, such guarantee can be compromised.

In this sense, it is important to provide a space of dialogue about an educational proposal, among the subjects involved in health care, which does not consider just the biomedical model, but rather ponders issues associated to gender, sexuality, autonomy and freedom. They contribute to build non discriminating practices that will guarantee the promotion, protection and exercise of sexuality and reproduction as a right, grounded on the integral attention as a guide for practice in the ambit of health care[2].

For a better understanding of this context, a study was carried out addressing the work of teams in sexual and reproductive health care. The subject of the investigation were the transversal competences of the health team required for sexual and reproductive health in primary healthcare. For such, an approximation to the concepts of competence was necessary, which have been described in the literature as the capacity to articulate and mobilize knowledge, skills and attitudes, putting them into action to solve problems and face unpredictable situations in a certain work situation and cultural context[9]. Gebbie and Gill[10] define transversal competences as those that transcend the limits of specific disciplines and help unify the practice in the ambit of public health. Thus, this study intends to provide health care professionals a reflection on their practices with the identification and analysis of competences they believe to be necessary to provide a qualified care.

In Public Health, competences facilitate the communication between programmatic and organizational lines, and also strengthen professional growth[10]. It is important to think about a set of competences for programs recommended for assistance like SRH, for groups of workers or essential services, reinforcing the importance of interdisciplinary work in the primary healthcare context.

Ciência & Saúde Coletiva, 23(11):3481-3490, 2018

International literature documents and studies on these competences address the need of formation on competences to act in the sexuality area through the proposal of a training program for clinical assessment of sexual and reproductive health for professionals in primary healthcare[11]; the need to train nurses to work in sexual and reproductive health[12]; assessment of knowledge on these issues with physicians in Pakistan[13]; barriers and challenges found by primary healthcare professionals to provide counseling and assistance in reproductive planning[14]. In this same context, competences were identified for physicians, nurses and pharmacists in primary healthcare to subsidize these professionals' actions in SRH[15] and for public health nurses associated to family planning contemplating educational aspects and anti-conception counseling[16].

The World Health Organization counts on a considerable number of publications on SRH and presented, in 2011, a document on essential competences on sexual and reproductive health recommended to be used in primary healthcare[17]. This document describes attitudes, tasks, knowledge and skills required for professionals to promote these practices within the community in the light of human rights.

During literature review related to the theme in Brazil, it was observed that the most recurring objects of study have been the impact of family planning actions on individuals, particularly youth and adolescents, and prevention of unwanted pregnancy[18,19] and transmission of sexually transmitted diseases[20]. Though studies were found addressing the theme in primary healthcare, one investigation that associates professional competence and anti-conception assistance[21] verified that there are gaps in this competence that, associated to the lack of team work systematization, generate distortions in care quality.

After discussing such problems, the research question was formulated: what are the transversal competences necessary for teams to work in sexual and reproductive health care in primary healthcare? In this context, this study intends to build a reference frame of transversal competences for care in Sexual and Reproductive Health in Primary Healthcare based on the view of specialists.

Method

In order to reach the objectives proposed a descriptive and exploratory study with mixed approach (quali-quantitative) was developed using the Delphi technique. It is based on a systematized method of judgment of information, to obtain consensus among specialists in complex themes through validations articulated in phases or cycles[22,23]. The online Delphi Technique was used[23] which provides the circulation of structured questionnaires, repeated times, by a group of experts in the theme studied, with statistical feedback of each answer until reaching a consensus[22]. For this study Delphi technique was chosen to prepare a list of transversal competences to work with sexual and reproductive health in primary healthcare.

A Curriculum Platform, maintained by Brazilian Government (Lattes) was accessed for selection of specialists, using as search criteria: subject (sexual health, reproductive health, sexual and reproductive health in primary care, sexual and reproductive health in primary healthcare, sexual rights, reproductive rights and sexual and reproductive rights), on the data base of Brazilian doctors. To refine the research the filter used was the Portuguese language, and 41 specialists were selected. The specialists were chosen according to the competence in the field, considering the experience in the subject area, as well as common language and culture to avoid interpretations distinguished by social perception. Among the participants selected, three reported via email that they were not interested in participating in the research, because they were not working with sexual and reproductive health. Thus an invitation was sent to a sample of 38 specialists. Of them, 18 participants participated of the first and second rounds and 17 of the third round, corresponding to 47.36% and 44.73% feedback rate respectively.

Three questionnaires with open-ended and closed-ended questions were used for data collection. Delphi was operationalized by successive rounds of questionnaires. The first questionnaire had three open-ended questions for the group of selected specialists to list competences they considered necessary for teamwork in SRH in primary healthcare. The instrument was submitted to a pre-test with three teachers working in the area in order to assess the questionnaire construct and confirm that information could be clearly understood.

After qualitative analysis of competences resulting from the first questionnaire, a new questionnaire was sent where Likert Scale with options from 1 (strongly disagree) to 5 (strongly agree) was assigned to each competence, so

that participants could express their agreement. Those questions that reached consensus were extracted; the questionnaire was reviewed by the researcher and sent again to participants with information obtained in the first round. The process was repeated for the third questionnaire sent with competences that did not obtain consensus in the second round to be re-assessed by the study's subjects. Information collection was mediated by information and communications technologies and occurred with the use of Google Docs, virtual environment available on the internet where several media, languages and resources can be used in an organized way, in addition to the preparation and sharing of information collectively[24].

In Delphi technique the analysis of information occurs along with data collection and a quali-quantitative analysis approach is used. The qualitative analysis was used to produce statements of competences that arose in the first questionnaire, based on the competence listed and comment)[25], resulting in 51 suggestions of competences. Key-terms were created in order to facilitate the grouping of common components. For the standardization of statements a format comprising verb and noun was used based on the understanding that competence can't be separated from action[9].

The construction of statements also considered recommendations by the World Health Organization that competences should be comprehensive enough to be used in international or national ambit, and at the same time specific to subsidize decision making, and relevant to the practice[26].

From the analysis and compilation of answers 36 competences resulted. They were classified in four domain areas[17]: Ethics and professional principles; Leadership and management; Works with the Community, Health and education, Counseling and assessment; Provision of care.

Descriptive analysis was used in order to establish a consensus among participants in Delphi second and third rounds. The criterion adopted was 70% for values 4 and 5 of Likert scale (agree and strongly agree)[22,27].

Ethical precepts were respected in all phases of the study as recommended by Resolution nº 466/12 of the Ministry of Health[28]. The research project was approved by the Committee of Ethics in Research (CEP) of Rio Grande do Sul Federal University.

Results and discussion

The analysis of the 51 suggestions of competences of the first round resulted in 36 statements of competence that were classified in four domain areas. They were considered by specialists in the second and third rounds of Delphi Technique.

In the second Delphi round as shown in Table 1, four competences did not obtain the consensus established in this study of 70% for scores 4 and 5.

Competences that did not obtain consensus in the second round were sent again to participants for appreciation in the third round. Results are shown in Table 2.

Based on the analysis of competences in ethics and professional principles domain, it is observed that specialists are concerned with professional work based on dialogical communication, care, empathy, respect and development of confidence, in ethics, culture as health determinant, in solving problems, equality and in professional secrecy. It is incontestable that these competences influence the quality of attention given in primary healthcare services in the ambit of sexuality and reproduction.

With regard to dialogical communication, it is observed that listening and developing the dialogue during assistance in SRH depends a lot on the interaction between health professional and patient. Based on the understanding of dialogical communication, some fragilities are observed in the communication model and the need of health professionals' training since graduation, with knowledge that will make feasible the exercise of dialogical communication practices. Moreover, it is fundamental to provide spaces for continuous training in practicing scenarios, so as to encourage sharing of knowledge that will promote the understanding among players involved in the communication act[29,30].

Competences that obtained consensus in this domain, except for "Acknowledges the other person as a life worth professional investment" were listed as essential for the work with SRH in primary healthcare international literature[17,15]. This competence was associated by specialists to the equality principle:

One must acknowledge that the other (and his/her life) is important and is worth the professional investment (ESP 4).

However, universal and integral implementation is still a big challenge to primary healthcare when we consider the diversity of actions and the difficulties of access in face of professionals' prejudgments and taboos. They prejudice the

Ciência & Saúde Coletiva, 23(11):3481-3490, 2018

Table 1. Means, standard deviation and percent of scores 4 and 5 of competences, per domain area, obtained in the second round. Porto Alegre, RS, 2016.

Domain/Competences	Mean	Standard deviation	Percent % (scores 4 and 5)
Ethics and professional principles			
Offers active listening	4.61	0.50	100
Establishes dialogue to promote sharing of knowledge	4.61	0.58	94.44
Communicates dialogically	4.5	0.46	94.44
Shows capacity of care without prejudices and judgments	4.72	0.46	100
Shows empathy, respect and develops confidence when providing care	4.61	0.60	94.44
Understands the ethical/bioethical and humanization grounds in people-centered care and family approach	4.77	0.42	100
Considers the cultural, economic and social context of individuals	4.61	0.69	88.88
Respects different knowledge and cultures	4.55	0.70	88.88
Promotes empowering of subjects	3.16	1.46	50
Shows initiative to solve problems	4.38	1.03	94.44
Acknowledges the other person as a life worth professional investment	4.11	0.96	72.22
Acknowledges his/her beliefs and values against those of patients	2.94	1.30	38.88
Ensures professional secrecy	4.83	0.38	100
Leadership and management			
Assures access to serology exams and medications for sexually transmitted diseases	3	1.37	33.33
Establishes networks for eventual referrals	4.38	0.63	100
Promotes care longitudinality	4.5	0.64	100
Promotes intersectoriality	4.44	0.61	94.44
Work with the community, health and education, counseling and assessment			
Demonstrates understanding of the political and legal, national and international referential frameworks on rights in Sexual and Reproductive Health	4.72	0.46	100
Articulates interdisciplinary knowledge inherent to population health in the area of Sexual and Reproductive Health	4.6	0.50	100
Provides counseling and referrals for cases of sexual violence	4.72	0.46	100
Promotes and encourages self-care in Sexual and Reproductive Health	4.61	0.50	100
Articulates educational activities that address Sexual and Reproductive Health for men, women and youth	4.72	0.46	100
Promotes Sexual and Reproductive Health of individuals, families and community	4.55	0.70	88.88
Understands the social and cultural dynamics considering gender, class, race, ethnic group and social diversity aspects	4.66	0.48	100
Provision of care			
Works with woman, man, family and community in the ambit of pre-conception	4.72	0.46	100
Works with the woman, man, family and community in the ambit of reproductive planning	4.72	0.46	100
Works with the woman, man, family and community in the ambit of prenatal	4.77	0.42	100
Works with the woman, man, family and community in the ambit of birth	4.38	0.97	77.77
Works with the woman, man, family and community in the ambit of climacteric period	4.61	0.60	94.44
Works with the woman, man, family and community in the ambit of menopause	4.44	0.65	88.88
Works with the woman, man, family and community in the ambit of andropause	3.88	1.27	66.66
Guides and provides actions of care to the woman and man in the context of sexual and reproductive health	4.55	0.51	100
Provides pre and post test counseling	4.77	0.42	100
Establishes diagnosis according to his/her professional field	4.55	0.61	94.44
Uses problem solving skills in face of male and female sexual dysfunctions	4.33	0.68	88.88
Demonstrates technical capacity for sexual and reproductive health clinic exercise	4.61	0.50	100

Source: Research data, Telo SV, Porto Alegre, 2016. Conclusion.

Table 2. Means, standard deviation and percent of scores 4 and 5 of competences, per domain area, obtained in the third round. Porto Alegre, RS, 2016.

Domain/ Competences	Mean	Standard deviation	Percent % (scores 4 and 5)
Ethics and professional principles			
Promotes empowering of subjects	3.41	1.17	52.94
Acknowledges his/ her beliefs and values against those of patients	3.70	1.10	58.82
Leadership and management			
Assures access to serology exams and medications for sexually transmitted diseases	3.23	1.20	41.17
Provision of care			
Works with the woman, man, family and community in the ambit of andropause	3.58	0.93	52.94

Fonte: Dados da pesquisa, Telo SV, Porto Alegre, 2016.

care of homeless, of those who live in prisons, or from prostitution, youth, elderly and LGBT population. These people already have their care traditionally marginalized and, when they don't access the services they become still more vulnerable to sexually transmitted diseases, which worsen their health condition with regard to already installed pathologies, submitting them to unsafe practices that may cause severe complications[1]. In this domain, two competences did not obtain consensus. The competence that addressed the empowering of subjects presented controversial results and was considered as very important and hard to be promoted. With regard to beliefs and values, specialists related the competence to the influence of their own beliefs and values in the care provided. These results indicate the difficulty of specialists to visualize the need to have professionals encouraging these people to seek their rights, strengthen their self esteem and control their personal and social relations.

In the leadership and management domain, the competences identified involved aspects related to network, recommending the longitudinality of care and the practice of intersectorial actions to promote sexual and reproductive health. Though longitudinality is a guiding principle for primary healthcare, it was not considered as a competence in the perspective of sexual and reproductive health in other studies.

For Higa et al.[31], the Health in Schools Program (PSE) is one example of intersectorial policy in SRH, involving the Ministry of Health and Ministry of Education, organized in axis that address the assessment of health conditions of students, promotion of practices in health and prevention of diseases, as well as training of educators and continuing education for health professionals. The monitoring of actions to improve life quality in school community is also recommended in the program.

The guarantee of access to serology exams and medications for sexually transmitted diseases was a competence that did not obtain consensus in this domain. For WHO[32], the access to examinations for detection of sexually transmitted diseases and to essential medications should be guaranteed by primary healthcare services as part of the right to health and should be offered by professionals to the users of the service. Though the legislation and the literature emphasize the importance of access to exams and medications in primary healthcare, the subjects in the study associated this competence to management responsibility. This reading is based on a simplistic approach of the primary healthcare professional work with the community and exempts this professional from demanding this access to the population, leaving the responsibility of care to the management level.

With regard to the work with community, health and education, counseling and assessment domains, competences were identified that address theoretical references, interdisciplinary work, counseling and referral of sexual violence cases, promotion of self care, educational work, promotion of care and the understanding of the social and cultural dynamics considering gender, class, race, ethnic group and social diversity aspects.

The promotion of self care was not identified in texts used as reference for the present study though being a recommendation for public health approach in SRH[32].

The interdisciplinary work, as basis for primary healthcare was addressed in "Articulates interdisciplinary knowledge inherent to popula-

Ciência & Saúde Coletiva, 23(11):3481-3490, 2018

tion health in the area of Sexual and Reproductive Health" competence. For this competence specialists mentioned the importance of each discipline's contribution:

The professional object is defined with the actions of the professional and for such, different skills acquired during the academic qualification of the nurse are necessary (ESP 7).

Interdisciplinary and team work are the guiding principles of the WHO[17] document that lists competences that are essential to sexual and reproductive assistance in primary healthcare. For Cappielo et al.[15] collaborating with members of the interdisciplinary team through common objectives, efficient communication, mutual respect and understanding of each other's roles is indispensable in the provision of sexual and reproductive health care.

Coping with AIDS epidemic is an example of the need to use interdisciplinarity, since the understanding of attitudes and behaviors, life styles and social and cultural aspects involved in the exposure to risk are necessary. The care provided by different professionals who work in the care of persons with sexually transmitted diseases or HIV, should reflect the subjectivity that involves living with these diseases, invest in new actions and build knowledge to obtain good results in health promotion[33].

Specialists also acknowledged primary healthcare as alternative to coping with violence. Providing counseling and referral to sexual violence cases is the most challenging competence to primary healthcare in this domain, considering the complexity involved, the proximity of relations and bonds, the need of quick identification and the difficulty to change the situation[34]. This is a complex problem and transversal competences can contribute to reorganize care practices, qualification of health professionals and promotion of partnerships with public and private institutions, as well as the organization of supporting groups for women and families.

In the provision of care domain, competences were identified for work in reproductive planning, pre-conception, prenatal, assistance in delivery and care in climacteric period, as well as provision of actions, counseling, choice of diagnosis, problem solving in face of sexual dysfunctions and technical qualification for clinic care. Such competences were considered fundamental for qualification of care provided in sexual and reproductive health in the ambit of primary healthcare[15-17], and necessary for sexual and reproductive health care practice[1].

The competence that involved care in andropause did not obtain consensus among specialists. Subjects stated to not have knowledge to discuss this competence, even being researchers in sexual and reproductive health. Despite the incentive to include men in sexual and reproductive health care through policies and actions, this result indicates a fragility involving the development and divulgation of the necessary knowledge to the approach of men's health[35].

According to Separavich and Canesqui[36], concepts like erectile dysfunction and male hormone replacement have been often addressed in the media and in spaces of public political agenda for male health, and must also be prioritized in the assistance provided in the ambit of primary healthcare. Schraiber et al.[37] highlight that most services in primary healthcare involve women's health problems, since prevention and health care are socially considered as essentially feminine tasks. So, the same logics structures the services, interventions and interlocutions among health professionals and users, reproducing traditional gender relations.

Important competences identified in international literature addressing assistance in postpartum period, in cases of abortion (induced or not) and concerning infertility were not mentioned in this study. Competences involving mental health and drug use were not addressed. Though primary healthcare is reference for counseling and quick testing for HIV and other diseases, assistance and treatment of sexually transmitted diseases were not identified by specialists as necessary competence to work with SRH.

Though women and men's health were addressed in several competences, strategies for screening for breast, uterus and male cancers as recommended by the Ministry of Health, were not described as specific skill. This fact indicates the need to expand the focus to beyond preventive actions and campaigns in SRH issues in the perspective of integral care.

This reference of competences confirms the need to expand the range of actions of professionals in primary healthcare for new fronts of care universally and equally contemplating all individuals, and constituting an instrument for the development of actions in SRH, including populations traditionally marginalized. Competences reflect the current stage of discussion and consolidation of knowledge on the Brazilian reality and are the element for international interlocution in the discussion on the organization of assistance in SRH. They can subsidize the training of health

professionals and, for being transversal, the planning of actions and practices of teams in the ambit of sexual and reproductive health.

Collaborations

SV Telo and RR Witt participated equally in all stages of the paper preparation.

References

1. Brasil. Ministério da Saúde (MS). *Saúde sexual e saúde reprodutiva*. Brasília: MS; 2013.
2. Lemos A. Direitos sexuais e reprodutivos: percepção dos profissionais da atenção primária à saúde. *Saúde Debate* 2014; 38(101):244-253.
3. Souza KV, Tyrrell MAR. Os fatos & atos relacionados ao (difícil) exercício dos direitos sexuais e reprodutivos: em recortes, o processo de viver de um grupo de mulheres de classes populares. *Texto Contexto - Enfermagem* 2007; 16(1):47-54.
4. Brasil. Ministério da Saúde (MS). *Política nacional de atenção integral à saúde da mulher*. Brasília: MS; 2011.
5. Ramos FIS. *Análise histórica das políticas de planejamento familiar no Brasil* [tese]. Rio de Janeiro: Universidade Estadual do Rio de Janeiro; 2008.
6. Corrêa S, Ávila MB. Direitos sexuais e reprodutivos: pauta global e percursos brasileiros. In: Berquó E, organizador. *Sexo e vida: panorama da saúde reprodutiva no Brasil*. Campinas: Unicamp; 2003. p.17-78.
7. Rios RR. Para um direito democrático da sexualidade. *Horizontes Antropológicos* 2006; 12(26):71-100.
8. Poli MEH. A anticoncepção como instrumento do planejamento familiar e da saúde. *Scimed* 2006; 16(4):168-171.
9. Ramos MN. *A pedagogía das competências: autonomía ou adaptação?* 4ª ed. São Paulo: Cortez; 2011.
10. Gebbie MK, Gill ES. *Competency-to-curriculum toolkit*. New York: Association for Prevention Teaching and Research, 2008. [acessado 2016 Jun 25]. Disponível em: http://www.phf.org/resourcestools/Documents/Competency_to_Curriculum_Toolkit08.pdf
11. Hutchinson J1, Evans D, Sutcliffe LJ, MacQueen RA, Davies J, Estcourt CS. Competency: development and evaluation of a new clinical training and assessment programme in sexual health for primary care health professionals. *Int. J. STD AIDS* 2012; 23(8):589-592.
12. Shawe J, Cox S, Penny N, White A, Wilkinson C. A service-based approach to nurse training in sexual and reproductive health care. *J Fam Plann Reprod Health Care* 2013; 39(4):285-288.
13. Khanam M, Perveen S, Mirza S. Reproductive and sexual health issues: knowledge, opinion and attitude of medical graduates from Karachi. *J Pak Med. Assoc.* 2011; 61(7):648-652.
14. Akers AY, Gold MA, Borrero S, Santucci A, Schwarz EB. Providers' perspectives on challenges to contraceptive counseling in primary care. *J Women Health* 2010; 19(6):1163-1170.
15. Cappielo J, Levi A, Nothnagle M. Core competencies in sexual and reprodutive health for theinter professional primary care team. *Contraception* 2016; 93(5):483-545.
16. Hewitt CM, Roye C, Gebbie KM. Core competency model for the family planning public health nurse. *Public Health Nursing* 2014; 31(5):472-479.
17. World Health Organization (WHO). *Sexual and reproductive health core competencies in primary care: attitudes, knowledge, ethics, human rights, leadership, management, teamwork, community work, education, counselling, clinical settings, service, provision*. Geneva: WHO; 2011. Disponível em: http://apps.who.int/iris/bitstream/10665/44507/1/9789241501002_eng.pdf>. [acessado 15 set. 2016.
18. Dirksen RR1, Shulman B, Teal SB, Huebschmann AG. Contraceptive counseling by general internal medicine faculty and residents. *J Women Health* 2014; 23(8):707-713.
19. Ribeiro CPS, Martins MC, Gubert FA, Almeida NMGS, Silva DMA, Afonso LR. Percepção de adolescentes escolares sobre transformações corporais, gravidez e caderneta de saúde do adolescente. *Revista Cubana de Enfermería* 2016; 32(1):27-36.
20. Santos JCA. O enfermeiro e o ensino na assistência às doenças sexualmente transmissíveis: revisão integrativa. *Revista Brasileira de Educação e Saúde* 2016; 6(2):8-12.
21. Moura ERF, Silva RM. Competência profissional e assistência em anticoncepção. *Rev Saude Publica* 2005; 39(5):795-801.
22. Castro AV, Rezende M. A Técnica Delphi e seu uso na pesquisa de enfermagem: revisão bibliográfica. *Rev. Min. Enferm.* 2009; 13(3):429-434.
23. Silva GF, Moura MAV, Almeida MVS, Sá SPC, Queiroz ABA. Influências do climatério para o envelhecimento na percepção de mulheres idosas: subsídios para a enfermagem. *Rev. Eletr. Enf.* 2016; 17(3). [acessado 2016 Jun 23]. Disponível em: https://revistas.ufg.br/fen/article/view/29072/20750
24. Scarparo AF, Laus AM, Azevedo ALCS, Freitas MRI, Gabriel CS, Chaves LDP. Reflexões sobre o uso da técnica Delphi na pesquisa em enfermagem. *Revista da Rede de Enfermagem do Nordeste* 2012; 13(1):242-251.
25. Souza PA, Frade MHLBC, Mendonça DMMV. Um modelo de organização e partilha de informações de enfermagem entre hospital e centro de saúde: estudo Delphi. *Acta Paulista de Enfermagem* 2005; 18(4):368-381.
26. World Health Organization (WHO). *Competency in nursing*. Geneva: WHO; 2003.
27. Witt RR, Almeida MCP. Identification of nurses' competencies in primary health care through a Delphi study in Southern Brazil. *Public Health Nursing* 2008; 25(4):336-343.
28. Brasil. Ministério da Saúde (MS). Conselho Nacional de Saúde. Resolução nº 466, de 12 de dezembro de 2012. *Diário Oficial da União* 2013; 13 dez.
29. Raimundo J, Cadete MMM. Escuta qualificada e gestão social entre os profissionais de saúde. *Acta Paul. Enferm.* 2012; 25(n. esp. 2):61-67.
30. Teixeira RR. Humanização e atenção primária à saúde. *Cien Saude Colet* 2005; 10(3):585-597.

31. Higa EFR, Bertolin FH, Maringolo LF, Ribeiro TFSA, Ferreira LHK, Oliveira VASC. A intersetorialidade como estratégia para promoção da saúde sexual e reprodutiva dos adolescentes. *Interface (Botucatu)* 2015; 19:879-891.
32. World Health Organization (WHO). S*exual health, human rights and the law*. Geneva: WHO; 2015. [acessado 2016 Set 15]. Disponível em: http://apps.who.int/iris/bitstream/10665/175556/1/9789241564984_eng.pdf
33. Araújo IA, Queiroz ABA, Moura MAV, Penna LHG. Representações sociais da vida sexual de mulheres no climatério atendidas em serviços públicos de saúde. *Texto e Contexto* 2013; 22(1):114-122.
34. Soares JSF, Lopes MJM, Njaine K. Violência nos relacionamentos afetivosexuais entre adolescentes de Porto Alegre, Rio Grande do Sul, Brasil: busca de ajuda e rede de apoio. *Cad Saude Publica* 2013; 29(6):1121-1130.
35. Brasil. Ministério da Saúde (MS). *Política nacional de atenção integral à saúde do homem: princípios e diretrizes*. Brasília: MS; 2009.
36. Separavich MA, Canesqui AM. Saúde do homem e masculinidades na política nacional de atenção integral à saúde do homem: uma revisão bibliográfica. *Saúde Soc* 2013; 22(2):415-428.
37. Schraiber LB, Figueiredo WS, Gomes R, Couto MT, Pinheiro TF, Machin R, Silva GSN, Valença O. Necessidades de saúde e masculinidades: atenção primária no cuidado aos homens. *Cad Saude Publica* 2010; 26(5):961-970.

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