

Women's experience with contraception from the perspective of gender

Vivência de mulheres quanto a contracepção na perspectiva de gênero
Experiencia de las mujeres sobre la contracepción en perspectiva de género



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How to cite this article:

Medeiros TFR, Santos SMP, Xavier AG, Gonçalves RL, Mariz SR, Sousa FLP. Women's experience with contraception from the perspective of gender. Rev Gaúcha Enferm. 2016 Jun;37(2):e57350. doi: <http://dx.doi.org/10.1590/1983-1447.2016.02.57350>.

DOI: <http://dx.doi.org/10.1590/1983-1447.2016.02.57350>

ABSTRACT

Objective: To analyse the experience of women with contraception from the perspective of gender.

Methods: Qualitative and exploratory-descriptive study conducted at three basic healthcare units in the city of Lagoa Seca - PB, Brazil, with 15 women interviewed between January and May 2013. The content analysis technique was used to process the data.

Results: Data analysis led to the core category 'women's contraceptive choices and their relationship with gender dynamics', that subsequently led to the subcategories 'unequal construction of gender identities in childhood and adolescence', 'outcome of gender dynamics in (contra)ception during adolescence', and 'medicalisation of the female body'.

Conclusions: It was observed that the experience with contraception is related to the dynamics of gender, with the outcome of teenage pregnancy and the medicalization of the body.

Keywords: Women's health. Sexual and reproductive health. Contraception. Gender and health.

RESUMO

Objetivo: Analisar a vivência de mulheres quanto a contracepção na perspectiva de gênero.

Métodos: Estudo qualitativo e exploratório-descritivo. Realizado em três unidades básicas de saúde, na cidade de Lagoa Seca-PB, com 15 mulheres entrevistadas entre janeiro e maio de 2013. Para tratamento dos dados, foi utilizada a técnica de análise de conteúdo temática.

Resultados: A partir da análise emergiu a categoria central 'escolhas contraceptivas femininas e sua relação com a dinâmica de gênero' e a partir dela, emergiram as subcategorias 'construção desigual das identidades de gênero na infância e adolescência'; 'desdobramento da dinâmica de gênero na (contra)cepção na adolescência' e 'medicalização do corpo feminino'.

Conclusões: Observou-se que a vivência em contracepção guarda relação com a dinâmica de gênero, tendo como desdobramento a gravidez na adolescência e a medicalização do corpo.

Palavras-chave: Saúde da mulher. Saúde sexual e reprodutiva. Anticoncepção. Gênero e saúde.

RESUMEN

Objetivo: Analizar la experiencia de las mujeres sobre la anticoncepción en la perspectiva de género.

Métodos: Estudio cualitativo y exploratorio-descriptivo. Llevado a cabo en tres unidades básicas de salud en la ciudad de Lagoa Seca-PB, con 15 mujeres entrevistadas entre enero y mayo de 2013. En los datos recogidos se utilizó la técnica de análisis de contenido.

Resultados: A partir del análisis, surgió la categoría central 'opciones anticonceptivas de las mujeres y su relación con la dinámica de género' y de ella surgieron las subcategorías 'construcción desigual de las identidades de género en la infancia y la adolescencia'; 'despliegue de la dinámica de género en el diseño en (contra)concepción en la adolescencia' y 'medicalización del cuerpo femenino'.

Conclusiones: Se observó que la experiencia en la anticoncepción se relaciona con la dinámica de género, con el embarazo en la adolescencia despliegue y la medicalización del cuerpo.

Palabras clave: Salud de la mujer. Salud sexual y reproductiva. Anticoncepción. Género y salud.

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■ INTRODUCTION

According to Article 226 of the Federal Constitution of 1998, Brazilian citizens have the right to receive family planning assistance, which includes contraception, and the state has the duty to provide all the means necessary to ensure full access to this assistance. According to Law 9263/96, health management bodies must ensure the provision of comprehensive healthcare⁽¹⁾.

However, the traditional roles learned by women and men are still considered natural and unquestionable, and condition their sexual and reproductive health practices⁽²⁾. A reflection of the historical and social determinants that are interwoven in the construction of public family planning policies, which reveal the exaltation of motherhood, is the lack of focus on protecting women against vulnerabilities whilst maintaining the power relations between the sexes. Thus, care involving contraception calls for a debate on the relationships and construction of gender identities.

Gender is a relational concept that refers to the forms of social, cultural and linguistic constructions that differentiate people. The construction of gender identities is based on labels that distinguish the male from the female and express the (di)vision of subjects, namely as woman/weak/passive, man/strong/active. Attributes that serves as bases for power relationships, and family, economic and social articulations, however, are relational aspects that should be the target of healthcare intervention strategies⁽³⁾.

An analysis of the evolution of public policies on women's health shows that the focus shifted from strictly reproductive to understanding women in their social, economic, cultural, and historical contexts, while observing the different ways of being a woman, all of which require the qualification and expansion of contraception assistance from the perspective of gender⁽¹⁾. However, despite important achievements, contraceptive care is marked by the dissociation between the needs of women and the assistance provided by the healthcare services. Qualitative and quantitative constraints compromise the exercise of women's free choice of contraception⁽⁴⁾.

Given the complexity of this subject, it is necessary to conduct studies that promote the practice of listening to women. This practice would help implement actions that are more connected to the demands of reproductive planning. This leads to the question, how do women experience contraception? Consequently, the aim of this study was to analyse the experience of women regarding contraception from the perspective of gender.

■ METHOD

This is a descriptive and exploratory study with a qualitative approach. This strategy sought to address the subjectivity and contexts involved in the relationships between the investigated subjects and the researcher.

The qualitative method is applied to the study of the history, relationships, representations, beliefs, perceptions, and opinions that result from the way humans interpret their lives, how they build their artefacts and themselves, and how they think and feel. Exploratory research seeks to obtain greater familiarity with the problem by means of bibliographic surveys and interviews. Descriptive studies allow the description of features of a group or phenomenon, and may also establish the relationship between the variables and determine the type of relationship⁽⁵⁾.

This study is based on the scientific research project ("PIVIC") with the title, "Práticas em Planejamento Reprodutivo: Uma análise a partir da categoria gênero". It was conducted at three basic health units, one of which was located in a rural area. This unit was linked to a national programme for the reorientation of professional healthcare training and an education work health programme with the Universidade Federal de Campina Grande in Lagoa Seca, a small city in the metropolitan region of Campina Grande, Paraíba, Brazil, which has a predominantly urban population and an agricultural economy. A semi-structured script with open questions was used to interview 15 women selected by means of a draw of medical records.

The inclusion criteria were users between the ages of 10 and 49, since this is the age group of women in the reproductive stage, and women who are specifically registered at the basic health units of the municipality of Lagoa Seca - PB. The criterion for exclusion was users who were not of reproductive age. The units offer primary healthcare services, including family planning.

Data were collected from January to May 2013. The interviews were conducted in rooms provided by the health professionals. The users were identified with the number of the interview to guarantee secrecy and anonymity. The women were notified of the manner of participation and subsequently signed an informed consent form. The key issues covered in the interviews included socioeconomic profile, experiences with sex and contraception, partner participation and assessment of the healthcare service.

The material was examined using thematic content analysis, as follows: *pre-analysis*: detailed reading of the collected data; *exploration of the material*: the data were organised and categorised according to the guiding study question; and *results and interpretation*: the catego-

ries were analysed and interpreted according to the theoretical framework⁽⁵⁾.

To maintain the reliability of the reports, the interviews were fully transcribed and the resulting data were organised and categorised according to the guiding study question. The categories were analysed and interpreted in accordance with the studies that address gender, and sexual and reproductive health.

The research observed the recommendations of Resolution 196/96, in force at the time, and was approved by the research ethics committee of the Alcides Castro University Hospital, under CAAE. 03466612.7.0000.5182 and protocol #52909.

■ RESULTS AND DISCUSSION

The central category 'Women's contraception choices and their relationship with gender dynamics' led to the subcategories 'unequal construction of gender identities in infancy and adolescence'; 'outcome of gender dynamics in (contra)ception during adolescence'; 'medicalisation of the female body'.

Characterisation of users

The age of the respondents ranged from 16 to 48, and the prevailing ages were 15 to 19 years (3), 20 to 25 years (3), and 26 to 30 years (3), followed by 36 to 39 years (2), 40 to 45 years (2), 31 the 35 years (1), and 46 to 48 years (1).

Most respondents stated they were Catholic (12), married (9), with an individual income under the minimum wage (12), and a paid informal work activity (8). The number of children of the respondents ranged from none (2), 1 child (8), 2 children (2), and 3 or more children (3).

The analysis of these variables did not expressively represent the experiences of the women with contraception. Similarly to the findings in literature, there was no significant association between the use of a birth control method and the analysed demographic and socioeconomic variables⁽⁶⁾. However, there was a greater social and economic vulnerability among the respondents, such as low individual income, a predominance of low education, and the performance of work activities that require minimal professional training (manicure, farmer and salesperson).

More vulnerability factors were identified among the women living in rural areas, such as income lower than the minimum wage. Moreover, these respondents married earlier than the others, which was probably due to cultural issues and the lower perspective of a future outside marriage.

Unequal construction of gender identities in infancy and adolescence

The influence of power relations becomes evident among these women, especially those with a lower income and those living in rural areas, based on a rigid and oppressive discipline that was mostly enforced by the father figure.

He was very withdrawn [the father], he didn't let me play with boys, didn't let me go out on the street, he always deprived me of lots of things that I only found out after I married (User 1).

Even when I turned 15, if I wanted to go to the square, a party, he [father] would make a terrible fuss (User 8).

The statements showed that the female identity was built on rules that restrict women to a private space. When women leave this space, they are constantly monitored by the oppressive figure (male) or by another designated figure (mother, brother, aunt, grandmother). The curtailment of freedom is not always perceived by the woman, as it is often masked, and instilled and naturalised in social practices via gender stereotypes.

My father was very harsh, but not to the point of locking us inside the house [...]. We could play, but it was really about who worked the most, who helped our parents the most. In the morning I studied and in the afternoon I helped my mum, because my mother did a lot of things, food at home to sell and I helped, both with the food and with the household chores, so I didn't have much time, I played more with my brother, who is a year younger than I. So, I couldn't go out [...] he [father] wouldn't let me leave because there was nobody to go out with [accompanying, watching], as my brother was smaller and my mother didn't get out much, I just left the house with her or him, or to school alone, from home to school and back. And so, apart from the other things everything was normal (User 10).

If I came home with a boyfriend, and they saw me, I would be punished, you see. We didn't have a lot of freedom (User 7).

The role of women was apparently restricted to household chores, the right to play as a reward for work, and surveillance by the authority figure in the family who was designated the paternal role.

According to some of the respondents, the perceived freedom in childhood turned into control and surveillance

when they became adolescents, especially due to the changes of puberty (menstruation) and sexuality (sexual intercourse and pregnancy). Female sexuality has been historically repressed due to the maintenance of the androcentric order, considering that the sexually dominant, normative, and socially accepted model corresponds to the male sexuality, while the female sexuality remains veiled in many contexts, thus reinforcing beliefs and behaviour patterns among women⁽⁷⁾.

Although some of the women stated they did not have a strict upbringing, this was not the case regarding sexuality.

Mother never spoke about preventing pregnancy at all! (User 3).

When I still lived at home, you know, I realised that my mother was taking something [oral hormonal contraceptive], but I didn't know that it was supposed to prevent [children], then my aunt who was younger told me, but my mother didn't say anything (User 2).

The statements demonstrated the fragility of the type of guidance the women were offered and the lack of dialogue in the family. Only one of the users heard about birth control for the first time from her mother, whereas the other respondents stated they heard about contraception for the first time from friends, aunts, sisters-in-law or through television.

Their concerns with the quality of the information they received is important, as birth control guidelines do not merely involve methods, but also their correct use, the individual choice of the best method, and its advantages and disadvantages⁽⁸⁾.

In order to cope with the restrictive family experience, the women chose to establish affective relationships in their adolescence to gain greater autonomy and freedom.

He didn't let us go out [father], it was very difficult. I got married because of that! Because they [parents] didn't let me, so I married. I didn't even leave the house anymore (User 7).

The lack of perspective outside the emotional union and the absence of professional projects lead to choices that legitimise and strengthen the status of the submission and male guardianship. Marriage is the means by which they structure their life expectations⁽⁹⁾.

The private character of family education marks the experience of these women and has little or no repercussion on their sexuality and contraception, which causes them to

immerse in a relationship without the basis for contraception in adolescence.

Outcome of gender dynamics in (contra) ception during adolescence

The entire interviewed universe revealed that the first sexual encounter occurred in adolescence, during the heterosexual dating stage.

I started dating my husband, I was 13 years old, then we dated for 3 years. For the first 2 years, we did nothing, and then when it happened, we started to use condoms, that 's it [the first relationship was unprotected]. But I knew there were other things [pill], but because of that problem of not going out, going out without my mum realising and all that [...]. I needed a doctor's appointment to explain, to gain access to the pills, so we used a condom, but it was very difficult (User 10).

For the first sexual encounter, most of the women (8) did not use any contraceptive method. Of those who used contraception (7), they all reported the use of condoms. In fact, condoms are the best known method among adolescents. However, women tend to become more involved with contraception, while men experience their sexuality in a carefree way, which increases the frequency of unplanned pregnancy and sexually transmitted infection (STI), besides burdening women with the responsibility of contraception. The gender issue is also important; if on the one hand the boys feel less responsible, the girls feel ashamed and are consequently less eager to use this method⁽⁸⁾.

The male condom is used at the beginning of sexual relationships. However, its use is discontinued once the bond become more stable, and when one partner starts to "trust" or "know better" the other partner⁽¹⁰⁾. When questioned about this method, the respondents revealed minimal knowledge and a fragile female autonomy, which leads them to leave the choice of method to the men.

Yes, if it were up to me [I would not choose the condom], 16 years, right? Even if I were just a girl (User 07).

At first it was the condom, and that was his choice [partner], right? (User 14).

Condom use at the beginning of the relationship, which is when the partner assumes this responsibility, leads us to question female autonomy, marked once again by the lack of information on contraception at this stage of life⁽¹¹⁾.

Unprotected sexual initiation during adolescence is related to structural and intra-family inequalities and may increase the vulnerabilities of early and unprotected sexual activity, such as exposure to STI and unplanned pregnancy. The interaction between poverty, low education, and low self-esteem makes teenage girls more vulnerable and less prone to build self-protection mechanisms⁽¹²⁾.

Unplanned pregnancy, reported by some respondents (13), all of which occurred during adolescence, reveals some ambivalence regarding teenage pregnancy, such as sadness and satisfaction with the expectation of acquiring greater autonomy.

I cried, I was 16 [...] it got better, I completed 17, got older (User 06).

I sort of stopped in time, I didn't think I was prepared, but then I got used to the idea, and married my husband (User 4).

Despite the greater access to information and contraceptives, every year an estimated 80 million women worldwide experience an unwanted pregnancy, which is related to the influence of contextual and individual factors⁽¹³⁾.

Although the women reported that pregnancy was not planned or desired, they did not use birth control and subjected themselves to the risk of an unwanted pregnancy. Accepting an unplanned pregnancy for these women and their families is permeated by the transfer of guardianship to the male partner.

It was an accident. I wasn't using anything, but I didn't want to [laughs]! It was when we were dating, that's when we got married! (User 15).

Regardless of the social arrangement, the phenomenon of unplanned pregnancy, mainly in puberty, causes health risks and social implications, such as limitations on education that lead to restrictions on their livelihood, economic independence and empowerment in adulthood⁽¹⁴⁾.

Studies show that adolescents have some knowledge and appropriate attitudes in relation to contraception, however prevention and sexual orientation actions are still required given the minimal dialogue with their partners, the non-use of birth control methods in all sexual relations, and unplanned pregnancies⁽⁸⁾. The statements also revealed a widening gap between the healthcare services and these issues for all age groups.

These gaps of the health services in relation to providing information, guidance and birth control methods are accentuated in the analysed context. The role of health ser-

vices is to guarantee the sexual and reproductive rights of adolescents by expanding their knowledge, strengthening their care practices or promoting debates on the repercussions of gender inequality, well-being, and quality of life⁽¹⁵⁾.

Medicalisation of the female body

The choice of a contraceptive method was defined by gender inequality and the medicalization of the female body.

Most of the interviewees (13) mentioned the use of condoms at some point in their lives, especially in adolescents (sexual initiation). However, once the relationships is stabilised, the use of condoms is reduced (4) or maintained mostly due to difficulties with oral contraceptives. Only one woman reported condom use as a way of preventing STI.

I use both [...] because husbands always have their bits on the side, don't they? I don't know if he has other women, so I have to take care of myself, too. The pill is to prevent pregnancy and the condom prevents other things (User 07).

This is worrisome, because the low rate of condom use makes women, especially married women, more vulnerable to the risk of acquiring sexually transmitted diseases⁽¹⁶⁾.

The second most widely used method by women was the oral contraceptive, which was mentioned as the preferred method at some point in their lives or for the future⁽¹¹⁾. Only some of the women (4) currently used this method. It was observed that these results closely match those found in another study that points oral contraceptive as the most frequently used method, mainly due to poor knowledge and lack of access to other methods⁽¹⁷⁾.

The interviewed women reported various complaints related to the use of the oral contraceptive, which was the main motive for unwanted pregnancies and for abandonment and/or the selection of the other methods mentioned, namely tubal sterilisation (4), injectable methods (1), lactation and amenorrhoea (1).

I don't get along with certain type of pill, so while I was changing, without protection, without knowing [...] then I got pregnant [got pregnant using oral contraceptive] (User 01).

I felt short of breath all the time, I used that [type of oral contraceptive 1], then I had her [daughter], I used that one [type of oral contraceptive 2], then I got sick, my milk dried up, then I started taking injections (User 02).

These findings demonstrate the fragility of accessible information and the difficulty women have associating their reproductive goals with using a method that is safe, effective and compatible with their wellness.

Birth control pills, used mostly without prescription or monitoring from health professionals, are purchased with their own resources and, despite contraindications, are often used erroneously. This leads to increased adverse and/or sub-therapeutic effects that, in turn, can lead to inconsistency⁽¹⁷⁾.

To ensure control over fertility, there is a high rate of users that opted for tubal sterilisation, which is an irreversible, albeit widely used method that is considered the most extreme aspect of birth control medicalisation⁽¹⁸⁾.

A friend of mine said, do you want to tie your tubes? It's a policy thing, you know? [...] I said woman, and I know, I'm so young, I had them tied when I was 25, but you live in your mother-in-law's home and all, so I got it done, and I don't regret it to this day (User 05).

Submission to tubal sterilisation once again reinforces the lack of autonomy of women regarding birth control and power over their bodies⁽¹⁸⁾. The abusive use of surgical procedures and the high prevalence of women who are sterilised or using inadequate contraceptive methods are clear examples of distortions in family planning and the biomedical control over women's bodies⁽¹⁹⁾. Medicalisation is responsible for unnecessary interference and women's shift from the protagonist role to the object of intervention.

None of the users mentioned that their partner performed a vasectomy. When questioned about this issue, they understand that the responsibility should be assumed by both partners, although they felt burdened and induced to perform the process since their partners were unwilling to have a vasectomy.

They should recognise it more, shouldn't they, that women suffer more, right? And men don't, just that little thing and that's it, he can go back to work the next day, but women can't. But there was no way around it (User 03).

The lack of involvement of the health services with these issues was evident since none of the users mentioned participating in family planning programmes at the unit and many did not even know they existed. The majority also reported that the method they used was not provided by the health unit.

When I was taking the pill there was still a lot left. So what do you do? [...] You go on the pill and if you don't buy it [...] (User 04).

Literature reveals that the health services are not properly structured to accommodate the demands of women regarding contraception. The reasons include the incipient supply of methods, the restricted participation of team members and low female adherence to the offered programmes⁽²⁰⁾.

These issues can intensify when the health services disregard the gender biases still interwoven in women's experiences with contraception. This finding reinforces the argument that to ensure women's reproductive right and autonomy implementation strategies must be efficient, especially in terms of healthcare.

■ CONCLUSION

The analysis of women's experience with contraception revealed the ramifications of gender stereotypes in childhood and throughout adolescence, and their reproduction in adult life.

It was demonstrated that the restrictions in women's lives are associated with their early and unprotected sexual initiation and, in some cases, unplanned pregnancy, which also reinforces the lack of resources for planning reproductive goals.

These results highlight the need for the development of integrated strategies and actions (health, family, school, community) to effectively implement the right to free choice. This would require the overcoming of gender stereotypes that delimit and separate the experience of sexuality for men and women in adolescence and adulthood.

The limitation of this study was the restriction of analysing the female universe. Thus, it is suggested that studies and healthcare service actions include the perception of men. Ultimately, men should be as committed to the choice of contraception as women. Acknowledging the demands of users can ensure that the right to sexual and reproductive health is observed in comprehensive care.

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Received: 27.07.2015

Approved: 04.04.2016