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FAMILY PLANNING AND MENTAL HEALTH IN PRIMARY CARE: NURSES' PERSPECTIVES

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ABSTRACT

Family planning is included among the actions in Primary Care that are relevant and impactful on women's quality of life indicators. However, the particularities of women with mental disorders are still invisible to health professionals. The study aims to evaluate the family planning carried out by Primary Care nurses aimed at women with mental disorders. This is a qualitative and cross-sectional study with the aid of the Alceste Software for content analysis. The results showed that Primary Care nurses who perform family planning have difficulties in managing the program in their routines. When women with mental disorders are scored, these difficulties are accentuated, and in many cases, they are not even identified during the care, which remains fragmented in the demand presented, without looking at the woman's integrality. The nurses also pointed out that they feel a lack of matrix support and the collaboration of the CAPS in carrying out the program. We conclude that family planning should have a prominent place in continuous training and integrate nurses working in Mental Health, to achieve comprehensive care for women, demystifying myths instilled about pathologies and providing quality of life for this population.

Keywords: Family Planning. Women. Mental health. Primary Health Care.

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INTRODUCTION

The World Health Organization (WHO), aiming at Sustainable Development, defines goals aimed at reducing maternal mortality and ensuring universal access to sexual and reproductive health for the population, specifically for women, as well as the expansion of gender equality, for this purpose lists family planning, currently, reproductive planning replacing family planning, as an essential action to achieve these objectives and guarantee the right to access health care actions that achieve comprehensive access with active and qualified listening, involving not only the individual but also their socioeconomic and cultural context (Rodrigues *et al.*, 2023). Thus, family planning becomes fundamental, contributing to the reduction of maternal mortality and negative outcomes for women's health, such as abortion and poor quality of life for the mother and the fetus, which translate into serious public health problems, especially for population groups in situations of inequality and vulnerable (Rodrigues *et al.*, 2023).

Nevertheless, mental health is in growing demand in the current reality, according to Araújo and Torrenté (2023) there is a growing global increase in cases of mental disorders, in Brazil, even with the struggles for psychiatric reform that praises psychosocial care based on the community, public policies maintain a gap in the implementation of these services, generating a lack of adequate assistance. The authors point out that currently "mental disorders represent one third of the total cases of Chronic Non-Communicable Diseases" (p.1) and directly affect the quality of life and health of people with mental disorders, as they have greater difficulty in accessing health services and deprivation of their rights.

That said, the integration of family planning and mental health is justified as a relevant intervention to achieve the objectives of agenda 30, since twenty percent of the care provided in Primary Care is related to mental disorders (Melo *et al.,* 2021).

Family planning aimed at women with mental disorders is a topic of great relevance, however, it has a scarcity of publications, and studies are directed mainly to pathologies or the maternal puerperal period, thus, family planning seems to be forgotten, perhaps due to the erroneous social view where people with mental disorders are exhibitionists, exacerbate their sexuality or are asexual beings, there is a need to envision women with mental disorders as people who experience sexual activity, and that this is present, exacerbated or not, in their daily lives and does not determine a symptomatological characteristic of the disorder (Pereira *et al*., 2020; Marcolino; Almeida; Nogueira, 2019)

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Primary Care (PHC) is capable, through qualified reception, of integrating the principles that govern the SUS (Unified Health System) and breaking the sphere of the traditional health care model (Souza, Amarante and Abrão 2019). With the implementation of the Psychiatric Reform, the CAPS (Psychosocial Care Center) emerged, a mental health equipment that emphasizes the territory as a field of care, inserted in the precepts of PHC, as they aim at the autonomy of the subjects, universal, integral and qualified access to mental health users, being continuous care services, without fragmenting care. In this way, the integration of mental health in PHC consolidates the strategy of rupture in the traditional model of care and promotes advances in the clinical spheres of psychosocial care in mental health (Souza; Amarante, & Abrão, 2019; Mendes *et al.*, 2024).

In addition, PHC, as well as the CAPS, promotes the socialization of people in the community in which they are inserted, placing the family unit as co-responsible for care and care, a primordial point of the psychiatric reform; however, the invisibility of women remains in daily care (Rotoli et *al.*, 2019; Mendonça et al., 2019; Silva et al., 2019; Flowers; Silva Filho, 2020; Oliveira et al., 2020; Melo *et al.*, 2021).

Women constitute the largest public in follow-up both in Primary Care and in mental health, due to their vulnerabilities acquired with gender, which is closely linked to hormonal, social and psychological factors, in addition to the ease of identifying psychic suffering and admitting them, and needs a comprehensive look at their health, because as a result of the disorder they suffer discrimination and have their rights violated, with significant social and economic losses and restrictions on reproductive rights education (Santos *et al.* 2019; Pereira *et al.* 2020).

Thus, the present study aims to analyze the nurses' perception and knowledge about the needs of women with mental disorders related to family planning.

METHODOLOGY

This is a qualitative and cross-sectional study carried out in a city in the state of São Paulo. The municipality studied in 2022 had 47 Primary Care units, the research received authorization from 26 Health units that were the field for interviews with nurses, units with outsourced administration or linked to Universities were not included in this study.

The target population was Primary Care nurses who perform family planning, to reduce the possibility of bias and sampling error, the study was carried out with the total

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population after applying the inclusion and exclusion criteria. The term nurses was considered, thus covering both female and male professionals to describe this group.

The inclusion criteria were: having a degree in nursing, being a public servant or a municipal employee with an employment relationship with the direct municipal administration, being active during the data collection period, performing family planning in their routine, signing the Informed Consent Form (ICF) and providing *personal e-mail* .

The exclusion criteria were: being in administrative positions at the Health Unit, regardless of providing service to the public (management), being on sick leave, maternity, vacation, premium leave or other leaves or leaves of absence of more than 30 days during the data collection period.

For data collection, a questionnaire was used through *Google Forms*. This questionnaire was developed by the researcher with determinant variables in the characterization of nurses, as well as questions about family planning, its performance in the work routine, training, mental health and contraception, through open and closed questions. The *link* for participation was sent via *e-mail*, as well as the ICF, the only mandatory question, which only proceeded after acceptance of participation, in which case the participant chose not to agree, the acknowledgment page was directed.

At the time of the field research, 87 nurses were assigned to the participating units, of which 52.9% (46) answered the research questionnaire. The justifications for exclusion were: 6.9% (6) excluded for being on leave for a long or indefinite period, for having assumed a management position or for having been dismissed from the position; 8% (7) of the nurses did not accept to participate in the research, they did not respond to all forms of contacts or did not provide personal e-mails. Of the 52.9% (46) nurses who responded, 47.1% (41) were considered to be part of the corpus of this study, as 5.7% (5) were excluded for not performing family planning in their routine.

For the qualitative analysis, the *software Alceste* (Anaylese Lexicale Par Contexte D'un Ensemble de Segments de Texte) was used, which is a *computerized* text analysis software operating in a pragmatic way centered on lexial competition in a contextual unit of the text, not being a statistical distribution of words but a structural form in the given corpus, examining the resonances of meaning that are established (Alves, 2019).

For the preparation of the material, a single text (*corpus) was created* and submitted to the program, the text was grouped and centered on a theme that received the creation of an utterance, or command line, formed by asterisks with variables previously chosen for the

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identification of the texts. The *corpus* was organized as an Initial Context Unit (ICU) for each nurse, the command line was generated from the data described in table 1, and was inserted in the text as follows: **** *e_01 *sex_1 *id_5 *tpat_1 *tform_4, by rule of the program itself, the command line always starts with a sequence of four asterisks (****), identifying a new ICU, and the qualifying data of this ICU (nurse) should be preceded by an asterisk (*).

Table 1 Data for the formation of the command line for the analysis of *the Alceste corpus* in the nursing group.

Nurses Command Line Identifiers (Corpus Alceste)		
*p = professional nurse	Numbering 01 to 41	
*sex = sex	1 = male	2 = female
*id= age	1 = 18 – 20 3 = 26 – 30 5 = 36 – 40 7 = 46 – 49	2 = 21 – 25 4 = 31 – 35 6 = 41 8 = 50 + – 45
*tpat = time working in Primary Care	1 = less than 1 year 3 = 6 to 10 years 5 = 16 to 20 years 7 = 26 to 30 years	2 = 1 to 5 years 4 = 11 to 15 years 6 = 21 to 25 years old 8 = more than 31 years old
*tform = training time	1 = 1 year less 3 = 6 to 10 years 5 = 16 to 20 years 7 = 26 to 30 years	2 = 1 to 5 years 4 = 11 to 15 years 6 = 21 to 25 years old 8 = more than 31 years old

Source: By the authors.

For the analysis, Alceste performs four steps in sequence, which are automatic (A, B, C, and D), where the program prepares the corpus and recognizes the ICUs, performs the text segmentation and groups the occurrences of the words according to the roots using the frequency calculation, segmenting the texts into Elementary Context Units (ECU); then the ECUs are classified using the chi-square test of association and the Descending Hierarchical Classification Method (CHDs) is applied, obtaining a definitive classification. After it performs the description of the classes of ECUs, and the complementary calculations are performed for each of the classifications found, allowing the description of each class of word, presenting the results of a correspondence analysis from the DHC and finally contextualizing the typical words, allowing the study of the relationships of the intraclass elements (Alves, 2019).

This study was submitted to and approved by the Research Ethics Committee of the University of São Paulo School of Nursing in Ribeirão Preto through CAAE: 39220320.1.0000.5393 and by the Research Project Evaluation Committee of the Municipal Health Department of the Municipality of Ribeirão Preto through Official Letter No.

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3045/2020 – CAPP, of September 14, 2020, all participants signed the free and informed consent form, by Resolution No. 466/12.

RESULTS

Of the 41 participating nurses, all of them work in Primary Care (PHC) and perform family planning (FP) in their work routine, 85.4% (35) reported being female and 14.6% (6) male; the mean age was 41.6 years, with the youngest being 24 years old and the oldest being 65 years old; as for the time since graduation, the average was 17.9 years, in the period between 1979 and 2018, with an average of 105.9 months of work in Primary Care (approximately 8.8 years), a minimum of 5 months and a maximum of 34 years. They worked in family planning for an average of 75.2 months (approximately 6.2 years), with a minimum of 2 months and a maximum of 21 years.

Regarding the analysis of the *Alceste Software*, 41 interviews (UCI) were considered with a word richness of 97.03% and recognition of 8,768 words, 1,143 distinct words, with an average frequency of 8 times per word, maximum frequency of a single word of 368 times and 574 words that appeared only once in the corpus; which formed 295 textual units that were organized into their classes according to lexial coherence. The text presented a utilization rate of 85% of the textual units of the corpus, which according to the program itself is considered to have a very high level of relevance and rejected for analysis only 15% of the corpus. The classified units were divided into 6 groups that are called classes of significant utterances or just classes. The classes were grouped into three thematic blocks for analysis and discussion.

VOCATIONAL TRAINING AND LEGISLATION

This block is composed of only one class, class 1 and points to three key ideas, the time to carry out family planning, training to carry out the program and compliance with the legislation studied in the health units; the legislation questioned were: Law 9.263/96 (Law that deals with family planning) and Law No. 13.146/2015 *(*Brazilian Law for the Inclusion of Persons with Disabilities).

Regarding the time of implementation of the family planning program and participation in the training carried out by the Municipal Health Secretary (SMS), it was observed that there was an increase in the number of nurses performing the actions after the training in 2021 and 2022:

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I have been doing family planning for six months and I was trained by the SMS in two thousand and twenty-one (e01; e18).

However, many nurses, even with recent training, only received training from co-workers in the health units where they work or worked to develop actions related to the program, as observed in the following statements:

I have been doing family planning for seventeen years and I was trained by other nurses in the unit (e27);

I have been doing family planning for six years and I was trained by other nurses in the unit (e06; e28);

It was possible to identify that to meet the demand of the units, many nurses were initially trained by their co-workers and later underwent the SMS training. According to the nurses, the health department carried out general training in 2000, 2003, 2011, 2015, 2021 and 2022. We evidence that there was adherence to the last training sessions of the nursing team in general, aiming at the qualification of care and expansion of the program in the units, favoring the population of the municipality.

The second key idea of this class is compliance with the legislation in the care provided for family planning, in the answers, mostly as pointed out in the following statements, the professionals were evasive, not justifying their score, this fact may be related to the fear of breach of confidentiality and having institutional and administrative problems; due to the lack of knowledge of the questioned legislation; due to the deficiency of the program in their unit or just not knowing how to correlate with legislation and the actions carried out:

I think that the current legislation is being complied with in twenty percent in my unit (e18);

I think that the current legislation is being complied with by forty percent (e20).

The statements presented showed insecurity about the terms addressed by the legislation or even misinformation about it, as those justified for the assigned score seem evasive centered on the current protocol of the SMS and not on the specific terms of the laws. Evidence of misinterpretation of the legislation, or ignorance of its content, as observed in the following mentions:

> I think that the current legislation is being complied with in eighty percent, we follow the SMS protocol (e08; e35);
> I think that the current legislation is being complied with in my unit, because we follow the law (e01);

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> I think that the current legislation is being complied with in my unit by seventy percent, there is a lack of knowledge (e15).

On the other hand, measures by the legislation were also observed, such as the evaluation of the multidisciplinary team, which is part of the protocol of the Ministry of Health, and the evaluation of the psychiatrist, being a joint and qualified care without exposing the woman and devaluing her autonomy. Although the SMS protocol does not include care specifically directed to women with mental disorders, the nurses pointed out discussion with the Women's Health program of the SMS, which is a relevant factor because there is the possibility of discussions with the program itself, in addition to the multidisciplinary team, which maintain constant support to the nurses in monthly meetings.

FAMILY PLANNING

This block is formed by classes 5 and 6, with the central idea being the concept and development of family planning according to the nurses' observations and understanding.

According to Law No. 9,263/1996, in its article 2, the concept of family planning is based on the set of actions to regulate fertility, with preservation of the rights of men and women and limitation or increase of offspring; based on this definition, we observed that the nurses presented coherence in the answers, as well as the importance of clarification and offer about the available methods, encouraging the regulation of fertility and discouraging irreversible methods:

> It is guidance on contraceptives and respect for women's choices, in addition to being a sexual and reproductive right, ensuring the desire to have children or not (e22);
> Family planning is the set of actions to plan the number of children, regarding the contraceptive methods available (e08).

Another key point is the awareness of the breadth of the actions contained in the family planning program, not just care for tubal ligation or vasectomy:

Family planning is the sum of actions aimed at guiding contraceptive methods for women to plan their family constitution, as well as guidance on the prevention of pregnancy, desire, and right to choose whether or not to have children (e27).

It is noted that the nurses' global view of the actions contemplated by the program includes guidance, information on the methods available for a safe choice, preserving the

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person's quality of life, their desire and autonomy for family constitution, following the legislation and the constituted human rights.

Regarding the second key idea, the nursing actions carried out to develop the family planning program, standardized both by the SMS and by the Primary Care units, although there is a municipal protocol, each nurse, manager and unit adapt to better meet the profile of the population. The statements suggest that the actions are present in the nurses' care:

> I attend individually or the couple, after the case discussion between the nurse and the doctor, the consultation with the psychologist and returns to the nurse to forward to the SMS for hospital scheduling (e37);
> In my unit, we held the group with couples or single people who would like to undergo definitive procedures, after we carried out individual consultations, we requested the exams and referred them to a social worker and a doctor (e26).

Although they did not express all the protocol actions, it is perceived that there is uniformity in the care and that they are by the guidelines of the SMS. It is possible to observe that some scored the evaluation of the multidisciplinary team by the psychologist and others by the social worker, this is due to the distribution between districts and professionals, because depending on the district where the unit is located, it is referred for care with one or another professional.

Another important point in this class is the reference to the integrality of care, as recommended by the Ministry of Health (MS), not only seeing the demand (surgery) but the facets of the woman about contraception and other care, such as universal access, cytopathology and the collection of tests.

The bureaucratization of the process for carrying out family planning was also highlighted, as there is a need to fill out documents that are additional to the service, extensive forms that make the consultations long and tiring for professionals and patients, discouraging many nurses from carrying out the program. It should be discarded that in normal care, vital signs are measured, anthropometry, Nursing Care Systematization (NCS) and specific documents of the program are filled out, so the time of care ends up being limited to the completion of documents and not focused on the guidelines:

The difficulties are in the bureaucracy related to filling out the medical record, scheduling with the psychologist and forwarding the surgery request (e40).

Furthermore, in the daily reality, there seem to be professionals still strictly based on the biomedical model, without interaction with the multidisciplinary team, who only perform

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routine care, without thinking about the integrality of the care that involves many professionals and the need for the participation of the collective in the care.

FAMILY PLANNING FOR WOMEN WITH MENTAL DISORDERS AND THE PANDEMIC

Block 3 is composed of 3 classes, classes 2, 3 and 4 and presents the following points: the recognition of women with mental disorders in family planning care, knowledge about the drug interaction of psychotropic drugs and contraceptives, the particularities of family planning for women with mental disorders, the responsibility of carrying out the program and the impact of the pandemic on the program on vulnerable groups.

Regarding the recognition of women with mental disorders, this stigmatization in care is still observed, and its invisibility in Primary Care, as evidenced in the statements:

I had not thought about family planning for women with mental disorders before (e11; e20; e30; e38).

In the nursing consultation, it is necessary to analyze the woman's history in its entirety as part of the family planning process, which is often interpreted by some professionals as just filling out the physical protocol recommended for the program. Without the effective performance of the consultation accompanied by this completion, the integrality of care and the possibility of qualified actions are lost, not only for vulnerable groups but for the entire population.

The lack of association between family planning and mental health exposes women with mental disorders to sexual and reproductive risks, as well as social and cultural risks. Although the study represents a small fraction of the population of nurses, the data lead to reflection on the need to include the subject in care. On the other hand, when there is a reflection on integrating the protocols with the nursing consultation, we observe a change in the attitude of the professionals:

I had already thought about family planning for women with mental disorders, I had already discussed some cases (e34).

The comprehensiveness of care provides assertive measures for the conduct of the health team's actions, even due to the high demand of chronicity, which with the overload of life affects more women who predominate among mental health clients:

> I had already thought about family planning for women with mental disorders before because women with anxiety are very common (e03)

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> I had already thought about family planning before for family planning for women with mental disorders, in the unit I work there is a great demand for psychiatric patients (e08).

Inherent to this context, there is a concern about drug interactions between psychotropic drugs and contraceptives, since it is up to nursing professionals to guide the family planning process on the use of contraceptives, interactions, adverse reactions, method failure rate**,** among others, and there is, therefore, the need for these professionals to have specific knowledge.

Although in many nursing education institutions the curriculum includes the discipline of pharmacology that is mandatory in the undergraduate course, it seems to be approached superficially. The view of all specialties is a relevant factor for health education and defragmentation of nursing care, unlike the view of a single perspective of action, knowledge in pharmacology is essential, especially about dosages and effect on nursing care, since the absence of this information brings a real deficit for many nurses, as shown in the following statement:

I can't say which psychotropic drugs interact with contraceptives (e01; e02; e29; e30; e32, e34).

However, some medications, such as anticonvulsants and barbiturates, are recognized by nurses as the classes that interact with contraceptives, as they increase the metabolism of hormonal contraceptives, reducing their efficacy. However, the issues to be discussed with gynecologists or psychiatrists regarding the change in the contraceptive methods used were not pointed out, and there should be greater empowerment of nurses to designate actions by recognizing the concomitant use of psychotropic drugs and avoiding unwanted pregnancies, since the action and effects of contraceptives are described in the package inserts. as well as in the literature, especially in the ministerial and World Health Organization notebooks.

When asked about what would be the specific actions to work with women with mental disorders, we observed misinformation or lack of knowledge on the subject:

I do not know of any specific particularities for family planning for women with mental disorders (e01, e03, e04, e06, e30, e11, e12, e14, e16, e29, e31, e34, e38).

In this way, we end up placing women with any mental disorders in a position of disrespect for their autonomy to choose the best method for themselves, a situation that can be observed in the following statements:

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> A particularity for me would be the capacity of women in their autonomy to manage the regular use of medication (e02);
> I can point out as a specific particularity for family planning for women with mental disorders the lack of cognitive capacity for women to take responsibility for their actions (e35).

It is necessary to consider that the professional can definitively take away women's autonomy, but most women with this pathological situation make frequent use of other medications, and are therefore fully capable of using contraceptives appropriately when they receive the correct and clear guidance.

Thinking about the issues pointed out, the question arises as to which service is responsible for carrying out the program for women with mental disorders.

Regarding the question of which health service would be responsible for the family planning program for women with mental disorders, we noticed in this study that there is a division of opinions in relation to Primary Care:

> Primary Care should carry out family planning for women with mental disorders , there is no need to separate, but to serve this public according to their needs (e21);
> Primary Care should carry out family planning for women with mental disorders because it is a routine activity, with matrix support and training so that the professional in Primary Care does not have difficulty in how to carry out the process with women with mental disorders (e05).

As we can see, the routine of family planning and comprehensive care are already instilled in the nurses' perception, with reservations about the inclusion of training, matrix support, and support from CAPS. Training, as nurse 5 points out, helps in the management of cases and in reducing the difficulties encountered in routine care, being an effective way to manage this problem.

Another point of fundamental questioning is the performance of the CAPS in addition to Primary Care, which finds itself without help to know about psychiatric conditions due to the lack of communication and support:

> I believe that both CAPS and Primary Care should carry out family planning for women with mental disorders; the two services should interact for the process to be effective (e13).
> They can be mild disorders, which would be possible to attend to Primary Care, and other very serious disorders that require knowledge about the woman and the diagnosis to conduct (e31);
> Primary Care should carry out family planning for women with mental disorders, but with the support of the CAPS, which is exempt from this responsibility (e34).

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We noticed in these statements of the nurses that, in some cases, considered to be more severe, there is no flow in the services to discuss the cases, only a letter from the psychiatrist. When the Primary Care nurse identifies a disorder and requests an evaluation by the specialized service, this woman may often not return to the unit with the report. Thus, the woman is referred from one unit to another without being able to achieve her goals, the psychiatric declaration that she is able to make a conscious decision about the procedure she is seeking, tubal ligation, which often results in giving up the procedure and depriving her of her rights.

However, we know that psychiatric pathology is often more emphasized by women and their families than the demands of health prevention proposed in Primary Care, with care in CAPS being prioritized. Often, they do not attend the other health units, so some of the nurses defend the realization of the program by the nurses of the CAPS:

> The CAPS should carry out family planning for women with mental disorders due to knowledge and longitudinal follow-up, knowing the behavior of women, bonding service and frequency of attendance (e12);
> The CAPS should carry out family planning for women with mental disorders because there are several psychiatric diagnoses and conducts according to the diagnoses, which in my opinion require specific and specialized knowledge (e31).

The nurses allege the specificities of the pathologies and the knowledge of the CAPS professionals as an important factor for the development of the program, although the CAPS are restricted to mental health. In addition, they mention longitudinal follow-up, proximity to family members and contexts experienced by these women, the situation of the pathology, and its particularities as determinants for sexual health actions. They attribute greater engagement to specialized professionals in the management of specific cases, hence they consider it opportune to include the family planning program in the CAPS, although they do not have the knowledge about family planning.

In 2019, we experienced something new in our reality, the SARCOV-19 pandemic, which significantly changed the reality of care in Primary Care, in view of this, we sought to analyze the nurses' view of family planning, the actions developed and the concern mainly with vulnerable groups during this period.

The nurses were asked about the interruption of family planning as a whole (prescription renewal, listening and welcoming related demands, delivery and administration of contraceptives, care, tubal ligation):

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There was an interruption of all activities during the pandemic (e01; e10; e17; e20; e29; e30; e34).

We observed in the nurses' statements that regardless of the woman's motive and search for family and reproductive planning, it was interrupted, with no forms of help for the continuity and preservation of sexual and reproductive rights, even with guidelines from government agencies that determined the continuity of care for family planning, considering this care to be of fundamental importance, where reversible methods should be continued or started, especially taking into account issues related to the approximation of a person in the family niche and the increased risk of sexual violence.

However, we noticed from the reports of some nurses that some units, following the guidelines, interrupted only the collective care, and the other actions were maintained, however, the failure in communication between the technical and care teams, the professional risk and the increase in demand, are reflected in the reality of the vast majority of nurses through the reports:

> I don't know what the guidelines on family planning were during the pandemic (e01; e03; e10; e17; e20; e23; e30; e31; e34);
> I know that one of the guidelines on family planning during the pandemic was to extend the expiration date of prescriptions (e29).

It is possible to observe that in many units the guidance was not received in order to understand the continuity of family planning actions, and when received, they may have been fragmented.

4 DISCUSSION

The results found demonstrate that family planning care has important limitations for women with mental disorders, mainly related to contraceptive methods and the choice of more modern and effective methods for women in vulnerable situations (Carregal *et al*., 2021).

Our country is supported by legislation that seeks to defend human rights and people's quality of life, after a long historical journey, our legislations were based on great struggles to constitute their bases, in force until now, in this study we are pointing out two vulnerable classes of society, women and people with mental disorders, who still suffer prejudice and violence against their rights, maintaining gender inequality and men's

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authoritarianism over their lives, exacerbating mental pathologies, often already installed (Teixeira and Paiva 2021).

Throughout the history of health and nursing itself, several paradigms and myths have been created about women linked to madness, which confuse professionals, bring doubts and fears about care, especially in relation to family planning (Zanello, 2018).

Health professionals have a clinical view crossed by gender issues, leading to a hyperdiagnosis in women regarding mental disorders, due to the different tolerance between being a woman and a man, as women are historically linked to the care of offspring and family members, among others, in addition to oppression and violence perpetuated over time, playing multiple roles in her life, added to issues inherent to being a woman, such as hormonal changes, especially estrogen, which acts monthly in the modulation of mood, which often portrays the medicalization of female suffering (Boeff; Souza, 2020).

Health, especially Primary Care, the gateway to the SUS, must be prepared to accommodate the demand related to violence, mainly related to family planning and mental health, as they are fundamental services in mental health care, as proposed by the Psychosocial Care Network (RAPS), as they establish proximity to people's life stories, their integration with the community and the territory in which they are inserted, thus modifying mental health issues, reassessing and reformulating diagnoses, maintaining longitudinally only the real conditions of each person, however, these services are still restricted to medical consultations and prescription of medications, evidencing the disease and ignoring people's experience in their singularity (Pereira *et al*., 2021).

The gender issue is commonly treated with psychotropic drugs, without qualified listening to people's narratives and intertwining this conduct with the failure in professional practice, especially in academic training to deal with people in psychic suffering (Pereira *et al*., 2021).

There is a gap between the Ministry of Health's protocols, current legislation, and actual health care, especially in mental health, leaving these women neglected and suffering everyday violence (Teixeira, Paiva, 2021; Zanello, 2018; Pereira *et al*., 2021).

However, even with the broadening of the view on mental health, female sexuality remained stigmatized, women with mental disorders maintained the concept of asexual, with their desires ignored, decriminalized and taxed as aggravating the pathology (Marcolino; Almeida; Nogueira, 2019). Consequently, they are more prone to unwanted

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pregnancies, a greater number of sexual partners, risky sexual relations, mainly related to diseases, an increase in the rate of rape, sexual abuse, and low rates of regular use of contraceptives due to misinformation (Pereira *et al*., 2020; Marcolino; Almeida; Nogueira, 2019; Monti; Camiá, 2016; Detomini; Rasera, 2018).

The nurse becomes a transforming object in these services, as he is the protagonist of family planning in Primary Care, his care is strategic and indispensable, however, there is a need for trained professionals to carry out the program, with the nursing consultation being an opportune and differential moment in the lives of women, helping to reduce the vulnerabilities experienced (Cardoso *et al*., 2021).

There is a need for training professionals, expanding the vision for all issues related to sexual and reproductive health, which despite the advances remain based on a unilateral configuration, for this it is necessary that the recognized guidelines are disseminated to professionals and respected in their care, this health education is built through training with current themes and professional expertise in the subject, and must be constant and comprehensive (Chaves; Souza, 2021).

This need is characterized mainly by the new concept of family constitution, which is currently a complex issue due to the diversity and breadth of the concept, as it has undergone several changes in the last 140 years in Brazil, influenced by the evolution of family institutions, legislation and culture experienced (Chaves; Souza, 2021).

Thus, trying to understand the view of the concept of family planning, the actions carried out in the care and listing the difficulties and facilities in carrying it out, becomes of paramount importance to evaluate the care provided by the nurses and adapt the training to meet this demand, as well as the importance of protocols to assist in the conduct of care for vulnerable groups, because women are still exposed to various forms of violence, which affect their physical, psychosocial, economic, labor, and mental health status **(** Coelho dos Passos *et al., 2023;* Teixeira; Paiva, 2021).

Therefore, it is important to rethink the training of professionals in relation to primary mental health care, strengthening the national mental health policy**,** with the recognition of people with mental disorders as subjects of rights, including the recognition of autonomy regarding desires related to sexual and reproductive health (Silva *et al.*, 2021).

And although Primary Care is the place to develop all health promotion and prevention actions, it is of fundamental importance to train teams to serve specific groups, and it is necessary to assign intersectoriality to complement these services, reorganization

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of services that have little flexibility in meeting people's needs, due to inadequate regulation of access to services as a constitutional right, extending the wait for care and procedures by professionals (Rodrigues *et al*., 2023).

In addition, the mismatch between Primary Care and CAPS (mental health) culminates in the difficulty of referrals and counter-referrals, generating fragmentation of care for people with mental disorders, emphasizing that services should promote the integration of health systems and networks, but still encounter limitations due to the very absence of professional practice (Santos *et al.,* 2019).

Thus, there is a need for a service articulated with mental health, through an integrated network of services aiming at coordinated and continuous work that involves the multiple dimensions of people's lives and daily lives, extrapolating the scope of health and working on the construction of relationships, through continuous matrixing, close to Primary Care professionals and with co-responsibility for mental health services (Souza; Amarante; Abraão, 2019).

Since the CAPS are places of longitudinal and continuous care, the population, in addition to having several professionals engaged in care, must also develop actions mainly in the field of family planning, because many women in mental health follow-up are not in the habit of seeking Primary Care, making the CAPS the only reference service, therefore, an appropriate place to develop family planning actions, in its entirety, or collaborating with the other services through referencing and matrix support (Monti; Camiá, 2016).

Mental health care should include sexual and reproductive screening, which is ignored justified by the discrimination of mental health professionals regarding the sexual stigmas of women with disorders, compromising the provision of care (Fortes *et al*., 2021).

In view of this, with mental health acting together in this process with Primary Care, reducing bureaucracy and speeding up the provision of care in planning for women with mental disorders, women's autonomy can be preserved and respected, in order to avoid damage, such as unwanted pregnancy that impacts various aspects of life (Fortes *et al*., 2021).

Because women's health is still fragmented in the different health equipment, compromising its integrality, and the CAPS, in partnership with Primary Care, transcend the traditional, biologist and medication model, following the National Mental Health Policy (PNSM), and provide changes in women's sexual life, improving and preventing a decrease

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or absence of libido, lack of prevention of Sexually Transmitted Infections (STIs) and unwanted pregnancy (Pereira *et al.,* 2020).

These points have a negative impact on the lives of women with mental disorders, as it reduces self-care and the adoption of preventive measures, especially in crisis situations, where it is necessary for both services to carry out an individualized care plan in family planning, recognizing the reproductive rights of these women, through the transversality of policies to compose the care for women with mental disorders, guaranteeing the care that encompasses the gender singularities, including the prevention of cervical and breast cancer in mental health services (Pereira *et al.,* 2020).

Therefore, it is of paramount importance to train professionals to recognize women with mental disorders, but it is also important that these professionals have knowledge of laws and policies related to the area of family planning and mental health, and that both are interconnected in favor of their rights (Teixeira; Paiva, 2021).

The findings regarding the difficulties in carrying out family planning are corroborated by authors who evidence the need for training nurses in Primary Care to better serve the population, some difficulties pointed out in the implementation of actions are characterized as the lack of adequate places to carry out orientations, absence of specific actions and lack of articulation with other health services; the lack of training and lack of knowledge of the As relevant factors to be worked on, especially in terms of interaction, side effects and correct use of these medications, a highlight in the difficulties presented is the absence of formal training, as many nurses who provide care in women's health do not have adequate training for family planning actions, being an obstacle in care, requiring not only local but also governmental measures to provide care to nurses (Lima; Oliveira, 2020; Coast; Castro; Silva, 2020).

In line with the training, we should develop another important point raised in this study, matrix support, included in the RAPS, and with the aim of strengthening care in the territory, permanent education in the workplace, as a strategy that supports Primary Care, proposing reformulations in organizations and mental health care, which in care practice appears as another difficulty in routines (Ribeiro *et al*., 2020; Iglesias; Avellar, 2019).

It is necessary to restructure power relations through dialogue, especially between professionals from different areas, placing matrix support as technical and pedagogical support for Primary Care teams, promoting the shared construction of care and interpellations of service institutions, overcoming the verticalized models of reference and

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counter-reference, developing horizontal mechanisms of sharing in the care network (Melo *et al.* , 2021; Iglesias; Avellar, 2019).

However, the interaction between Primary Care and mental health professionals still presents itself as the main challenge for the effectiveness of matrix support and expansion of care, promoting a feeling of helplessness of Primary Care professionals, who are faced with high demand, insufficient health network and difficulty in sharing the proposed actions in mental health (Ribeiro *et al.*, 2020; Iglesias; Avellar, 2019).

Nevertheless, we must correlate the invisibility of women with mental disorders in sexual matters and the risk related to domestic and sexual violence, especially when they are dependent on their caregivers, and in times of social isolation, such as the COVID-19 pandemic, where quarantine measures have modified life and social routines, increasing these risks, because their aggressors can use the recommended restrictions as a means of masking violence, and the difficulty in accessing health can mean obstacles to defense or expression and communication of this violence, requiring the maintenance of access to reference units, whose women have confidence in the care for a differentiated look, enabling the prevention of damage regarding veiled violence, help in understanding them and reporting them if necessary, especially by analyzing and welcoming the demand for family planning (Padilha *et al.*, 2022).

The COVID-19 pandemic has impaired the population's care and access to health services, which has ceased to fulfill its social functions, to offer health in a comprehensive, universal and equitable way, which has resulted in complications for populations that need continuity in care, and it is necessary, in addition to fighting the pandemic, to keep their basic services in operation, mainly aimed at women, who need quality access to contraception, family planning and methods (Guedes; Raimundo; Bastos, 2021).

Worldwide, about 47 million women had difficulty accessing family planning, which resulted in about 7 million unwanted pregnancies, so in the midst of major catastrophes, services must rethink their conduct and not just focus on the demand of the moment to maintain the continuity of family planning, for this they must maintain contingency plans and train teams for these approaches in advance (Guedes; Raimundo; Bastos, 2021).

Therefore, in times of adversity such as the pandemic, we have to develop quick and objective actions in order to maintain the continuity of essential actions, in this sense, health promotion actions are essential to point out the rights in family planning for women,

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encouraging prevention, we can use teleservice, which has shown advantages for women who sought advice on methods during this period (Romano *et al.,* 2021).

It is important to think about strategic actions for the future with concrete applications in the field of family planning, Brazil, in addition to the COVID pandemic, also suffered and suffers the consequences of the Zika Virus epidemic, which was declared by the WHO in 2016 as a public health of international importance, that is, the increased demands that epidemics impose, the quality of sexual and reproductive care suffers a strong impact, especially in vulnerable groups. It is important to recognize that extreme situations affect women more than men, for this there is a need for local and government policies for these periods, and professionals are aware of the actions they must maintain and carry out without harming or exposing this population to risks (Coutinho *et al*., 2020).

CONCLUSION

The present study made it possible to evaluate the profile of nurses who perform family planning in Primary Care in Ribeirão Preto, with a prevalence of females and with a considerably high level of education, who receive training regularly, both in their work environments by colleagues or by the Municipal Health Secretary, and attend to patients with mental disorders in their routine, However, it made it possible to verify that there is a need for continuous training, with a diversity of themes, presentation of general and specific current legislation for vulnerable groups in order to train nurses who, without information, can cause harm to the population. It is perceived that nurses seek training and understand its importance, as well as the protocols, however, for them to be effective, these training must be reviewed, updated and comprehensive.

Thus, the interconnection between the training of nursing professionals, psychiatrists, gynecologists and family health physicians becomes of fundamental importance within family planning for women with mental disorders, as it makes it possible, through comprehensive care and evaluation of medical records, to present patients with better living conditions, reduction of the risks generated by the excessive use of medications and interactions, unwanted pregnancy and STIs.

In line with the training, he highlighted another important point, matrix support, included in the RAPS, and with the aim of strengthening care in the territory, permanent education in the workplace, as a strategy to support Primary Care, proposing reformulations

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in organizations and mental health care, which, as pointed out, is non-existent in care practice, which makes it difficult to clarify doubts that arise in mental health routines.

Another relevant point identified was the lack of interaction between Primary Care and mental health professionals, which still present themselves as the main challenge for the effectiveness of matrix support and expansion of care, generating unnecessary referrals, delay in resolving the demand presented by the woman and frustration of the Primary Care nurse.

We also conclude that mental health services, CAPS, as they are longitudinal outpatient clinics, close to the users, family and community in which they are inserted, with a multidisciplinary team, should develop actions in family planning and sexual health, since integrality of care is among its principles, providing awareness of the sexual rights of the women accompanied, and avoiding devaluation of women's autonomy, non-compliance with their rights, unwanted pregnancy, drug interaction and STIs.

Although the data collected represent only one municipality, it is expected that the results of the present study will offer contributions to a better understanding of family planning for women with mental disorders in Primary Care. We propose that more studies be listed for a better understanding of the theme, as well as the proposal of an effective experimental work of family planning in a CAPS.

The study achieved its objective by identifying and characterizing nurses working in Primary Care, who perform family planning in their routines, as well as identifying the weaknesses and possibilities in care related to family planning, especially aimed at women with mental disorders, analyzed the perceptions and considerations existing in this care and the proposals for improving care.

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