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Theoretical model of sexual and reproductive health care: subsidies for evaluative research

Modelo teórico da atenção à saúde sexual e reprodutiva: subsídios para pesquisas avaliativas

Modelo teórico de la atención a la salud sexual y reproductiva: subsidios para investigaciones evaluativas

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ABSTRACT

Objective: To elaborate a Theoretical Model of Sexual and Reproductive Health care offered in Primary Health Care.

Method: Documentary research, with a qualitative approach. Government documents and evaluative studies constituted the data sources, collected between August 2018 and June 2019, and analyzed based on the health evaluation literature.

Results: Promotion of Sexual and Reproductive Health and Clinical Care were two structural components of the theoretical model of sexual and reproductive health care in Primary Care. The model includes disease prevention activities, health promotion, treatments, and diagnoses related to sexual and reproductive health.

Conclusion: The theoretical model developed in this study presents the theory that supports the operationalization of sexual and reproductive health care in primary care according to government regulations in Brazilian scenario and may be useful in future evaluative research on the subject.

Keywords: Sexual and reproductive health. Models, theoretical. Evaluation studies as topic. Primary health care. Public health nursing.

RESUMO

Objetivo: Construir um Modelo Teórico da atenção à saúde sexual e reprodutiva ofertada na Atenção Primária à Saúde.

Métodos: Pesquisa documental, com abordagem qualitativa. Documentos governamentais e estudos avaliativos constituíram as fontes de dados, coletadas entre agosto de 2018 e junho de 2019 e analisadas com base na literatura de avaliação em saúde.

Resultados: A Promoção da Saúde Sexual e Reprodutiva e a Assistência Clínica foram os dois componentes estruturantes do modelo teórico da atenção à saúde sexual e reprodutiva na Atenção Primária. O modelo contempla atividades de prevenção de doenças, promoção da saúde, tratamentos e diagnósticos relacionados à saúde sexual e reprodutiva.

Conclusão: O modelo teórico elaborado apresenta a teoria que subsidia a operacionalização da atenção à saúde sexual e reprodutiva na atenção primária, segundo as normativas governamentais no cenário brasileiro, e poderá ser útil em pesquisas avaliativas futuras sobre o tema.

Palavras-chave: Saúde sexual e reprodutiva. Modelos teóricos. Estudos de avaliação como assunto. Atenção primária à saúde. Enfermagem em saúde pública.

RESUMEN

Objetivo: Construir el Modelo Teórico de atención en Salud Sexual y Reproductiva ofrecida en la Atención Primaria de Salud como una de las etapas iniciales del proceso de evaluación de implantación.

Método: Investigación documental, con enfoque cualitativo. Los documentos gubernamentales y los estudios evaluativos constituyeron las fuentes de datos, recopilados entre agosto de 2018 y junio de 2019 y analizados con base en la literatura de evaluación de la salud.

Resultados: La Promoción de la Salud Sexual y Reproductiva y la Atención Clínica fueron los dos componentes estructurantes del modelo teórico de atención de la salud sexual y reproductiva en Atención Primaria. Incluye actividades de prevención de enfermedades, promoción de la salud, tratamientos y diagnósticos relacionados con la salud sexual y reproductiva.

Conclusión: El modelo teórico desarrollado en este estudio presenta la teoría que apoya la operacionalización de la atención de la salud sexual y reproductiva en la atención primaria de acuerdo con las normativas gubernamentales en escenario brasileño, y puede ser útil en futuras investigaciones evaluativas sobre el tema.

Palabras clave: Salud sexual y reproductiva. Modelos teóricos. Estudios de evaluación como asunto. Atención primaria de salud. Enfermería en salud pública.

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INTRODUCTION

Social claims at the international and national levels and the purpose of strengthening the right to freedom of choice, autonomy and security in the experience of sexuality and reproduction contributed to the recognition of sexual and reproductive rights[1], as a basis for the incorporation of Sexual and Reproductive Health (SRH) in the health policy agendas of the Brazilian population in the 20th century[2,3].

It is up to the state to provide resources, facilitate access to information and provide services that favor the exercise of sexual and reproductive rights. Within the scope of the Unified Health System (*Sistema Único de Saúde* – SUS), SRH care has a wide scope of actions and services, including educational activities, counseling and clinical activities[3,4]. Big part of this care should be primarily offered in Primary Health Care (PHC), a privileged space for comprehensive care practices, a locus of greater proximity to the lives of the subjects, which develops actions to promote health, disease prevention, recovery and rehabilitation[3–5].

Every action in health (programs, policies and/or care actions) has a theoretical plan of a technical-operational and prescriptive nature. However, the theories underlying this plan are not always described or made clear in official documents[3,6]. Therefore, modeling or Theoretical Model (TM) is one of the strategies used in evaluative research to describe the elements that make up the program or the object of evaluation and to present the rationality of the intervention theory[6].

As a visual scheme, the theoretical model allows for an easier understanding and the definition of the objective-image of a program theory, with no standard, correct or unique form for its construction[6]. The TM must contain the actions and its objectives, the contextual, temporal and cultural determinants, and the elements (components, inputs, products and results), to better understand the intervention in its complexity[4]. The specification of actions to be taken to achieve the desired effects, other impacts that could be considered and the mechanisms through which these effects and impacts would be produced is also useful for the construction of evaluation criteria[6].

Explaining the complex relationships between structure, processes and results[7], identifying relevant data to support the planning, implementation and evaluation of programs, supporting judgment and analysis of public policies, are among the possibilities of using TM[4].

The health evaluation literature describes the applicability of TM in the field of policies and programs evaluation[6,8,9,10], however, there are still few implementation evaluation studies that present SRH care models with a focus on PHC, considering the multiplicity of approaches, as observed in a scope review on this subject[11]. This review retrieved 3,788 articles and 687 theses and dissertations, of which only 14 studies addressed the evaluation of the implementation of actions, programs and/or practices of sexual and reproductive health in the context of PHC, however, only four publications presented theoretical models covering the attention to SRH in a broader way, beyond prenatal care and sexually transmitted infections[11].

What is presented above about the relevance of this tool and its scarcity in the national literature justifies and reiterates the importance of the content provided in this article, which presents the construction of a theoretical model of attention to Sexual and Reproductive Health offered in Primary Care, based on the government regulations that guide the implementation of this care in the SUS. Its structure was guided by the following guiding question: What is the theoretical plan of attention to SRH in PHC, according to government regulations present in the Brazilian scenario? It is noteworthy that the proposed model was used to support an evaluation study of the implementation of SRH in PHC in a municipality in Zona da Mata, Minas Gerais, and that it may also be useful for future evaluative research on the subject.

METHOD

The model presented in this article followed the theoretical and methodological assumptions of the evaluation applied to health[6,9,12] and document collection and analysis[13], and the systematization was guided from the perspective of program modeling[6,12]. The process of elaboration of the model was developed between August 2018 and June 2019 and involved five distinct and complementary stages: 1) Document collection and analysis[14]; 2) Scope review[11]; 3) Systematization of data and elaboration of descriptive matrices containing actions, structure, process and results that represent the theory of implementation of SRH care; 4) Identification and classification of program components, and 5) Presentation of the theoretical model. These two last stages are the focus of the proposal presented in this article.

The documentary research had, as data sources, laws, guidelines and government documents, accessed via the Ministry of Health's website, in particular on the Department of Primary Care (*Departamento de Atenção Básica* – DAB) website — today called the Portal of the Department of Primary Health Care (*Portal da Secretaria de Atenção Primária à Saúde*) — and in the Ministry of Health's Virtual Health Library – VHL (*Biblioteca Virtual em Saúde do Ministério da Saúde* – BVS/MS)[14]. The option to concentrate the document analysis on

institutional documents of the Ministry of Health was due to the fact that municipal programs adopt guidelines and activities defined and recommended at the federal level, with subnational entities being responsible for their execution in the scope of Primary Care.

On the DAB website, a search was made for documents, manuals, booklets, and care notebooks directed to SRH, selecting them based on the reading of the document's title, regardless of whether or not it has a reference to the PHC. On the VHL website, it was used the filter "Sexual and Reproductive Health" in the search. At this stage of the search, documents that were not available for online access were excluded. It was also decided to exclude documents with a restricted focus only on prenatal care, considering that the particularities of this care are beyond the scope of this research proposal.

The documents obtained from the two sources were subsequently selected by reading the title, abstract, when available, and the initial pages when it was not present, applying the following inclusion criteria: institutional authorship of the Ministry of Health (or its Secretariats and Departments), focus on SRH, and clear that PHC professionals and managers are one of the publication's target audiences. Nineteen documents were selected and analyzed according to the main actions, services and attributions of the PHC in attention to SRH. The systematization of these documents was presented in another publication[14].

Another stage consisted of a scope review, which proposed to map and characterize the implementation evaluation studies published on SRH care in PHC, additionally describing the main factors that favor or hinder the implementation of such actions[11]. For this, a bibliographic search was performed using the following databases MEDLINE (via Pubmed), SCOPUS, Web of Science, Cumulative Index to Nursing and Allied Health Literature (CINAHL), POPLINE and Latin American and Caribbean Health Sciences (LILACS), as well as in the Brazilian Digital Library of Theses and Dissertations. Fourteen studies were selected (5 articles and 9 academic productions, including theses and dissertations) that aimed to evaluate, describe or analyze the implementation or implantation, in Brazil, of interventions at the locus in question, covering the SRH actions present in the Primary Care Booklet of the Ministry of Health[3].

With the information from the document analysis and scope review, it was necessary to organize the data obtained and classify them according to the Donabedian triad structure, process and result[7]. The structure includes structural conditions, human resources, physical conditions, facilities, and equipment. The process, on the other hand, refers to the operationalization of activities as planned, and is directly related to the practice and the services offered. Finally, the results are related to the capacity of the services to achieve their goals, that is, the outcomes achieved[7].

The classification of SRH care components in primary care was based on other models published in the national context and the details of the actions of each one of the components constitute the core of the results presented and discussed below.

It is also noteworthy that the construction of the theoretical model, presented in this article, is one of the stages of an evaluative research, whose proposal is to evaluate the implementation of sexual and reproductive health care in the Family Health Strategy in a municipality in the Zona da Mata Mineira. It is part of an ongoing doctoral thesis, scheduled for defense in late 2021, linked to the Graduate Program in Public Health of the *Instituto de Medicina Social Hesio Cordeiro* of the *Universidade do Estado do Rio de Janeiro*, whose research was approved by the Ethics Committee of that institution, CAAE No. 23878719.0.0000.5260.

RESULTS AND DISCUSSION

Two main components of SRH care in the PHC scenario – the Promotion of Sexual and Reproductive Health and Clinical Care, compose the Theoretical Model of SRH care in Primary Health Care. Both components have three action cores each, which are detailed and presented below.

Theoretical Model —Sexual and Reproductive Health Promotion Component in Primary Care

The promotion of SRH is considered a fundamental role of the PHC[3,4]. It involves actions for the well-being in the experience of sexuality and reproduction, through health education, guided by the perspectives of respect to sexual and reproductive rights. There are three action cores added to this component: educational activities; welcoming and advising; individual and family approach (Chart 1)

The educational activities have the objective to offer information, guide, provide reflection and share knowledge about issues related to sexuality and reproduction, collaborating for people to make choices in a free, informed, autonomous and safe way[3,14]. It is recommended that health education to be a process of permanent construction, with the active participation of all team members and users, through interactive pedagogical practices that consider the knowledge and experience of those involved[3]. These activities must take place not only in the spaces of health services, but also in schools and in the diverse social spaces existing in the community[3,4].

Purpose of the component: To promote gender equality and well-being in the experience of sexuality and reproduction, through health education. Strengthen the exercise of Sexual and Reproductive Rights.			
Action core	**Educational activity**	**Welcoming and Advising**	**Individual and family approaches**
Related activities (description)	• Offer information and guidance on contraceptive methods, conceptives and emergency pills, reproductive planning; • Conduct educational activities on sexual and reproductive health for men, women, adolescents, elderly, people with disabilities, the population of Lesbians, Gays, Bisexuals, Transvestites, Transsexuals and Intersex, among other people in vulnerable situations, pregnant women and their partners; • Guide on the realization of pap smear test, breast self-exam, prostate exam; • Guide women in peri-menopause, postpartum, post-abortion and people living with HIV/AIDS and on contraception; • Inform about HIV rapid testing, treatment and prevention of STIs, including HIV/AIDS; • Inform people in vulnerable situations about contraceptive methods, STI prevention; • Guide pregnant women about sexual and reproductive health before, during and after childbirth; • Promote educational activities on post-pregnancy reproductive planning for pregnant teenagers (especially 10-16 years old); • Guide and resolve doubts about sex during pregnancy, prenatal care, childbirth and puerperium; • Guide and encourage the father's participation in prenatal care and responsible parenthood;	• Welcome and answer questions about curiosities, concerns and fears related to sexual and reproductive health issues; • Advise on the decision to use the surgical contraceptive method; • Welcome and analyze situations of individual or couple vulnerability to HIV infection and other STI; • Welcome women in situations of abortion; • Welcome pregnant teenagers; • Welcome people with difficulties in getting pregnant; • Advise on the treatment of diseases that may negatively interfere with sexual and reproductive health; • Advise on the realization of a rapid HIV test; • Advise the population, especially pregnant women, about the rapid syphilis test; • Offer reproductive counseling for HIV-positive women and men, considering the prevention of HIV transmission, including vertical transmission; • Welcome and monitor the health of HIV-positive women and men, also	• Conduct thematic campaigns on sexual and reproductive health in conjunction with the population, local institutions and other sectors; • Develop strategies to increase vaccine coverage of Hepatitis and Human Papillomavirus vaccine for adolescents between 9 and 12 years old; • Approach sexuality in a positive way, considering the right to feel comfortable to feel and give pleasure (satisfaction, safe sex practice, existence and types of difficulties); • Ensure respect for people's autonomy, rights and freedom of decision on issues related to their bodies and their lives; • Ensure the guarantee of privacy and confidentiality in individual and collective approaches to sexual and reproductive health; • Provide person-centered sexual and reproductive health care, considering their life context and aspects involving family, work and beliefs; • Act in sexual and reproductive health with a focus on the family and considering family interactions and/or tensions;

Chart 1 – Theoretical model related to the component of sexual and reproductive health promotion in Primary Health Care.

Purpose of the component: To promote gender equality and well-being in the experience of sexuality and reproduction, through health education. Strengthen the exercise of Sexual and Reproductive Rights.			
Action core	**Educational activity**	**Welcoming and Advising**	**Individual and family approaches**
Related activities (description)	• Guide couples about the rights of parents after the birth of their child; • Encourage self-care and self-knowledge of the body; • Approach thematic educational activities on sexual dysfunctions, infertility, pleasure, gender equality, climacteric sexuality, adolescent sexuality, gender identity diversity, sexual violence; • Dialogue about sexuality and sexual health for elderly people, people with disabilities and serodiscordant couples; • Guide and undo myths and taboos about sexual and reproductive health; • Encourage communication between partners.	exploring their expectations and interest in becoming pregnant; • Welcome the pregnant woman's parents and family (affective supporters); • Advise and guide about breastfeeding; • Advise and guide about the use of contraceptive methods and other medications in the puerperium; • Advise teenagers on the responsible exercise of fatherhood and motherhood; • Conduct welcoming of women and men with sexual problems/ dysfunctions;	• Assess the family structure and functioning in the approach to sexual and reproductive health; • Conduct an individual approach to sexual and reproductive health, considering the person's or couple's life context; • Assess religious and cultural influences, quality of the relationship and communication with the partner, use of alcohol and other drugs, desire or not to have children, among other issues that may be related or interfere in the healthy and safe experience of sexuality and reproduction.
Expected performance	• Primary care professionals are trained in sexual and reproductive health care and the health unit provides educational activities to promote Sexual and Reproductive Rights and sexual and reproductive health; addressed to women, men, teenagers, elderly, people with disabilities, population of Lesbians, Gays, Bisexuals, Transvestites, Transsexuals and Intersex, Asexuals, among other people in vulnerable situations, pregnant women and their partners, contemplating their needs, recognizing the singularities and respecting the diversities of users.	• The service is based on listening and understanding individual and social aspects, identifying possibilities for the service to act in advising and welcoming issues that compose sexual and reproductive health.	• Individual or collective approaches are considered an opportunity to build knowledge based on the reality of individuals and the territory and are guided by active methodologies; • The activities are continuous and are developed by the multidisciplinary team, intersectorial and with the participation of the community.

Chart 1 – Cont.
Source: Research data, 2019.
Legend: HIV: Human Immunodeficiency Virus; Aids: Acquired Immunodeficiency Syndrome; STI: Sexually Transmitted Infection.

Welcoming and advising, as the second action core, are related to the professional's ethical conduct, that is, it materializes through the humanization of health practices. Welcoming is characterized as a way of operating health work processes, implying a respectful posture, free from judgments and/or prejudice[3]. Counseling in the practice of SRH care, on the other hand, is based on dialogue to strengthen the bond between the health professional and the individual or couple, and should be flexible and without obligation, allowing each person to know what the service offers and to be able to make their own choices within the scope of SRH.

The individual and family approach constitutes the third and last action core of the SRH promotion component. The approach centered on the individual considers their life context and stage of personal development, which includes paying attention to aspects involving family, work, beliefs, difficulties, potentialities. The family approach, on the other hand, seeks to understand the context of people's lives and its influences on the health situation[3,4,14]. In this case, the family can be defined as a group of people who share a relationship of care (protection, food and socialization), affective bond (relational), of coexistence, of blood kinship or not[3,5].

Health education, advising/welcoming and the individual and family approach contribute to empowerment and autonomy in decision-making, encourage self-care, promote social inclusion, strengthen the bond between the professional and the user, favor listening, and they reinforce the professional's responsibility and commitment to resoluteness and continuity of care in PHC[3,14].

The implementation of the three action cores is directly influenced by the training of professionals and by the planning, organization and management of assistance to SRH, in the context of the PHC work routine[4,15]. It is also understood that these three action cores correspond not only to SRH actions but are cross-sectional to other programs and policies implemented in the context of PHC.

Regarding this component, it is also mentioned that studies reiterate challenges to be overcome for the effective implementation of such actions, such as the scarcity of educational activities for SRH care; approach centered on the figure of the woman; content often limited to sexually transmitted infections; difficulty of adherence and participation of users in educational activities; need for welcoming and preconception care; absence of counseling and/or moments of dialogue with users who seek such assistance, and prescriptive conduct of professionals[2,14–17].

Theoretical model — Clinical Care Component for Sexual and Reproductive Health in Primary Care

Consultations, prescriptions, monitoring, and referrals are part of the Clinical Care component, which, in turn, was divided into the following action cores: prevention and diagnosis; treatment, monitoring and referral to other services; health surveillance and care management (Chart 2).

The first core of the care component, prevention and diagnosis includes anamnesis, physical examination, availability, guidance, prescription and provision of the contraceptive method, as well as vaccination for hepatitis B and Human Papillomavirus (HPV), guidance and collection of Pap smear, colposcopy and biopsy of the vulva and cervix (when available), advising and syndromic assistance for STI, care and monitoring of HIV-positive people, collection of serology for STI/AIDS, encouragement of dual protection, the contraceptive method and serology for HIV and syphilis in the first and third trimester of pregnancy, among others[3,4].

The action core for treatment, monitoring and referral to other services encompasses the provision of adequate treatment and/or therapeutic resources for diseases or conditions that are interfering with SRH, such as gynecological, urological and chronic degenerative diseases, such as high blood pressure, diabetes[3].

Finally, the action core of health surveillance and care management actions involves the records of information relevant to health surveillance (such as vaccination and Pap smears, active search for users); notification of injuries, followed by control of communicators and the environment, partnership with other sectors and calling individuals, dissemination and use of information systems, surveillance of altered exams and absentee patients. Care management includes strategies for dissemination of actions of SRH, flows, records and frequency of activities[3,11,15].

The actions of this second component of SRH care are essential for the promotion and prevention of diseases; in this sense, it is possible to observe the complementarity of the activities mentioned with the component previously presented. Specifically, in this component related to care, it is central to emphasize the importance of care flows, communication with other levels of care and the establishment of references for specialized services[3,11].

Purpose of the component: Assistance for prevention, diagnosis of STIs, treatment, monitoring, care and support for individuals with SRH-related diseases, considering the concept of vulnerability in its individual, social and programmatic aspects. Articulation with other services and definition of strategies for carrying out health information and surveillance activities.

Action core	Prevention and diagnosis	Treatment, monitoring and referral to other services	Health surveillance and care management
Actions and related activities (description)	• Ensure access to reversible and surgical contraceptive methods; • Ensure access to male and female condoms for STI prevention; and to preconception exams in case of pregnancy planning; • Offer individual care, anamnesis, physical examination, seeking to identify individual and/or couple's needs, and prescription of contraceptive methods chosen by the user according to a medical evaluation guided by the eligibility criteria; • Provide guidance about resources for conception or contraception, encouraging active participation in individual or couple decisions; • Perform pregnancy diagnosis and promote early prenatal care; • Advise on use of condom and communication with partners in cases of positive STI diagnosis; • Offer screening for early detection of breast cancer and uterine cervical neoplasms • Provide specific protection activities, including vaccination; • Develop strategies to increase vaccine coverage for Hepatitis and HPV vaccine for adolescents aged 9 to 12 years old;	• Prescribe contraceptive methods; • Conduct return consultations to monitor the health of the person or couple who use contraceptives; • Identify and replace, when possible, medications that may interfere with sexual and reproductive health; • Institute treatments for diseases or conditions that are interfering with sexual health: gynecological and urological diseases, chronic-degenerative diseases, such as high blood pressure, diabetes, among others. • Guarantee access to information, methods and means for regulating fertility and protecting against HIV/AIDS and other diseases; • Identify the cases that need referral for specialized care, being the management's responsibility to establish flows and agreements for that referral. • Promote clinical care in the climacteric/menopause; • Perform syndromic treatment of STIs, including; condyloma acuminata cauterization; • Treat pregnant women with syphilis and her partner;	• Record relevant information for surveillance and work organization, including procedures, vaccinations and negative notification of conditions such as congenital syphilis; • Conduct surveillance of exams and absentees; • Notify the CND, carry out actions to control contacts, environment and health education; • Offer syphilis diagnostic tests and check the vaccination schedule; • Perform active search for partners of users diagnosed with STI; • Invite users to participate in educational activities aimed at SRH; • Register and monitor users who have access to contraceptive methods in the health unit; • Identify SRH-related needs and vulnerabilities during home visits; • Identify all pregnant teenagers in the territory and, in particular, those in a situation of greater vulnerability (living on the street, in conflict with the law, users of alcohol and other drugs, indigenous people, quilombolas, riverside dwellers)

Chart 2 – Theoretical model regarding the Clinical Care component for Sexual and Reproductive Health in Primary Health Care

Purpose of the component: Assistance for prevention, diagnosis of STIs, treatment, monitoring, care and support for individuals with SRH-related diseases, considering the concept of vulnerability in its individual, social and programmatic aspects. Articulation with other services and definition of strategies for carrying out health information and surveillance activities.			
Action core	**Prevention and diagnosis**	**Treatment, monitoring and referral to other services**	**Health surveillance and care management**
Actions and related activities (description)	• Perform timely diagnosis of HIV and other STIs, with the offer and performance of exams; • - Identify sexual dysfunction and other difficulties regarding sexual relations; • - Promote prevention and guidance actions on prostate cancer and penile cancer, uterine and breast cancer; • - Identifies the date of the last collection of the preventive exam for uterine cancer and assesses the need for a new collection; • - Perform preconception evaluation in cases of chronic diseases; • - Offer assistance to infertile couples; • - Offer clinical-gynecological consultation.	• Afford medication for sexually transmitted infections and conditions for the application of benzathine penicillin; • Ensure scheduling of appointments and home visits, during prenatal and puerperium; • Have a network of services to assist infertile couples; • Refer cases of positive results in rapid tests, especially for HIV, to specialized care and continue monitoring in the unit.	so that they can be welcomed and receive differentiated care, according to their health needs and demands;
Expected performance	• Offers all contraceptive methods to prevent unplanned pregnancy and STI; • Offers actions for the diagnosis and prevention of STI/HIV/AIDS, as well as screening for cancers related to sexual transmission, from the perspectives of gender, vulnerability and sexual and reproductive rights; • Ensures autonomy in reproductive choices; • Encourages responsible fatherhood and motherhood;	• Offers treatment and monitoring of STI cases, incorporating the syndromic approach, advising and communication to partners; • Provides treatment for pregnant women with syphilis and their partner; • Offers support to users with HIV/AIDS in their treatment jointly with the specialized service; • Provides clinical evaluation and offers periodic monitoring;	• Performs disease notification; • Performs active search for absentees; • Promotes the record of health information; • It has computerized systems; • Monitors the health indicators of the population involved.

Chart 2 – Cont.

Source: Research data, 2019.

Legend: HIV: Human Immunodeficiency Virus; Aids: Acquired Immunodeficiency Syndrome; STI: Sexually Transmitted Infection; CND: Compulsorily Notifiable Diseases; SRH: Sexual and Reproductive Health.

Although scarce, studies already done show that inadequate physical spaces, lack of supplies, lack of trained human resources, work overload, fragmentation of care, moral and religious precepts, lack of communication in the care network and precariousness of physical facilities and working conditions are issues that directly influence the supply and quality of promotion activities and clinical care of SRH care in the context of primary care[4,11,15–17]. These and other aspects, therefore, need to be considered in the context of public health and deepened in the scope of the construction of theoretical models, analysis, and evaluation of public policies.

It is also worth mentioning that all the precepts and actions recommended by government documents on SRH, described in the TM that we present in this article, are based on the proposals agreed in the world scenario in 1994, at the International Conference on Population and Development (ICPD). However, 25 years after the ICPD, the conservative restoration of the current Brazilian government, confronting the gender ideology and promoting a rights agenda in clear dissonance with international agreements are aspects that can impact political advances in the field of sexual and reproductive rights such as, for example, education on sexuality and abortion rights[2].

These gaps demonstrate the urgency in facing some challenges for the effectuation and implementation of care to SRH in the SUS, especially with regard to the fragmentation of health care and the invisibility of the topic of sexual and reproductive rights in political agendas.

The construction of the SRH theoretical-conceptual model with a focus on primary care, with the explanation of its underlying rationality, is potentially useful for the development of indicators for the evaluation and monitoring of SRH care in the SUS, as it makes it possible to understand the complexity and the specifications of this care, something that raises reflections on the context, content and attributes necessary to achieve the expected effects[3,9].

The subjectivity, inherent and always potentially present, in the understanding and description of attention to SRH established by personal reading and analysis of the normative framework used, linked to the non-discussion and/or validation of this construction with other researchers and professionals involved in SRH, may have limited the study.

Despite the delimitation of the TM with a focus on attention to SRH in the PHC setting, the relevance of modeling initiatives that address this assistance at other levels of care should also be highlighted, since this resource is an important instrument for understanding the complexity of the intervention and can be used in several studies in the field of evaluation of health policies, programs and practices.

FINAL CONSIDERATIONS

The theoretical model presented in this study, as a visual scheme of the theory of SRH care in PHC, proposed based on government regulations in the Brazilian scenario, presents the promotion of SRH and clinical care as the main components of this care.

Although the model presented has not been subject to analysis and evaluation by specialists in the area, it is believed that this limitation does not prevent its dissemination, nor does it testify against its applicability, since it was constructed based on government documents that inform about the operationalization of SRH in primary care. Its dissemination can support and inspire the construction of new models on SRH, as well as stimulate dialogue about the complexity involved in the theory and practice of implementing these actions.

In addition to providing support for future evaluative research in the field of sexual and reproductive health care, the proposed theoretical model is relevant to bring students and nursing professionals working in PHC closer together, as it presents the theory of functioning (how it must be done) for the implementation of this care. Additionally, researchers and managers in the field of public health can make use of this perspective to systematize criteria, formulate indicators and identify aspects that influence the operation of SRH care in PHC.

The experience of building a theoretical model of SRH care directed to primary care, as part of an evaluative research, was a dynamic and challenging process. The few models already published in the literature at the national level and the wide range of the expected scope of SRH care actions, in terms of activities and target audience, justify this statement.

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