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ORIGINAL ARTICLE

# PARTICIPATION OF THE PREGNANT WOMAN´S PARTNER IN PRE-NATAL CONSULTATIONS: PREVALENCE AND ASSOCIATED FACTORS

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## ABSTRACT

Objective: to identify the prevalence and factors associated with the participation of the pregnant woman's partner in prenatal care.
Method: cross-sectional study conducted between March and July 2018 by interviewing 655 puerperal from a regional office in Northeastern Brazil. Associations were estimated using Chi-square and Prevalence Ratio.
Results: Among women with a partner who had prenatal care (85.6%; n= 561), the partner's participation was (44.2%; n=248), being higher among those who planned pregnancy (PR: 1.25; 95% CI: 1.07-2.10), desired to become pregnant (PR: 1.22; 95% CI: 1.01-1.98), initiated early follow-up (PR: 1.31; 95% CI: 1.01-2.46), and had six or more consultations (PR: 1.49; 95% CI: 1.32-1.81). There was lower participation among women with low education (PR: 0.72; 95% CI: 0.39-0.77) and who used public services (PR: 0.65; 95% CI: 0.24-0.85).
Conclusion: the low prevalence of the pregnant woman's companion participation in prenatal care highlights the need to further encourage their inclusion in this process.

**DESCRIPTORS:** Pregnancy; Prenatal Care; Paternity; Men's Health; Public Health.

## *PARTICIPACIÓN DEL COMPAÑERO DE LA EMBARAZADA EN LAS CONSULTAS PRENATALES: PREVALENCIA Y FACTORES ASOCIADOS*

***RESUMEN:***

*Objetivo: identificar la prevalencia y los factores asociados a la participación del acompañante de la gestante en el prenatal. Método: estudio transversal realizado entre marzo y julio de 2018 mediante una entrevista con 655 puérperas de un hospital regional del Nordeste de Brasil. Las asociaciones se estimaron mediante la Chi-cuadrado y la Razón de Prevalencia. Resultados: entre las mujeres con pareja que tuvieron control prenatal (85,6%; n= 561), la participación de la pareja fue (44,2%; n=248), siendo mayor entre las que planificaron el embarazo (PR: 1,25; IC 95%: 1,07-2,10), deseaban quedarse embarazadas (PR: 1,22; IC 95%: 1,01-1,98), iniciaron precozmente un seguimiento (PR: 1,31; IC 95%: 1,01-2,46) y tenían seis o más consultas (PR: 1,49; IC 95%: 1,32-1,81). La participación fue menor entre las mujeres con bajo nivel educativo (RP: 0,72; IC 95%: 0,39-0,77) y que utilizaron los servicios públicos (RP: 0,65; IC 95%: 0,24-0,85). Conclusión: la baja prevalencia de participación del acompañante de la gestante en el prenatal evidencia la necesidad de un mayor estímulo a su inclusión en este proceso.*

*DESCRIPTORES: Embarazo; Atención Prenatal; Paternidad; Salud del Hombre; Salud Pública.*

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## INTRODUCTION

Prenatal care aims at the development of a healthy pregnancy from the approach of biopsychosocial, diagnostic and therapeutic aspects and offering educational and preventive activities suitable for this process[1-2]. Historically, health actions aimed at the pregnancy-puerperal period were directed exclusively to the woman and the fetus/newborn, with a notable difference in the focus of health promotion to the mother-baby binomial and to men's health. There is also a cultural barrier motivated by stereotypes in the visitation of men to health services, especially in Primary Care[3-4].

In Brazil, the Ministry of Health published in 2016 a Guide to Partner Prenatal Care for Health Professionals, which establishes: 1° encouraging the participation of men in prenatal consultations and educational activities; 2° performing rapid tests and routine exams on the partner (blood typing and RH factor, HBsAg, treponemal and/or non-treponemal test for syphilis detection, anti-HIV and anti-HCV antibody research, hemogram, lipid profile, glucose dosage, hemoglobin electrophoresis, blood pressure measurement, weight check, and BMI calculation); 3rd update the vaccine card of the partner; 4th approaches to issues aimed at the male audience; and 5th guidance on the role of men in pregnancy, prepartum, childbirth, immediate postpartum and childcare[3].

However, although the participation of the pregnant woman's partner in prenatal consultations has been encouraged in recent years in the country, many men still do not understand the importance and/or purpose of participating in this process. Authors attribute this problem to health professionals in Primary Care when they ignore and/or disqualify the partner's participation in pregnancy. Many partners are not even invited to enter the room where the woman's care is provided[5-6].

It is noteworthy that the participation of men in prenatal care is a determining factor for the creation and strengthening of healthy emotional bonds, besides favoring the realization of prenatal care with better quality indicators[3]. The presence of a partner in prenatal care can contribute to a greater number of consultations performed[2], as well as influence the physical and psychological health of women and children, reduce anxiety, relieve pain, reduce the duration of labor, promote breastfeeding, and reduce the rates of domestic and/or obstetric violence[6-8].

Finally, it should be added that the National Policy for Integral Attention to Men's Health (PNAISH) also advocates the involvement of fathers in the pregnancy-puerperal cycle, seeking to consolidate the crucial shift from focusing on the mother-child binomial to the father-mother-child binomial[3,9-10]. Given the above, the aim of this study was to identify the prevalence and factors associated with the companion's participation of pregnant women in prenatal consultations.

## METHOD

This is a cross-sectional, descriptive, and inferential study, conducted between March and July 2018. A total of 655 puerperal women were evaluated by interview and viewing of the prenatal card during the immediate postpartum period. The place of performance was a usual risk maternity hospital located in Lagarto, Sergipe, Brazil. The institution has four private obstetric beds, six pre-delivery beds, and 31 beds for joint housing. It attends publicly and/or privately funded deliveries of women at usual risk from Lagarto and other cities in the south-central region of the state.

The eligible population for the study consisted of 1,250 women based on the annual

estimate of deliveries made available by the management of the institution. From that, a sample calculation was performed using the formula of Barbetta (2014), considering a confidence level of 97% and sampling error of 3%[11]. A safety margin of 10% was added to the calculated number, resulting in 655 puerperal women.

Participants were selected by simple random sampling from a daily inpatient listing, and all women who delivered a live fetus of any gestational weight or age were considered eligible. Women who did not speak and/or understand the Portuguese language and/or had severe mental disorders were not included.

For data collection, questionnaires were applied during interviews with puerperal women, respecting a minimum interval of six hours after delivery. The questionnaire addressed maternal sociodemographic questions, related to pregnancy and prenatal care of the woman and her partner.

It is noteworthy that associations were estimated between maternal sociodemographic variables (age group, race, housing area, education, and paid work), pregnancy-related (reproductive planning, feeling about the pregnancy, and perception of the time of pregnancy), and prenatal care (first trimester, number of consultations, follow-up by the same professional, and type of service) with the participation of the pregnant women's partner in these consultations.

Statistical analysis was performed in IBM® SPSS 20.0 Mac. The uni and bivariate techniques were used to obtain the distribution of absolute and relative/proportional frequency values. Associations were estimated using the Chi-square test between categorical variables, using the Prevalence Ratio as a measure of association and their respective 95% confidence intervals (95% CI). A 5% significance level was adopted in all cases.

This study is linked to the Projeto Nascer ("Project Born") in Lagarto, SE: Municipal Survey on Birth and Labor, approved by the Research Ethics Committee of the Federal University of Sergipe, under opinion number 2,553,774. The researchers followed the guidelines and regulatory standards recommended in Resolution No. 466/12 of the National Health Council on research involving human beings[12].

## RESULTS

Among the women with a partner at the time of the survey (85.6%; n=561), (99.8%; n= 560) reported attending prenatal visits. However, only (44.2%; n=248) of them had the partner's participation in these consultations, being (33.1%; n=82) with total participation/in all consultations and (66.9%; n=166) with partial participation/some consultations.

The analysis of associations between maternal sociodemographic characteristics and partner participation in prenatal care showed a lower prevalence among women with low education (PR: 0.72; 95% CI: 0.39-0.77) (Table 1).

Table 1 - Associations between maternal sociodemographic variables and partner participation in prenatal care (n=560). South-Central region of Sergipe, Brazil, 2018 (continues)

| Sociodemographic variables | Partner participation in prenatal care | | p-value | PR (CI 95%) |
|---|---|---|---|---|
| | Yes (%) (n=248) | No (%) (n=312) | | |
| Age Group | | | | |

| | | | | |
|---|---|---|---|---|
| ≤ 19 years old | 45,5 | 54,5 | 0,861 | 1,02 |
| ≥ 20 years old | 44,4 | 55,6 | | (0,65-1,64) |
| Race/Skin color | | | | |
| White/Yellow | 50 | 50 | 0,267 | 1,15 |
| Black/Black | 43,6 | 56,4 | | (0,82-2,04) |
| Housing zone | | | | |
| Rural | 41,6 | 58,4 | 0,169 | 0,88 |
| Urban | 47,4 | 52,6 | | (0,80-1,77) |
| Education | | | | |
| Illiterate/Fundamental | 36,7 | 63,3 | **0,001** | 0,72 |
| High School/Higher Education | 51,1 | 48,9 | | (0,39-0,77) |
| Has a paid job | | | | |
| Yes | 49,1 | 50,9 | 0,176 | 1,15 |
| No | 42,8 | 57,2 | | (0,89-1,86) |

Legend: PR= Prevalence Ratio, 95% CI= 95% Confidence Interval.

Planned pregnancy (PR: 1.25; 95% CI: 1.07-2.10) and maternal desire to become pregnant in that period of life (PR: 1.22; 95% CI: 1.01-1.98) were shown to be associated with partner participation in prenatal care (Table 2).

Table 2 - Associations between pregnancy-related variables and partner participation in prenatal care (n=560). South-Central region of Sergipe, Brazil, 2018

| **Variables related to pregnancy** | **Partner participation in prenatal care** | | **p-value** | **PR (CI 95%)** |
|---|---|---|---|---|
| | **Yes (%) (n= 248)** | **No (%) (n=312)** | | |
| Planned Pregnancy | | | | |
| Yes | 49,8 | 50,2 | **0,017** | 1,25 |
| No | 39,7 | 60,3 | | (1,07-2,10) |
| Feeling about the pregnancy | | | | |
| Satisfied | 46 | 54 | 0,288 | 1,12 |
| More or less/unsatisfied | 41,1 | 58,9 | | (0,84-1,76) |
| Perception of gestation time | | | | |
| I wanted to get pregnant now | 49,1 | 50,9 | **0,041** | 1,22 |
| I wanted to get pregnant later | 40,4 | 59,6 | | (1,01-1,98) |

Legend: PR= Prevalence Ratio, 95% CI= 95% Confidence Interval.

A higher prevalence of participation of the pregnant woman's partner in prenatal visits was also observed among women who started their follow-up early (PR: 1.31; 95% CI: 1.01-2.46) and who had six or more visits (PR: 1.49; 95% CI: 1.32-1.81), and lower among those who used the public service in this process (PR: 0.65; 95% CI: 0.24-0.85) (Table 3).

Table 3 - Associations between prenatal care characteristics and partner participation in these consultations (n=560). South-Central region of Sergipe, Brazil, 2018

| Prenatal care variables | Partner participation in prenatal care | | p-value | PR (CI 95%) |
|---|---|---|---|---|
| | Yes (%) (n=248) | No (%) (n=312) | | |
| Early start | | | | |
| Yes | 46,6 | 53,4 | **0,046** | 1,31 |
| No | 35,6 | 64,4 | | (1,01-2,46) |
| Number of consultations | | | | |
| 6 or more consultations | 47,7 | 52,3 | **0,004** | 1,49 |
| ≤ 5 consultations | 32 | 68 | | (1,32-1,81) |
| Follow-up by the same professional | | | | |
| Yes | 45,6 | 54,4 | 0,502 | 1,07 |
| No | 42,6 | 57,4 | | (0,79-1,59) |
| Kind of service that performed most of the consultations | | | | |
| Public | 41,5 | 58,5 | **<0,001** | 0,65 |
| Private | 64,1 | 35,9 | | (0,24-0,85) |

Legend: PR= Prevalence Ratio, 95% CI= 95% Confidence Interval.

## DISCUSSION

The benefits of prenatal care have been widely discussed in the scientific community, although addressed in perspectives exclusively focused on the mother-baby[13]. Thus, in one of the axes of PNAISH, the Partner Prenatal Strategy was developed, which aims to engage the involvement of men in prenatal care, delivery and postpartum[9]. This scenario justifies the production of scientific evidence that contributes to encourage the practice of prenatal care to the partner, with a view to family empowerment[3].

In the present study, it was evidenced that 44.2% of the women interviewed had their companion participate in prenatal consultations, with only 14.6% participating in all consultations. This result differs from the findings of a nationwide survey conducted by the Ministry of Health between 2017/2018 with 37,322 men, in which 72.2% of participants reported having accompanied their partners to prenatal consultationss[14]. Moreover, in an international context, a study conducted with 5,333 women in England showed that more than 80% of partners accompanied their wives' pregnancy, delivery, and puerperium[8].

In Sergipe, one of the main reasons reported by parents for not attending Basic Health Units (UBS) was the need to work (76%)[15], a result like that found in other studies[16-17]. It is noteworthy that the Law No. 13,257/2016 gives the worker the right to be absent

from work for up to two days to monitor consultations and complementary exams, without prejudice to wage[18].

However, even though they are protected by law, many workers are afraid of being absent from work for health reasons, a fact that, added to the low resolvability of the services and/or the long waiting time for care, makes it difficult for men to go to basic and/or specialized health care services in the country[6].

Moreover, when the companions are present, in many cases, activities that include them are not carried out, making the man not feel invited to prenatal care[5-6]. It is evident that most prenatalists are still focusing their orientations exclusively on the pregnant woman (69.1%), which also shows an invisibility of the father, even when he is present in the health service[5-6,15].

It is reinforced that the Ministry of Health recommends the offer of some preventive and diagnostic activities for pregnant women's companions during prenatal care. Among them, we mention the request for rapid tests, HIV, Syphilis and Hepatitis; counseling and routine tests, and updating the vaccine card[3], in addition to participation in educational activities to encourage parents to actively participate in the care of the child[19].

We also identified a characteristic profile of women and prenatal care that best favored the partner's involvement in pregnancy follow-up: women who desired or planned the pregnancy and/or started prenatal care early and/or had six or more consultations and/or women with higher education and/or used private services.

Authors present education as an important factor in the use of health services by less favored population layers[2]. When the couple's level of education is higher, there is a greater adherence by women to prenatal care, and the participation of men during the pregnancy cycle is usually more active[17].

In addition, another study found that paternal involvement is higher among self-declared white/yellow women[8]. This can also be explained by a possible institutional racism in health, since brown/black women have less access to quality services, gynecological and obstetric care[20].

The limitation of this study is related to obtaining data exclusively from the reports of the puerperal women interviewed, without obtaining data directly from the partners of the pregnant women during the prenatal visits.

## CONCLUSION

A low prevalence of participation of the pregnant woman's partner in prenatal consultations was evidenced, with an association of maternal sociodemographic variables and health care characteristics. The factors associated with greater participation of the pregnant woman's partner in prenatal care were high maternal education, use of private services, planned pregnancy, maternal desire to become pregnant, early initiation of prenatal care, and six or more consultations.

These findings reinforce the need for greater encouragement of the inclusion of men in this care process. It is recommended, especially to Nursing professionals, attention to the fact that pregnancy is also a man's affair, so that stimulating the participation of the father/partner throughout this process can be fundamental to the biopsychosocial well-being of the mother, the baby, and himself.

It reinforces the need to raise awareness and prepare health teams to receive and

welcome men in a comprehensive and appropriate way to this follow-up. The nurse plays a key role in this aspect, since he must guide and encourage pregnant women about the possibility and importance of the presence of the partner in prenatal care, not offering obstacles to their participation, but a qualified listening about the expectations of the couple in relation to fatherhood/maternity. Thus, the father will feel safe to offer the necessary support to the woman and the child, since he will understand the physiological/emotional changes pertinent to the pregnancy/puerperal cycle in which he is inserted.

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