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Possibilities and limits of Prenatal Care for Men in a city in Northeastern Brazil

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Abstract *Men's Prenatal Care is a strategy to expand and promote the health of these people. We evaluated how the Family Health teams (eSF) conduct this artifice as a care strategy for the male population in Recife-PE, Brazil. This evaluative, cross-sectional, qualitative study involved nurses, doctors, dentists, nursing technicians, and community health workers. We applied a semi -structured questionnaire, followed by six focus groups with the eSF with the largest number of respondents in the first stage to deepen the development of the strategy. The thematic content analysis proposed by Bardin was performed. The evaluation matrix developed identified the main strengths and difficulties in the strategy's structure, work process, and results. We observed that, while accepted as an excellent strategy, we identified a resistance that permeates from structural to cultural issues, hindering the proposal to expand access to actions and services to promote men's health, preserving the biomedical model. Care refers to the unfolding of care already provided to pregnant women but faces limiting obstacles for its sustainability.*

Key words *National Men's Health Policy, Prenatal Care, Primary Care, Comprehensiveness*

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Introduction

Despite the high morbimortality rates and incidence of chronic diseases, men rarely use health services, resulting in higher vulnerability to illness and complications, which has been the subject of discussion in studies, mainly within PHC[1-4].

Considering the comprehensive actions, the Partner's Prenatal Care Program (PNP) was presented as a strategy to expand the promotion of men's health care in 2015[5]. This care was implemented by the National Men's Health Comprehensive Care Policy (PNAISH), and the municipalities should coordinate, implement, monitor, and evaluate this policy in their territory, prioritizing PHC as a gateway[6].

Men's inclusion in the prenatal care routine allows them to promote and care for their health and strengthen bonds by including men in the mother-father-child trinomial[7]. However, even when encouraged by health workers, it is common for men to participate in the PNP limited to the economic and affective support of pregnant women, with attendance at the Family Health Units (USF) generally related to the prevention and treatment of Sexually Transmitted Infections (STIs)[8].

One of the main reasons men distanced their involvement in prenatal care is the USF's opening hours common to work activities. The PNP usually occurs ad hoc and is associated with other Ministry of Health programs due to the patriarchal and hegemonic male culture, thus involving economic, cultural, and family issues[8,9].

Data referring to the number of appointments in the SUS for PNP and pregnant women in Brazil revealed that the number of PNP visits (44,233) is still negligible compared to female prenatal care (29,158,779), evidencing the need for greater reflection and investment to increase adherence to the strategy[10].

We observe that there are still limits to male adherence to aspects involving health promotion in PHC, and its effectiveness seems to depend on a set of factors that involve gender issues, professional training, readjustment of the physical space, and, above all, the work process[11,12].

In Recife, the PNP named Men's Prenatal Care (PNH) was established in 2015 as one of the main gateways for men in health services through the Family Health Strategy (ESF)[13]. After seven years, we cannot identify any published evaluation with a critical reflection on its relevance in the care of men in the municipality.

In this setting, strengthening the strategy allows for building a comprehensive care path for promoting men's healthcare in the SUS. Thus, the study aimed to assess how the Family Health (eSF) teams conduct the PNH as a care strategy for the male population in Recife to improve professional practice.

Methods

This evaluative, cross-sectional, qualitative, descriptive, and exploratory study was conducted in Recife, the capital of Pernambuco, Brazil, the fourth urban concentration in the country, with an estimated population of 1,633,697 inhabitants[14]. It is divided into 94 neighborhoods, grouped into six Political-Administrative Regions and eight Health Districts. The research was carried out in two stages, the first of which invited all ESF workers from the seven Health Districts who agreed to run the survey.

In the first stage, from November/2021 to March/2022, data were collected with the application of a semi-structured questionnaire, disseminated in WhatsApp work groups and emails via Google Forms, including a simple random sample of workers from the teams that accepted to participate in the research, considering having at least one-year seniority in the current team. Fourteen doctors, 50 nurses, 13 dentists, five nursing technicians, and 20 Community Health Workers (ACS) participated in the collection.

An instrument was used to collect information, including questions related to sociodemographic and work data and female and partner prenatal care performed at the worker's USF.

Based on the answers obtained in the questionnaire, the eSFs with the highest number of respondents in the first stage were invited to participate in Focus Groups (FG) to deepen questions related to the PNH's potentialities and difficulties. We selected the FG technique to obtain descriptive data from the interaction between its participants in a debate on a subject common to all[15].

We held six FGs, from March to April/2022, representing five Health Districts of the municipality. The discussion occurred in person at the USF of the eSFs, with a pre-scheduled date and time. Each FG involved about ten workers, including doctors, nurses, dentists, nursing technicians, and ACS.

The FG script was guided by questions involving knowledge and practice of the strategy; comprehensive, recommended actions between Rede Cegonha and the PNP; expanded access to

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health services through parenthood, considering the COVID-19 pandemic; and possibilities and limitations.

The discussions were guided by the previously prepared roadmap and followed by the researcher, with an average time of 40 minutes to 1 hour, after the presentations, clarifications about the FG's purpose and conduction, until saturation. At the end of each meeting, a discussion summary was presented with collective validation of the statements, where participants could adjust any idea presented. Field notes were also prepared after the FGs were carried out, contributing to data analysis.

At each session, the moderator and observer met to assess the FGs' operation, share perceptions, and identify possible needs for adjustments to qualify the conduct of the next meetings. The collected material was audio-recorded, and all content was transcribed using fictitious names that refer only to the professional category.

Data from the Municipal Health Plan 2018-2022[16] were also used in the study to obtain information regarding the population coverage of the municipality by the ESF.

Qualitative data were retrieved through the FG transcripts, from which the thematic content analysis proposed by Bardin[17] was performed through pre-analysis, material exploration, and treatment of results, inference, and interpretation.

The structure-process-outcome model for the Evaluation of Health Policies proposed by Donabedian[18] was adopted as a theoretical approach to perceive the factors relevant to the quality of care offered by the PNH, as described in Chart 1.

The Research Ethics Committee of the Medical Sciences Center of the Federal University of Paraíba approved the study under Opinion No. 5.012.792/2021 and followed the precepts of Resolution No. 466/2012 of the CNS/MS, which governs the ethical principles of human research[19].

Results

Most of the 102 research participants were women (87.2%), with a mean age of 46 years, ranging from 30 to 60 years, married or in common-law marriage (77.5%), white or brown (84.3%), with complete post-graduation (76.5%), mainly at the specialization level (65.7%), showing a satisfactory qualification.

Most respondents worked in Health District V, 97.1% of which are statutory, with a mean of 13 years seniority in the ESF in Recife, where 33.3% worked 11 to 15 years at the current USF, thus ensuring bonding between the team and the community.

When questioned about the practice of the PNH strategy, approximately 60% claim to be active. Next, the results will be presented per the proposed dimensions.

Structure dimension

In the structure dimension of Chart 2, against *human resources*, there is a convergence of the statement presented with the data that 60.8% of the study participants do not have a complete team, with most of the shortage referring to ACS professionals (47.1%). In 2017, the population coverage estimated by PHC in the municipality was 73%, 58% by eSF, and 14.5% by ACS teams[14], which the workers point out as a difficulty for including men in prenatal care.

For the 61 study participants who claimed to be active in the PNH strategy, most of the use of *material resources* occurs in the availability of immunobiologicals (47.5%) and routine tests (59%). Most participants (88.5%) reported difficulty providing educational material for professionals and the community, hindering the dissemination and provision of care training.

Process dimension

In the process dimension, regarding the *management*, *planning*, *and development* of including men in the prenatal care routine, we observe in the statements shown in Chart 2 the variation between professionals who always request the presence of men in the prenatal care follow-up and those who claim not to remember the invitation often, pointing to a strategy that is not yet included in the flow of prenatal care at the USF. It is common to search for partners only in case of test alterations that reveal STIs in pregnant women, in specific actions, or at the initiative of the community, suggesting that the worker's profile and the encouragement involved in the process are important.

It is common to speak of the first contact associated with the presence of men in female prenatal care, and from then on, appointments or necessary procedures are scheduled. The report of male visits needing to be more continuous during the prenatal care, limiting their presence to submit to procedures only, is frequent. Also, some partners do not return to perform them,

Chart 1. Men Prenatal Care practice analysis matrix, ESF - Recife-PE, 2022.

Donabedian Triad	Analysis categories	Thematic axes
Structure	Human resources	• ESF population coverage
	Material resources	• Availability of medicines • Availability of immunobiologicals • Availability to take tests • Availability for procedure registration in the e-SUS AB • Availability for educational activities
Process	Management, Planning, and Development	• Including men in the Prenatal Care routine • Municipal management support • Using clinical and technical protocols • Developing practices during the COVID-19 pandemic
Outcome	Access	• Accessibility • Availability of men Prenatal Care strategy
	Therapeutic relationship	• Relationship, longitudinality, and comprehensive care
	Resoluteness	• Adherence to health activities

Source: Authors (2022).

and others send test results via pregnant women to be evaluated by medical professionals, perpetuating the idea of professional-centered care.

Workers claim that society strangely receives prenatal care aimed at those who do not have the biological function to be pregnant, highlighting the lack of information about the strategy. Only one professional mentioned holding a situation room discussion with the community, bringing men's health data:

I think that the person who thought of it, who planned this strategy, was very unfortunate in choosing that name! This is a huge obstacle! How do you do that? We live in a sexist society! It is strange for us. Imagine in the community? (Dentist E).

Adherence and commitment of the entire eSF are relevant for developing actions among the study participants. Regarding municipal management support, they brought up the importance of shared responsibility between workers and management concerning greater dissemination and training for care. The statement in Chart 2 suggests some distance from management to strengthen the strategy over time.

Regarding clinical and technical protocols, more than half of the participants claimed to know the PNP Guide for health professionals, although 64% reported never having participated in any PNAISH training. On the other hand, 69% of the participants do not know the ACS Guide. The statements in the FGs reiterate those of professionals who did not receive training to work in the PNH strategy. Those who reported having participated in some training believe it was conducted during the strategy's implementation period in the municipality.

When answering about the PNP Guide recommended practices and instructions that present a technical protocol for health professionals, its instructions have been clearly observed, as per Table 1. However, 50% of respondents said they did not know it.

When asked about any PNH-related practices being modified due to the COVID-19 pandemic, just over half of the workers answered "no" (53%), as highlighted in the statement in Chart 2, including in this percentage of those no longer active in the strategy. Among those who stated that there had been changes, the restriction to companions in the USF was the main change and most influenced following the program (19.4%), followed equally by the lower number of appointments and tests and group activities (6.12%), sharing the opinion of some FG workers that the strategy was neglected at the time.

Outcome dimension

In the outcome dimension, regarding men's *access* to the USF for care, a considerable number of respondents (69%) stated that men participate, albeit infrequently, in some activities related to their partners' prenatal care (72.5%). Most refer to difficulty related to work activities (52.6%) and 31% to cultural issues, hampering accessibility

Chart 2. Structure, Work Process, and Impact of the Men's Prenatal Care Strategy, ESF - Recife-PE, 2022.

Structure Dimension		
Analysis categories	**Thematic axes**	**Registration Units**
Human resources	ESF population coverage	"The difficulty that we often find here is human resources, right? Sometimes we don't have a doctor, a professional who left for health reasons and doesn't have a replacement, right?" (Dentist A)
Material resources	Availability of medicines and immunobiologicals, availability to take tests, procedure registration in the e-SUS AB, and educational activities	"The Men's Health coordination sent [Partner's Prenatal Guide for Health Professionals and Men's Health Guide for ACS]...at the moment it didn't have much!" (Nurse B)
Process Dimension		
Management, Planning, and Development	Including men in the Prenatal Care routine	"...in prenatal care with the woman in my area, I always advise to have the husband come to the appointment if he can." (ACS A1) "...I myself completely forget about the PNH! I end up focusing more on the woman! I even forget to pass this information on to her." (ACS C1) "And the times they show up, it's because the pregnant woman has syphilis, so she needs to come for treatment too. When she shows up, right? In this case, it is because she has some disease, so you need to treat both the pregnant woman and the partner." (Doctor F)
	Municipal management support	"Men's Health needs to be strengthened! I think this is paramount! It is the most important thing, […] besides publicizing more, guiding professionals, being a strengthened strategy. Because many times we don't even remember her." (Nurse E)
	Using clinical and technical protocols	"The first thing is to get to know this PNH booklet, because it was really never presented to me! The first time I am hearing about this booklet is through you!" (Doctor B)
	Developing practices during the COVID-19 pandemic	"Even though they were at home [referring to COVID-19], if they were, I don't know either… but the same prenatal care continued, and just women come most of the time. Men adhere very little to it!" (Nurse D) "...With COVID, all these things took a back seat." (Nurse B)
Outcome Dimension		
Access	Accessibility	"…it's very rare for the husband to accompany her, because sometimes it's also work... work hours! This also hinders PNH adherence." (ACS C3) "Arriving at the health unit without being sick is a waste of time for him! It's cultural!" (Nurse F)
	Availability of the men's prenatal care strategy	"I think this is something that needed to be seen like this... on a national scale! I think it gains more visibility and they will really look for it. And companies will make it easy!" (Dentist D)
Therapeutic relationship	Relationship, longitudinality, and comprehensive care	"...You have the experience of bonding with the team, right? Coming to childcare with the child when the mother is working, and he was on a break from work and came. So, there's that bond with the team. It was the most positive experience I had... him continuing with the bond through the PNP!" (Nurse F)
Resoluteness	Adherence to health activities	"And if you ask him to come to the PNH... then it really is no use. He says, 'Am I pregnant?' [laughs]" (Nurse E) "…But it's interesting, and they like it when they come. So much so that they don't come just once, right? They always come with them! Those who come are interested, share, and women say that they are fine at home and that they support, you know? It's pretty cool!" (Nurse D)

Source: Authors (2022).

Table 1. Distribution of recommended practices in the PNP guide conducted in the USF where the ESF responding professionals work - Recife-PE. 2022.

Best practices in the PNP guide	Total (N=102)		
	Variables	n	%
Request for the partner to be present at the USF	Yes	82	80.4
	No	20	19.6
Offering and carrying out rapid tests	Yes	81	79.4
	No	21	20.6
Offering and performing routine tests	Yes	92	90.2
	No	10	9.8
Vaccination card update	Yes	96	94.1
	No	06	5.9
Encouraging the partner's participation in educational activities. appointments. and test	Yes	90	88.2
	No	12	11.8
Guiding and encouraging partner's participation during childbirth	Yes	93	91.1
	No	09	8.9
Informing and encouraging the right to paternity leave	Yes	93	91.1
	No	09	8.9

Source: Authors (2022).

due to society's lack of understanding of men's gestational role, as observed in the FG's statements in Chart 2.

As for labor issues, possibilities to facilitate male access to USF activities were also mentioned in the FG, as described below:

A while ago, there was a story of evening care for men. Moreover, that greatly improved their arrival. It brought them closer to the team. The demand was great when there was night service, and they were happy! (Doctor D).

Regarding the strategy's availability, teams refer to receiving men who attend the USF with their partners. However, sometimes they are only perceived by some professionals and society, emphasizing the relevance of increasing the policy's visibility.

For most of the workers who participated in the study, the strategy established in the city in 2015 needs to be disseminated more among professionals and society to have the necessary availability and scope. Some suggestions are made to improve the PNP's implementation and strengthening, including the need for it to be a federal government campaign, building a more active program, with the involvement of management and workers in performing actions to include men in this care.

In the *therapeutic relationship* category, we observed in the statements that some men have approached the USF from the female prenatal care, establishing a bond with the eSF, providing care continuity, and collaborating with the improved quality in family relationships.

Regarding the PNH strategy's *resoluteness*, we observed difficulty in this audience's adherence to their healthcare, either by the strangeness of the "prenatal care" name and dissociated relevance of men's involvement in gestation, often resulting from machismo with strong societal influence or even the difficulties of professionals.

Some reports pointed out that the eSF focuses more on pregnant women, sidelining the partner's involvement. This situation shows the difficulty of effecting the policy, highlighted in Chart 2, that the results are excellent when men are involved. Besides supporting the child's arrival in the family, men are also cared for and included in the promotion, prevention, diagnosis, and treatment activities.

When asked about what would facilitate the development of PNH practices, about 22% of research participants stated that the greatest influence on male adherence is related to the understanding of care by partners and society. There is also a tension between knowing how to guide the community about unknown care, which depends on variables related to the family's financial support and cultural issues beyond male will.

The evaluation matrix developed by the study allowed identifying the main potentials and difficulties cited by workers about the strategy (Chart 3).

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Discussion

Study findings show that PNH in Recife finds resistance that permeates structural and cultural issues. However, workers accept it as an excellent strategy, hampering the facilitated access to comprehensive male healthcare actions and services. It is also a poorly consolidated strategy in other places in Brazil, where professionals have some knowledge about the PNP and recognize their benefits but need help to implement it[20].

The most pointed out difficulties in conducting the strategy by the eSF were lack of informative material (instructions and for dissemination); discontinuous work process, harming care sustainability; and lack of intra and intersectoral actions to expand the relevance of the proposed care in society. This makes the PNH not allow a greater relationship between the PNAISH with that of women, where prenatal care actions do not naturally dialogue with actions to promote male health, distorting the idea of comprehensiveness[21].

Another hindering factor to expanding care-related actions is the insufficient ESF coverage in the municipality. The adequacy of the number of complete eSFs per inhabitant refers to an indispensable structural component. It is strongly linked to the best performance of the expanded clinic and shared responsibility of workers by clients[22].

Municipal management is responsible for making educational or care material resources available, which was a highlighted difficulty, which implies the non-consolidated strategy because the weak infrastructure and inputs compromise the development and quality of actions in PHC and lead to the dissatisfaction of professionals and limit the potential expanded actions from the perspective of reorganizing practices and the health care model[23].

Problems observed in the structural dimension of the PNP strategy are related to recent changes in federal PHC policies, involving the dismantling of PHC and NASF teams, with priorities focused on walk-in demand, coverage and financing linked to registration, focus on individual care and consequent weakened community territorial perspective[24]. These PHC counter-reform policies[25] directly impact PNH assessment since care focused on universality from the community perspective and territorial care becomes no longer a priority of the eSFs, and we observe the strengthening of the biomedical clinic based on financing indicators (which do not include Men's Health), far from health promotion.

The failures identified in the structure compromise the work process when there are not enough qualified workers for their good development. Thus, the study shows that most men are included in the program when STIs are found or imminent, reproducing the lenses based on the disease from a cure-oriented perspective, focused on the health of the mother and the child[26].

Structural machismo was a much-approached aspect in the FG as a limiting factor for male prenatal care inclusion. We raise the issue here that the couple's thinking about gestation may not be intrinsic in the professionals' understanding, reflecting this construction to the community[27]. Thus, the need for engaged continuing education to qualify professional practices and work organization focused on men's comprehensive care[28] is revealed.

To this end, workers must deeply know the strategy and thus incorporate the proposal into their list of actions. We should mention here the need to expand the lenses to male needs from vocational training[27]. The entire team should be encouraged, knowledgeable, and practitioner of the technical protocol established in the PNP guide and engaged in the process so that the presence of men is not reduced to being a listener of care provided to women[29].

The best fluidity of strategy development associated with the whole team's commitment to building comprehensive care is directly related to team climate and job satisfaction[30]. There will

Chart 3. Main strengths and difficulties of the PNH, ESF strategy - Recife-PE, 2022.

Dimension	Potentialities	Difficulties
Structure	Use of materials and inputs common to other health programs	Insufficient ESF coverage, shortage of instructional material
Process	Use of PNP Guide recommendations, team adherence	Unawareness of the strategy, lack of sustainability
Outcome	Creating bonds, comprehensive care	Lack of intra- and intersectoral actions

Source: Authors (2022).

be greater contentment at work, with the physical environment and hierarchical relationships, and the better the climate regarding the team objectives and guidance for the tasks. Hence the importance of mobilizing management, which follows and disseminates monitoring indicators as a useful, feasible, and user-friendly technical instrument, enabling understanding of the policy's ideological markers and, thus, evaluating its advance or setback[31].

Regarding coping with the COVID-19 pandemic, PHC has been organized and guided by four axes: health surveillance in the territories; care to COVID-19 clients; social support to vulnerable groups; and PHC continuing actions. Workers had to reinvent themselves and resort to technological devices for remote care, to reduce people's circulation in the USFs[32]. Even during the pandemic, the municipality maintained female prenatal care in person. However, it recommended a restriction regarding the companion in the USFs[33], making male adherence to PNH actions even harder.

Considering the intention of the PNP being a strategy for expanding men's healthcare promotion[5], the characteristics of the practice observed in this study reveal limited reach against the expected by care. The outcome dimension presents a low resoluteness strategy, especially due to the difficult access due to work-related reasons, where the USF's opening hours clashed with male labor working hours. Fear of being absent from work due to the vulnerability of job loss and financial instability is a common finding in other countries[34,35].

In order to expand access, Recife has been implementing a model called "Upinha-24horas" since 2013. This model associates PHC's activities with an extended time for appointments and emergencies (night shift) in some USFs and can be used as a device for care. However, no increase in partners' demand for this reason has been reported at the USF with this feature. In the daytime shift, the hours that exceed traditional USF are insufficient to receive people who work on a conventional shift due to the city's mobility problems, and care longitudinality is committed to having a team with on-duty staff who are not necessarily from their eSF[36] on night shifts and weekends.

Cultural issues, where the strong male provider only seeks the health service due to illness, are identified as barriers to accessing services. This masculinity model contributes to the need for more interest in self-care and caring for others[37]. The phrase with its intonation, "*Wow, so I am pregnant now?*" represents well this context of lack of motivation for caring and shows total ignorance of the strategy. Men's involvement with the prenatal care period would change this perspective[38]. Brazil still has cultural and institutional barriers that prevent men from realizing their rights, while most partners are aware and present in prenatal care[39] in more developed countries.

Therefore, joint work between municipal/national management, health workers, and organized society is necessary to break paradigms that hamper men's adherence to actions and services to promote and care for their health, making the strategy more available to society. An example is the legislation that allows the absence of only two days from work without loss of salary to accompany medical appointments and tests during the partner's pregnancy[40].

In this study, we observed situations in the ESF that corroborate Moreira *et al.*[41], such as the professional relationship being a promoter or health care element, and bring sexual and reproductive health and the promotion of responsible parenthood as lines for health actions, even if limited to a checkup or some intervention to break STI transmission. Cross-sectional policies and comprehensive actions should strengthen effective practices for health promotion and not merely fulfill the policy agenda without consolidation.

The study's limitations are difficulty in evaluating structure and some processes using the proposed method due to the need to collect more data; not being allowed to interview workers in one of the eight DS in the municipality; part of the collection was restricted to remote mode due to the COVID-19 pandemic; and the study was conducted only with workers from the ESF minimum team, considering that it is important to represent municipal management and service clients.

Despite the limitations mentioned, we recognized that, although the Prenatal Men's Care Strategy unfolds from the care already provided to pregnant women, it faces limiting mishaps for its sustainability, mainly due to the great difficulty in implementing intra and intersectoral actions that lead to equity and autonomy.

According to the study participants, it is necessary to escalate actions aimed at continuing health education and review routines and flows to achieve comprehensive care and a more resolute strategy in the teams' daily life. To this end, the PHC dismantling policies should be

reviewed, and PHC's character aimed at health promotion and prevention, built under a shared responsibility between the community and a multidisciplinary team to conduct the expanded clinic, should be strengthened.

This work's contributions include providing greater visibility for a powerful strategy that provides care and health promotion for part of the male population that does not arrive at the USF because of illness and pointing out possible ways to improve the strategy.

Collaborations

RRRB Melo, ASLG Leal, and GB Soares worked on the conception and methodological design of the study. RRRB Melo worked on data collection. RRRB Melo and GB Soares on the drafting and critical review of the article. All authors approved the final version to be published.

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