ADOLESCENT PREGNANT CARE IN THE SUS NETWORK - THE WELCOMING OF THE PARTNER IN PRE-NATAL

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ABSTRACT

Objective: to verify the reception and participation of partners of pregnant adolescents in the prenatal SUS network. Method: this is a descriptive, qualitative study with 79 pregnant adolescents assisted at health units of the Unified Health System (SUS). The selection criterion was to be between 10 and 19 years old. The semi-structured interview was used to produce the data, then processed in three stages: reading, identification of themes, an organization of reports in “drawers” and analyzed from hermeneutic-dialectic principles. The data were presented in a figure and transliteration of responses comments. Results: there was the desire of the partner to follow the prenatal appointments, but he is unaware of his right to participate. There are personal and institutional limits for the participation of the partners. Conclusion: governmental sexual and reproductive health programs are fragile in the inclusion and incentive to partner participation in prenatal care. Descriptors: Pre-Natal Care; Sexual and Reproductive Rights; Public Policy; Paternity; Adolescents.

RESUMO

Objetivo: verificar o acolhimento e a participação de parceiros de gestantes adolescentes no pré-natal da rede SUS. Método: estudo descritivo, de abordagem qualitativa, com 79 adolescentes grávidas, atendidas em unidades de saúde do Sistema Único de Saúde (SUS). O critério de seleção foi ter faixa etária entre os 10 aos 19 anos. Utilizou-se a entrevista semi-estruturada para a produção dos dados, os quais foram processados em três etapas: leitura, identificação dos temas, organização dos relatos em “gavetas” e analisados a partir dos princípios hermenêutico-dialéticos. Os dados foram apresentados em uma figura e transliteração de comentários das respostas. Resultados: houve o desejo do parceiro de acompanhar as consultas do pré-natal, mas este desconhece seu direito de participar. Há limites pessoais e institucionais para efetivar a participação dos parceiros. Conclusão: os programas de saúde sexual e reprodutiva governamentais são frágeis em relação à inclusão e incentivo à participação do parceiro no pré-natal. Descriptores: Assistência Pré-Natal; Direitos Sexuais e Reproductivos; Políticas Públicas; Paternidade; Adolescência.

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INTRODUCTION

The guidelines from the Cairo International Conference on Population and Development in 1994 and the Fourth World Conference on Women in Beijing emphasize the need for men to be included in Sexual Reproductive Health (SRH) programs.

They argue that gender inequality in society gives men greater power in negotiating and deciding on the form and frequency of sexual relationships. Therefore, they play a key role in the couple's sexuality and reproduction.

Despite the international guidelines cited, there is little evidence of a change in public sexual and reproductive health policies in Brazil. Most of them are directed almost exclusively to the female population. For example, the prenatal program hardly addresses the presence of the partner. The National Policy on Integral Care to Human Health (PNSH), in the chapter on SRH, deals superficially with the issue, stating that it is necessary to make men aware of the duty and the right to participate in reproductive planning, without proposing any strategy to achieve this goal. Also, the PNSH is aimed at the adult man, from 25 to 59 years old, leaving aside the adolescents and young people, responsible for a significant portion of the country's birth rates.

It is important to emphasize the need for the recognition of adolescents as subjects of sexual and reproductive rights for the construction of policies and programs subsidizing individuals in the transition to adulthood since, at this stage, the experience of the first sexual practices usually occurs.

There are few studies about the inclusion of the partner in the prenatal care of the adolescent pregnant, being this of the same age group or adult. This lack of material on the subject seems to be a reality also in other countries.

The few studies on the subject in the different nations show that the partner's participation in prenatal care is variable. Those in which the frequency of the partner is higher are related to the complete pregnancy-puerperal cycle and not only to the gestational period. A randomized study of 5,333 women in England showed that there was more than 80% participation in the gestation, delivery, and puerperium.

This study aimed to verify the reception and participation of partners of pregnant adolescents in prenatal SUS network in the city of Rio de Janeiro, according to the perception of their adolescents, understanding this issue and contributing with subsidies for the public policies of SRH in adolescence.

OBJECTIVE

- To verify the reception and participation of partners of adolescent pregnant women in the prenatal SUS network.

METHOD

This is a descriptive study with a qualitative approach, through semi-structured interviews with adolescents using prenatal SUS network in the city of Rio de Janeiro, Brazil. It is a cut of the research “Assistance to the sexual and reproductive health of adolescents in health units of the S.U.S. in the city of Rio de Janeiro,” in which all health units assisting adolescents in SRH (except one unit that did not authorize the research) were visited and their coordinators interviewed to identify the types of services offered, for a total of 148 establishments.

Data were collected between January and December 2012. The instrument used was a road map containing demographic, sexual and reproductive data, and open-ended questions about the partner's participation and the quality of the consultation performed. The inclusion criterion was between 10 and 19 years old. The investigation process had nine interviewers who were previously trained and evaluated before the start of the data collection period.

The recruited adolescents and their guardians, when under 18 years old, were informed about the content of the research and, in agreement, both signed free and informed consent terms. The adolescent was interviewed in an environment with privacy. The team visited all the health units of the SUS of the municipality that had prenatal service to compose the sample. The choice of the interviewees was random among the adolescent pregnant women enrolled in the prenatal care unit of the visited health unit, regardless of gestational age or marital status, while awaiting consultation or after the waiting room. In this way, we believe to contemplate a greater diversity of information. We closed the data collection when we evaluated saturation of information. The interviews were recorded and transcribed in full.

We proceeded to analyze the textual data from the transcripts in three stages: in the first stage, each member of the multidisciplinary team, composed of a...
physician, nurse, psychologist and social worker, read and reread the interviews, to familiarize their contents and view of the whole. Then, the identification of the main themes and the search for answers to the questions were made. In a second moment, we organized the reports in "drawers" according to the topic discussed, and we gather to analyze them in hermeneutic-dialectical principles, that is, in the search for understanding of the text and the contradictions in it.

We aim to validate the data from multiple perspectives, in the interdisciplinary dialogue and in the reading of publications of the Ministry of Health, considered references for Public Health Programs, Adolescent Health and studies of different authors on the subject with focus on sexual and reproductive health, foster care, gender, and the inclusion of the adolescent partner in health services. The results were distributed in thematic categories and for better didactic understanding were presented in Figure 1 and subsidized by the transliteration of respondents' answers.

In compliance with the ethical norms contained in Resolution 196/90 of the National Health Council. It was approved by the Research Ethics Committees of the Municipal Health Secretariat of Rio de Janeiro and the State University of Rio de Janeiro, under Protocol No. 89/10.

**RESULTS AND DISCUSSION**

The city of Rio de Janeiro (RJ), Brazil has a network of health services composed of 229 units at the time of data collection, distributed in all administrative regions. Of this total, 148 establishments assist adolescents, and they were visited. Prenatal care (PC) is performed in 141 of them. In 8.5% of the units, there is specific PC for the adolescent. The service is performed by doctors in 96.5% of the services, and 89.4% of the Health Units studied have a nurse.

The interviews of the pregnant adolescents attended in prenatal care were performed in 79 units, that is, in more than half of them, covering all the administrative regions of the municipality. Most of the interviewees (70) reported having a fixed partner, corroborating with the findings of another previous study, in which more than half of adolescents with recurrent pregnancies had a relationship time of years or more.\(^6\)

Only the interviews with the pregnant women who reported having a fixed partner were assigned to the object of analysis to meet the objective of the study. The remaining (9) were excluded.

The age of pregnant women ranged from 13 to 19 years old, with an average of 17 years old. The percentage of adolescents in stable union/married was 57.1%, and 42.8% were single. Most of them were in the first gestation (81.4%). As for education, only 25.7% were still studying, and most of them had not completed elementary school.

The analysis of the pregnant women’s narratives had three interrelated classificatory categories: the lack of knowledge about the possibility and the right of the partner’s participation in prenatal care, institutional limits: absence of “space” for the inclusion of the partner in the service of health; and barriers faced by those who express willingness to participate, according to Figure 1.

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**Figure 1.** Representative scheme of interrelated factors interfering with the participation of partners in the prenatal care of pregnant adolescents. Rio de Janeiro (RJ), Brazil, 2012.

- **The lack of knowledge about the possibility and right of the partner’s participation in prenatal care**

  The Unified Health System (SUS) has a set of actions and services aimed at ensuring access to integral care in an equitable manner, complying with the constitutional article on the defense of the right to health. Actions focused on the humanization of care have often been highlighted in health care. In 2005, Chapter VII was added to Law N°
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8,080/1990, dealing with “The Subsystem for Follow-up during Labor, Delivery and Immediate Postpartum.”

From this, the health services of the SUS were obliged to allow an accompanying person to be present during the labor, delivery and immediate postpartum period, favoring the participation of the partner in the follow-up of childbirth and puerperium. Since 2005, the Special Department for Policies for Women has been implementing its National Plan for Policies for Women, proposing as one of the priorities, to stimulate assistance in Family Planning for men and women, both adults and adolescents to integral health care.

More recently, other actions focused on encouraging men’s health already address the partner’s prenatal care, emphasizing paternity as a pathway for men’s health. These actions may stimulate the presence of the father/partner in the pregnancy process considering the biopsychosocial well-being of the mother, the baby and himself considering that pregnancy is also a man’s subject.

However, although there are already public and normative policies that advocate the inclusion of the partner, they do not seem to be effective, according to our study, in the narratives of the pregnant women interviewed. There is a certain lack of knowledge of the right of participation of their partners in prenatal consultations:

> I did not even know that [the father could participate]. I was upset because it’s his first child. If I had known I could, I was going to talk to him. He gave me strength to go, but if he could go too, he would surely. (Penna)

The reports of pregnant women allow us to infer that information about the importance and the right of parents to follow the pregnancy-puerperal cycle of their partner is not being passed to SUS patients. On the other hand, ignorance of the right to participate fits the hegemonic gender model in which men do not play any role in the gestation of their child and traditionally do not seek health care unless they are ill. Thus, the low presence of men may be related to the lack of information and to the very restriction of service to that right.

It is recommended that prenatal care should promote a strong parental alliance. They argue that father involvement reduces the risk of mental disorders such as depression, and their involvement makes them better understand what is going on with the mother and the child. Prenatal education should favor the development of ties between parents and babies and improve the ability to understand children's communication.

There is evidence that the partners are interested in participating in the actions related to gestation and delivery and postpartum. Despite this, the presence of the partners in the pregnancy-puerperal cycle is still not understood as essential and effective. The partner’s cooperation in pregnancy contributes to the early initiation of prenatal care for the health of the pregnant woman and her health, such as for sexually transmitted diseases.

A study on emotional indicators, with 430 adolescent mothers aged 14 to 16 years old in Porto Alegre, showed that the prevalence of intense psychological distress was 32.6%, being associated with non-acceptance of gestation by the partner and lack of support of the family against the gestation among other factors.

An integrative review shows that most publications on the topic of paternity in adolescence were in Brazil. However, in other countries, they already focus on the relevance of paternity in the pregnancy-puerperal cycle and other early stages of child development. Research carried out in Portugal states that there was a positive influence on involvement in pregnancy or the umbilical cord cut with the affective attachment between the father and the baby.

Research developed in the UK to assess parent-infant interactions and their consequences has shown that distant father-child relationships increase five times the risk of early behavioral problems in children (before one year old).

Although the studies underscore the magnitude of this issue and public policies indicate this need, most of our interlocutors have shown that there is no room for their partners, since they said that they were not invited and that if they had been, they would have appeared. Even so, some came to the service, on their initiative, which reveals the interest and desire to be included, as the lines below reveal it:

> He was not invited, but he came because he also wants to know how was it [the pregnancy]. He has come once. He came as a meddlesome wanted to come [laughs]. He thought it was strange [laughs]. He always comes and waits for me outside, but this time he came in, the doctor called to get in. (Vintém)

...
For me he was [invited]. He likes to come when I invite him […] It was from me. (Boanerges)
He has come with me here several times, but the doctor never called to talk […]. It would come in and sit quietly inside. (Dutra)
He did not come because the man is not invited. (Cruz)

♦ Personal and institutional limits: absence of “space” for the inclusion of the partner in the health service

Health spaces, particularly those of primary care, are privileged feminine. The professionals are mostly women, and there are a significant number of women and children in the waiting rooms, as well as posters and materials aimed at this population. Men do not feel that they are part of these spaces. In general, when they need care they look for emergencies. Prenatal clinics allow being even more focused on women.

According to the reports of the interviewees, some men show their interest in participating in prenatal care and attend the service, but only in the role of companions and waiting outside the waiting room. Those who enter the office feel a bit odd, for even those who are invited to enter are not included as a participant in the consultation with their partner as if it did not concern him.

Men cannot go in, do you understand? They stay outside. […] they lecture [pregnant woman's educational group], but I never saw a father coming in with us in the room. All my two prenatal care they never came. (Barreto)

We verified that for the health service, the presence of the father is not different from any other companion. Its relevance is not recognized or minimized because it is male in a female environment. In general, he is treated as a mere observer, without having an active voice, which makes him feel uncomfortable.

The authors’ experience in the observation of couples in labor demonstrates a time of great suffering and tension, especially for the father who is unaware of the context of pregnancy and labor and feels totally helpless to help his partner, but even so, they want to be present. A qualitative study developed in Sweden showed that parents felt welcomed and supported when they had the opportunity to ask questions, interacting with health professionals and being free to be involved in childbirth while those without support experienced feelings of impotence and fear.16

Based on the data found in this study and the studies cited, we infer that paternal involvement during the pregnancy-puerperal cycle may contribute to a better outcome in the perinatal context since the woman feels safer and supported and he also knows what is going on.

Study on the participation of pregnant women and partners in the prenatal education group considers that the active communication of the father in the educational activities of prenatal care should be encouraged because this measure produces benefits.17 These data can be a basis for teams and health services to become aware of the need to increase the inclusion of parents in the pregnancy-puerperal cycle of their partners.

♦ Barriers faced by those who express willingness to participate

There are several factors interfering with the partner’s follow-up of the puerperal pregnancy cycle stages. There is evidence that the low presence of the father in prenatal care services hinders to construct gender equity and guarantee sexual and reproductive rights in adolescence.18 However, some situations such as those related to labor legislation and the devaluation of the companions are also involved. The data from our study demonstrated that in some cases the adolescents considered the companion’s presence in the consultations to be inadequate. Thus, even when, in the rare cases that the health professional invites the partner, the pregnant women end up neglecting the father’s participation in the development of pregnancy. Let's look at their narratives:

The doctor said: I want to see the baby’s dad next time. He did not come because I did not tell him [laughs] no, I do not want him to come. (Zica)
[…] Once he was going to come, but I said no, he’s right there, there's nothing more here, he was going to participate in that, seeing me measuring my belly? (Silvia)

The adolescent’s speech shows that, although some health professionals already indicate the possibility of the companion’s participation in the prenatal care, it is noticed that even when the incentive is taken, the adolescent does not consider the partner’s presence. This fact may be related to the low importance given to the health services to the partner’s stay in the follow-up of the puerperal pregnancy cycle.
Another significant barrier contributing to the difficulties of the effective presence of the father is the labor situation. However, in our society a woman is inserted in the labor market, the man still represents the provider of the family and her, the reproducer, gender roles expected for both. The legislation reminds us of this understanding when comparing, for example, the time difference between maternity leave and paternity leave.

On the other hand, most parents cannot go to the health service to accompany their partner because they are not allowed to leave work, for this reason, even acknowledging that there have been changes in the traditional conceptions of male and female roles, while chief-provider and wife-mother respectively. So, he was invited, but he does not have much time because he works. (Barbosa)

When I did it in private he would because the doctor would give the certificate, but at the health center, they do not give me much of the certificate, so he does not come, because he cannot miss the work to come. (Gurgel)

[...] I always come with my mother or my grandmother. He already came with me too, but he came and then left, that he had to work. (Alba)

The narratives show that, although society, in general, seems to share the current gender culture that has women as the only person in the reproductive cycle, the partners of our interlocutors, in their perception, have shown that they want to participate, even with little incentive and availability. No adolescents reported her partner’s disinterest in getting involved in her son's gestational process.

It is important to highlight that a large part of the male population is not present in the process of gestation and birth of their children because factors such as the overload of work and the resulting fatigue and especially the vision and behavior of the employers that do not value the inclusion of men in prenatal care. The health service does not effectively promote the companion’s presence in prenatal care. Parental cooperation could contribute to the health of women and children, as well as be a possibility for reducing and controlling STDs.

However, this is a practice little adhered to SUS, full of the disinterested discourse of the partner. The lower access to health services and family relationships, as well as the vulnerability scenario to which the adolescents are exposed, can be pointed as a relevant fact for investments in the Public Policies aimed at this age group.

**CONCLUSION**

Despite these advances and efforts by the SUS to include men in the health service and specifically in prenatal care, this demand cannot always be met. Understanding that gestation is a phenomenon that requires actions that go beyond the labor, it is interesting to highlight the importance of the participation of men throughout the sexual and reproductive cycle of the couple, from family planning to postpartum.

The health care model in Brazil is still influenced by the cultural and historical context of public health, focusing only on the health of the mother and the child, based on a vertical and fragmented care, disregarding integrality in health. The inclusion of the man/partner and the family in the context of health, especially in sexual and reproductive health, is a recent issue in the scientific literature. It is already inserted in the health programs but little implemented in fact in the services. This new perspective of health care extended to the man/father/partner and the family can contribute to an equitable distribution of activities, greater responsibility in decisions between the couple in the raising of children and also helps to build a fairer society in the perspective of equality of gender.

It is emphasized that this study is limited to the perception of the adolescent woman about the participation of her partner in the prenatal, not contemplating the reflections of the subject. However, we believe that the issues raised provide important inputs that can contribute to public policies on sexual and reproductive health.

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