

PARTNER'S PRENATAL CARE IN PRIMARY HEALTH CARE: EXPERIENCES AND CHALLENGES

Sueli Antunes Aquino Cardoso Gonçalves¹, Camila Drielly Cruz Costa², Brunna Gonçalves de Castro Soares Lopes², Andreia Correia², Lucas Faustino de Souza², Greicy Kelly Duarte Lopes Pires², Fabiana Dourado Souza³, Joyce Micaelle Alves Caldeira⁴, Junilia Oliveira Santana⁵, Bryan Rocha de Oliveira⁶, Émile Lilian Pereira de Oliveira⁶, Sâmeque Veloso Rocha⁴, Joice Fernanda Costa Quadros Pimenta⁶, Márcia Beatriz Lima Pimenta⁷, Maila Dayane Capuchinho de Oliveira⁸, Gregório Ribeiro de Andrade Neto⁶

¹FIPMOC University Center. ²University Center of Northern Minas Gerais. ³City of João Pinheiro College. ⁴Montes Claros State University. ⁵Faculdade de Tecnologia e Ciências. ⁶Faculty of Health and Humanities Ibituruna. ⁷University Center of the Federal District. ⁸Southwest Bahia State University.

Abstract: This study aimed to evaluate the experiences of professionals in providing prenatal care to partners in primary health care. An integrative literature review was conducted, and articles retrieved from the secondary databases Virtual Health Library, Latin American and Caribbean Literature in Health Sciences, Scientific Electronic Library Online, and Online System for Medical Literature Search and Analysis were analyzed using the descriptors *descriptores hombre; salud del hombre y prenatal*. The main reported experiences are marked by a biomedical and utilitarian approach. Partner involvement occurs largely to ensure the treatment of Sexually Transmitted Infections and to safeguard the health of the mother-baby pair, neglecting the man's own health needs and his preparation for active fatherhood. In addition, professionals point out that male resistance, fueled by concepts of hegemonic masculinity, combined with the incompatibility between the operating hours of the health units and the partners' work schedules, constitutes the main barrier to participation. The identified limitations also reveal a deficit in professional training.

Keywords: primary health care; men's health; prenatal care.

INTRODUCTION

The gestational period is marked by several transformations in a woman's life. During this period, it is time to seek specialized help for prenatal care and childbirth preparation, to seek information and undergo periodic examinations for her health and that of the baby. In addition, it is essential that the woman has the support of her family and her partner (Balica; Aguiar, 2019).

In our culture and in our daily practices (including professional ones), we frequently reproduce the idea that caregiving is a women's responsibility. This cultural pattern often prevents us from recognizing the diversity of experiences of men and women, the plurality of family arrangements, and ways of caring (Medrado; Lyra, 2002).

However, in recent decades, the importance and need for greater male participation in reproductive planning, pregnancy, childbirth, and the postpartum period, as well as in the sexual division of domestic labor and childcare, have been consolidated in the field of reproductive health and rights, promoting debates, actions, and, above all, a change of perspective on the part of public policy makers, managers, health workers, researchers, and activists (Ariha; Unbehaum; Medrado, 1998).

In the daily routine of health services, there are recurring reports of men who do not get involved with their partners' pregnancies and others who do not develop any bond with their sons or daughters, even more so when they are not in an affective relationship with the mother. However, there is a great effort to change this situation (BRASIL, 2025).

Traditionally, the health strategies and actions of the Unified Health System (SUS) focused on reproductive rights, including pregnancy monitoring and childbirth, have centered almost exclusively on women and babies. However, there is strong evidence of positive results from the engagement of

partners throughout this process. For example, babies who have a paternal figure and care in the family dynamic develop better emotional security and have fewer health problems in childhood (BRASIL, 2025).

From the moment a man attends Primary Health Care, it becomes an opportune moment to take care of his health, undergo rapid tests, consult with professionals, and check if he has any disease, because the treatment of syphilis, for example, if detected, the pregnant woman is only completely cured when the partner is also treated. In cases where the partner is not treated, the contamination persists and can have consequences for the baby (Balica; Aguiar, 2019). In this sense, the present study sought to evaluate the experiences of professionals in providing prenatal care to partners in primary health care.

METHODS

An integrative literature review was conducted. This approach was adopted because it allows for the combination of data from investigative and theoretical research, which can thus be directed towards conceptualizations, recording gaps in research areas, theoretical review, and methodological analysis of studies on a specific subject, allowing for literature analysis (Ercole; Melo; Alcoforado, 2014).

In this sense, six interdependent and interrelated phases were considered: elaboration of the guiding question, search or sampling in the literature, data collection, critical analysis of the included studies, discussion of the results, and presentation of the integrative review. The guiding question was defined as: What are the experiences of professionals in carrying out prenatal care for the partner in primary health care? (Souza; Silva; Carvalho, 2010).

The collection of studies was carried out through electronic searches in the following databases available in the Virtual Health Library (VHL), Latin American and Caribbean Literature in Health Sciences (LILACS), the Scientific Electronic Library Online (SciELO) and Medical Literature

Analysis (MEDLINE).

As inclusion criteria, full articles available electronically, in Portuguese, English or Spanish, and that presented the proposed theme in the title, abstract or descriptors were included. Regarding the ineligibility criteria, letters to the editor, editorials, duplicate articles and those that did not unequivocally address the subject matter of the study were considered.

The survey of studies was conducted during the months of May to July 2026. As research strategies, the Health Sciences Descriptors (DeCS) were used, retrieved through the website: <https://decs.bvsalud.org/>, which were men; men's health and prenatal care. To refine the search and better select the data for analysis, the boolean operator AND was used to combine the selected descriptors.

For data collection, an instrument validated by Ursi (2005) for integrative reviews was developed, covering the following categories of analysis: identification code, publication title, author and author's background, source, year of publication, type of study, region where the research was conducted, and the database in which the article was published. After selecting the articles, the information to be extracted from the studies was defined. To facilitate the collection of information, a database created in Microsoft Office Excel 2010 was used, composed of the following variables: article title, year of publication, study design, and main outcomes. The data obtained were grouped into a table and thematic approaches and interpreted according to specific literature.

RESULTS

Fourteen studies that met the eligibility criteria were included in this review; the titles, methods, and main outcomes of the analyzed studies are described in the table below (Table 1).

Table 1. Studies included in the review and the characteristics evaluated.

	Article Title, Study Objective, Main Results	Article Title, Study Objective, Main Results	Article Title, Study Objective, Main Results
1	Partner prenatal care in primary health care: nurses' perceptions	To analyze the experiences of nurses regarding the inclusion of men in prenatal consultations.	Professionals acknowledge the importance, but report that the clinics' hours are the main obstacle to male participation.
2	Strategies used by nurses to involve men in prenatal care.	Describe the tactics used by the teams to attract the partner to the health unit.	Using the "Partner's Prenatal Card" and requesting routine checkups for the man are the most effective strategies.
3	Challenges for the family health team in implementing prenatal care for men.	To identify the structural and cultural difficulties in providing prenatal care for the partner.	It points to male apprehension about the "feminized" environment of the primary health care unit and the staff's lack of preparedness to handle non-obstetric demands.
4	Doctors' and nurses' perceptions of paternal involvement in prenatal care.	To investigate the professionals' views on the father's role during pregnancy.	The father is still viewed by the team more as a "support" for the pregnant woman than as an individual who also needs comprehensive care.
5	Prenatal care for men: perspectives from healthcare professionals.	To analyze the discourse of professionals regarding men's health in the context of reproduction.	There is an excessive focus on detecting STIs (especially syphilis), neglecting general emotional and preventative aspects of men's health.
6	Men's health care during prenatal care: challenges and advantages.	To map the positive and negative aspects of partner assistance from the team's perspective.	The ease of access arises when there is a prior bond with the family; the difficulty lies in the low health literacy of many partners.
7	Professional training and the inclusion of the partner in the pregnancy cycle.	To verify if the academic training prepares the professional for providing care to men in primary health care.	It revealed a gap in undergraduate education, where prenatal care is taught from an exclusively maternal-infant perspective.
8	Partner's prenatal care: institutional barriers and the professional's perspective.	To assess how institutional norms influence prenatal care practices for men.	The bureaucracy involved in issuing medical certificates and the lack of scheduling flexibility are barriers that frustrate professionals.
9	The role of nurses in preventing vertical transmission of syphilis via prenatal care from partners.	To discuss the nurse's experience in the simultaneous treatment of the couple.	Treating the partner is the biggest challenge in preventing reinfection of the pregnant woman, requiring constant active case finding.
10	Feelings of healthcare professionals when attending to men during prenatal care.	To explore the professional's subjectivity during the shared consultation with the couple.	Reports of professional satisfaction at seeing the strengthening of family ties, but also of technical insecurity.

11	Nursing consultations for men during prenatal care: practices and knowledge.	Describe the step-by-step process of a partner-focused consultation.	It was observed that the practice is often limited to checking vaccinations and laboratory tests, with little educational dialogue.
12	Male adherence to prenatal care: a perspective from the family health strategy.	To understand why, in the team's view, some men join and others do not.	Resistance is associated with concepts of hegemonic masculinity (men don't get sick) and fear of needles/exams.
13	Health education for parents during prenatal care: an experience report from professionals.	Describe the use of parent support groups as a tool for inclusion.	Parenting groups increase men's confidence in caring for their babies and reduce paternal anxiety.
14	Partner inclusion in the primary health care unit: a team perspective.	Evaluate how reception and triage handle the arrival of men for prenatal care.	Failures in the initial reception often drive men away even before they arrive for their appointment with the professional.

Source: study data.

DISCUSSION

This study evaluated the experiences of professionals in providing prenatal care to partners in primary health care. In this sense, the inclusion of the paternal figure in the pregnancy-puerperal cycle represents a strategic advance in the qualification of maternal and child care. The experience of health professionals is marked by the perception that prenatal care for the partner is a powerful tool for promoting male self-care and strengthening family bonds. However, although the theoretical relevance is recognized, daily practice is frequently hampered by a historically feminized care structure that alienates men from the clinical environment of primary care (BRASIL, 2016).

The implementation of partner prenatal care in Primary Health Care (PHC) is a complex process, and the experiences of physicians and nurses are hampered by multiple causal barriers. Although paternal involvement is recognized as strategic for strengthening family bonds, daily practice is frequently hindered by a historically feminized healthcare structure. In this scenario, the environment of Basic Health Units is still perceived by professionals as a hostile or alienating space for the male presence, making it difficult to provide support beyond the clinical examination (Cavalcante

et al., 2021).

One of the most prevalent barriers reported by physicians and nurses refers to programmatic and organizational vulnerability; the rigidity of the health units' business hours directly conflicts with the partners' work schedules, which is cited by professionals as the main reason for absenteeism. The lack of flexible scheduling systems and the overload of programmatic demands prevent teams from dedicating the necessary time to a comprehensive approach to men during prenatal consultations (Santos et al., 2020).

Sociocultural and gender barriers are also determining factors in the experiences of these professionals. Thus, the view that caregiving is a female responsibility still permeates the teams' imagination, resulting in a less incisive active search. Doctors and nurses face the challenge of deconstructing "hegemonic masculinity," which associates going to the health service with a sign of fragility, demanding communication strategies that the traditional biomedical model often does not provide (Jacometi et al., 2020).

The subjectivity of professionals directly influences the effectiveness of this policy; many health workers reproduce gender stereotypes that position men only as providers or passive companions, neglecting their condition as subjects who require specific care. In this sense, professional experience is permeated by a feeling of technical unpreparedness, since academic training, for the most part, does not address men's health in a cross-cutting manner in prenatal actions (Oliveira et al., 2022).

From an operational standpoint, the rigidity of the operating hours of Primary Health Care Units (PHCUs) emerges as a recurring logistical barrier in the professionals' accounts, making it difficult to reconcile the partner's work schedule with scheduled appointments. Concomitantly, the scarcity of specific protocols for partner care generates a disorganization of the care flow, resulting in fragmented and ineffective care (Pereira et al., 2019).

Regarding the clinical approach, qualified reception is the main differentiating factor in the experience of professionals who are successful in male adherence. However, an excessive focus on pathologization and the request for laboratory tests, to the detriment of dialogue and health education,

can discourage men from remaining in the service. Thus, partner integration should be seen as an opportunity to screen for chronic and infectious diseases, giving a new dimension to the practice of nursing and medicine in primary health care (Ribeiro; Silva; Lira, 2019).

Interpersonal relationships also shape these experiences; the health professional acts as a mediator of symbolic conflicts, needing to balance attention to the pregnant woman with the active inclusion of the partner without undermining female protagonism. The successful experience is linked to the team's ability to transform the primary health care unit into a "friendly space" for men, breaking down the cultural barrier that the health service is a place of fragility (Cortes et al., 2023).

Furthermore, the scarcity of diagnostic and therapeutic resources is highlighted as a practical obstacle, since, in many primary health care realities, the difficulty of quick access to screening tests for the partner (such as rapid tests and serologies) generates a fragmentation of care, frustrating the professional's expectation of providing timely and effective care (Silva et al., 2024).

In the field of technical-assistance competence, the literature shows a gap in training; doctors and nurses frequently report insecurity or lack of preparedness to handle specific demands of men's health that arise during prenatal care, such as sexual dysfunctions or urological issues. This technical limitation reinforces the maintenance of care focused exclusively on women, in which the partner is relegated to the role of passive companion (Seabra et al., 2023).

It is worth noting that the effectiveness of this policy in primary health care depends on continuing education processes that sensitize workers to the deconstruction of hegemonic masculinity; evaluating these professional experiences is, ultimately, diagnosing the degree of porosity of the health system to new family configurations (Dias et al., 2021).

CONCLUSION

The analysis of healthcare professionals' experiences in conducting prenatal care for their partners allowed us to conclude that, although male inclusion is recognized as a powerful strategy

for promoting health and strengthening family bonds, its implementation in Primary Health Care remains fragmented and challenging. The results demonstrate that professional practice is still strongly anchored in a maternal-infant care model, which hinders the visualization of men as subjects who also need comprehensive care.

The limitations identified also reveal a deficit in professional training. The absence of clear protocols and the lack of training for welcoming the male public generate insecurity in the teams, who often do not know how to integrate the partner into the obstetric consultation environment, traditionally perceived as feminine. The consolidation of partner prenatal care requires a restructuring of care management in PHC; it is imperative that institutions promote the flexibility of access and invest in Continuing Education strategies, training professionals for qualified listening and welcoming that deconstructs gender biases.

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