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# Experiences of men accompanying puerperal women hospitalized in the intensive care unit due to hypertensive syndrome

Vivências de homens acompanhantes de puérperas internadas na unidade de terapia intensiva por síndrome hipertensiva

Experiencias de hombres que acompañan a puérperas internadas en unidades de cuidados intensivos por síndrome hipertensivo

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**Abstract:** **Objective:** to analyze the experiences of men accompanying puerperal women hospitalized in the intensive care unit due to gestational hypertensive syndrome. **Method:** a descriptive an exploratory study with a qualitative approach, conducted in a public maternal-child hospital of Petrolina, Pernambuco. Eight men accompanying their hospitalized partners during the puerperium were interviewed. The data were submitted to thematic content analysis. **Results:** the participants experienced difficulties communicating with the health professionals and did not understand the health conditions and the risks of complications. Concern with delivery and the fluctuations in blood pressure permeated the care provided by the men. **Conclusion:** hospitalization modified family pace, the aid of a support network being unavoidable to share the difficulties and tasks required during this period. The professionals, especially the obstetric nurses, must encourage the partner's bonding and devise educational strategies for their active participation during the gestational-puerperal period.

**Descriptors:** Hypertension, Pregnancy-Induced; Pre-eclampsia; Eclampsia; Obstetric nursing; Paternity

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**Resumo: Objetivo:** analisar as vivências dos homens acompanhantes de puérperas internadas na unidade de terapia intensiva por síndrome hipertensiva gestacional. **Método:** estudo exploratório descritivo, de abordagem qualitativa, realizado em um hospital materno-infantil público de Petrolina, Pernambuco. Foram entrevistados oito homens que acompanhavam no puerpério sua companheira internada. Os dados foram submetidos à análise temática de conteúdo. **Resultados:** os participantes experienciaram dificuldades de comunicação com os profissionais da saúde e não compreendiam as condições de saúde e os riscos de complicações. A preocupação com o parto e as oscilações da pressão arterial permeavam o cuidado prestado pelos homens. **Conclusão:** a hospitalização modificou o ritmo familiar, sendo inevitável o auxílio de uma rede de apoio para compartilhar as dificuldades e tarefas que são demandadas durante esse momento. Os profissionais, principalmente enfermeiros obstetras, devem incentivar a vinculação do parceiro e elaborar estratégias educacionais para sua participação ativa durante o período gravídico-puerperal.
**Descritores:** Hipertensão Induzida pela Gravidez; Pré-eclâmpsia; Eclâmpsia; Enfermagem Obstétrica; Paternidade

**Resumen: Objetivo:** analizar las experiencias de los hombres que acompañan a mujeres puérperas internadas en unidades de cuidados intensivos por síndrome hipertensivo gestacional. **Método:** estudio exploratorio y descriptivo, con enfoque cualitativo, realizado en un hospital materno-infantil público de Petrolina, Pernambuco. Se entrevistó a un total de ocho hombres que acompañaban a sus parejas internadas durante el puerperio. Los datos fueron sometidos a análisis temático de contenido. **Resultados:** los participantes tuvieron dificultades de comunicación con los profesionales de la salud y no comprendieron el estado de salud y los riesgos de complicaciones. La preocupación por el parto y las fluctuaciones en los valores de presión arterial se hizo presente en la atención prestada por los hombres. **Conclusión:** la internación modificó el ritmo familiar, siendo inevitable la asistencia de una red de apoyo para compartir las dificultades y tareas que son necesarias durante este período. Los profesionales, principalmente los del área de Enfermería Obstétrica, deben incentivar la vinculación de la pareja de la mujer embarazada y diseñar estrategias educativas para su participación activa durante el período de embarazo-puerperio.
**Descriptores:** Hipertensión Inducida en el Embarazo; Preeclampsia; Eclampsia; Enfermería Obstétrica; Paternidad

## Introduction

The parenting experience underwent by women and men during the course of pregnancy until the birth of the child generates different feelings due to a unique psychic/psychological construction, conscious and unconscious, to welcome the baby. Faced with all the physiological changes that occurred during pregnancy, the couple needs to adapt to this new moment of emotional instability and often face an affective ambivalence that permeates feelings such as fears, doubts and anguishes.[1]

Therefore, pregnancy is a physiological phenomenon with changes starting from the first week until the end of pregnancy and, in most cases, with no dystocia. However, some pregnant women can develop complications in this period and the pre-existence of some disease or health problem can promote an unfavorable follow-up, generating risks and/or maternal and fetal sequelae.

These imbalance conditions need more attention and monitoring, and are then called high-risk pregnancies.[2]

Among the situations that lead to classifying a high-risk pregnancy are the Hypertensive Syndromes in Pregnancy (HSP), which are responsible for approximately 14% of the maternal deaths in the world and 22% in Latin America, being second in the ranking of causes of maternal deaths. It is noteworthy that 10% of all pregnancies in the world evolve with some multi-systemic hypertensive disorder, being classified into pre-eclampsia, eclampsia, chronic arterial hypertension (due to any cause), chronic hypertension with superimposed pre-eclampsia and gestational hypertension.[1-3]

Between 1996 and 2018, hypertensive syndromes caused 8,186 deaths, representing the largest cause of maternal deaths in Brazil, standing out along with the other direct obstetric causes: hemorrhage (5,160 lives lost), puerperal infection (2,624 deaths) and abortion (1,896 deaths).[4] They are the leading cause of maternal mortality in the country, as well as the greatest responsible for the high rate of perinatal and neonatal losses with sequelae, sometimes due to situations such as prematurity and intrauterine growth restriction, in addition to other complications such as premature placental detachment.[1-2]

In this perspective, the worsening of the HPS, especially the maternal repercussions of pre-eclampsia, predispose women to an emotional overload that can cause anxiety, dependence, depression and fear, aggravated by the inevitable maternal hospitalization, rest and subsequent interruption of pregnancy. These events modify the entire natural sequence of birth and change the pace of the entire family network. In view of this, the humanization of assistance by the health professional, in particular the obstetric nurse, must prioritize the individuality of this pregnant woman so that her family is well oriented and inserted in this health-disease process, collaborating for horizontal and responsible care.[5]

In order to minimize this problem and favor the insertion of the family in this path to birth,

based on the recommendations of the World Health Organization (WHO) and of the Humanization Program for Prenatal Care and Birth, Federal Law No. 11,108/2005, it is determined that the health services are obliged to allow the parturient the right to the presence of a companion, indicated by her, during labor, birth and immediate postpartum. Linked to this, the recommendation is given as regards humanized welcoming by the health professional who will provide assistance to the patient and her companion, which can be the child's father, the current partner, the mother or another person of her choice. Encouraging this presence, in addition to providing better care for women, favors the bond between partner and baby, reduces fear and tension and favors breastfeeding, among other benefits.[6]

It is known that the existing non-traditional family configurations, paternity and the concept of family go beyond the biological aspects and consanguinity as their conformation depends on the interactions, experiences, affinities and feelings established between spouses, parents, children, type of union and family size. Thus, this bonding between the child and the paternal figure can occur regardless of whether or not he is the biological father, of gender and/or of some type of kinship.[7] In this regard, it is observed that, in the last decades, men have gradually shown greater participation, interaction and involvement in the life and in the caring for their families, thus occupying a different role regarding paternity.[8]

In this situation, when the partner presents a diagnosis that reveals some health risk, her partner also experiences moments of anguish and fear. However, most of the times, the spouse represses his emotions as there is no room to resolve his doubts and insecurities within the care network aimed at the pregnant woman, especially regarding HPS. It is necessary to have sensitized health professionals to turn their attention to the partners and contemplate, through support, welcoming and education in health, their possible doubts and anxieties, thus guaranteeing their reproductive right.[5]

In this scenario, the role of the nurse stands out, especially the obstetrician, who must provide the couple with moments of an educational and assistance nature, welcoming both

throughout prenatal care, birth, postpartum and care for the newborn through effective communication, making them the protagonists of the gestational process.[5] Therefore, it is expected that reflections on the partner in the context of high-risk pregnancies can contribute to raising awareness of new humanized practices of the obstetric nurse's performance regarding the men, welcoming them, enabling their recognition as important actors in this care process aimed at the mother-father-son triad.

Starting from the assumption that a pregnant woman affected by the worsening of some hypertensive syndrome can impose numerous worries, concerns and new responsibilities, especially for her partner, it becomes pertinent to answer the following research question: What are the experiences of men accompanying puerperal women hospitalized in the intensive care unit due to gestational hypertensive syndrome? In view of this, this research defines as its objective to analyze the experiences of men accompanying puerperal women hospitalized in the intensive care unit due to gestational hypertensive syndrome.

## Method

This is a descriptive and exploratory study with a qualitative approach, developed in the Obstetric Intensive Care Unit (ICU) of a public maternal-child hospital in the municipality of Petrolina, state of Pernambuco, which is a reference for high-risk pregnancies and deliveries. This ICU has ten beds, with one for isolation, and had a mean of 110 new admissions per month. This institution provides services to women who are users of the Unified Health System due to spontaneous demand and/or through the Interstate Bed Regulation Center (*Central de Regulação Interestadual de Leitos*, CRIL) that regulates the beds of the Interstate Health Care Network of Vale do Médio São Francisco (*Rede PEBA*). This Network makes up the Interstate Macro-region of Vale Médio do São Francisco, encompassing 53 municipalities and an approximate population of 1.8 million inhabitants.[9]

The study participants were eight men who were accompanying the newborns and their partners, during hospitalization in the ICU. All the women had a diagnostic hypothesis of hypertensive syndromes during pregnancy. There were no refusals regarding collaboration.

To facilitate selection, the inclusion criteria were established: a) being male; b) having an affective bond with the hospitalized woman, regardless of whether or not he is the biological father; c) being a companion to the newborn, whose mother was hospitalized in the ICU; and d) visiting the Obstetric ICU during the hospitalization of his partner. Cases in which the men were under 18 years old were excluded, as well as those who were merely visiting the newborns.

This research consisted in a non-probabilistic sample of the intentional type, since it addressed a specific segment of the population previously chosen by the researcher. The number of participants resulted from closure due to exhaustion since eight eligible individuals were included and available to collaborate during the collection period.[10]

The data were obtained by means of semi-structured interviews conducted between November 2018 and January 2019, with the aid of an audio recorder, after a previous conversation with the study collaborators. The participants were invited to participate in the research immediately after an initial approach on the topic and the interviews were conducted at that same moment by the leading researcher in a private room provided by the hospital's Nursing coordination. For this purpose, an instrument was used to guide the collection of the empirical material, which favored the participant to expose his experiences during the hospitalization of his partner. This instrument asked for sociodemographic data for identification and diagnostic hypothesis of the female partner, and contained the following questions: Did any health professional inform you about your partner's situation? Can you tell me which professional passed on the information about your partner's health status? Do you know why your partner is hospitalized in the ICU of this hospital? Explain. How is it for you to take care of your partner and the child (practicalities and difficulties)? How do you feel about all this?

The empirical material obtained from the interviews was treated by means of Thematic Content Analysis, which was developed in three operational phases. The first was the pre-analysis that was subdivided into the following stages: floating reading of the material transcribed, constitution of the *corpus*, and formulation and reformulation of hypotheses and objectives. In the second phase, the data obtained were explored for the subsequent final stage: treatment of the results obtained and interpretation. In this last phase, contents relevant to the study object were apprehended, apparently hidden in the speeches.[11]

The interviews were conducted after approval of the Committee of Ethics in Research in Human Beings of the Prof. Fernando Figueira Comprehensive Medical Institute (CEP-IMIP) on October 24th, 2018, under opinion/protocol No. 2,979,373. The research was conducted according to the required ethical standards (Resolutions 466/2012 - 510/2016 – 580/2018, of the Ministry of Health) and after all the participants had signed the Free and Informed Consent Form. In order to ensure the men's anonymity, they were identified in the research by using the letter H ("*Homem*" in Portuguese), followed by the number referring to the order in which the interviews were conducted.

## Results

In relation to the characterization of the participants involved in the study, five were aged between 26 and 35 years old, one was between 18 and 25 years old, and two were over 35 years old. Regarding the schooling level, two of the interviewees had completed high school, four had not completed elementary school and two considered themselves illiterate. None of the participants was a graduate or was attending any higher education course. In addition, in terms of skin color, three participants declared themselves as brown-skinned, two as white-skinned and three as black-skinned. The majority (six) had a family income of 01 to 02 minimum wages, and two participants reported incomes below 01 minimum wage. Three respondents were married, two were single, and three lived in stable unions. All reported being the newborns' biological fathers.

Four categories emerged from the analysis of the interviews, namely: “Lack of information about their partner's health status”; “Care provided by the companions and their coping in the face of having their partners hospitalized”; “Care measures with the newborn in view of the gender relationships”; and “Men's coping during the puerperal woman's hospitalization process”.

**Lack of information about their partner's health status**

In the analysis of the reports, it was noticed that, due to difficulties in communication between health professionals and family members, the interviewees did not understand the real health conditions of their partners who were experiencing a high-risk pregnancy. In the testimonies, it is noticed that some men received superficial information only from the puerperal woman herself, making it difficult for them to understand the situation and its risks.

> *No, none. I only know what my wife said.* (H02)
> *She explained when she was already here in the ICU, the rest, she [partner] was the one telling me. Because they let me in when she was hospitalized. But the only thing I knew was what she told me. That her blood pressure was high, that she was going to take some medication to normalize it and try to have a normal delivery.* (H06)
> *No. So, it was one of the things that I though like [pause] everything was very confidential. Me as her companion, her husband. I know that I couldn’t have access to the place where she was. But, some information, I think it would be relevant. I was in the chair in front* [of the surgical block] *from four p.m. until six and something. I was seated there for more than two hours without any information. Then a person came to take her to the ICU and I stayed with the child. When I asked her about my wife, I said her name and she nodded and passed by me. She didn't give any information.* (H05)

Corroborating this same communication difficulty, when asked if they had been informed about the health situation of their partners, other accompanying men reported that they received superficial or little detailed information from the health professionals who provided assistance. It was noticed by the reports that the partner arrived at the service accompanying his wife; however, with the development of assistance and communication failures, he was not present at the moment

of birth.

> *No. I came with her on the stretcher, here to the delivery room, but it was cesarean because there was no dilation. Then I came back at around nine p.m. and the baby had already been born.* [...] *I saw her getting out the stretcher and they just told me she was being taken to the ICU to have a medication. But they didn't mention the reason.* (H01)
> *No. Only now I knew she would go to the ICU because her blood pressure was high. Up to now, just that.* (H04)

It is observed that the men did not show to clearly understand what had been, in fact, the follow-up given after the partner was admitted to the service. This lack of information can generate feelings of anxiety, stress, insecurity or fear that some complication occurs with the baby or the mother during this distancing.

**Care provided by the companions and their coping in the face of having their partners hospitalized**

When asked about how their opinion regarding the care provided to their partners, the men showed concern about the type of birth, about birth before the probable date, and fear due to the fluctuations in blood pressure. The reports reflect that the perception of care identified by the partners was limited to the feelings or afflictions they were experiencing. Other companions reported carrying out actions aimed at the direct care of the puerperal woman and, when exemplified, they only asked for help during positioning/movement on the bed.

> *The biggest concern was that I already came worried from there* [the hometown] *because of the child's heartbeats and her blood pressure too.* [...] *There should be more aid to help the person accompanying her. To not keep thinking about something. Maybe everything would be calm there, but I'm not going to guess or imagine.* (H05)
> *The baby should be born today, but it was not possible, the baby was born yesterday [...] Everything was fine for normal delivery, but they said that it had to be a cesarean, I don't know why [...]. But the blood pressure only fluctuated. It doesn't regulate, no, her blood pressure is always high.* (H02)
> *It's being quite an experience. Because it was like the cesarean, she can't move much and I have to help. Because in the situation she is there, she can't move. I'm worried about her moving, getting bad and getting worse.* [...]

> *Blood pressure was high before. She wasn't taking any medication. She only took it here*. (H01)

Part of the reports mentioned the fluctuations in blood pressure and the course of the surgical procedure as factors that generate anxiety about the health status of the binomial. These narratives suggest that the women was seen by her companions as fragile beings and needing more complex care, rest and help with small tasks during puerperium, a stage little known by most, which can generate doubts.

**Care measures with the newborn in view of the gender relationships**

When the companions were asked about care for the newborns, the testimonies portrayed an apprehensive father because they have never taken care of, or even needed to take care of, children before, as there was always a female figure present to perform this function.

> *For me it's being complicated, because I have never taken care of anyone. I have a family, I have two children, but I have never taken care of them, I have never participated. And now I was forced to participate, because none of the sisters came. None*. [...] *The difficulty is to change* [diapers]*, because I have never changed, I have never bathed. That's it! Because to go somewhere [...] I'm on foot [...] Now, the problem is to change, to bathe.* (H07)
>
> *It's three children already, four with her. I haven't bathed yet, but I don't know [laughs]. When the other children were little, I never had to take care of them. I always* [pause] *I even told my wife, I'm always more afraid.* (H05)
>
> *It's being somewhat hard so far. And when it's really time to change* [the diaper]*, something like that, it's going to be a little complicated. I have already changed diapers before, but this little no. The one accompanying is always my mother-in-law.* (H04)

In the excerpts from the testimonies, feelings of insecurity, fear and anxiety are shown when taking care of the newborn. They also unveil a partner who finds limitations to perform tasks that they consider to be a female assignment and that would commonly be performed by other family members.

However, although cases in which the man sought to insert himself in this process have been

observed, it was verified that some companions did not show active participation in the care of the newborn in a space socially seen as female. It also became evident that they received and needed help from the other female companions or health professionals to care for, change the diaper, feed and provide hygiene to the newborns.

> *It's being quite an experience. Because I never had another child. I didn't have any difficulties so far. But, when changing the diapers, I had the help of a woman here, because he was crying and I couldn't help him. She helped me. The ones changing the diapers is the staff here and my sister-in-lay when she comes.* (H01)
>
> *Her mother* [mother-in-law] *gives the milk in a little mug, she gives and I watch, paying attention. But I can do it too. The guy* [professional]*, I don't know his name, he said it was better to breastfeed more, they* [twins] *are weak, but they manage to breastfeed. He looked and said that they are fine. To change* [the diapers]*, she changes them too.* (H03)

According to the reports, it can be observed that part of the fathers was not prepared to take on the countless responsibilities regarding newborn care. It was also noticed that his partner's health status enabled new experiences that could directly interfere with the conceptions of fatherhood that each man built during his life.

**Men's coping during the puerperal woman's hospitalization process**

When the interviewees were asked about the main adversities they experienced during the hospitalization process, some of them reported about the difficulty falling sleep and others pointed out the physical distance between the ICU and the nursery. This distancing between the newborns and their female partners was considered a tiring and exhausting factor for the men.

> *It's not good, no. Because you always have to be up and down with the girl, keep taking her there* [ICU]. (H02)
>
> *I'm tired of being from here to there* [...]. *I'm worried because she's there, I'm not seeing here and she doesn't know where I am. Like now, the way she went there. She doesn't know where I am. She knows I'm going there and coming back, but she doesn't know the environment where I was.* (H07)
>
> *The difficulty is just sleeping, but I'm not worried, I'm more used to it. I have*

> *already worked for years staying up all night, working in a bakery* (H08).

In this sense, some study participants reported moments of difficulties related to the exclusive breastfeeding (EBF) process and mentioned strategies suggested by third parties to overcome these challenges. Thus, it is assumed that they have been proposed by health professionals from the service or even by other newborn companions. It can be seen from the testimonies that there was guidance as to the demand for time to offer the breast to the child.

> *They told me to take her every 3 hours there where she is to feed her, that's all. I took her to breastfeed at noon, but she didn't want to because she was sleeping, they told me to stimulate her, wake her up when it's time to take her, I'll go there again soon.* (H04)
>
> *One time she* [child] *was crying a lot, I didn't understand what it was because she was there* [in the ICU] *all the time, she ate a little and didn't get full. When she arrived here, she returned to cry again.* [...] *they told me that when she cried I should take her for breastfeeding.* (H07)

Another relevant aspect mentioned by the companions was the concern about the rest of the family who was at home, especially, the other children who were at that moment without assistance and without the direct care of their parents. In addition to that, they signaled the need to leave work to accompany the partner.

> *Like, the feeling* [pause] *in addition to being concerned about my wife and my son, I keep thinking about the others who are also there with the grandma. So, I get torn; There is concern on both sides. And I don't know what to do.* (H08)
>
> *So far, I'm concerned about the ones* [children] *who are at home.* (H04)
>
> *I stopped the service and accompanied her because of this transfer or I would miss the vacancy.* (H07)

According to the reports, it is noticed that hospitalization modified the family routine and, at that moment, the help of other family members was needed. Some men pointed out that they received support from the family to take care of the other children who were at home and, even so, this situation can generate anxiety and fear.

## Discussion

The effective communication of the health team with the family members becomes fundamental, especially in cases in which the woman needs hospitalization in Intensive Care Units, minimizing feelings of fear and insecurity that unawareness can cause. It is known that, for quality and humanized puerperal assistance, it is imperative to facilitate access to the health services and to develop welcoming conducts, free from unnecessary interventions. In this regard, the team needs to consider and be sensitive to the family that experiences a high-risk pregnancy, especially in the presence of some hypertensive syndrome, which can have an outcome earlier than expected, often with maternal or fetal complications.[12]

Therefore, integrating the partner, giving him access to the information, answering questions and providing him with direct involvement in pregnancy, childbirth preparations and postpartum care can motivate the relationship with the newborn and contribute positively to gender socialization.[13] It is highlighted that involving the man during delivery favors early bonding between him and the newborn. The presence of the father favors the activation of protective emotional responses.[14]

Although it is complex for some people, the participation of the man throughout this puerperal pregnancy process, as a husband and/or father, can be seen not only as a legal obligation, but as a reproductive right. It can be seen from the reports that the presence of the father as the woman's companion is little valued by the health professionals of the service. A number of studies highlight that this bonding of the couple can lead to a broader discussion about social identity, as well as to strengthening the exercise of active paternity.[13-15]

Commonly, the partners experience feelings of insecurity and fear during pre-birth; however, they keep top themselves this tension and concern about how the process will take place in order not to show this anguish to their partners. A fact that remains true until verifying that the woman and the baby are free of complications and only they can express their feelings.[14]

This perception of frailty can sensitize the man to a change of attitude that was previously

limited to providing for the family and now also starts to turn to care of his partner and children. This experience closer to the couple favors rest, distraction, a feeling of safety and support, as well as it minimizes the fears and anxieties of both.[16]

It is a consensus among the companions that ,in this postpartum period, attention, rest and care are imperative for a full recovery and prevention of complications to the health of the puerperal woman. During this phase of biosociocultural changes, health professionals, family members and the entire support network involved must be aware because, in the puerperium, it is common that feelings of vulnerability and insecurity are not truly understood by the family. [17]

In this regard, the importance for the health team, together with the companion, to stimulate the woman's self-care stands out, seeking to raise their self-esteem and improve the couple's well-being, being sensitive to the care of the woman's mind and body image. These efforts can also avoid possible psycho-affective disorders involving the family, considering that, in this period, the woman can become more emotionally vulnerable to presenting feelings of anxiety, doubts and insecurities about family adaptations, self-care and care for the newborn.[17]

In this family context, feelings of insecurity, fear and paternal anxiety are often shown when caring for the newborn. In a study carried out in the rooming-in sector of a hospital in Ceará on the care provided to newborns by the fathers, it was observed that the subjects pointed out that, when it was time to bathe the babies or even pick them up, they felt insecure due to fear of hurting them.[18]

Historically, care is intrinsic to women since, socially, the roles and functions of the actors in the family are organized by gender and, most of the time, do not assign family and/or household tasks to men. However, in the puerperium, women need care and this role of caregiver can be transferred to the partner, being able to avoid some possible complications and promoting the well-being of their partner. The fact of being able to count on male support for the care of the child, of themselves and even at their homes, can make the postpartum experience more peaceful for the puerperal women.[16]

Corroborating this, currently, the policies on gender equality and various achievements in the professional field of women, among other factors, enabled a more active participation of the partner in caring for the children, favoring early bonding and the satisfaction that an intimate relationship with their child can provide.[19] In this regard, a study suggests that fathers organize themselves during pregnancy to take on new roles according to the children and their requirements. However, this process culminates in changes in the life of the man who, in order to become a father, needs to appropriate a new social status and a sequence of new responsibilities.[19]

Culturally, sometimes men are not taught and prepared by the family, since childhood, to learn about the care and daily tasks that are experienced at home. This fact corroborates as a social and cultural obstacle for the inclusion of fathers in the direct care of children[20] and this was evidenced through the testimonies of the participants in this study. Paradigms referring to gender issues are still hegemonic for a significant part of the population; in view of that, the relevance for men to be sensitized and inserted in postpartum care is highlighted. This involvement is something indispensable for the full connection of the father-mother-son triad and should not be addressed only as a necessity of the binomial.[16]

By directly experiencing the provision of care to the baby, such as bathing, changing diapers and cuddling, the father can experience communication techniques with the child different from those developed by the mother, contributing to this bonding and involving him in the family routine. In this way, the newborn knows how to recognize the father figure and waits for him also to cuddle; at the same time, this man acquires security and feels increasingly closer to his child.[14]

This participative father can be designed through the search for knowledge and the involvement of professionals who perceive and assist them in a line of male care focused on sexual health, reproduction and paternity. When properly valued, encouraged and informed, men can feel more secure and aware of the importance of taking on new functions.[13]

In this context, health promotion and education play a fundamental role, especially with the

nurses as members of the support network for the couple and facilitator of the puerperal-pregnancy process. Their contributions can be made available during reproductive planning, prenatal consultations, collective activities, delivery and postpartum assistance, home visits, monitoring the child's growth and development, and on different occasions of access to the family.[20]

In this sense, even if belatedly, the opportunity to include men as integral components of the gestational, delivery and postpartum phase in the hospital environment stands out, taking the opportunity to teach them about the care of the newborn, clarifying doubts and solving possible complications during this period of development of paternity.[21] In addition, among the benefits of this, support for EBF until 6 months of life after the parents are informed about the psychological, biological and economic advantages that breast milk can provide to the binomial is verified, directly favoring the mothers to also perceive its importance.[22]

Corroborating this, a study points out that puerperal women who had support from their partners in post-operative care, household activities, and care for the newborn experienced a period of tranquility and comfort, especially during breastfeeding. It was also pointed out that they felt safe, welcomed, supported and happy during the puerperium, which prevented women's wear out and post-natal complications, in addition to contributing to milk production and encouraging exclusive breastfeeding, which favors family bonding.[15]

It is noteworthy that facilitating the approximation of the nursery and ICU sectors could make the breastfeeding process less tiring and more pleasurable for the actors, considering that the father's involvement in breastfeeding is exceptionally important for its continuity. In addition to that, the fathers' knowledge of the importance and the need for this support for the provision of breast milk to their children is fundamental. In this context, it is considered that health institutions should be prepared with professionals committed to this process, capable of welcoming and supporting the couple, collaborating with the success of breastfeeding.[23]

In relation to this aspect, it is recommended to encourage breastfeeding on demand, bearing

in mind that breastfeeding frequently and without regularity regarding the length of stay or hours is intrinsic to the newborn's normal behavior, emphasizing the attention to signs of hunger that the infant shows indicating the need for food. A study corroborates so by asserting that the baby should breastfeed after its request, on free demand, because the more often it is sucking the breast, the greater the production of breast milk must be, emphasizing that the duration of each feeding can differ between children.[24]

Ensuring effective breastfeeding during the first days of the puerperium is fundamental for the mother-baby binomial and generates numerous nutritional, emotional, economic and immunological benefits. Therefore, the training of the fathers and the strengthening of actions to promote, encourage and support EBF are essential to reduce child morbidity and mortality and favor adherence, in addition to encouraging protagonism and responsibility in caring for the newborn.[25]

Recognizing this importance, the institution where this research was carried out holds the title of the Baby Friendly Hospital Initiative (*Iniciativa Hospital Amigo da Criança*, IHAC) and should propose to strengthen and extend the duration of breastfeeding due to the positive repercussions on children's health. To such end, this strategy recommends paternal participation in this care, and the hospital must guarantee free access and permanence of the mother or father with the newborn for 24 hours.[25,26]

Another point worth mentioning is that the main financial provider is often the father, which can make it difficult for the family to support themselves when they need to leave work to the detriment of the care of women and newborns. This separation of home and daily routines can generate feelings and changes that exert an influence on family relationships, making them vulnerable and having a negative impact on everyone involved.[27]

The fact that the man is willing to be present at this moment of difficulty of his partner and vulnerability of the newborn shows that that figure, a distant member, socially seen only as a

financial provider and home authority can resignify his image. He can be perceived as a caregiver and be valued as a father by his partner and by the health professionals of the service. Given the above, there is the possibility that the father ceases to be affectionate, gradually becoming someone willing to expose his affective needs and start to exercise contact.[28]

It is believed that this entire hospitalization process should be shared by a family support network with the partner as a support for this situation, be it during pre-birth, birth and post-birth. When the entire family is synchronous in the care and clearly oriented about the hospitalization process, they become prepared to be proactive and for self-help.[5]

It is observed that, when the actors are properly informed, the guidelines facilitate the care actions and consolidate self-confidence. The absence of information since prenatal care favors the onset of insecurities in puerperal women and their partners, making it difficult for the couple to cope and adapt to this new moment. Therefore, it is necessary that health professionals, especially nurses, offer timely care guidelines and include the father in this process, in order to minimize the difficulties experienced by the spouses.[16]

In view of this reality, the care provided during the puerperal-pregnancy period must be focused on the entire family, in addition to care aimed only at women and children, so that the health services provide men with their participation through learning from education in health and the exchange of experiences. Sensitive professionals are essential to paternal importance and its positive impact on the health of the entire family, recognizing that men have different demands than those of women and their own way of being involved in the process. However, a study points out that the health services are not yet ready to meet the needs of the men who seek the exercise of active paternity and report as the main obstacles the limited offer of educational groups, lack of dissemination of actions, and insufficient encouragement for paternal participation in the community.[29]

In view of this, it is opportune for the services to be available to sociocultural changes in

society, which perceive man as a co-participant in the process and not as a person that can hinder the professionals' work. Therefore, health education practices must promote the inclusion of the partner and other family members of the woman in this continuous learning process.[30]

The following are highlighted as study limitations: scarcity of publications related to the theme in recent years, and it is suggested to conduct new studies that cover the current family arrangements, seeking to evaluate different perspectives beyond the heteronormative model within family institutions, considering that the man gradually ceases to be a mere spectator and becomes a protagonist alongside his partner during the gestation process.

## Conclusion

This study showed that the participants experienced difficulties in communicating with the professionals who provided assistance in the service, since they did not understand the real health conditions and the risks of complications during the hospitalization of their partners. The information was superficial or not very detailed, which made it difficult for men to understand it throughout this process. These communication failures generated feelings of anxiety and insecurity during the distancing between the mother-father-child triad, which could also compromise the entire process of essential bonding during this period.

As for the man as the woman's caregiver, it was noticed that the concern about the type of delivery and the fear of blood pressure fluctuations were present in most of the reports. The female partner was seen as a fragile being who required greater care during the postpartum period. Thus, in the midst of a context of afflictions, uncertainties and experiencing anxieties, the actions aimed at the direct care of the puerperal woman were hardly mentioned.

As for the care of the newborn, the figure of a man who had never cared for or needed to have this function before was perceived. The majority mentioned some woman who developed this role in their family context and, therefore, they presented limitations when faced with this demand

during the hospitalization of their partners, making it difficult for them to actively participate in the care and development of fatherhood. Thus, it was noticeable in the reports that hospitalization modified the entire family pace, care for the children, difficulties in financial support and absence from work, with the aid of a support network being inevitable to share the difficulties and tasks that are demanded during this moment.

It is emphasized that, health professionals, mainly obstetric nurses, must be sensitive to the importance of the partner, encourage their bonding, and develop educational strategies for the insertion and active participation of the partner during the puerperal-pregnancy period, providing benefits to the woman, the child and himself. In view of this, by means of this research, contributions can also be made to sensitize the health professionals who assist the family to develop welcoming conducts and free from judgments and/or prejudices. This study enables reflections on the role of men in the context of hospitalization due to high-risk pregnancies, considering their uniqueness and generating humanized practices, which can have a positive impact on the physical and mental health of the family members involved.

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