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Inclusion of men in health services and educational activities: the fathers' perceptions

Inclusão de homens em serviços de saúde e atividades educativas: percepção dos pais

Inclusión de los hombres en servicios de salud y actividades educativas: percepción de los padres

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ABSTRACT

Objective: To learn about the perception of fathers regarding their inclusion in health services and/or educational activities.

Method: Qualitative, exploratory, and descriptive study addressing 22 fathers participating in a group of pregnant women in Rio Grande, RS, Brazil. Data were collected through semi-structured interviews and analyzed using the content analysis technique.

Results: The following categories emerged from the participants' reports: fathers' perceptions regarding their presence in health services and fathers' perceptions regarding their participation in the group of pregnant women. Additionally, they provided contributions and suggestions regarding their experiences with the group's meetings.

Conclusion: The participants felt excluded from the services, which shows that health intervention strategies need to be (re) constructed to implement actions that include fathers as active participants in care, so they recognize the importance of their role in healthy human development.

Keywords: Nursing. Paternity. Health services.

RESUMO

Objetivo: Conhecer a percepção dos pais sobre a sua inclusão nos serviços de saúde e/ou em atividades educativas.

Método: Estudo qualitativo, exploratório e descritivo, realizado com 22 pais participantes de um grupo de gestantes, no município do Rio Grande/RS. Os dados foram coletados através de entrevista semiestruturada e analisados pela técnica da análise de conteúdo.

Resultados: A partir dos discursos dos participantes emergiram as categorias: percepção dos pais sobre sua inserção nos serviços de saúde; percepção dos pais frente sua participação no grupo de gestantes.

Conclusão: Participantes sentiram-se excluídos dos serviços, demonstrando que estratégias de intervenção em saúde precisam ser (re)construídas, visando implementar ações que insiram os pais como participantes ativos no cuidado, reconhecendo sua relevância para o desenvolvimento humano saudável.

Palavras-chave: Enfermagem. Paternidade. Serviços de saúde.

RESUMEN

Objetivo: Conocer la percepción del padre sobre su inclusión en los servicios de salud y/o actividades educativas.

Método: Estudio cualitativo, exploratorio y descriptivo, realizado con 22 padres participantes de un grupo de gestantes, en la ciudad de Rio Grande/RS. Los datos fueron recolectados a través de entrevistas semiestructuradas y analizados mediante la técnica de análisis de contenido.

Resultados: De los discursos de los participantes surgieron las siguientes categorías: percepción de los padres sobre su presencia en los servicios de salud; percepción de los padres sobre su participación en el grupo de gestantes y aportes y sugerencias a través de sus experiencias en la participación en los encuentros.

Conclusión: Los participantes se sintieron excluidos de los servicios, lo que demuestra que las estrategias de intervención en salud necesitan ser (re)construidas, con el objetivo de implementar acciones que incluyan al padre como participante activo en el cuidado, reconociendo su relevancia para el desarrollo humano saludable.

Palabras clave: Enfermería. Paternidad. Servicios de salud.

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INTRODUCTION

When we consider the search for healthcare services, whether for others, or ourselves, it becomes clear that women most frequently access such services to meet their needs or those of their family members, especially children.

Specifically regarding family/sexual/reproductive planning, the guidelines and health actions are explicitly directed to the female audience. In most cases, women receive guidance and are solely responsible for sharing knowledge with their partners and/or other family members. However, when a couple chooses to have a child, whether this decision is planned or not, both are supposed to care for and assume joint responsibilities for that child and be an emotional, physical, social, and educational reference, in addition to being the providers, offering what a child needs for her healthy development[1].

Note that including men in family care and encouraging them to engage in parental care and decision-making concerning reproductive planning, among other situations determining the health of this social group, remains a challenge. In addition to the factors hindering men from seeking health services, health professionals fail to adopt strategies that include men in these services and health actions, which generally hamper their participation in the family context[2].

Even though Brazilian Public health policies address the different stages of the life cycle, they are fragmented because they are directed to the different stages of life but do not contemplate family health in its integrality. Therefore, further research is needed to focus on family health promotion for professionals to (re)build care strategies and actions within the scope of public health and the Brazilian Unified Health System (SUS), heeding the needs of each social group. Among them, demystifying that care exclusively belongs to women's realm and including men in different interventions, encouraging their effective participation in family health promotion[1].

Health services are, for the most part, organized to welcome pregnant women, mothers, and their children. However, despite campaigns based on the National Policy for Integral Attention to Men's Health (PNAISH)(3), through Ordinance No.1,944 from 2009, men still have difficulties adhering to self-care and family care practices, revealing an absence of healthcare strategies directed to men as caregivers in the family context[4].

Even Brazilian law shows little appreciation for the fathers' active participation in the pregnancy-puerperal cycle. For example, a five-day maternity leave after birth is granted to fathers by the Federal Constitution of 1988 in its articles 7th and 10th, § 1, of the *Ato das Disposições Constitucionais Transitórias* (ADCT); it used to be a day only, according to article 473rd, III of the CLT. Thus, one day was considered sufficient because only the mother would care for the baby. On the other hand, women have a 120-day leave with job security, which is extended to the gestational period, when their health condition requires them to attend at least six consultations and take other complementary exams[5].

Fathers usually do not accompany their partners or children to consultations/exams in the health services assisting pregnant and postpartum women. Another aspect that probably influences their non-participation of fathers in the pregnancy-puerperal cycle and actions throughout human development is the working hours of Basic Health Units. Furthermore, when fathers participate in these events, they are not adequately welcome, encouraged, or appreciated by the health team as a significant persons in prenatal and postpartum consultations, among other health interventions. Hence, they are mere listeners or spectators of actions, playing a secondary role in family health promotion[6].

To propose practices that promote and facilitate the inclusion of fathers in the different stages of their children's development (pregnancy, childbirth, postpartum), we need to understand how each individual perceives his insertion in the care provided by professionals, how he sees his family's dynamics, the importance of his active participation, and how he can be and feel included in such spaces, by his partner, family, and health professionals. It is also important to observe public health policies, such as the National Policy for Integral Attention to Women's Health, the National Policy for Integrative Attention to Men's Health, the National Policy for Primary Care (PNAB), and the current actions of professionals in different scenarios and health settings regarding the inclusion of fathers as active participants in the care provided to their children[4,5].

The transformation, deconstruction, construction, and reconstruction of paradigms more easily occur when professionals are open and accessible to attentively listen and welcome individuals considering their worldview and life experiences. Such reception enables professionals to learn more about the family context, dynamics, and functioning to design and promote the family's health, considering its needs, peculiarities, and strengths[7].

When fathers are included in prenatal care, they feel more confident about parenting and become more capable of recognizing and meeting their children's basic needs, developing self-confidence and basic parenting skills, such as changing diapers, dressing, and holding a newborn. Studies show that the earlier fathers become involved with their children and families, the more committed they become

in the family context. Inclusive parenting preparation leads fathers to take greater responsibility, even before the child is born. In addition, such preparation helps fathers to identify and express their weaknesses and strengths, enabling interventions to be organized considering their difficulties. However, how interventions contribute to promoting the fathers' participation and inclusion in health services, and actions needs to be investigated to promote healthier family interactions and the healthy development of children[8].

However, when considering fatherhood as an essential aspect in promoting family health and human development, the following question emerges: How do fathers perceive themselves within health services, be it when attending a healthcare appointment or an educational action? Therefore, this study's objective is to identify the perception of fathers regarding their inclusion in health services and educational activities promoted by health professionals.

METHOD

This qualitative, exploratory, and descriptive study was conducted in Rio Grande, RS, Brazil. The study sample comprised a group of pregnant women addressed by the Viver Mulher Research Group in 2015. The participants' experience with this group before the pandemic was a weekly meeting held in a classroom on the university's premises. Nurse and medical educators, undergraduate and graduate students from the Universidade Federal do Rio Grande (FURG), and health professionals from the University Hospital (UH-FURG) and the Rio Grande Health Department integrated the team coordinating this group directed to pregnant women, postpartum women, and their respective families.

The study included 22 men who attended at least one meeting between 2017 and 2019 and had experienced the pregnancy-puerperal cycle. This period was chosen because another study had already been conducted with the mothers in the group's first edition (2015). Therefore, there was a high likelihood of losing participants and, consequently, data if the participants had more than five years of fatherhood experience, in addition to the possibility of them changing their telephone/address, which would impede locating them for interviews. Thus, the inclusion criterion was parents who attended one or more meetings promoted by the group between 2017 and 2019. The exclusion criteria were being under 18 at the time of the interview and having lost their babies.

One of the researchers collected data after the Institutional Review Board approval (opinion report No.4,993.113 on September 23rd, 2021) according to ethical guidelines by the Brazilian National Health Council (CNS) regulating research with human subjects[9]. The coordinator of the Viver Mulher research group was asked to authorize the researcher to collect data. Next, an active search was initiated on the group's records concerning the period between 2017 and 2019 to identify potential participants. The fathers were then contacted via telephone, and an informed consent form was sent. The participants were asked to read, sign, and forward a copy to the researcher. A day and time were scheduled with those who consented to the semi-structured interview. The online interview was conducted via the Google Meet platform and was recorded. The aspects proposed in this study's objective were addressed, and the interview was held between October and December 2021, lasting 50 minutes on average.

A semi-structured interview using an elaborated research instrument allowed us to address the reports' subjectivity more deeply. This instrument was composed of two blocks. The first addressed sociodemographic data, including age, profession, income, address, marital status, number of children, period of participation in the group and number of meetings attended, the children's birthdate and age, and prenatal care consultations. They were also asked whether they accompanied their partners during consultations. Next, the questions composing the second block of the instrument were addressed. These were organized into 11 open questions and guided the interview, corresponding to this study's objectives. The interviewer was a Master's student, who conducted and recorded the interviews after the participants' consent.

The participants are identified by the letter P (participant), followed by the number corresponding to the order in which the interview was held (P1, P2, ...). The researcher remained in a private room during the interview, without interferences or ambient sounds, and was inaccessible to people. Additionally, the participants were informed that they were free to drop out of the study at any time without penalty. The computer was protected with passwords and antivirus for the researcher's exclusive use. Headphones were requested during the interviews. The participant was instructed to stay in a private room, without the presence of other people, and free from noise during the interview.

Data were analyzed using Bardin's[10] content analysis, which allows us to systematically describe the reports and behaviors associated with the enunciation context. Data were analyzed manually without using any software. The pre-analysis stage included the exploration of material and the formulation and reformulation of assumptions. Then, the

researcher entered into direct contact with the participants' reports to further deepen data and establish categories. During the material exploration, the researcher searched for units of records, listing the categories in this study. These categories were established a priori to correspond to this study's objective and organize content. Afterward, the researcher categorized and analyzed data based on current literature (last five years) on the topic addressed here.

RESULTS

Twenty-two participants were included in this study. The participants were aged 36 on average, all had attended at least high school, and 50% were self-employed. All the participants lived in the same household as their partners, the mothers of their children. They attended at least one meeting between 2017 and 2019, and all their partners attended prenatal care: seven in the public health network and 15 in the private health system. All the participants accompanied their partners in at least 80% of the consultations, depending on their availability or because they shared the consultations with other family members. These and other data characterize the participants' profiles shown in Table 1.

Two categories emerged from the participants' reports. The first, Fathers' perception about their inclusion in health services, concerns the perceptions and feelings of fathers about their experience in accompanying their partners and/or children to health services. The second category, Fathers' perceptions regarding their participation in the pregnant women group, emphasizes the participants' experience of participating in the group. The fathers provided contributions and suggestions based on their experiences with the meetings

Fathers' perceptions regarding their inclusion in the health services

The participants reported attending at least 80% of their partners' prenatal consultations. However, their reports regarding their experiences with health services show that the orientations and reception are directed almost entirely at the mother and child. At the same time, the father's figure remains invisible, i.e., the fathers' participation in their children's development and family relationships is not as valued as that of mothers because the professionals see fathers as mere companions and listeners.

The professionals had the mother as the reference for care. For this reason, they did not even direct their attention to the fathers, who were often participatory, asking questions, and showing their interest and responsibility for their children and families.

> *We attended the appointments, hers or the children's, together whenever possible. The orientations in the children's consultations flowed like a conversation among us all, not directed to the mother only, though most orientations were directed to her* (P7).

> *I always accompany her during consultations, vaccination, and everything. After she was born, we both always attended monthly consultations. It has changed after the pandemic because only one companion is allowed, and the professionals always call the mother directly. So, we automatically are left out. But really, you go to a healthcare unit, and clearly, all the children are accompanied by their mothers* (P9).

> *We went through two pediatricians. It was clear that they only looked at my wife's face when they gave orientations. It was like I didn't exist; my presence and their willingness to pass on the knowledge to me didn't matter to them at all. I had my doubts and expressed them, but she didn't consider them. That's what all professionals do, having the mother as a reference for the child's care. It may not be intentional; maybe it's a habit. Some failed to include me more evidently than others, but practically all the ones I went through didn't include me; they let me go with her because I was her companion, that's what I think. The obstetrician was already more open to this, I felt that the consultation was for both of us, and I didn't notice any difference* (P12).

> *I've always interacted well in my daughter's appointments, but because I tried to include myself. During the pregnancy consultations, the obstetrician practically did not look at me. All information was directed to my wife, my questions were somewhat ignored, and the concern was all for my wife, physiological issues, and nothing else. However, the pediatrician, in general, listens to me a lot, the ophthalmologist and otolaryngologist too. Always returning my questions, equally providing directions and providing clarifications to the couple, the Family* (P21).

When asked about their participation and how they experienced their inclusion in health services, the participants reported that they accompanied their wives and children in prenatal consultations. However, they did not feel welcomed or were encouraged by health professionals to care for them, nor were they given information and/or guidance. Thus, apparently, there are no strategies to include men in care delivery.

Table1 – Participants' profile. Rio Grande, Rio Grande do Sul, Brazil, 2021.

Characterization	No. of participants	percentage (%)
Age group		
28 – 37 years old	14	63.7
38 – 47 years old	7	31.8
48 – 57 years old	1	4.5
Education		
High School	8	36.3
College degree	14	63.7
Employment		
Self-employed	11	50
CLT hired	06	27.3
Public employee	05	22.7
Marital Status		
Married	10	45.5
Stable union	12	54.5
No. of children		
1	12	54.5
2 or more	10	45.5
City of residence		
Rio Grande	20	91
Others	2	9
Live in the household as partner	22	100
Group participation		
2017	6	27.3
2018	13	59.1
2019	3	13.6
Prenatal care		
Public health system	07	32
Private health system (health insurance/private)	15	68
Attendance in Prenatal care consultations		
All	10	45.5
8 or more	12	54.5

Source: Study's data, 2022.

Fathers' perceptions regarding their participation in the pregnant women group

The participants showed great sensitivity and a differential when seeking knowledge and participation in the group. They considered the group to be an inclusive space, which is a subjective aspect of each father. Feeling included is also about feeling prepared to listen, participate, and receive guidance aimed at the couple, both regarding basic and primary care provided to the child and sharing responsibility in the family context.

> *The group has always been very inclusive. The actions were aimed at me, and I believe that all fathers also see this experience that way. Although I think this is part of being a father, it is subjective to feel included, and it is a little out of the professionals' control. It depends on the father wanting to listen and being prepared to listen. But I felt included. The guidance was directed to the couple, like changes, about change diapers, how to help with breastfeeding*(P1).

Regarding the activities developed by the group addressing pregnant women, the fathers mentioned that they felt included in the activities proposed, making it clear that the activities were aimed at the family, not only the women and babies. Therefore, the fathers considered that the orientations were directed at them and the couple.

They reported that the group was beneficial, especially in their marital relationship, preparing the couple to experience motherhood and fatherhood. In addition, attending the meetings together, exchanging information and receiving knowledge, and sharing experiences between couples and families, significantly strengthened the relationship and united the families even more.

> *I think that the group helped a lot in terms of preparation when it came to assuming fatherhood and motherhood, somewhat influencing my marital relationship as well. You know, like having that moment together, meeting, listening, sharing, and exchanging experiences with other couples. It helped me to see that we are not a different case and that the difficulties are common to everyone, fears and problems shared with several people. These were the main points helping us a lot as a family and couple* (P21).

> *Participating in the group is very important because, from the beginning, it promotes a union between the couple in the sense of raising children. Because when we're together in the group, we're going through that together, getting information, getting ready, and then, at bath time, for instance, we both know what to do, and we start making decisions together from the very beginning. So, I think the group is essential to make men aware of their responsibilities, leaving sexism aside and deconstructing this exacerbated sexism that still exists. Men learn about everything and start doing things our fathers did not do with us as children. We've learned several things there about breastfeeding; everything is very delicate, so the more information we get, the better* (P12).

This study's participants also suggested qualifying the pregnant women group for health workers to encourage men to participate more and care for their children and families. In addition, they understand that having one or more fathers as speakers will significantly help the group participants understand this phase of the life cycle better.

The participants reported that it is essential to provide more opportunities for men to discuss and express their doubts, anxieties, concerns, and fears with other men so they can share experiences and be empowered to help their children and partners during the pregnant-puerperal cycle and throughout human development. They believe these are inclusive actions that can support their dedication to competently playing their role as fathers.

> *What could they have done? I think a conversation that included only the fathers, especially the more assiduous ones. Sometimes the wives themselves don't let us talk, understanding that the space for these subjects is always theirs. Moreover, men often no longer understand it as a space where they belong. So, a moment just for the fathers would benefit everyone* (P4).

> *One suggestion is for a class to be designed with the fathers in mind and given by a male father speaker. It'd bring the experience closer. Call a psychologist or psychiatrist to talk about it. I think it'd be valid to call anyone who is a father, regardless of profession, as long as it is in the health field, obviously. Pregnancy is very stressful; the woman goes through changes, gets stressed, and her mood fluctuates, so I think you need a father to share this with other fathers and exchange these experiences* (P13).

DISCUSSION

This study presents evidence from the participants' reports about their more effective participation. Even though men have sought health services more frequently and attempted to be part of the care provided to their children, women still predominate in care institutions.

The literature describes some aspects of why health services are not directed at men. The main obstacles include how health units work. For example, the services' working hours hinder the presence of fathers because working hours do not reconcile with the fathers' working hours. Another aspect that may hinder the inclusion of fathers is the number of consultations, where production is more important than quality/innovation. Hence, one consultation does not cover all of a woman's needs, much less those of a couple or family. It is likely that an emphasis on women's care and consultations, not implementing actions and/or strategies to include the fathers, will require more time for men to be sensitized and become aware of how essential their role is in promoting their children's healthy development, strengthening their marital relationship, and parenting[11].

For the most part, health services are established to receive pregnant women, the mother, and her child, hindering the inclusion of fathers in the care. Despite the campaigns promoted by the National Policy for Integral Care to Men's Health (PNAISH, Ordinance No. 1944, 2009)[3], men continue to face difficulties in adhering to care and self-care practices, traditionally seen as "feminine" and "contrary" to social beliefs and images about masculinity; not to mention the absence of specific healthcare strategies directed to men[8]. When prenatal care includes the father, he feels more confident about performing his role. Generally, he becomes more capable of recognizing and meeting the basic needs of his children, developing self-confidence and basic parenting skills such as changing diapers, dressing and holding a newborn, and showing affection.

Men are entitled to receive care for themselves and accompany their partners in the Basic Health Units of the Brazilian Unified Health System (SUS). PNAISH foresees a strategy called "*prenatal parceiro*" [supportive prenatal care], sought to sensitize healthcare managers, health workers, and the population to involve the fathers and future fathers in reproductive planning, pregnancy, labor, delivery, puerperium, and childcare throughout the children's development. It is intended to strengthen the bond between the parents and children, to promote healthier intra-family relationships. Supportive prenatal care is promoted as health workers direct their attention to the fathers, including them in health actions, such as updating their immunization schedule, including them in their partners' prenatal consultations and educational activities, to provide guidance to fathers and identify their expectations, so they establish bonds with health services and their partners. The objective is to promote positive affection and a better quality of life for the family[11].

It is essential to overcome the almost absence of fathers in health services, devising actions to encourage their active participation in self-care and their families' care. We wonder whether this happens due to a lack of interventions directed to fathers or due to health workers' perception of the impact of fatherhood on human development and health intra-family relationships. This question shows there may be gaps in professional training and continuing education in the health field regarding the importance of fathers in children's healthy development. Such information can equip and update professionals' knowledge to improve the effectiveness and quality of healthcare actions aimed at integral care.

Prenatal care is an opportunity for men to support their partners during pregnancy, childbirth, and throughout their children's development and take care of their families' health from the beginning of pregnancy. Assistance intended to include fathers in care actions includes topics related to sexual health and fatherhood. Such actions can be highly beneficial among men from different contexts, showing them the relevance of their involvement in the prenatal period, family planning decisions, and parenthood to develop and maintain healthy intra-family relationships[1].

Health professionals play a fundamental role in implementing actions that include men in the care provided to women, children, and families. Three important aspects justify these actions: giving men opportunities to undergo routine clinical examinations, valuing fatherhood within the prenatal strategy, and including men in family planning, thus, consolidating the precepts of the National Policy for Integral Men's Health Care (PNAISH)[3].

Health education is an essential responsibility of nurses and can be implemented in different settings addressing different audiences. Its main objective is to provide tools by exchanging scientific knowledge and experiences between professionals and families. These interactions benefit from group actions, including the group of pregnant women, the main objective of which is to go beyond knowledge, that is, to enable families to be prepared and have peace of mind during all phases of the pregnancy-puerperal cycle. Specifically, the group of pregnant women must include strategies to cope with the changes resulting from pregnancy since it is therapeutic and intended to provide information to women and families. Some investigate the contribution

of such an activity exclusively for women, as usually their partners are only briefly addressed, a fact that may be linked to the place and time that these meetings take place[12].

The meetings of the pregnant women group addressed in this study took place at 7 pm, which probably favored the participation of men. Another positive aspect was the flexibility proposed, as pregnant women and family members could join the meetings at any time during the program. Such situations seem to reflect health promotion strategies, as they include and place the focus on the family, in addition to carrying out actions that include the father as an active participant in the pregnancy-puerperal cycle.

The participants reported that the group provided much more than clarification and scientifically proven information but also, and primarily, supported their maturation as men, human beings, and fathers in the pregnancy-puerperal cycle. All the meetings emphasized the importance of the fathers' attendance and participation from pregnancy to the puerperium, instructing them about the care they could provide to their partners and children. These reports show how much health education can promote family health, especially during the pregnancy-puerperal cycle, as prenatal consultations cannot meet all a woman's and her family's needs. Additionally, educational actions, specifically those developed in groups, enable exchanges between professionals and those using health services and vice-versa, enabling individual and collective reflections on their contexts, social environment, lives, and health[13,14].

CONCLUSION

Even though men are more sensitized to their fatherhood role, health services still lack strategies to include these fathers in the services or include and encourage their participation in educational activities. Hence, fathers may still be invisible in these spaces. Note that the fathers felt excluded from the care provided by health professionals, and it is possible that health strategies need to be (re)built, through training and continued actions, aiming to implement actions that include fathers as active participants in the care process, recognizing their relevance for healthy human development and positive intra-family interactions.

As for the educational activities, the group contributed significantly and encouraged the participants to reflect on and understand their family's new life during the pregnancy and mainly after the child's birth. Moreover, when educational activities are performed in groups, they enable the construction of care strategies based on the real world and each family's needs, difficulties, and strengths, reinforcing the relevance of the couple's union and companionship and strengthening the intra-family relationship.

Thus, this study can support health professionals to qualify primary health care, considering the connection between public policies directed to women's health, men's health, family health promotion, and healthy human development, considering the perception of men regarding fatherhood.

The fathers were flattered by the invitation to participate in this study, which initially caused some surprise, as women are usually invited to talk about their children and families. Listening to the fathers was essential for the researcher as a nurse, as it made it possible to recognize the importance of listening and understanding what fathers think and feel during the pregnancy-puerperal cycle and the development of their children in order to think about effective care actions to promote family health.

Therefore, future studies investigating fatherhood are needed to implement strategies intended to increasingly include fathers in health services, learn how health professionals perceive the role of fathers in the promotion of health throughout a child's development, develop actions to qualify care, emphasizing each family's needs and strengths, and implementing new health care models to effectively meet this population's needs and support the qualification of health practices and actions.

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