DOI: 10.1590/1413-81232015215.26842015

Lines of male care geared to sexual health, reproduction and paternity

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Abstract *The article seeks to propose principles for male care geared to sexual health, reproduction and paternity, as well as present a blueprint for the involvement of men in prenatal care. The proposal of the authors was submitted to a consensus building process with invited experts. The main results presented include: (a) the principles of lines of male care geared to sexual health, reproduction and paternity; and (b) a blueprint for the involvement of men in prenatal care. The conclusion drawn is that the cultural preconceptions of how males should lead their lives, including their social relations and roles as fathers interfere in health care actions and touch on three main points: (a) the idea of man as a collaborator in the promotion of the health of his partner while pregnant and/or his offspring; (b) the idea of paternity being strongly linked to being the financial provider; (c) the hiatus generated between the traditional concept of paternity and the new family and gender patterns.*

Key words *Men, Prenatal care, Paternity, Line of care*

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Initial Considerations

This article, which is objective and opinionated in nature, seeks to propose principles for male care geared to sexual health, reproduction and paternity, as well as present a blueprint for the involvement of men in prenatal care.

We understand *principles* to mean the basic structural foundations that provide guidelines for male care geared towards sexual health, reproduction and paternity. They are the starting points that enable new actions to be designed or for existing ones to be discussed in the light of the inter-relationships upon which they are based and according to their contexts. These are not norms procedures that should be followed.

We understand *lines of care* to mean *an image that is created in the mind to express a blueprint for safe and guaranteed care for the users, so as to meet their health requirements*[1]. In one line of care, *the managers of services can agree on norms, re-organizing the work process, so as to facilitate a user's access to the Units and Services they require*[1].

In this case, *sexual and reproductive health* is associated with *the right and the desire of an individual to plan the formation or otherwise of his family or family entity, increasing, limiting or avoiding having any offspring*[2].

However, *paternity* is seen as the involvement of men and the possibility of these individuals experiencing pleasure in questions related to pregnancy, birth and more democratic and equitable relationships within the domestic sphere[3].

Our discussion is based on a gender related perspective, in the belief that:

The engagement of men in the provision of care has a positive effect on the gender socialization of boys and girls and makes children more open to question traditional gender roles[4].

In addition, we begin with two questions. The first refers to the participative role of men in sexual and reproductive health. When mentioning that some health professionals traditionally understood that men should be encouraged to participate as collaborators in the health of their partners, Arilha[5] asked:

[...] *is this really desirable*? *Should not men, of all age groups, also become subjected to rights in the field of sexual and reproductive rights*?[5].

Another issue is related to the thoughts expressed by Gomes[6] about the exercise of paternity that end with the following questions:

How is paternity exercised in situations where a woman is the head of the household? How does one define a paternal figure in the case of a homosexual couple who decide to adopt a child? What is it to be a father when there is no mother figure?

These questions, that date back more than fifteen years, are still valid today, in spite of some progress in the area. One of these was the creation of a national male health policy in Brazil[7], where these questions are debated. In addition, several studies have been addressing the issue of the involvement of men in prenatal care and paternity[8-10].

In these studies, the following questions are highlighted: (a) women continue to be held responsible for family planning and child care[8]; (b) there is still a certain amount of apprehension between genders as regards their relevant participation in health care issues[9]; (c) involving men in child care involves issues such as: paternity and/or parental leave; working hours and transformations in gender relationships[10]; (d) recognizing the importance of paternal participation as an instrument to improve maternal and child health, though difficulties exist in recognizing this participation as a man's right[10]; (e) men feel intimidated by the attitude of a health professional who does not involve them in the process of childbirth as being an important player within this scenario[11]; and (f) some men do not participate in the medical consultations of their partners due to the embarrassment this causes the pregnant women or their partners themselves; these appointments coincide with their working hours and with restrictions imposed on fathers by prenatal care services[12].

With regards to the queries raised by Arilha[5] and Gomes[6], we do not intend to directly respond to these by putting forward specific recommendations, but to present proposals that – either directly or indirectly – relate to these issues instead.

Methodological Framework

This study consists of an opinion-based work on the experience of the authors, and is one that further goes on to seek the validation of experts on the subject, thereby broadening the forum of opinions in order to attain a consensus. For this, we adapted the consensus conference technique proposed by Souza et al.[13]. As regards the methodological process, this adaptation was divided into six stages.

The authors prepared two models, based on the references mentioned here and on their accumulated experience related to this subject, one of which is called "Image-objective for lines of male care geared to sexual health, reproduction and

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paternity," and another called "A blueprint for the involvement of men in prenatal care."

Experts were then selected by searching through scientific database search engines, such as *Scientific Electronic Library Online* (SciELO), the Lattes Platform and The Virtual Health Library (VHL), using the following key words: male health, prenatal care and paternity. During this search, it was possible to identify eighteen experts, of whom eleven, four men and seven women, who completed all the validation stages. In professional terms, three were doctors, four were nurses and four were psychologists. All of them had experience in the area or were involved in working with issues that articulate the theme of male health, prenatal care and paternity.

During the third stage, by using an online research tool, the two models we submitted to the eleven experts for due validation. The first model presented fourteen principles divided into three dimensions: the political/management dimension; the health care dimension and the education in health dimension. The second model presented steps and actions related to the proposal for a blueprint for the involvement of men in prenatal care. In both models, each expert could award points to the proposed principles and actions on a scale from zero to ten, where zero represented an issue of no importance or one that should be excluded, and ten represented one of maximum importance. In addition, in the final section of each dimension it was possible to include observations or suggest principles with key words or stages with relevant actions, if the experts judged this to be necessary.

In the fourth stage, the authors analyzed the scores for the first version of the models, consolidating data and checking the consensus of opinion for each of the principles/stages, based on Souza et al.[13], by means of an analysis of average and standard deviations; averages lower than seven and/or standard deviations higher than two were considered as dissensus. Based on this analysis the two models were reformulated, taking into consideration the suggested changes and inclusions made by the experts. None of the experts suggested excluding a principle or an action.

The fifth stage involved re-submitting the two models to the experts. At this stage, any suggestions for the inclusion or exclusion of principles or actions were no longer taken into account, only scores.

Lastly, a final validation analysis was conducted, taking into account the same parameters[13] used in the first analysis.

Findings

There was a consensus as regards most of the principles and stages proposed and only one principle was removed from the original proposal. These findings can be seen in the two charts shown below.

In Chart 1, the lines of male health care geared towards sexual health, reproduction and paternity involve three principles: macro principles that provide guidelines to plan actions and their management (management-policy); relations between professionals and users in dealing with issues highlighted by this paper (health care), and educational actions geared towards professionals and users (education in healthcare).

Chart 2 sets out a proposal for a blueprint for the involvement of men in prenatal care. The stages are not necessary linear or exclusive. At certain moments, these can co-exist and even overlap.

We believe that integrating principles (Chart 1) and the blueprint (Chart 2) represent what we understand to be lines of care.

Discussion

The principles and blueprint include cross-sectional issues that serve to help develop the discussion. This debate reexamines philosophical perspectives, which serve as guidelines for reflection and criticism, leading to the acquisition of knowledge. And we highlight here, the fact that this philosophy does not only indicate a benefit in itself, but represents the first systemized form of questioning the world and the search for explanations that can lead to different responses and actions. Thus, we have adopted the proposal based on three cross-sectional themes that generate change, geared towards diversity and plurality: 1) the polarities in masculine representations that serve as a benchmark and give prominence to relations with feminine and childhood dimensions, which need to be reexamined and reevaluated in the light of the battle for hegemony; 2) equity in recognizing the social markers of differentials; 3) social participation as a tool to promote rights of access and care.

Chart 1. Goal-Image for lines of male care geared to sexual health, reproduction & paternity.

Management-policy dimension	
Principle	**Key word**
Gender equity	Equal rights between genders & efforts to seek to overcome inequalities between men & women.
Plurality in the concept of male identity.	Concept of specific features of male socialization based on a relational view of gender, color/race, social class, age and sexual orientation.
Organization geared to the health care needs of men with different profiles.	Organization of actions geared to the health-disease-care process, considering the biopsychosocial needs of men with different profiles and taking into account different local and regional contexts.
Organization of a healthcare network.	Valuing the symbolic dimension of social bonds that traverse gender relationships, promoting inter-sectorial dialogue (work, health, leisure, among others).
Management follow-up, evaluation & transparency.	Follow-up and evaluate actions geared to men within an ambit of sexual health, reproduction and paternity in order, on one hand, to produce evidence about their reach and impact and, on the other, to promote transparency in communicating with people, families, those responsible and with the media and society in general.
Create an environment geared to gender relationships, paternity and reproduction.	Organize healthcare services not only on the basis of their basic function of providing treatment, tests, medication, practices & techniques, but also as meeting spaces & as a means of changing attitudes. This involves promoting other values that deconstruct the association made exclusively about men as representing contamination/transmission/danger/threat
Healthcare dimension	
Promote all-round care.	Organize male healthcare practices (individual & collective), based on identifying their biopsychosocial needs, considering actions involving promotion, prevention, treatment and rehabilitation.
Care based on acceptance.	Guarantee an inter-sectorial perspective in the dialogue between spaces where men construct references, such as educational areas, the home, the workplace and related groups, involving functions & institutions that are not necessarily related to health systems. This also means accepting all complaints or reports from users, even when these do not appear to be directly relevant to diagnosis & treatment.
Involvement of men in prenatal care, childbirth & post-partum consultations.	Valuing & encouraging the participation of men with different profiles in all stages of pregnancy (prenatal care, childbirth & post-partum), respecting a woman's right to choose the person who will accompany her during this process.
Care related to vulnerability & risk.	Discuss the dissemination of images that associate men with risk, in particular to transform the image men have as an individual who is easily influenced, violent, takes illegal & legal drugs; or even as someone who is never present to take care of his children.

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Chart 1. continuation

Education in healthcare dimension	
Principle	**Key word**
Education, health & communities of practice.	Consider possible general healthcare spaces, and particular those related to men, taking into account the relationship differences between genders, class and ethnic backgrounds.
Professional training.	Training healthcare professionals to work with men from different backgrounds from a gender perspective, based on the realities of healthcare work.
Promote male and/or mixed groups.	Encourage the creation of discussion groups that are focused on gender & health issues, geared to men, or for men and women, within the ambit of sexual health, reproduction and paternity, using a strategy to transform gender relationships.
Reflection by professional health teams on masculinity, health and paternity.	Encourage people to reflect on issues related to masculinity, health, paternal care and methodologies for working with men.

Chart 2. Blueprint for the involvement of men in prenatal care.

Stages	Actions
Acceptance	• Discuss with the father and mother or same-sex partners, or even with the mother (in the absence of the father) how the father can participate in the prenatal care, childbirth and post-partum process • Listen to the father & mother, or same-sex partners about their expectations as regards paternity, prenatal care, childbirth and the post-partum period. • Prepare a line of prenatal care, with the participation of the father & the mother or same-sex partners. In other words, – with the participation of the father and mother or same-sex partners – plan actions and a blueprint for the care that should be assured to them so that the needs of the parents and the child are met. • Discuss their expectations in relation to family planning, bearing in mind the production or otherwise of other children and, if necessary, methods of contraception. • Organize assistance to men during period his companion or same-sex partner receives prenatal care, taking into account the existence of specific features that will be better worked on without his partner and which highlight the importance that men have during this process. • Discuss with the mother, in the event that the presence of her partner is not possible, participation strategies geared to prenatal care, childbirth and the post-partum period.
Having examinations, quick tests & vaccinations.	• Discuss with the father and the mother or same-sex partners the importance of having health checks, rapid tests and vaccinations for their own health and that of their child. • Make sure that examinations, rapid tests and vaccinations are included in healthcare actions
Prenatal consultation follow-ups & evaluations	• During prenatal care consultations, establish a dialogue with the father and the mother or same-sex partners about the progress, possible complications & possible stress factors related to pregnancy. • Make a regular evaluation of how the involvement and participation of the father and the mother or same-sex partners during the prenatal care period can help guarantee and maintain the health of the child and the parents.
Involvement of men in childbirth & during the puerperium period.	• Discuss their participation with the father and the mother or same-sex partner, respecting the right of the woman to choose the person who will accompany her during this process.

The first assesses *cultural representations*[14] *about males*, which associate men with concepts of danger, strength, haste and provision. These representations reinforce a model of masculinity that distorts or eliminates other forms of masculine existence that can impose limits on actions involving male healthcare and reduce the possibility of support being given to men/partners/fathers in the healthcare process of a woman and her child, and/or associates males with ideas of contagion, violence and oppression of this diad. These are concepts that tend to distance men from health services. Based on Gramsci[15], we understand that certain cultural notions become hegemonic, prevailing in space and in time. Even though these are not unique, they become established based on a position established in the field, serving to organize social forces and, in the case indicated above, organize roles related to gender. We venture to suggest that, within this tradition, the level of ideas, notions, values, shared social expectations – which constitute the raw material of cultural notions[14] – play a fundamental role in bringing about social change. In this sense, we should ask what would happen if we had a movement where men pursue certain male initiatives – as, for example, men who when they marry take the surname of their wives[16], and not the contrary; or even men who run the home and take care of their children, while their wives go out to work – would be highlighted and associated with movements for broader rights?

The second evokes *social difference markers, equal access and the need for equal healthcare* – gender, race/color, social class, age, education, sexual orientation – with emphasis on *sexual orientation and gender roles*. Issues that address the debate related to new family and gender arrangements based on the satisfaction of looking after oneself or another person, related to emotional and sexual involvement, and in the construction of parenthood. In this respect, several ideas have already been discussed in a previous study[3], but give rise to further discussions. One of these, which involves our principles and blueprint, is the desire to discuss frontiers between sex and gender, men and women, masculine and feminine, and father and mother[3], taking into account different family arrangements[3]. In this sense, there will be moments when something more than paternity, and parenting will have to be addressed, as a set of functions geared towards developing autonomy and a sense of security for children, which guarantees generativeness[17]. We need to think about homosexual-parenting, in the case of families formed by people of the same sex. Or even, parenting by transsexual and/or transvestite people[3,18]. And, within this diversity, it will be important to ensure that the care and upbringing of a child is seen from the point of view of establishing bonds, and as a relationship of healthcare asset exchange[3].

The third issue evokes evidence of the right to access and health decisions: health care *participation* which involves men, women and children in different scenarios and health promotion spaces, where physical and conceptual changes are required, as well as environmental requalification. As far as possible, and while protecting aspects that requires discretion and privacy, the whole idea of going beyond the consulting room and a relationship seems very promising, to converse in waiting rooms or chat circles, a process that encourages reflection, appraisals and participation. This idea functions as a dialogic strategy of acceptance of another person in their diversity, where the solitude felt by those who are waiting for healthcare can be reconfigured through conversation, through inter-action, transforming a conflict of ideas into working material.

These conversations can also make full use of playful activities, of games, to promote discussions about gender roles, diversity, daily difficulties related to healthcare choices, how to manage domestic and public life, the education of one's children and the exercise of parenthood. Thus, health services can be viewed as spaces that promote life, health and personal bonds. The theme of *participation* also involves the potential itself to invite healthcare professionals to place themselves in a counter-hegemonic movement, repositioning themselves as users and adopting an attitude related less to teaching, and more to a process of exchange and learning.

The need to highlight other possible ways of interpreting male care – care for yourself and what this offers to others – becomes an urgent priority when we recognize that health care actions exemplify a tradition whose models are faced with a multiplicity of contemporary transformations, and by male morbid-mortality rates, when compared to those of females[19,20]. Thus, even after nearly two decades, the observations made by Arilha[5] and Gomes[6] remain surprisingly relevant even today.

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Final considerations

The opinions discussed in this work confront several limitations. One of these relates to the fact that, since this involves a very recent and contemporary debate, we have not based this work solely on our own experiences, but have instead submitted our opinion to a broader forum. However, the search to find experts in this subject was something of a challenge, since it is not easy to find specialists in a field that is still not given much visibility.

The second limitation refers to what this article offers or attempts to offer by way of a contribution to the field of health care. It may well express the tensions that exist between the traditional family model and other family arrangements. Thus, when proposing arrangements that deal with lines of care for healthcare actions that are geared, for example, to "same-sex couples," we may at the very least be putting forward ideas that will appear rather unusual to both users and health professionals alike.

The interfaces between cultural constructions about the role that men play in life, in their social relationships as a father, and that which involves healthcare actions touch on three points: (a) the idea of man as a collaborator in the promotion of the health of his partner while pregnant and/or his offspring; (b) the idea of paternity being strongly linked to being the financial provider; (c) the hiatus generated between the traditional concept of paternity and the new family and gender arrangements. We highlight the fact that these points are included in an intense political arena of national and international debates about male involvement in healthcare, in the exercise of paternity and in promoting gender equality. Thus, we cannot detach our analysis from the wider global context in which these issues are continually being debated.

These ideas/understandings encounter strong opposition from traditional groups and reflect attitudes that ignore the changes that are currently taking place with regards the way these groups and individuals battle to affirm and receive recognition for their rights. These efforts occur on several fronts, for example, within the scope of the Federal Legislative Power, where a proposed bill presented as "Family Bylaws," ignores the diversity of family arrangements, or the satisfaction that cements emotional relationships and the changes that have occurred in gender roles, and thereby proposes only one family model, which goes against what we observe in reality.

Collaboration

L Albernaz, CRS Ribeiro, MCN Moreira and M Nascimento participated in every phase of this study and in writing this article, under the general coordination of the R Gomes.

Acknowledgements

For their participation in the consensus technique, we would like to thank the following professionals: Bárbara Tarouco da Silva, Caroline Oliveira de Castro, Eduardo Schwarz Chakora, Fabio de Mello, José Medeiros do Nascimento Filho, Márcia Reis Longhi, Marcus Renato L. N. de Carvalho, Maria Cristina Montenegro Pereira, Maria Luiza Mello de Carvalho, Viviane Manso Castello Branco and Waglânia de Mendonça Faustino e Freitas.

References

1. Pessôa LR, Santos EHA, Torres KRBO, organizadores. Manual do Gerente: desafios da média gerência na saúde. Rio de Janeiro: Fiocruz; 2011. [acessado 2015 out 17]. Disponível em: http://www5.ensp.fiocruz.br/biblioteca/dados/txt_379517240.pdf
2. Gomes R. *Os cuidados masculinos voltados para a saúde sexual, a reprodução e a paternidade a partir da perspectiva relacional de gênero: projeto de pesquisa*. Rio de Janeiro: Fiocruz; 2013.
3. Ribeiro CR, Gomes R, Moreira MCN. A paternidade e a parentalidade como questões de saúde frente aos rearranjos de gênero. *Cien Saude Colet* 2015; 20(11):3589-3598.
4. Instituto Promundo. Programa P. Manual para o exercício da paternidade e do cuidado. Rio de Janeiro: Instituto Promundo; 2014. [acessado 2015 out 12]. Disponível em: http://promundoglobal.org/wp-content/uploads/2014/12/Programa-P-Manual-para-o-exercicio-da-paternidade-e-do-cuidado.pdf
5. Arilha M. Homens: entre a "zoeira" e a "responsabilidade". In: Arilha M, Ridenti SGU, Medrado B, organizadores. *Homens e masculinidades: outras palavras*. São Paulo: ECOS, Ed. 34; 1998. p. 51-77.
6. Gomes R. As questões de gênero e o exercício da paternidade. In: Silveira P, organizador. *Exercício da paternidade*. Porto Alegre: Ed. Artes Médicas; 1998. p. 175-181.
7. Brasil. Ministério da Saúde (MS). *Política Nacional de Atenção Integral à Saúde do Homem: Princípios e Diretrizes*. Brasília: MS; 2009.
8. Ávila MB, Ferreira V, organizadores. Trabalho remunerado e trabalho doméstico no cotidiano das mulheres. Recife: SOS Corpo; 2014.
9. Kato-Wallace J, Barker G, Eads M, Levtov R. Global pathways to men's caregiving: Mixed methods findings from the International Men and Gender Equality Survey and the Men Who Care study. *Global Public Health* 2014; 9(6):706-722.
10. Nakano AMS, Silva LA, Beleza ACS, Stefanello J, Gomes FA. O suporte durante o processo de parturição: a visão do acompanhante. *Acta paul enferm* 2007; 20(2):131-137.
11. Medrado B, Lyra J, Oliveira AR, Azevedo M, Nanes G, Felipe DA. Políticas públicas como dispositivo de produção de paternidades. In: Moreira LVC, Petrini G, Barbosa FB, organizadores. O pai na sociedade contemporânea. Bauru: EDUSC; 2010. p. 53-79.
12. Pesamosca LG, Fonseca AD, Gomes VLO. Percepção de gestantes acerca da importância do envolvimento paterno nas consultas pré-natal: um olhar de gênero. *Rev Mineira de Enfermagem* 2008; 12(2):182-188.
13. Souza LEPF, Silva LMV, Hartz ZM. Conferência de consenso sobre a imagem-objetivo da descentralização da atenção à saúde no Brasil. In: Hartz ZMA, Silva LMV, organizadores. *Avaliação em: dos modelos teóricos à prática de programas e sistemas de saúde*. Salvador, Rio de Janeiro: EDUFBA, Fiocruz; 2005. p. 65-102.
14. Laplantine F. Antropologia dos sistemas de representações da doença: sobre algumas pesquisas desenvolvidas na França contemporânea à luz de uma experiência brasileira. In: Jodelet D, organizadora. *Representações Sociais*. Rio de Janeiro: Eduerj; 2001. p. 241-259.
15. Gramsci A. *Os intelectuais e a organização da cultura*. Rio de Janeiro: Civilização Brasileira; 1978.
16. Quando o homem assume o sobrenome da mulher. [acessado 2015 out 18]. Disponível em: http://oglobo.globo.com/sociedade/quando-homem-assume-sobrenome-da-mulher-17805074
17. Barroso RG, Machado C. Definições, dimensões e determinantes da parentalidade. *Psichologia* 2010; 52(1):211-229.
18. Zambrano E. Parentalidades "impensáveis": pais/mães homossexuais, travestis e transexuais. *Horiz. antropol.* 2006; 12(26):123-147.
19. Gomes R. *Sexualidade masculina, gênero e saúde*. Rio de Janeiro: Editora Fiocruz; 2008
20. Couto MT, Gomes R. Homens, saúde e políticas públicas: a equidade de gênero em questão. *Cien Saude Colet*. 2012; 17(10):2569-2578.

Article submitted 19/10/2015
Approved 10/12/2015
Final version submitted 12/12/2015