Doi: 10.4025/psicolestud.v21i1.28323

HEALTH PROFESSIONALS AND LACK OF ASSISTANCE TO THE MAN AND FATHER: AN ANALYSIS OF SOCIAL REPRESENTATIONS[1]

Mirian Beccheri Cortez[2]
Nathália Meneghel Machado
Zeidi Araujo Trindade
Federal University of Espírito Santo, Brazil.
Luiz Gustavo Silva Souza
Fluminense Federal University, Brazil.

ABSTRACT. We investigated social representations of paternity according to health professionals and how these representations may affect the way they stand in relation to the assistance offered to fathers who use the public health system. An individually interviewed based on a semi-structured questionnaire, with 19 professionals, doctors and nurses who worked at a public maternity or at one of the six Family Health Units researched was carried out. Results confirmed data from other studies and showed that the professionals had no academic training to deal with paternity and that the services had no infrastructure to assist fathers. Although assessed as important, the fathers' presence at the appointments with doctors were not encouraged. Paternity, according to the representations investigated, is about provision, being distant from care and self-care and anchored on traditional beliefs on masculinity. The popular-class man and father is represented as "vulnerable" and "at risk". We discussed that these representations may hinder a father's participation in the course of pregnancy and, consequently, the father-child bonding.

Keywords: Paternity; health services; health professionals.

PROFISSIONAIS DE SAÚDE E O (NÃO)ATENDIMENTO AO HOMEM-PAI: ANÁLISE EM REPRESENTAÇÕES SOCIAIS

RESUMO. Investigamos representações sociais de paternidade, segundo profissionais de saúde, e como essas podem intervir nos posicionamentos destes sobre o atendimento aos pais usuários do sistema público de saúde. Baseados em um roteiro semiestruturado, foram entrevistados individualmente 19 profissionais, médicos e enfermeiros atuantes em serviços públicos na área de saúde reprodutiva. Os resultados corroboram dados de estudos e revelam não haver preparo acadêmico dos profissionais para lidar com a paternidade e que os serviços não possuem infraestrutura para acolher esses pais. Verificamos que a presença paterna nos atendimentos não é incentivada, mesmo sendo avaliada como importante pelos participantes. Nas representações investigadas, a paternidade configura-se como função de provimento, distante do cuidado e do autocuidado, ancorando-se em crenças tradicionais sobre a masculinidade. O homem-pai de classe popular é representado como "vulnerável" e "de risco". Discutimos que essas representações podem dificultar o acompanhamento paterno durante a gestação e, consequentemente, o vínculo pai-filho.

Palavras-chave: Paternidade; serviços de saúde; profissionais de saúde.

[1] *Support and funding*: Coordination for the Improvement of Higher Education Personnel [Coordenação de Aperfeiçoamento de Pessoal de Nível Superior] (CAPES)

[2] *E-mail*: mibecz@yahoo.com.br

PROFESIONALES DE LA SALUD Y EL (NO) ATENDIMIENTO A EL HOMBRE-PADRE: INVESTIGACIÓN EN REPRESENTACIONES SOCIALES

RESUMEN. Se investigó las representaciones sociales de la paternidad según profesionales de la salud y cómo esas representaciones afectan sus posiciones sobre el atendimiento de padres usuarios del sistema público de salud. Con base en un cuestionario semiestructurado se entrevistaron a 19 profesionales de la salud, médicos y enfermeros, trabajadores de una maternidad pública o de uno de los seis Servicios de Salud Familia investigados. Los resultados confirman los datos de otros estudios: muestran que los profesionales no tienen preparación académica para tratar la paternidad y que en los servicios no hay infraestructura para atender a los padres. Aunque evaluada como importante, la presencia del padre durante las consultas no es incentivada. Las representaciones son vistas cómo relacionada con la provisión, prácticas deficientes de cuidado y autocuidado ancladas en creencias tradicionales de masculinidad. Los hombres-padres son representados cómo vulnerables y en situación de riesgo. Se discutió que esas representaciones pueden perjudicar el acompañamiento paterno de la gestación y, también, el vínculo padre-hijo.

Palabras-clave: Paternidad; servicios de salud; profesionales de la salud.

Introduction

In this article, we use the concept and theory of Social Representations in order to discuss perceptions and practices of health professionals about paternity and assistance to fathers. According to Oliveira (2004), one of the main focuses in Serge Moscovici's studies, a Romanian psychologist who proposed the Theory of Social Representations, when it comes to social representations is to understand how and why people and social groups create a common reality by sharing ideas elaborated by the common sense. According to Sá (1998), a social group can be defined as a set of people who share interests and a sense of identity. A group can be "organic", when it effectively shares routine practices (e.g. a healthcare team), or "taxonomic", when it only presents common identity traits (e.g. health professionals in general).

Jodelet (2000) explains that social representations refer to common sense knowledge used in everyday actions and which is formed in the "interaction and contact with discourses that circulate in the public space" (p. 10). According to Jovchelovitch (2000), the public space can be defined as that space, in a certain society, which suspends exclusively private interests and which is constituted as a space for the negotiation of singularities of various social actors and groups. Jodelet (2000) states that, in addition to guiding actions in the world and serving as an instrument to read reality, social representations allow the interpretation of facts and social relations.

Based on the understanding that social representations lead ways of thinking and acting, the matter of paternity from the perspective of health professionals will be analyzed considering that their stances and actions regarding fathers and their professional interactions with them are based on pre-established representations about fathers.

Studies indicate that stalemates arising from a traditional and patriarchal culture of paternity affect a father's participation starting when he is following the gestation of his child and even afterwards. Commonly mentioned obstacles are the duration time of paternity leave (only five days in Brazil), absence of company policies that make it easier for fathers to escort their wives and children at services attended during business hours, exclusion of men from services targeted at family planning, and precarious actions aimed at effecting public policies which encourage the participation of fathers in gestation and postpartum periods (Pierre & Clapis, 2010; Pontes, Alexandrino e Osório, 2009; Silva & Piccinini, 2007).

We highlight, just as Fleming, King and Hunt (2014) stated, that encouraging the paternal bond is important as it benefits the children in question, the father himself, interpersonal relationships of both and society in general.

According to Perdomini and Bonilha (2011), the genitor can be considered the ideal company at the moment of childbirth, which would increase the chances of strengthening the bond with the mother and the baby himself or herself. Moreover, presence during childbirth would favour the recognition of the man as a paternal figure, thus valuing his role as a father. Benefits from the presence of and support

from fathers during breastfeeding were surveyed and discussed by Sherriff and Hall (2014), Silva, Santiago and Lamonier (2012) and Pontes et al. (2009). According to Coutinho and Trindade (2006), taking care of children contributes to improving a man's self-care.

Despite these benefits, health services are mostly constituted to receive expectant mothers, mothers and their children, which hinder assistance to the man and father. Despite campaigns following the launch of the National Policy for the Comprehensive Care of Men's Health [*Política Nacional de Atenção à Saúde do Homem*] (PNAISH) of the Brazilian Ministry of Health (Portaria nº 1.944, 2009), men continue to face difficulties with care and self-care practices, traditionally seen as a woman's thing and contrary to naturalized beliefs and images about masculinity. It is also possible to notice the absence of health assistance strategies specific for men (Levorato, Mello, Silva & Nunes, 2014; Pierre & Clapis, 2010; Schraiber, et al., 2010; Silva, Silva & Bueno, 2014; Tarnowski, Próspero & Elsen, 2005).

In addition to the recognition of health services as women's spaces, keeping men away from them (Tarnowski et al., 2005), relations between social representations about health and what masculine is mean, for men, the devaluation of medical attention in situations of primary healthcare. The level of Primary Healthcare values ongoing care of chronic conditions, disease prevention and health promotion practices, which involve self-care and changes in lifestyles that may bring risks. Prevention and self-care do not agree with culturally traditional qualities of men and masculine, such as strength, autonomy, independence and virility (Gutierrez, Minayo & Oliveira, 2012; Levorato, et al., 2014). As stated by Gutierrez, Minayo and Oliveira (2012), resorting to public health services, as a citizen of rights, "is oftentimes seen by men, intolerably, as a submissive position" (p. 876).

The perception about men as subjects who need to have their health monitored and cared of seems not to have support nor strength inside or outside services, which would also result in the exclusion of fathers from services aimed at their children and the mothers of their children throughout gestation, birth and the postpartum period, as observed by some authors (Carvalho, 2003; Lacerda, Vasconcelos, Alencar, Osório & Pontes, 2014; Locock & Alexander, 2006; Pierre & Clapis, 2010; Silva, et al. 2014).

In this way, there seem to be at least two movements based on the same sexist culture, which keeps men away from health services: resistance from potential users to preventive care practices and absence or little engagement of health professionals with practices targeting the male population (as fathers or not).

A response to this evidence of lack of engagement on the part of men is the study by Perdomini and Bonilha (2011), which identified at the moment of birth a unique experience in the life of men and women, and, therefore, according to the authors, the team of health professionals should promote a pleasant moment for both, thus seeking to include fathers in the gestational process. For this reason, they assess as necessary the overcoming of pre-existing barriers fostered by beliefs linked to the male gender, which do not allow fathers to have an outstanding role when the baby is born and other moments of the child's life.

Moreover, several authors agree on the importance of developing a positive and inclusive relationship between health professionals and fathers in order to support the experiencing of unique and delicate situations such as gestation, birth and the postpartum period through adequate orientations (Lacerda, et al., 2014; Perdomini & Bonilha, 2011; Shia & Alabi, 2013; Silva, et al., 2014).

Considering that one of the objectives of the PNAISH (Portaria nº 1.944, 2009) is "to stimulate the participation and inclusion of men in the planning of their sexual and reproductive life, focusing on educative actions, concerning paternity as well" (paragraph 8 of Article 4, Portaria nº 1.944, 2009), in order to propose the construction of practices that promote/facilitate the integration of fathers in the several periods of the life of their children (gestation, birth, postpartum period), it becomes necessary to understand current actions by health professionals with this group, as well as social representations of paternity and fathers that guide them. We understand that identifying common sense theories that base the exclusion of fathers by healthcare services and teams is an important action for the construction of interventions that can act with greater effectiveness towards changing this picture of paternal invisibility.

Objective

To investigate social representations of paternity constructed by health professionals and discuss how these representations can intervene in the professionals' stances on assistance to fathers who use public health services.

Method

Participants

This study counted with the participation of 19 health professionals (10 doctors and 09 nurses) who developed activities related to the Family Health Unit (FHU), pregnancy, birth and postpartum period at health services in Vitória, ES. The average age was 39.22 ((N = 18; MIN= 26 e MAX = 75). One of the health professionals did not disclose her age.

Among the professionals, 12 worked at the FHU (six doctors and six nurses) and seven (four doctors and three nurses) worked at a hospital in the city which was a reference for public reproductive health services (hereafter referred to as "Maternity" as well).

The following criteria were used for the choice of professionals and services: doctors and nurses are the higher-education professionals who compose Family Health teams and the largest professional categories at health services and those which perform most of the procedures related to reproductive health. The FHUs approached served the population residing in popular-class neighborhoods and were located in six different health regions in the city. The selection of Units in different regions aimed to ensure greater variety in data collection. The hospital, in turn, was also reference in the assistance to popular-class people who resorted to the Brazilian Unified Health System, being adequate to the research scope. Throughout data analysis (described below), it was observed that the number of interviews conducted was enough to reach saturation (Pope, Ziebland, & Mays, 2005).

Data collection procedures and instruments, and ethical aspects:

A semi-structured script was used for the interviews, whose first part collected sociodemographic information, while the second one contained questions concerning: how the health professionals assessed fathers and their participation in the gestation and raising of their children; actions by health professionals aimed specifically at fathers; perceptions and beliefs about what being a father and a "good father" is and about the academic formation for assistance to fathers.

Individual interviews with the professionals who accepted the invitation for the research lasted around 20 minutes and took place at the participants' workplace, being audio recorded. After the interviews, the participants signed an informed consent form. This study was approved by the Ethics and Research Committee of the Federal University of Espírito Santo and authorized by the SEMUS/ETSUS (Municipal Secretariat of Health/Technical School for Health Professional Formation, *Secretaria Municipal de Saúde/Escola Técnica e Formação Profissional de Saúde*) of the city of Vitória/ES. All guidelines on research ethics were complied with (Resolution of the National Health Council, *Conselho Nacional de Saúde*, CNS 466/12).

Data analysis procedures

The interviews were fully transcribed and then analyzed by means of thematic content analysis. The analysis was based on Bardin (2009), who considers this process a method referring to a set of strategies for the analysis of communications which use systematic and objective procedures to describe the content of messages. Categories related to the thematic division in the interview script were constructed through units of record, that is, statements made by the participants.

Results and Discussion

From the thematic content analysis, 10 subcategories were identified and grouped into four main categories: 1. Paternal profile, 2. Context of Social Vulnerability, 3. Professional Practice and 4. Fathers as Accessories. Below we present the categories and subcategories, the number of participants (n) who mentioned each subcategory, as well as the amount of participants who integrated each category, and the transcription of a few reports as examples.

Representational elements of the paternal figure according to the interviewees are contained in the PATERNAL PROFILE category (n = 18). All professionals reproduced traditional aspects of fathers associating them to the figure of family providers, those responsible for supporting the household *"the first thing is to have a job, right? Being aware that now he has a child and that now he has to take care, help to take care of him/her..."* Nurse, FHU, 61 years old.

Additionally, being with children, sharing advices, keeping up with their academic life and following their development were actions described as part of roles played by a *"good father"*. A father, regardless of any difficulty, should be present in the life of his children *"at all times"* (Doctor, Maternity, 31 years old), according to the interviewees.

We therefore identified in the social representations of participants elements related to beliefs and images about the traditional adult man: provider, especially financially, of security and examples for a developing child. This representative figure of a father, the 'man and father', can be considered one form of objectification of the social representation about paternity, since it emerges from consistent references to elements regarding paternity and masculinity which, repeated, entangle in such a way that the exercise of paternity appears linked necessarily to the exercise and affirmation of masculinity and the traditional adult man.

These results dialogue with the argumentation by Navarro (2009), according to which the health system reproduces, with its practices and discourses, a culturally accepted division of gender roles as to paternity and maternity. We assess that this crystallizes a mode of operation and assistance aimed at paternity which is not necessarily consonant with current demands.

Influences from the social context and territory on the involvement of the man and father with gestation and afterwards in the raising of his child are grouped in the CONTEXT OF SOCIAL VULNERABILITY category (n = 08), which includes the following subcategories: a) Influence of legal and illegal drugs (n = 08) and b) Perception of an environment of risk (n = 05).

According to Tarnowski, Próspero and Elsen (2005, p. 106), a father's involvement "is more complex than it seems to be", especially during childbirth, "when routines change abruptly". For these authors, the exercise of paternity should be taken inside a context of various influences. For this reason, it is important to highlight, initially, that the participants claimed working mainly with families coming from low-income communities. According to them, the environment in which these parents are inserted influence their involvement with the gestation of the baby and their actions as fathers.

In this way, when speaking of the spaces where these families live, they talked about an environment with generally precarious houses, violence and drug dealing, a context which was also identified in the study by Kanno et al. (2012). This environment, according to the professionals, hinders the engagement of the man and father in the gestation, since he may be subject to situations of risk that impair their involvement with paternity or make it impossible. *"This context of violence, of little perspective,... Pregnancy ends up not being a big deal for them"* - Nurse, HFU, 29 years old; *"drug user, who is in jail, who drinks alcohol, so it is about treating him... How is he supposed to participate as a father if he is ill?"* - Doctor, FHU, age not disclosed.

Difficulties as having no money or access to formal education are identified as factors that hinder assistance to fathers and their families *"they are really needy [the families], not only financially, needy of knowledge, you talk to them but they barely know what you are talking about, they are like that".* - Nurse, Maternity, 27 years old.

Considering his socioeconomic context, the man and father, for the health professionals, becomes the *Man and father* user of the public health system: a man who belongs to a little educated and low-income group likely to get involved with situations of risk and less likely to engage in the care of his

children. The subcategories herein identified suggest that the health professionals perceive the father who is or could be served by public health services as an unlikely, disinterested patient who is hard to assist.

Just as in the study by Souza (2012), it was observed that the professionals represented users in general also considering their socioeconomic insertion as a filter. Souza found that Family Health professionals regarded popular-class users as "inhabitants of another reality". In their representations, this reality was characterized by precariousness and need: poor housing, nutrition, leisure and resources (financial precariousness); absence of dialogue, sociability and presence of unemployment, drugs and violence (social precariousness) and absence of self-esteem and projects for the future (psychological precariousness).

The elements of this category indicate the existence of a network of representations that articulates representations about the low-income adult man and father, generating the figure of a man and father with scarce skills and no conditions to exercise paternity.

The PROFESSIONAL PRACTICE category (n = 17) allows us to analyze how the health professionals perceived their practice regarding fathers/paternity in terms of how it is and how it should be. It includes four subcategories: a) The man's rather than the father's health (n = 10); b) Structural deficiencies (n = 4); c) Suggestion of educative group/Actions/ Alternative schedule (n = 16); d) Professional (lack of) information (n = 17).

Most of the health professionals (n = 17) claimed having some trouble talking about or even assisting men when it comes to paternity and revealed not having had contact with this matter in the course of their academic formation or afterwards, through specialization courses or training, a situation which is also identified by Silva et al. (2012). *"We had nothing related to men; when I finished college, in 2008, we were starting the process about men care, of men's health".* (Nurse, Maternity, 27 years old); *"When one leaves college, in the beginning you do not have much preparation"* (Nurse, FHU, 61 years old).

This situation has to do partly with the fact that these professionals graduated before the PNAISH was launched (Portaria nº 1.944, 2009). Even so, for working in the reproductive health field, they are expected to be more updated about this recent policy through training and courses conducted by the very service at which they work.

It is worth highlighting that the matter of Family Planning is addressed in training courses for health professionals but it is commonly related only to women's health and female birth control. Thus, as we could see in our study, Navarro, López, Calvente, Ruzzante and Rodríguez (2009) identified as constant in the discourse of parents interviewed in their research that the attention to pregnant women from health services places fathers as a secondary actor in the assistance situation.

About this male invisibility, Pierre and Clapis (2010) assess as essential for the full exercise of sexual and reproductive rights the implementation of actions that allow men to discuss family planning together with women. In this sense, so the work with families is effective, it is important to recognize that fathers can develop a healthy and close relationship with their children (Fleming et al., 2014).

The professionals described as another hindrance to the assistance to fathers the lack of general recognition on the part of fathers concerning physiological and psychological transformations that accompany pregnancy. For this reason, they defended (n = 16) that fathers need more information to deal with the matter of pregnancy... *So, like, women come in pain and this bothers them, and the fathers get, like, anxious, about the patient's pain"* (Doctor, Maternity, 46 years old).

According to Carvalho (2002, p. 396), this difficulty mentioned by doctors "has as backdrop their [the fathers'] exclusion from reproductive and pediatric health services, out of step with the increasing involvement of men in the education of their children". Inside this logic, the cycle of exclusion by lack of information tends to become stronger if health professionals are not willing to be healthcare agents who also provide information about care actions.

The detachment of the man and father from the reproductive health field can have a negative impact considering the relationship between health professional and father. The difficulty professionals have in welcoming men in a way that makes them feel included by health services is described in several studies already mentioned, including Coutinho and Trindade (2006), Levorato et al. (2014) and Pierre and Clapis (2010).

For understanding that the man and father lacks information about pregnancy, childbirth and care of children, all the professionals presented as plausible alternatives for the resolution of the problem the promotion of educative groups and actions (lectures, conversations and orientation groups). In these actions, fathers would be informed about events that permeate pregnancy and childbirth, thus receiving other tools for them to be inserted more actively in processes concerning gestation, birth and the postpartum period of their children. *"So, it should be, like, they should give more information, create groups too, right, create groups of… and invite them, right (…)"* (Nurse, FHU, 61 years old). Even though possibilities have been identified, no initiative was described as effected in their services.

It is worth mentioning herein the study by Fletcher and StGeorge (2011), which presented the internet as a form of support to fathers: online communication (chats) between men who have gone through the paternity experience brings feelings of confidence and calmness to those who are now facing this situation. Recognizing that currently the internet reaches all socioeconomic strata, serving as a means of formation and information for a good portion of the population, it seems to be important to identify and indicate, on the part of professionals, relevant websites with proper information provided by professionals from the area, since online content is oftentimes produced by lay people and may be wrong and even dangerous. Besides the quality of information, we asses that the way it is transmitted (videos, online booklets, tutorials, illustrations… could be considered as well, since fathers with different education levels now have access to this means of communication and (in) formation.

Considering time restrictions of men and fathers especially due to their work schedule, the establishment of alternative working hours at the FHU and Maternity was one of the most commented solutions (as a possibility or as a fact) by the interviewees (n = 16) so that fathers could be more present and became more involved in the birth and postpartum period of their children. *"... when they say they cannot come during visiting hours, we make an exception, so they can be present"* (Nurse, Maternity, 30 years old).

Regarding obstacles faced by health professionals for the effectiveness of the insertion of fathers in their services, some problems at the FHUs differed from those described at the Maternity. A problem mentioned only by the FHU professionals was the very work system that values the number of consultations rather than the quality of the services provided to users and/or caregivers.

> *"It is the city government's protocol... a medical consultation lasts around twenty minutes, and thirty minutes for prenatal visit. A twenty-minute consultation for a Family Health Strategy doctor who approaches the patient as a whole is not viable."* (Doctor, FHU, 38 years old).

A hindrance to the offering of a better assistance to fathers at maternity services was the structural deficiency of the latter. The participants reported that some maternities have poor physical structure (small space, lack of proper clothing), which prevents fathers from being present at the moment of childbirth, in C-section cases for instance. Such situation, although it is in noncompliance with Law No 11.108 of April 7, 2005, known as the Carer Law (Lei nº 11.108, 2005), was reported by one of the professionals as a routine aspect and which does not need to be improved, thus disregarding the law, deliberately or not.

According to the professionals, the presence of the father after birth is impaired also due to the flawed structure. They state that while the private sector room at the Maternity is occupied only by one parturient woman, allowing for greater privacy, the rooms reserved to "SUS patients", that is, users of the Brazilian Unified Health System, are occupied by more than one parturient woman. For this reason, they claimed that the constant presence of a man in those places would cause discomfort and/constraint in the parturient women who did not have ties with such carer.

Structural issues, reported also by Kanno, Bellodi and Tess (2012) and Carvalho (2003), reflect the scrapping of many public health services due to lack of investments or proper management. Although Carvalho (2003) mentioned that discomfort with the physical structure is, in some cases, shared between professionals and users of health services, we should still take into account the pain of the family which is separated at a so meaningful moment.

The FATHERS AS ACCESSORIES category (n = 18) illustrates how health professionals stand as to the presence or absence of fathers during gestation, birth and, oftentimes, the raising of children,

comprehending two subcategories: a) Fathers as carers/listeners (n = 12) and b) Work as hindrance (n = 15).

Throughout the analysis of reports, we see that the speech of the health professionals reproduces an idea of ambiguous nature about the paternal figure: he is an important figure but, even so, is not the focus of attention. *"I have to confess that I do not call fathers, invite fathers, but it is something important"* - Doctor, FHU, 39 years old.

All interviewees stated that the man and father had a place of importance in the raising of children and the gestational process, with his presence being positive for children and also during pregnancy, as support to women. On the other hand, they admitted that this father is not received as an important actor at prenatal or postpartum consultations or at other services, playing, most of the times, the role of a mere listener to what doctors want to say to mothers (when invited to participate or enter the room), as observed in the following reports: *"When they come to the Unit, because like, we do not go after them. If the pregnant woman misses a consultation, we do not go after the man and say 'oh, father, why she has not come?' We look for the woman"* (Nurse, FHU, 32 years old).

In this way, there is a reinforcement of the figure of the accessory-father who may or may not be present at events prior or related to the baby's birth, just as identified by Martins (2009) and Navarro et al. (2009). About that, Martins states that despite the potential to stimulate interaction between father and child, the health area is one of the areas that most reinforces women as the carers of children, at the same time it "keeps the father who is interested in participating in the process away" (Martins, 2009, p. 13).

The main explanation provided by the health professionals about the little/no importance given to fathers is that the latter, most of the times, are not present at consultations or during birth due to work, a constant discourse among the interviewees:

> *"Because of this difficulty with their jobs and because of all this story I think it is hard, their bosses do not accept… when you give mothers a note saying that they came to accompany their children, their bosses accept it better compared with when we do it for fathers"* (Doctor, FHU, age not disclosed).

Although work is, as identified by Gonçalves et al. (2013), one of the justifications for the absence of fathers at prenatal exams, it is important to highlight that, since job is a strong element in the social representations about fathers, for being linked to the image of provider, their absence at health services is configured as 'just and understandable' for the professionals. This is one of the aspects that weaken discussions on the rights of fathers from a professional perspective aiming at changes in employment relations such as allowing the man and father to go with their partners to medical consultations in the course of gestation.

Final considerations

When investigating social representations of doctors and nurses about paternity, we discussed the figure of the man and father who is assisted at public health services investigated and found that the paternal figure, even though idealized and referred to as important, is underappreciated by said professionals and disregarded at reproductive health services.

The perception about the exclusion of fathers at public reproductive health services configures a context of poor physical infrastructure, absence of training for professionals to deal with this target population, limiting regulations for professional practice and discredit as to the potential of the exercise of paternity for popular-class men residing in neighborhoods seen as precarious/violent.

Lack of investment in adequate rooms for welcoming mothers and fathers during these periods and little information and training aimed at raising the awareness of health professionals of the relevance of active paternity evidences the precarious condition of the health area and also the lack of interest from managers of the area in providing spaces where "somebody else" – the father – can and have the right to enter.

There is thus a disregard for the benefits of this insertion to the family, the child's development and the couple's wellbeing. There is a disregard for the rights conquered for fathers for them to be together with their partners and children also during prenatal care, birth and postpartum period. There is a disregard for and lack of stimulation of the capabilities of men for them to recognize themselves increasingly as active agents of affection before their families, overcoming the sexist dogmas which are so strong in our culture.

In this sense, it is important to develop more projects with the matter of paternity involving health professionals in order to make them see changes necessary in the way fathers assisted at health services are perceived, towards a greater inclusion of these individuals throughout the gestational process.

Institutional, educational and informational interventions which promote the organization of new representational elements about paternity are necessary so that fathers can effectively participate in a so unique moment in their lives, which is the birth of a child, and so this greater participation can influence the raising of this child in a positive way.

We know that changing a paradigm that is so deeply rooted in our culture is a hard movement and that the inclusion of fathers in spaces of care and affection, also in the health area, requires changes in other dimensions such as family and work spaces. The proposal of making fathers be actually valued should overcome difficulties beyond those identified at health services, for being a greater issue, given that our entire social organization is still based on patriarchal precepts.

Concerning the development of this study, we assess as relevant that it continues, including for instance health professionals who have just graduated and entered the job market, or medicine and nursing students, in order to observe whether their practices of assistance to the man and father are considerate when compared with practices by professionals who have been working in the area for a longer time, as it is the case of the interviewees in this study.

Other researches, with a research-action proposal, could intervene directly with professionals, discussing multiple family constitutions, the impact of social context and cultural practices on expectations about the performance of paternal and maternal roles, and the importance of health professionals in the strengthening of family ties (father-child; mother-child, father-mother).

We thus see the great field of research (in terms of methods, target population and approaches) that we still have open when discussing the important relationship between health professionals and fathers/paternity. Recognizing the positive impacts that the intervention of these professionals can promote on both the formation of family ties and the child's development, we conclude highlighting the relevance of this focus in researches and studies in order to generate data that strengthens more humanized practices at health services and which allows fathers to engage and feel part of the various stages in the development of their children.

References

Bardin, L. (2009). Análise de Conteúdo. Lisboa: Edições 70, LDA.

Carvalho, M. L. M. (2003). Participação dos pais no nascimento em maternidade pública: dificuldades institucionais e motivações dos casais. *Caderno Saúde pública, 19*(2), 389-398.

Coutinho, B. B. & Trindade, Z. A. (2006). As representações sociais de saúde no tratamento de leucemia e linfoma. *Psic: Revista da Vetor Editora, 7*(1), 9-18.

Fleming, J., King, A.; Hunt T.(2014). Just call me dad: health and social benefits to fathers and their children. *Children Australia, 39*(1), 34-41.

Fletcher, R. & Stgeorge, J. (2011). Heading into fatherhood - nervously: support for fathering from online dads. *Qualitative Health Research, 21*(8), 1101-14.

Gonçalves, T. R., Guimarães L. E., Silva, M. R., Lopes, R. C. S., & Piccinini, C. A. (2013). Experiência da paternidade aos três meses do bebê. *Psicologia Reflexão Critica, 26*(3), 599-608.

Gutierrez, D. M. D., Minayo, M. C. S., & Oliveira, K. N. L. C. (2012). Homens e Cuidados de Saúde em Famílias Empobrecidas na Amazônia. *Saúde e Sociedade, 21*(4), 871-883.

Jodelet, D. (2000). Representaciones sociales: contribuición a um saber sociocultural sin fronteras. In D. Jodelet & A. G.

Tapia (Orgs) *Develando la cultura: estúdios em representaciones sociales* (pp. 07-30). México: UNAM.

Jovchelovitch, S. (2000). *Representações sociais e esfera pública: a construção simbólica dos espaços públicos no Brasil.* Petrópolis: Vozes.

Kanno, N. P., Bellodi, P. L., & Tess, B. H. (2012) Profissionais da Estratégia Saúde da Família diante de demandas médico-sociais: dificuldades e estratégias de enfrentamento. *Saúde e sociedade, 21*(4), 884-894.

Lacerda, A. C. T., Vasconcelos, M. G. L., Alencar, E. N., Osório, M. M., & Pontes, C. M. (2014). Adolescent fathers: Knowledge of and involvement in the breast feeding process in Brazil. *Midwifery, 30*, 338–344.

Lei nº 11.108, de 7 de abril de 2005. (2005, 6 de abril). Altera a Lei no 8.080, de 19 de setembro de 1990, para garantir às parturientes o direito à presença de acompanhante durante o trabalho de parto, parto e pós-parto imediato, no âmbito do Sistema Único de Saúde – SUS. Brasília: Subchefia para Assuntos Jurídicos. Recuperado em 20 de janeiro, de 2015, de http://www.planalto.gov.br/ccivil_03/_Ato2004-2006/2005/Lei/L11108.htm

Levorato, C. D., Mello, L. M., Silva, A. S., & Nunes, A. A., (2014). Fatores associados à procura por serviços de saúde numa perspectiva relacional de gênero. *Ciência & Saúde Coletiva, 19*(4), 1263-1274.

Locock, L & Alexander, J. (2006). 'Just a bystander'? Men's place in the process of fetal screening and diagnosis. *Social Science & Medicine 62,* 1349-1359.

Martins, A. C. (2009) Paternidade: repercussões e desafios para a área da saúde. *Rev Genero, 10*(01), 239-250. Recuperado em 20 de janeiro, de 2015, de http://www.revistagenero.uff.br/index.php/revistagenero/article/view/50/33

Navarro, G. M.; López, E. C.; Calvente, M. M. G.; Ruzzante, N. H.; Rodríguez, I. M. (2009). Paternidad y servicios de salud. Estudio cualitativo de las experiencias y expectativas de los hombres hacia la atención sanitaria del embarazo, parto y posparto de sus parejas. *Revista Española de Salud Pública, 83*(2), 267-278.

Oliveira, M. S. B. S. (2004). Representações sociais e sociedades: a contribuição de Serge Moscovici. *Revista Brasileira de Ciências Sociais, 19(*55), 180-186.

Perdomini, F. R. I. & Bonilha, A. L. L. (2011). A participação do pai como acompanhante da mulher no parto, *Texto Contexto Enferm, 20*(3), 445-52.

Pierre, L. A. S. & Clapis, M. J. (2010). Planejamento familiar em Unidade de Saúde da Família. *Revista Latino-Americana de Enfermagem*. Recuperado em 1 de junho, de 2015, de http://www.scielo.br/pdf/rlae/v18n6/pt_17.pdf

Pontes, C. M., Alexandrino, A. C., & Osório, M. M. (2009). O envolvimento paterno no processo da amamentação: propostas de incentivo. *Revista Brasileira de Saúde Materno Infantil, 9*(4), 399-408.

Pope, C., Ziebland, S., & Mays, N. (2005). Analisando dados qualitativos. In C. Pope & N. Mays (Orgs.). *Pesquisa qualitativa na atenção à saúde* (2a ed., pp. 87-99). Porto Alegre: Artmed.

Portaria nº 1.944, de 27 de agosto de 2009. (2009, 27 de agosto). Institui no âmbito do Sistema Único de Saúde (SUS), a Política Nacional de Atenção Integral à Saúde do Homem. Brasília: Ministério da Saúde. Recuperado em 04 de fevereiro, de 2014, de http://bvsms.saude.gov.br/bvs/saudelegis/gm/2009/prt1944_27_08_2009.html

Sá, C. P. (1998). A construção do objeto de pesquisa em representações sociais. Rio de Janeiro: Eduerj.

Shia, N. & Alabi, O. (2013) Male partners' perceptions of antenatal classes in a national health service hospital: implications for service provision in London. *The Journal of Perinatal Education, 22*(1), 30-38.

Sherriff, N. & Hall, V. (2014). Rhetoric or reality? Father support in promoting breastfeeding. *International Journal of Birth and Parent Education, 1*(4), 19-22.

Silva, B. T., Santiago, L. B., & Lamonier, J. A. (2012). Apoio paterno ao aleitamento materno: uma revisão integrativaa *Rev Paul Pediatr, 30*(1), 122-30.

Silva, B. T., Silva, M. R. S., & Bueno, M. E. N (2014). Eventos intra e extrafamiliar significativos no processo de construção da paternidade. *Escola Anna Nery Revista de Enfermagem, 18*(4), 710-715.

Silva, M. R. & Piccinini, C. A. (2007). Sentimentos sobre a paternidade e o envolvimento paterno: um estudo qualitativo, *Estudos de Psicologia, 24*(4), 561-573.

Schraiber, L. B., Figueiredo, W. S., Gomes. R., Couto, M. T., Pinheiro, T. F., Machin R., Silva, G. S. N., & Valença, O. (2010). Necessidades de saúde e masculinidades: atenção primária no cuidado aos homens. *Caderno Saúde Pública, 26*(5), 961-970.

Souza, L. G. S. (2012). *Profissionais de Saúde da Família e representações sociais do alcoolismo.* Tese de Doutorado Não-Publicada, Programa de Pós-Graduação em Psicologia, Universidade Federal do Espírito Santo, Vitória, Espírito Santo.

Tarnowski, K. S., Próspero E. N. S., & Elsen I., (2005). A participação paterna no processo de humanização do nascimento: uma questão a ser repensada. *Texto & Contexto - Enfermagem, 14*(spe), 102-108.

Received: Jul. 08, 2014
Approved: Oct. 23, 2015

Mirian Beccheri Cortez: Psychologist, postdoc in Psychology from the Federal University of Espirito Santo [*Universidade Federal do Espírito Santo*] (UFES), currently working with Women's Protection Management at the State Secretariat of Security and Public Defense. Invited researcher of the Study and Research Network in Social Psychology [*Rede de*

Estudos e Pesquisas em Psicologia Social] (RedePso-UFES)

Nathália Meneghel Machado: Psychology Undergraduate Student at the Federal University of Espírito Santo (UFES), with Facitec scientific initiation scholarship, member of the Study and Research Network in Social Psychology (RedePso-UFES).

Zeidi Araujo Trindade: Psychologist, PhD in Psychology from the University of São Paulo [*Universidade de São Paulo*] (USP). Professor at the Department of Social Psychology and Development and in the Postgraduate Program in Psychology of the UFES. Coordinator of the Study and Research Network in Social Psychology (RedePso-UFES)

Luiz Gustavo Silva Souza: Psychologist, PhD in Psychology from the Federal University of Espírito Santo (UFES), with PhD traineeship at the University of Provence [*Université de Provence*] (France). Adjunct Professor at the Department of Psychology of the Fluminense Federal University, Campos dos Goytacazes campus. Collaborator Professor of the Postgraduate Program in Psychology of the UFES (PPGP-UFES).