

Men and health care in the social representations of health professionals

Homens e cuidado à saúde nas representações sociais de profissionais de saúde

Hombres y el cuidado con la salud en las representaciones sociales de los profesionales de salud

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ABSTRACT

Objective: This study aimed to describe the social representations of health professionals about men and health care, from the content and structure of these representations. **Methods:** This is a descriptive and qualitative study, having as theoretical and methodological referential the Structural Approach of the Social Representations Theory. It was performed with 104 health professionals of the primary care in the city of Aracaju - SE, through the Technique of Free Word Evocation to collect the data that were processed by the software EVOC 2003. **Results:** 487 words were evoked in response to the inductive term "men and health care". The results evidenced that the workers have a negative representation of men and care about their health, being the disinterest, fear and carelessness the most evoked terms. **Conclusion:** Thus, it is necessary to sensitize health professionals, users and the general population to the negative effects of these conceptions perpetuated in the social imaginary that distance the man of the health care.

Keywords: Men; Masculinity; Behavior; Primary Health Care.

RESUMO

Objetivo: Descrever as representações sociais dos profissionais de saúde sobre homens e cuidado à saúde, a partir do conteúdo e da estrutura dessas representações. **Métodos:** Trata-se de um estudo descritivo, qualitativo, que teve como referencial teórico-metodológico a Abordagem Estrutural da Teoria das Representações Sociais. Realizado com 104 profissionais de saúde da atenção básica do Município de Aracaju - SE, utilizou-se a Técnica de Evocação Livre de Palavras para coleta dos dados, estes foram processados pelo *software* EVOC 2003. **Resultados:** Foram evocadas 487 palavras em resposta ao termo indutor "homens e cuidado à saúde". Os resultados evidenciaram que os trabalhadores têm uma representação negativa acerca dos homens e o cuidado à sua saúde, sendo o desinteresse, medo e descuidado os termos mais evocados. **Conclusão:** Dessa maneira, é importante sensibilizar profissionais de saúde, usuários e a população para os efeitos negativos dessas concepções perpetuadas no imaginário social que distancia o homem do cuidado a saúde.

Palavras-chave: Homens; Masculinidade; Comportamento; Atenção Primária à Saúde.

RESUMEN

Objetivo: Describir las representaciones sociales de profesionales de salud sobre hombres y el cuidado de la salud, a partir del contenido y de su estructura. **Métodos:** Estudio descriptivo, cualitativo, realizado con 104 profesionales de salud de la atención primaria de la ciudad de Aracaju - SE, a través de la Técnica de Evocación Libre de Palabras. Los datos fueron recolectados y procesados por el *software* EVOC 2003. **Resultados:** Fueron evocadas 487 palabras en respuesta al término inductor "hombres y cuidado de la salud". Los resultados evidenciaron que los trabajadores tienen una representación negativa de los hombres y el cuidado de su salud, siendo el desinterés, miedo y descuidado los términos más evocados. **Conclusión:** Se hace importante sensibilizar a los profesionales de salud, los usuarios y la población para los efectos negativos de estas concepciones perpetuadas en el imaginario social que aleja el hombre del cuidado de la salud.

Palabras-clave: Hombres; Masculinidad; Comportamiento; Atención Primaria a la Salud.

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INTRODUCTION

Although being more vulnerable and dying earlier, men do not almost seek health services, especially the primary care, because they considered themselves being invulnerable. Like this, they take care less on themselves, having the risk of getting sick. There are several causes showing this difficulty, divided into two groups: Sociocultural and institutional barriers¹.

The sociocultural barriers are related to gender stereotypes that they conceive to be a man, as a strong, virile and invulnerable human being². This idea is linked to gender identity image and cultural issues, as there are patterns of masculinity that repress the needs and the health care, fed the social imaginary, in which the care is not treated as a practice of male health, so that cultural ties and the imaginary of being a man, imprison the individual^{3,4,5}.

Among the institutional barriers that endanger men seeking the health services are the hours of operation of the units, similar to their work; health teams consisting predominantly of women; the delay in being attended; poor reception; unpreparedness of professionals; the absence of programs for male; the physical structure without privacy attendance; precarious and poor solutions of health services, especially in primary care^{4,6,7,8,9}.

This image of being a man has a reductionist social representation of health care professionals not perceiving men as subjects to care. Many times, this behavior is related to the unpreparedness of these professionals to work with the new demands and needs of specific health of the male population, because each mode of living life translates different health needs. Thus, the apprehension of the social imaginary of masculinity by health professionals, mobilizes emotions, play a redefinition and social representations, which reflects in the form of health producing^{2,4,7,9}.

In this context, the current technological structure of the technical care model in health services, is centered on the problem of health and medical consultation, operating in the hegemonic medical model and puts the caring dimension to a minor and secondary role¹⁰.

Alternative care models have been developed, such as the Family Health Strategy (FHS), trying to overcome this way of producing health established by hegemonic model¹⁰.

To attend the individual and the collectivity, the FHS is operationalized by multidisciplinary teams that have the promotion and protection of health, treatment and rehabilitation, the pillars of their work. Besides the individual procedure, with the expansion of the FHS, there was also increased health care targeted to specific population groups such as women, adolescents, the elderly and children. However, to reach all individuals, it is necessary to develop actions to rescue the completeness, strengthening networks and social participation.

The work developed in the FHS, even to the individual and communities, prioritizes care to specific groups and men remain in this model of care, in a distant way to some approaches of the strategy, as the promotion and prevention health.

To change this estrangement between man and the health care and incorporate him into all levels of care, especially those between 20 and 59 years old, the Ministry of Health established in 2009, the National Policy of Integral Care to Men's Health (PNAISH). Accordingly, this policy reflects the need to put men and their health demands in the focus of public health programs, because it is known that many of the problems affecting men could be avoided if they were inserted in the health care services¹.

However, to institute health policies and make them work depends not only on the elaboration, implementation and financing by managers, because there are the human resources involved in this process, which are necessary for the operation "instruments" and therefore the success or failure of these policies.

Policies and health programs instituted at FHS attempt to standardize the daily practice of professionals, but the power of influence of these standardizations is limited, since in everyday life is their subjectivity and their relation to the user that will define how care will be held. That is, although the family health teams work guided by normative rules only the performance of each professional who composes these teams will be different and singular¹¹. Therefore, PNAISH is not inserted into the routine of a health professional because for many years they had not given attention to the male population, determinants and health indicators.

In this perspective, to change the mode of production of care is needed dispossession of healthcare professionals and users, as these workers operate from existential territories organized by their subjectivity and from that, building a new social representation of men to health professionals. To modify an organizational structure, a work process, it is necessary to (re) build a subjectivity in that worker producing this dispossession and a new representation. This process is difficult and complex and involves much more than the implementation of a new policy or a new organizational structure¹¹.

In this way, man and health care can also be configured as a phenomenon of social representation among these professionals, with this pioneering study demonstrating the relevance and "social thickness" of this object, being as the basis for construction and soundness of these representations¹². Thus, how the professional recognizes the user within the health service and the social representation of this professional can influence his action in the production of care, since there is the subjectivity of each professional.

In this sense, it was based on the Social Representations Theory (SRT)^{13,14} seeking to understand this phenomenon in the perception of social subjects that operate in the FHS,

elucidating the inherent subjectivity of the care that man has with his health. Moreover, a social representation is anchored in advance of an action, relying on the behavior guide and in the meantime, the theoretical basis of the SRT will understand the dynamics of the FHS professionals facing this problem¹⁴. This apprehension may guide future studies of social intervention on the topic, being directed to combat the stigma and prejudice that many health professionals have about the man and healthcare.

Therefore, in the moments that they implement PNAISH, to evaluate the effectiveness of their actions, it is important to understand the meaning that health professionals have about the man and be careful with his health. In this context, the aim of this study was to describe the social representations of health professionals on men's health care, from the content and structure of these representations.

METHODOLOGY

It is a descriptive study, of a qualitative approach, having as theoretical methodological referencial the SRT working with the Structural Approach or central core of this SRT¹⁴. The Central Core Theory aims to cognitive and structural dimension of social representations, since it is structured and organized in a central core by its significance and organization, showing sturdiness and sustenance to this representation^{13,14}.

This study is from the main Project "Work process of the FHS teams acting in men's health". The data collection was between January and August 2013, in the city of Aracaju, Sergipe, Brazil. It was performed in twelve Family Health Units (FHU), selected randomly by drawing lots.

In the FHUs were 36 family health teams, being 36 doctors, 36 nurses, 36 assistant nurses, 28 dentists, 28 assistants of dental office and 180 community health and endemic disease agents.

The selection of the research participants was by convenience adopting the following criteria: health professionals who were in the FHU in the moment of the researcher's visit were informed about the research and being invited to participate voluntarily. The one who accepted to participate were included in the study.

For data collection a questionnaire was performed composed by two blocks, the one about socio-demographic data for participant's characterization and the other constituted by the Technique of Free Word Evocation⁵, used the phrase "men and health care" as the inducing term.

For the evocation Technic execution, the participants were asked to evoke up to 5 words coming immediately to their mind, after given the stimulus inductor¹⁵. From this data, there was elaborated a word dictionary, with all the evoked terms and after that, the semantic analysis with all the terms

approximation was performed. Then, considering the evocation spontaneous order, these data were processed in a software denominated *Ensemble de Programmes Permettant L'Analyse des Évocations* (EVOC)¹⁶, version 2003, and after this they were organized according to the distribution technic of the terms produced in a Four Houses Chart¹⁵ analyzed according to the SRT structural approach.

In the four houses chart there are the content and the structure of social representations about a specific object and it is constituted from the crossing between frequency and hierarchical order of evocations. For this, the EVOC establish evocation frequency through the summation of frequencies that the term was evoked in positions 1 to 5. After this, the average evocation order is calculated through the weighted arithmetic average using weight 1 to the evocation in the first place, weight 2 for the second evocation and so on until the fifth position. Consequently, the program calculates the evocation order through the division of weighted by the sum of the evoked word frequency in the different positions and finally, it calculates the average of the average evocation order obtained through the average arithmetic order and the average of evocation of each word^{15,16}.

With these data, the EVOC distributes the processing results in the quadrant chart, being a similar diagram to a Cartesian system, which horizontal axis is represented by the average evocation order and the vertical axis is the evocation frequency. The upper left quadrant is composed of the most frequently evoked order and with low average order, indicating the probable central core. The lower right quadrant is formed for the least evoked terms and greater average order, indicating the probable periphery system^{15,16}.

Like this, the construction of the chart considered the average frequency of words evocation and the average of the average word evocation, described above. Finally, the EVOC excluded from the quadrants all words which frequencies were below the minimum frequency by the researchers and only after the distribution of produced terms, the interpretation of the chart was done¹⁵.

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RESULTS

The study sample was characterized by 104 health professionals, 79 were female (76%) and the other were male, with average age of 39.6 ± 10.90 , varying from 23 to 68 years old. From them 98 (94.2%) were state employees and 6 were (5.8%) contracted, with average service time of 7.64 ± 5.66 years.

From the participants 47 (45.2%) are health community agents, 17 (16.3%) nurses, 16 (15.4%) doctors, 12 (11.5%) dentists, and also 4 (3.8%) dental assistants, 4 (3.8%) nursing assistants, 3 (2.9%) endemic disease agents and 1 (1.0%) operational agent.

From the corpus analysis composed by the participants' evocations, there were 487 evocated words, that after semantic approximation, 117 different words and expression were systematized, with minimum frequency (cutoff) of 8, average of 17, and the average of average evocation order of 2.9. In this way, 175 words or expressions were excluded for being evoked with a frequency below the cutoff. With these data, the 117 words were categorized in 18 semantic groups, for being more important in the cognitive scheme of the participants.

Through the RANGMOT of the EVOC 2013, classifying words in lexical affluences according to the evocation occurrence, based on the simple and accumulated frequency calculation, it was possible to organize the 18 evocated semantic groups with higher frequency, from 1st to 5th evocation.

Taking into consideration the RANGMOT and the TABRGFR report, the EVOC showed as final construct the Four Houses Chart¹⁶ (Chart 1), expressing the content and structure of social representations of the health professionals in the men's and healthcare. For this chart, it was used for each evocated word or expression, the minimum evocation frequency (8), the average frequency (17) and the weighted order frequency of evocations or rang (2.9)¹⁵.

For the description and interpretation of the categorized results in Chart 1, the method of structural approach proposed by Abric was adopted, in which the terms attending simultaneously the evocation criteria with less frequency and in the first places, probably will present higher importance in the cognitive scheme of the professional with higher chance of being a central core hypothesis of social representation.

In Chart 1 there are four important elements for the apprehension of social representations of the professionals about the men and healthcare: the central core (upper left quadrant); the elements of the 1st periphery (upper right quadrant) and 2nd periphery (lower right quadrant); and contrast elements of representation (lower left quadrant)¹⁵.

Consequently, Chart 1 was descriptively analyzed, establishing the correlation between the evocated terms for the structural organization understanding of the representation¹³. Then, the evocations in the upper left quadrant are considered more significant for the professionals, composing the central core and the possible representation of the subject studied: disinterest, fear, careless, luck of prevention and prostate cancer.

The terms composed by the first periphery system were: chronic disease, immediate attendance and machismo. These evocations act as reinforcing elements of the core elements, characterized as peripherals, flexible and tangible elements,

with greater frequency and lesser importance given by the professionals.

In the second periphery, located in the lower right quadrant the evocations categorized were: care, lack of time, provider and health. These lexical terms are clearly more peripheral elements, given that they are less frequent and less important for professionals in their representations.

Finally, it was found that the terms STD, prejudice, difficult of access, irresponsible, smoking and shame are elements less frequently, but with greater importance in the cognitive scheme represented the contrast elements of representation, providing support and strength of the central core.

DISCUSSION

The terms mentioned in this study show a negative representation of the health professionals about the men in healthcare and reveal probably how social thinking and gender stereotypes are signifying praxis and producing professionals in these affections reflecting in the daily work process. The main evoked terms, central core, reaffirm the social imaginary perpetuated by sexist hegemonic model that imprisons man the idea of being strong, manly, invulnerable, home and family provider.

The association between this image of man in the healthcare image results in careful incipient, sloppiness, objectivity and practicality in attendance, valuing merely curative and the medicalization of the body depreciating prevention and health promotion. It is in this sense that disinterest, careless and lack of prevention terms appear in the central core of the study^{3,6}.

This image is reinforced due to a reductive representation of some health professionals in relation to human health, limiting it to prostate and sexual problems or chronic diseases and not recognizing care as inherent in male and consequently does not stimulate or even discourage prevention and health promotion⁵.

Many times this behavior is related to the unpreparedness of these professionals to work with the new demands and specific health needs of the male population, reflecting in a limited social significance, mobilizing few affections in care to them^{6,7,9,17}.

However, this reductionist view may be linked to the fact that men access health services seeking urologist, concerned with the prostate, or when suffering from acute problems such as pain, or chronic diseases such as hypertension and diabetes or questions of a sexual nature, such as sexually transmitted diseases^{5,8}.

Despite the careless of health, fear of discovering some serious disease and/or death, it is generally present in the male imaginary, accentuating the chasm that separates man and healthcare services^{2,5,8}. Study with male found that 57.62% of the men surveyed revealed that feeling¹⁸.

Chart 1. Four Houses Chart to inductor stimulus “men and healthcare”. Aracaju/SE, 2013

Central core			First periphery		
AF ≥ 17	AEO ≤ 2.9		AF ≥ 17	AEO > 2.9	
ET	F	AEO	TE	F	AEO
Disinterest	45	2.489	Chronic disease	46	3.43
Fear	31	2.613	Immediate attendance	19	3.63
Careless	24	2.208	Machismo	17	3.35
Lack of prevention	20	2.05			
Prostate Cancer	17	1.941			
Contrast area			Second periphery		
AF < 17	AEO ≤ 2.9		AF < 17	AEO > 2.9	
TE	F	AEO	TE	F	AEO
STD	11	2.36	Care	14	3.00
Prejudice	9	2.67	Lack of time	11	2.91
Difficulty to access	8	2.37	Provider	8	4.37
Irresponsible	8	2.62	Health	8	3.62
Smoking	8	2.62			
Shame	8	1.87			

AF: Average Frequency; ET: Evoked Terms; AEO: Average Evocation Order; F: Frequency.

Besides this, the shame is another feeling that appears in contrast of this study area, by the shame of exposing the body, especially regarding the prevention of prostate cancer, to share educational spaces with women, to demonstrate a sign of weakness seeking health services, which historically is a female behavior and even ashamed to expose their needs to a female professional, which also appears in the literature as an expression of male resistance to self-care¹⁷.

Immediate attendance, the first periphery element evoked, reflects an elaboration characterizing the man within the health service, negatively depending on their impatience in waiting for service. Men seek immediate attendance and so often prioritizes the services of pharmacies and emergency rooms, or even self-medication. This delay in treatment is considered one of the difficulties in access to health services^{4,6,9}.

Men assign to the timeliness in attendance as an indicator of satisfaction to the good attendance¹⁷. Furthermore, the time spent for appointments and for waiting for appointments becomes incompatible with users entered the labor market⁸.

Even in the first periphery, the term machismo is the essence of the various evocations of this study and reflects the perceived social thought in which man does not get sick, the image of maleness associated with adoption of risk behaviors such as alcohol use, licit drugs and illicit acts of violence (external causes), demobilizing affections that would allow these professionals seeking new ways to reframe the man and care^{8,19}.

These behaviors are factors that possibly worsen the health of men because beyond this hardly dispense time to care for their own health, or perhaps not to conduct a care in the manner that, currently, the models of health care mainly the FHS, based on surveillance, prevention and health promotion, it adopts behaviors that can make them even more vulnerable.

Given this scenario involving machismo in the care of their health, prejudice, evoked by professionals in the contrast area, highlights the perceived sense that health services, especially primary health care, are spaces for women, children and the elderly, causing certain discomfort and fear to the men in this environment. In this sense, disability specialists, such as urologists, programs, actions or activities specifically addressed the demands of men, contribute to the perpetuation of this concept, as well as reducing access to these health services^{2,3,6,8}.

The difficulty of access element of the contrast area, was because men do not seek health services or they are invisible in them. This idea is, again, linked to gender identity and cultural issues, as there are patterns of masculinity that repress the needs and health care and demobilize the signs of weakness and vulnerability, enhancing the strength and virility as a social representation to be man in society^{3,5,9}.

However, despite the barriers that hinder men access to health services, they have sought care. Study highlights that in the services surveyed there was notorious male presence, although predominant seniors and children⁶. This suggests that

even incipient, there is the production of new affections in men mobilizing new ways to mean the health care and the social role of man in health care.

The aforementioned lack in health facilities is strongly influenced by the work, coinciding with the opening hours of the units as well as the culture perpetuated in society and the world of work that devalues the work absence due to health/disease in men^{4,8,9}.

Research found higher male presence in health services which have alternative customer Service schedules, as third shift (night), Saturday or services that operate 24 hours, indicating a need for managers to assess the representation of social work and health society and especially for men and with it the possible expansion of hours of operation of health services, with a focus on prevention and health promotion, in an attempt to facilitate access of the working class to health care⁶.

In this perspective the work, the term provider, present in the second periphery, is socially recognized as a feature of masculine identity, attitude that dignifies and gives moral value to man and is the work that drives the recognition and social respectability, allowing it to fulfill with their obligations before the family and society. It is through work that man can signify the role of head of family⁹. However, this social obligation that makes the man primarily responsible for supporting the family and relieves him of the role of taking care of their own health, forcing him to prioritize his time at work, instead of health.

The evocation lack of time, which appears in the second periphery, complements the sense of evocation provider, because man does not prioritize health, especially in aspects involving the prevention. As the opening hours of primary care units is generally incompatible with the work schedule, the work in this dispute is priority, consequently, man neglects health. The care and health terms, which also appear in the second periphery, are evoked in this sense, where men need to prioritize more care of their own health.

The transformations that have occurred in society over time, as the increasing participation of women in the labor market, often making the head family and providers of home assignments yet, hegemonic masculine, mobilized affections in men, producing new meanings and representations to the ideal of masculinity constructed and socially seized, leaving them to their role as affected and frustrated with some social institutions such as marriage and work⁷.

So, even with the changes in society in recent years, when the man tries to break through these barriers imposed by hegemonic masculinity model and reframe the health care also becomes the target of criticism because the representation of society opposite to be man is still somewhat limited deserving several analyzes. It is necessary to act intensively to deconstruct the image of masculinity prevailing in the social

imaginary, in an attempt to bring the asset to the male universe with health care.

FINAL CONSIDERATIONS

The findings and conclusions of this research show the social representations of health professionals on men and health care. Based on the assertion that man remains distant from the actions of health care, it should be emphasized that this fact is due not only issues of service delivery, not only the managerial nuances of the system, but also dealing with issues that involve masculinity, being a man in society, gender issues, education and the prejudices surrounding them.

Even with changing the culture and customs ahead of time to progression, many social paradigms involving masculinity, arising from differences of gender, are perpetuated in the social environment and can have serious consequences for men's health conditions.

As observed in this study, these cultural issues still are present and negatively interfere with vision and consequently, professional behavior since the care is influenced by the subjectivity of those who produce it. Health professionals still do not recognize the men as protagonists of their own health care, therefore, shall not encourage that care primarily focus on prevention and health promotion because, somehow, men have become accustomed to this behavior.

With this increased awareness of managers, professionals and health workers, service users and the general population, giving greater flexibility to these conceptions that interfere negatively in men's health is necessary because male mortality indicators show that there is a pressing development of intervention strategies political, economic, social and organizational change that may be this conception of man and healthcare. An important step was taken in 2009, with the implementation of PNAISH, however, it is necessary to sum efforts to decrease the chasm created over the years, among men and health care.

Despite the importance in knowing the social representation of health professionals in relation to human health, especially in those years preceding the implementation of PNAISH, to strengthen strategies for the effective functioning of this policy, this study had some limitations such as: reduced number of professionals in the sample, the non-segregation of representations by gender and professional category.

It is interesting to investigate the subjectivities that involve the action of these health professionals, as well as the possible justifications for this view of the human being and the strategies that can be developed to minimize the effects of this reductionist view, as well as investigate the subjectivities that permeate the men in relation to this attitude of health professionals.

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