The standpoint of professionals on the presence and demands of men on the healthcare services: perspectives for the analysis of the implementation of the Comprehensive Healthcare Policy for Men

A visão dos profissionais sobre a presença e as demandas dos homens nos serviços de saúde: perspectivas para a análise da implantação da Política Nacional de Atenção Integral à Saúde do Homem

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Abstract ***In 2009, the Brazilian Comprehensive Healthcare Policy for Men (PNAISH) was launched in Brazil, seeking to reduce morbidity and mortality in this population group. This article strives to analyze the conceptions that health professionals have about the specific demands and behaviors of the male population served by the healthcare services. The data analyzed are part of a larger research project, the objective of which was to evaluate the initial actions of the implementation of PNAISH. Ethnographic observations in 11 health services and semi-structured interviews were conducted with 21 health professionals. From the perspective of health professionals, the presence of men in the healthcare services is still limited. According to them, it is comprised of two types of clients: workers and the elderly. The male behavior characteristics – haste, objectivity, fear and resistance – and the difficulty faced by health services in receiving this population are the main factors that drive men away from health services. Although the concept of gender is central to PNAISH, it is only triggered by healthcare professionals in order to justify the social standards expected in terms of men's behavior. The attribution of men's behavior to cultural factors ultimately obscures the relations of power that underlie gender relations.***

Key words ***Men's health, Gender and health, Health policy***

Resumo ***Em 2009 é lançada, no Brasil, a Política Nacional de Atenção Integral à Saúde do Homem (PNAISH), que tem por objetivo reduzir a morbimortalidade deste grupo populacional. O presente artigo tem por objetivo analisar as concepções que os profissionais da saúde possuem sobre as demandas e os comportamentos específicos da população masculina atendida nos serviços de saúde. Os dados analisados são parte de uma pesquisa maior, cujo objetivo foi avaliar as ações iniciais da implantação da PNAISH. Foram realizadas observações etnográficas em 11 serviços de saúde e entrevistas semiestruturadas com 21 profissionais de saúde. Na perspectiva destes, a presença dos homens nos serviços de saúde é ainda bastante limitada, sendo constituída, por dois tipos de clientela: trabalhadores e idosos. As características do comportamento masculino - a pressa, objetividade, medo e resistência -, e a dificuldade dos serviços em acolher esta população, são os principais fatores que afastam os homens dos serviços de saúde. Apesar do conceito de gênero se encontrar no centro da PNAISH, este é acionado pelos profissionais de saúde apenas no sentido de justificar os padrões socialmente esperados em termos do comportamento dos homens. A atribuição do comportamento dos homens a fatores culturais acaba por ocultar as relações de poder que permeiam as relações de gênero.***

Palavras-chave ***Saúde do homem, Gênero e saúde, Política de saúde***

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Introduction

In Brazil, healthcare policies have historically been geared to mother/child healthcare. This situation was criticized by the feminist movement which, in the late 1970s, demanded broader government action in terms of women's health, as well as to offset the dominant model by means of discussion on the implications of gender standards for health. As a result of this debate the Comprehensive Healthcare Program for Women (PAISM) was launched in 1983, which represented an important milestone in the sphere of public policies geared to women's health, including family planning among other points[1]. The program was based on a criticism of the dominant pregnancy-childbirth approach in the health services and called for comprehensive healthcare for women. The concept of comprehensive care was one of the core tenets of the Program which implied that health professionals needed to adopt a new approach that should include educational practices to give women control over their health[2-4].

Twenty years after launching PAISM and due to the fact that it was never fully established nationwide, in 2004 the Ministry of Health launched the National Comprehensive Healthcare Policy for Women (PNAISM), making women's health a priority[5]. The broader emphasis on women's health of PNAISM had little impact for the inclusion of men, even in family planning actions, in terms of the healthcare services. In light of the fact that the development of public policies from a gender standpoint has been fostered since the International Conference on Population and Development in Cairo in the mid-1990s, it is important to note that in terms of health services in general, improvements have so far been limited to mother/child care, offering programs for cervical cancer prevention, contraception, but they still continued to be geared towards women and children[6].

It was only in 2009 that the Brazilian government launched a specific policy for the male population, namely the Brazilian National Men's Health Policy (PNAISH)[7]. This policy, according to the official document, aims to reduce morbidity and mortality among men by increasing and facilitating access and care in terms of prevention and assistance for this population group. According to Carrara ***et al.***[8] PNAISH is considered by the Ministry of Health as a vanguard of public policy from a global standpoint, as it is the first in Latin America and the second in the Americas, after Canada. In the authors' analysis, although gender and the principles of prevention and health promotion are present in the official text of PNAISH, what stands out in the document is a focus on erectile dysfunction as a public health problem, and consequently the risks of medicalization of the male body are pointed out.

Despite the delay by the government in tackling the problem of male health, several studies have already pointed out the different profiles of illness and death between men and women since the 1990s. In addition to issues related to work, issues related to reproduction and sexuality, particularly after the HIV/Aids epidemic, have also become the subject of research and intervention[9]. More recently, the theme of violence has been included, where men are seen as being not only the main actors of gender-based violence but also the main victims of urban violence[10].

The type or absence of their relationship with the health services depends on how men perceive it. According to Figueiredo[11], several explanations have been put forward for the male relationship with the health service, either based on man's masculinity and/or the structure of the health services. The lack or invisibility of men in the health services shows, according to the author, a mismatch between needs and/or expectations of men's health and the structure and functioning of the health services, particularly for primary healthcare services. However, it is not a case of blaming men or the health services, but of considering the complex relationship established between them, based on the particularities of one and the other[11]. While according to Carrara ***et al.***[8]***,*** male resistance to health policies is due, above all, to the position they hold in the gender hierarchy, being primarily more of a strategy for not being considered equal to women.

Within this context, this paper seeks to contribute to greater in-depth understanding of the relationships that are established within the health services between health professionals and male users. Based on a survey that focused on evaluating the implementation of PNAISH, the specific aspect under scrutiny of the research undertaken here analyzes the perceptions that health professionals have about the specific demands and behaviors of the male users of the health services. We believe that this focused analysis enhances the understanding of institutional barriers (services versus users) and relationships (professionals versus users) that impact on acceptance of the male demands on the services and on comprehensive care offered to users; as well as pointing out the limits and potential of the initial actions to set up PNAISH.

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Methodology

This study is part of a larger research project that evaluated the initial actions of setting up the Brazilian National Men's Health Policy (PNAISH), carried out by the Fernandes Figueira National Institute for Female, Child and Adolescent Healthcare (IFF) of the Oswaldo Cruz Foundation (Fiocruz), with funding from the Department of Science and Technology (DECIT) of the Department of Science, Technology and Strategic Inputs (SCTIE) of the Ministry of Health (MOH)[12].

The larger study, approved by the Ethics Committee of the above mentioned Institute, was guided by a case study, or rather a set of five case studies, with the triangulation of methods[13,14] being the methodological benchmark, encompassing the epidemiological and anthropological approaches and using the questionnaire, narrative and semi-structured interview techniques, as well as observation based on ethnographical principles.

The selection of the five cases arose initially from the analysis of the Action Plans (AP) of the states, municipalities and the Federal District, and subsequently from the analysis of data derived from an evaluation form prepared and sent to municipal managers and the Federal District manager. The data from these two sources were compared and evaluated for consistency between the results and the guidelines of PNAISH and the National Action Plan (NAP)[15]. Finally, the following municipalities – one per region – were selected as being representative in Brazil: Rio Branco, State of Acre; Goiania, State of Goiás; Petrolina, State of Pernambuco; Rio de Janeiro; State Rio de Janeiro; and Joinville, State of Santa Catarina.

The survey in the municipalities was conducted by contacting local research supporters chosen by municipal healthcare managers. This prior contact defined: services to be investigated (according to the criteria to be used to set up male health actions and the different levels of care); and the time to carry out the survey and its logistics. After which, teams of experienced researchers, trained and supervised by members of the general/ national coordination of the project went to the five municipalities and carried out the survey in a week, totaling 40 hours of field work in each municipality. The research took place in August 2011 and all the empirical material produced was duly recorded on audio (interviews) or recorded in field diaries (observational reports).

In all, 11 services were surveyed, and eight of these were concentrated in Primary Healthcare Services. The remainder included services of medium and high complexity in which specific activities/care for sectors of the male population were researched. As for direct observations, the main roadmap covered different levels of healthcare: general characterization of services; organizational and operational characteristics of general care and specific actions/activities for the male population aged 20-59; detailed list of the presence of male users in the services and their relationship with professionals in the healthcare context.

With respect to the semi-structured interviews, they were staged with 21 health professionals whose work was related to male health in the five regions of the country. The interviewees were mainly in the 40-49 year age group, married and had been trained predominantly in health courses (nursing, medicine, psychology and social services). Also noteworthy is the fact that more than half (12) of them had completed a ***lato-sensu*** post-graduate course. Many of them had more than one job: many doctors in the public service also work as teachers or tutors at universities and there are those who maintain private practice or work in private companies. Also there are doctors and nurses who work in more than one public service – state and municipal governments – or within the basic network and public hospitals. Many of these professionals have some flexibility in working hours in the public service and can thus work in other places. The interviewees accumulate weekly hours of work to improve their incomes.

Since the specific aspect under scrutiny here is the perception of health professionals about the presence and demands of service users that are implementing actions related to PNAISH, it is important in general terms to stress the involvement of these individuals with this policy. In general, such involvement was through an invitation to attend an event – for training or awareness – regarding the new policy. The invitation was proffered either so that the interviewee might become involved with the new policy or it was made because it was already certain that in his/her unit or team there would be actions geared to men aged 20-59 years. However, despite being identified by the local managers and policy partners at the local level, the respondents in many cases had little or no familiarity with the policy in terms of knowledge of the general guidelines and, furthermore, of the plans that the state and municipality proposed for the first triennium (2009-2011).

During the review process the data from interviews with healthcare professionals and the direct observations of activities/services were con-

sidered the most relevant. The specific aspect of the analysis under scrutiny was possible by making scripts that emphasized this dimension. Thus, the demands and health needs presented by the users and the responses in terms of care given (or not) based on what the health service professionals said as well as the interaction between these professionals and with the former in the healthcare context are discussed below. In order to illustrate and clarify the results obtained, excerpts from interviews and field diaries will be presented.

The data was handled as follows: primary reading of the selected material and classification of sections by theme, detailed reading of the theme sections, identification of categories and meanings, interpretation and construction of a synthesis of same, elaboration of the issues found compared with the literature about the attention and care for male health, from the perspective of gender and masculinities.

Results and discussion

Male users in the health services: workers and the elderly

One of the first things to consider is that in the five target municipalities in the study (and in these, the health services investigated) there are not, in fact, any ongoing actions geared to the male population in the age group surveyed (20-59 years of age). Likewise, it was not possible to identify actions that address, effectively, the main factors of morbidity and mortality in male health, as shown in the literature[16,17], as well as the social determinants that result in the vulnerability of the male population to health problems, highlighted in the principles and guidelines of PNAISH[7]. Thus, the existing activities geared to men are isolated, with little connection to the proposed guidelines in PNAISH and generally focused on clinical-care actions. Health promotion and prevention activities were observed in the routine operations of only one APS service unit.

From the viewpoint of the professionals interviewed, the health service clients continue to be mostly women and children despite the timid start up of PNAISH. Estimates show that the male population represents a maximum of between 30% and 40% of the demand. However they recognize that this situation is changing rapidly, since at present the number of men is already higher than that observed some years ago.

Men identified by health professionals as users of the services are divided into two categories: workers and the elderly. The first group, a minority, is made up of men between 30 and 50 years of age who are employed and thus have little time to go to the health services. The second group, the elderly group, is the majority of the male users who go to the health clinics, due to some chronic disease, such as hypertension or diabetes, as well as for consultation, seeking prescriptions or medicine.

This last finding should be examined in line with the type of services, since most of the users were at the primary care level. The APS has historically been focused on the maternal and child segment, but since the 1980s it has been receiving a greater number of the elderly. In recent years, programs for chronic diseases, such as the Hiperdia program (arterial hypertension and diabetes mellitus), have given easier access for the elderly and their needs, thus attracting elderly male users to such services[18].

The fact that a majority of males are employed in the formal labor market is considered one of the reasons for the low demand of health services by this population. The fear of being penalized at work for time off for medical appointments, even with a certificate for sick leave, is one reason that keeps the men away. Besides this factor, the interviewees point out that many companies and local industries only authorize days off with the presentation of a medical certificate, which is not provided by health services in the case of appointments, group participations, collecting medical prescriptions and other activities related to prevention.

We also have great difficulty ... Men come here, we provide a statement of appointment attendance, you understand? There is no need for a day-off or sick certificate. And we have great difficulty for the companies to sanction this day, as time off, or as ... understand? We have a lot of problems with this here – not just for men, but for women too, when it comes to prenatal care – so many of them do not come because of that, "oh, I will not go because my company will not authorize it, I'll be considered absent without leave" (Nurse Int.05).

The certificates or statements that the user has been at the health clinic are of little use for men. Moreover, for men just scheduling an appointment takes a long time and is different from the time they spend at the clinical appointment itself.

The extended opening hours of the health facilities is seen as a move that could attract a greater number of male users. This has been seen, for

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example, in a service where the extended opening hours have brought improvements in the organization of activities, including the increased number of men coming to the service.

Also along these same lines, Machin ***et al.***[19] and Gomes ***et al.***[20], in their studies with the professionals and users of the APS, stress that work is among the main reasons for the failure or difficulty of users to come to the health clinics. The reference to work involves the justification of the gender order that associates man with work and thus prejudices the man who is absent from work for questions of health/illness and makes it difficult for men to seek health services for fear of showing weaknesses in their ability to work. Indeed, this may bring about the argument that there is a lack of health services for them because they lack longer opening times (third shift) for 'working men.' It is considered, however, that the association between man-work is based on an elaboration of a socio-cultural and historically-established gender differentiation, which is little questioned by professionals.

Male health service users: time constraints, objectivity, fear and resistance

Some gender characteristics attributed to men are perceived by the interviewees and were identified from the observations made at the health clinics, such as the factors that impede the male population from attending or seeking out health services. Among these characteristics the interviewees highlighted sexism/***machismo***, which is associated with the idea that "men do not get sick" and also the typically masculine behavior, such as alcohol use, smoking and violence.

Macho, macho, many rural workers, I would say drink heavily, smoke a lot, but generally speaking they are well, obviously there are some that are healthy, but in general they are macho, drink heavily, smoke a lot; thus they have a risky life style, don't they, very violent, I would say (Int. 01 Psychologist).

Cultural factors are considered responsible for these behaviors that ultimately hinder a more comprehensive monitoring as well as prevention for the male population.

Even within the cultural explanations, the male user is identified in a negative way by health professionals. The male user shows little patience while waiting for care as opposed to female users who are more patient. As shown by the findings of Toneli ***et al.***[21], Machin ***et al.***[19] and Couto ***et al.***[18], the male users are in a hurry, are objective as they want medicine without wanting to talk. The testimony of one of the interviewees demonstrates this perspective:

When they decide to do it, they do not care about impotence; he arrives with the decision made, he has already got all the information, has already decided he wants to do it, he does not worry, he just wants to do a vasectomy because he already has three children and he cannot stand it anymore and that is our concern [...] ***They're not worried about anything else; when he comes here it is because the case is serious*** (Social Worker Int.03).

This situation reported in interviews was also reported in observational reports of the care activities offered to the population that were recommended for this study. Men, in general, when they arrive at a health clinic will go directly to the pharmacy queue carrying their health card; they enter and leave as fast as possible.

From the point of view of the interviewees, in addition to practical problems, such as work and limited free time, one of the factors that hinder the pursuit of health resources by the male population is fear. The idea that men do not get sick, from the point of view of the health professionals, is less the result of machismo and more an expression of their fear of becoming ill. The men themselves who were interviewed identified with this feeling, and women often refer to the experience with a close male relative, for example:

No, I think men are less, have less courage ... I, for example, am a doctor, but I do not like to go to a doctor as a patient (Doctor Int10).

Another aspect that could be interpreted from a gender relationship and health perspective, concerns the position that men assume when they are present in the clinic. It is noticeable that the services, especially primary care, are not usual places for men. In other words, the position of men in these environments denotes some fear, distrust, discomfort, which shows little familiarity with the space and routine of the services, as pointed out by Figueiredo and Schraiber[22].

As with primary care services, the men also occupy the places closest to the entrance/exit (Field diary, Goiânia).

When men come to the front of the unit, they stop, they think and then decide to enter; they appear to rehearse before entering the health clinic (Field diary, Rio Branco).

Emergency x prevention

The professionals' point of view, in terms of motivation and the type of healthcare sought by

the users, reveals and reinforces opposing attitudes between males and females. According to studies already cited[19, 21], health professionals tend to associate healing practices with men and preventive practices with women. According to Gomes ***et al.***[23], there is in the discourse of the health professionals, the (re)production of a cultural marking – learning how to care for yourself – that divides and places male and female in opposing camps. The model of care for men and women is reinforced by the understanding that men only come to seek health services when they have serious complications or when they are unable to carry out their role as a worker. The explanation for this behavior is connected to the demands of the traditional model of masculinity. Thus, although there has been a steady accumulation of reflections in the areas of health promotion and prevention from a gender perspective, taking care of themselves, in the sense of health, and also care of others are still missing in the socialization process of men and constitute important references of how professionals see male users of their services. This perspective on men's behavior appears in the observations and interviews and refers to the difficulty of working with the male population because of the 'demand for service', by male users only in situations of acute diseases and/or emergency. In the view of the professionals, men do not seek services for preventive purposes.

The main health complaints of men, according to the professionals, are related to acute symptoms that are noticeable and those that hinder work activities, cardiovascular diseases, hypertension and diabetes and questions related to sexuality.

Impotence, right? I think what most brings men to the doctor's surgery are issues of sexuality. I think the second leading reason men consult the doctor is related to work. If he cannot go to work, you understand? So, it will involve if he has high blood pressure, pain or any other problem. But if you look for the main reasons for men, it is about their sexuality, work and pain (Doctor Int.21).

Oh, they say they're not feeling well, their pressure is high. They tend to talk more of health, their pressure is high, their cholesterol is high, they need to lose weight, they have back pain and their knee is messed up (Social Worker Int. 03).

It is general, not only about the prostate and, in my view, the diseases that I noticed were of the most concern are cardiovascular disease, diabetes, hypertension and cholesterol and dyslipidemia (Doctor Int.12).

In the health services studied, there is greater demand or participation of men in activities/actions related to their specific needs (those related to urological problems). This situation can be illustrated by the observational reports of these services. According to the field diary, in one of the actions carried out to commemorate Men's Day, the media announced that a health clinic in the city would be a reference unit for male health. This caused many men to go to the unit, seeking consultations with urologists. Upon arrival and failing to find this professional they felt frustrated and did not want to participate in any other activity. Note that the information concerning the presence of a urologist was given by the professional responsible for the Men's Healthcare Program on the television program. Nevertheless, other staff saw that these users had other healthcare needs over and above the ones they came for, as reported by a professional:

I wanted to take advantage of the presence of so many men at the clinic, who came for a prostate examination, and offered to do blood glucose and blood pressure examinations. Some refused because they had come only for the prostate exam (Field diary, Rio Branco).

The association between male health and the prostate is one of the criticisms raised by several interviewees to the setting up of PNAISH at a local level. Male health is reduced to urological health, and more than that, the policy is emphasizing prostate cancer in particular, at the expense of other problems that affect male health and quality of life.

I'm talking about prostate cancer specifically, and to what extent it is possible... to have a broader discussion or a trace or early medical iatrogenic diagnosis in men, in the case of prostate cancer, and this could drive men to get tested too early – they died of other causes. Prevention of this other cause of death may not be as important as this concern with the prostate don't you think? [...] ***So, we do not have an Achilles heel, we have an Achilles prostate*** (Doctor Int.10).

This perceived association between PNAISH and urological health results, according to Carrara ***et al.***[8], from effective participation of the Brazilian Society of Urology (SBU) in the elaboration and dissemination of PNAISH. The author also stresses the National Campaign for Clarification on Men's Health, broadcast by the SBU, a year before the launch of the policy.

Although the professionals identified that the male concern was prevention of prostate cancer, the observations found that some men, perhaps

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a minority, could perceive other health needs. This is the case, for example, of a young white male, aged 21, who upon seeing the poster about male healthcare sought a consultation hoping that his complaint of weakness and fatigue would be solved. The young man said he had sought medical help to treat this complaint before, but without a positive result. He believed that now, with a doctor specifically for male healthcare things might be different.

Faced with such data we can ask ourselves if the male demands are in fact limited to problems in the genital tract or if the professionals and services, due to the socially constructed view on men and health, cannot see the other demands. Or, we can hypothesize that men who bring other demands to the health service do not fit in the expected traditional model of masculinity and therefore are not considered masculine in their condition, but as young, old, or homosexuals. According to Couto ***et al.***[18], there are different dimensions which cause invisibility of men in the health services: health interventions are a privilege granted to women, the inability of professionals to notice the presence of some men as users of the services or in matters brought by them and the idea that men do not take care of themselves and consequently do not seek health services.

Difficulties for the health services to attract the male population

Working with the male population, namely dealing with men in the health services is not identified as a problem, especially with regard to the treatment of diseases. On the other hand, as already noted, the difficulty perceived by the professionals interviewed concerns the change in male attitudes regarding their own health:

Look, what is difficult for a man to overcome, is the way he sees his own health. This is the hardest thing and it has to be solved, you know. I mean men still cannot see themselves as a whole and how they can deal with all this from the point of view of prevention and health. This is difficult, that is, to change the mentality of men in relation to their own health and their own way of seeing it. This is the hardest part, you see (Doctor Int.10).

So men's health, for me to work with men's health I would have to be working in preventive health, and today unfortunately we do not do male preventive health work, we do not have male heath work, we work with male diseases because they arrive with the disease established, unfortunately (Nurse Int.08).

Professionals recognize that the greatest challenge for working with male health is to make them come to the health service before getting sick. This implies, in view of the interviewees, a change not only in the health services, but in the culture itself, in men's ***mentality***. It is necessary to convert men in regard to caring for their own bodies or, in the words of Carrara ***et al.***[18], an educational problem "dissipating the magical thinking that (dis)oriented them and that makes them prey to their own prejudices". The effectiveness of the policy therefore requires the birth of a new man.

Apart from the minds of men, the precariousness of the network for referrals and the criteria used for scheduling, are identified by most interviewees as the main difficulty in serving the male population, particularly due to the male demand for objectivity and speed. The shortcomings of the service network impact directly on the credibility of the work of professionals and health facilities, as indicated by their statements:

What is more difficult to deal with is ... When we cannot, shall we say, solve a problem of our client. Then, the client loses confidence in the health unit. If we cannot provide a solution ... For example, a patient whose problem is ... erection, an example of an erection, does not seek ... why ... I've had so many patients like that, and all the more so since I work with diabetes, of erectile dysfunction. And then, we bring them in through the clinics and the clinician forwards them to the urology service. We schedule them, then the SISREG says: "erection problem is not an emergency issue," then the paper comes back, and what will I say to the patient? This makes me lose face. "The unit does not solve this, so why bother going back?" You know? So this is a big problem (Nurse Int.08).

It is easier to say that there is a policy. He needs to listen. He must care. He must take care of himself, yes. The hardest thing is to see this health unit adapted to receive this man and actually provide the service. Because speaking, we are prepared to speak with great satisfaction, with great pleasure, because we know that it is necessary and important ... Now we speak, motivate, entice almost taking them by the arm and leading ... get there but the clinician is not there, or there is one or there isn't, it's really annoying ... those natural mishaps... guarantee effective service. Not only encourage. Because we encourage and after getting there for the consultation ... there is none, then frustration, and loss of faith (Social Worker Int.13).

This difficulty in solving the health problems of the APS users is not only related to the male

population, but there are important consequences for this population, according to the interviewees. This is basically due to the ***mentality*** of men, who are not concerned with prevention, and also the short time available they have to attend health services. Thus, the time involved from seeking care until they solve their problem is perceived as one of the things that tends to keep men away from the health services.

Conclusions

Findings related to the low numbers of men using the healthcare services, the predominant composition of the clientele (workers and the elderly), the characteristics of male behavior (lack of time, objectivity, fear and resistance) and the difficulty of the services in attracting this population corroborate recent studies about the relation between men-health-care within the scope of APS or other levels of care and whose empirical references are the users themselves[18,20,23,24], the professional care givers[19] or both[21,22,25].

It should be noted that although the concept of gender is at the center of PNAISH, this is quoted by healthcare professionals only in order to justify the expected social patterns of behavior in male terms. The use of the term ***machismo*** by some health professionals interviewed to describe male behavior already indicate that these are superficial concepts of gender. The attribution of male behavior to cultural factors ultimately conceals the power relations that underlie gender relations. In this sense, according to Carrara ***et al.***[8] "for men to articulate demands from a gender position and become visible as "men" means putting themselves on the same plane as women". Thus, the change in the ***mentality*** of men (in the sense of greater body self-care) that is necessary to ensure better health conditions, presupposes egalitarian gender relations. This implies, therefore, that women and men, blacks and whites, young and old heterosexuals and homosexuals are equally vulnerable.

Collaborations

DR Knauth, MT Couto and WS Figueiredo participated equally in all stages of preparation of the article.

References

1. Osis MJMD. Paism: um marco na abordagem da saúde. ***Cad Saude Publica*** 1998; 14 (Supl.1):441-453.
2. Caetano AJ. O declínio da fecundidade e suas implicações: uma introdução. In: Caetano, AJ, Alves, JEDA, Corrêa, S, organizadores. ***Dez anos do Cairo***: tendências da fecundidade e direitos reprodutivos no Brasil. Campinas: Associação Brasileira de Estudos Populacionais (ABEP), Fundo de População das Nações Unidas (UNFPA); 2004. p.11-19.
3. Costa AM. Desenvolvimento e implantação do PAISM no Brasil: revisitando percursos. In: Galvão L, Díaz J, organizadores. ***Saúde sexual e reprodutiva no Brasil***. São Paulo: Hucitec; 1999. p. 70-103.
4. Costa AM. Participação social na conquista das políticas de saúde para mulheres no Brasil, ***Cien Saude Colet*** 2009; 14(4):1073-1083.
5. Brasil. Ministério da Saúde (MS). Secretaria de Atenção à Saúde. Departamento de Ações Programáticas Estratégicas. ***Política nacional de atenção integral à saúde da mulher***: princípios e diretrizes. Brasília: Editora do Ministério da Saúde; 2009.
6. Ferraz D, Kraiczyk J. Gênero e políticas públicas de saúde – construindo respostas para o enfrentamento das desigualdades no âmbito do SUS. ***Revista de Psicologia da UNESP*** 2010; 9(1):70-82.
7. Brasil. Ministério da Saúde (MS). Secretaria de Atenção à Saúde. Departamento de Ações Programáticas Estratégicas. ***Política nacional de atenção integral à saúde do homem***: princípios e diretrizes. Brasília: Editora do Ministério da Saúde; 2009.
8. Carrara S, Russo JA, Faro L. A política de atenção à saúde do homem no Brasil: os paradoxos da medicalização do corpo masculino. ***Physis*** 2009; 19(3): 659-678.
9. Schraiber LB, Gomes R, Couto MT. Homens na pauta da Saúde Coletiva. ***Cien Saude Colet*** 2005; 10(1):7-17.
10. Souza ER, Lima MLC de. The panorama of urban violence in Brazil and its capitals. ***Cien Saude Colet*** 2006; 11(2):363-373.
11. Figueiredo W. Assistência à saúde dos homens: um desafio para a atenção primária. ***Cien Saude Colet*** 2005; 10(1):105-109.
12. Gomes R, Leal AF, Lima AM, Knauth DR, Moura EC, Nogueira da Silva GS, Couto MT, Urdaneta M, Figueiredo WS. ***Avaliação das ações iniciais da implantação da política nacional de atenção integral à saúde do homem***. ***Relatório Final***. Rio de Janeiro: IFF; 2012.
13. Denzin NK. ***The research act***. Chicago: Aldine Publishing Company; 1973.
14. Minayo MCS, Assis SG, Souza ER, organizadores. ***Avaliação por triangulação de métodos: abordagem de programas sociais***. Rio de Janeiro: Fiocruz; 2005.
15. Brasil. Ministério da Saúde (MS). Secretaria de Atenção à Saúde. Departamento de Ações Programáticas Estratégicas. ***Plano de Ação Nacional 2009-2011 da Política nacional de atenção integral à saúde do Homem***. Brasília: Editora do Ministério da Saúde; 2009.
16. Laurenti R, Melo-Jorge, MHP, Gotlieb SLD. Perfil epidemiológico da morbi-mortalidade masculina. ***Cien Saude Colet*** 2005; 10(1):35-46.
17. World Health Organization (WHO). ***Men, ageing and health***. Geneva: WHO; 2001.

18. Couto MT, Pinheiro TF, Valença OA, Machin R, Silva GSN, Gomes R, Schraiber LB, Figueiredo WS. O homem na atenção primária à saúde: discutindo (in)visibilidade a partir da perspectiva de gênero. ***Interface Comun Saúde Educ*** 2010; 14(33):257-270.
19. Machin R, Couto MT, Silva GSN, Schraiber LB, Gomes R, Figueiredo WS, Valença OA, Pinheiro TF. Concepções de gênero, masculinidade e cuidados em saúde: estudo com profissionais de saúde da atenção primária. ***Cien Saude Colet*** 2011; 16(11):4503-4512.
20. Gomes R, Schraiber LB, Couto MT, Valença OA, Silva GSN, Figueiredo WS, Barbosa RM, Pinheiro TF. O atendimento à saúde de homens: estudo qualitativo em quatro estados Brasileiros. ***Physis*** 2011; 21(1):113-128.
21. Toneli MJF, Souza MGC, Müller RCF. Masculinidades e práticas de saúde: retratos da experiência de pesquisa em Florianópolis/SC***. Physis*** 2010; 20(3):973-994.
22. Figueiredo WS, Schraiber, LB. Concepções de gênero de homens usuários e profissionais de saúde de serviços de atenção primária e os possíveis impactos na saúde da população masculina, São Paulo, Brasil. ***Cien Saúde Colet*** 2011; (Supl. 1):935-944.
23. Gomes R, Moreira MCN, Nascimento EF, Rebello LEFS, Couto MT, Schraiber LB. Os homens não vêm! Ausência e/ou invisibilidade masculina na atenção primária***. Cien Saude Colet*** 2011; 16(Supl. 1):983-992.
24. Noone JH, Stephens C. Men, masculine identities, and health care utilization. ***Sociol Health Illn*** 2008; 30(5):711-725.
25. Schraiber LB, Figueiredo WS, Gomes R, Couto MT, Pinheiro TF, Machin R, Silva GSN, Valença OA. Necessidades de saúde e masculinidades: atenção primária no cuidado aos homens. ***Cad. Saude Publica*** 2010; 26(5):961-970.

Apresentado em 13/06/2012
Aprovado em 05/07/2012
Versão final apresentada em 10/07/2012