

Integral Assistance to Men's Health: needs, barriers and coping strategies

Assistência Integral a Saúde do Homem: necessidades, obstáculos e estratégias de enfrentamento

Asistencia Integral a la Salud del Hombre: necesidades, obstáculos y estrategias de afrontamiento

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ABSTRACT

Objective: To know the health needs, to identify obstacles in the health needs of men and to present coping strategies for integral and human assistance to a group of men. **Methods:** This study was a descriptive, exploratory with qualitative approach. Data collection was conducted in February 2012 through semi-structured interviews and analyzed with theoretical reference.

Results: The male population has health needs to be met and they have obstacles as the shame of being exposed, impatience, lack of time and lack of resoluteness health needs. Health humanization prevailed as a coping strategy, through access, reception, communication and bond. **Conclusion:** The creation of the Policy for Integral Health of Man was not enough to put the man in the context of health. Thus, it proposes to change the health care model.

Keywords: Men's Health; Primary Health Care; Humanization of Assistance.

RESUMO

Objetivo: Conhecer as necessidades de saúde, identificar os obstáculos que impedem o atendimento das necessidades de saúde do homem e apresentar as estratégias de enfrentamento para uma assistência integral e humana a um grupo de homens.

Métodos: Estudo de cunho descritivo e exploratório, com abordagem qualitativa. A coleta dos dados foi realizada em fevereiro de 2012 por meio de entrevista semiestruturada e analisadas à luz do referencial teórico. **Resultados:** A população masculina tem necessidades de saúde a serem atendidas e referenciam como obstáculos, a vergonha de se expor, a impaciência, a inexistência de tempo e a falta de resolutividade das necessidades de saúde. A humanização em saúde predominou como estratégia de enfrentamento, através do acesso, do acolhimento, da comunicação e do vínculo. **Conclusão:** A criação da Política de Atenção Integral a Saúde do Homem não foi suficiente para inseri-lo no contexto de saúde, desta forma, propõe-se mudanças no modelo assistencial.

Palavras-chave: Saúde do Homem; Atenção Primária à Saúde; Humanização da Assistência.

RESUMEN

Objetivo: Conocer las necesidades de salud, identificar los obstáculos que impiden el atendimento de esas necesidades y presentar estrategias de afrontamiento para una asistencia integral y humana a un grupo de hombres. **Métodos:** Estudio descriptivo y exploratorio, de abordaje cualitativo. La recolección de datos se realizó en febrero de 2012 a través de entrevistas semiestructuradas y analizadas a la luz del marco teórico. **Resultados:** La población masculina tiene necesidades de salud que deben cumplir y referencian como obstáculos, la vergüenza de ser descubierto, la impaciencia, falta de tiempo y falta de soluciones para las necesidades de salud. La humanización de la Salud se puso como estrategia de afrontamiento a través del acceso, alojamiento, comunicación y vinculación. **Conclusión:** El establecimiento de la Política de Atención Integral a la Salud Humana no fue suficiente para colocarlo en el contexto de la salud, por lo tanto, propone cambios en el modelo asistencial.

Palabras-clave: Salud del Hombre; Atención Primaria de Salud; Humanización de la Atención.

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INTRODUCTION

The masculinity was conducted by a historical process through patriarchal culture since the origin of humanity, in which a hierarchy between men and women was established. It can be seen that man since the origin had a supremacy, seeing as invulnerable, taught not to cry and to repress their emotions, putting masculinity as synonymous with virility¹.

Heavily based on history arguments, the male population perceives health care as something that is not peculiar to masculinity, ignoring the importance of disease prevention. Together with this fact, the position of the health service raises feelings of intimidation and detachment, without knowing about the many opportunities provided by the Family Health Strategy (FHS), causing the expansion of the vulnerability of this public in the mortality index.

According to the World Health Organization (WHO), the global average expected male and female life, in 2009, differed in five years: women lived an average of 71 years old and men 66 years old. Regarding mortality, in Brazil, the difference between men and women is significantly higher between 15 and 39 years old and in 2010, the chance of 22 years old men die was 4.5 times higher than women at the same age, with external causes being cited as the main causes of death among Brazilian men in this age group².

In Brazil, human health has been slowly inserted in the public health agenda since the launch of the National Policy for Men Integral Health Attention (PNAISH), formalized on August 27, 2009. This policy is based on the following objectives: to qualify assistance to male health in the perspective of care that will protect the integrity and to qualify primary care so that it is not restricted only to recovery, especially ensuring the promotion of health and prevention of avoidable health problems³.

However, a study that explored the implementation of PNAISH in five municipalities in the country found that the Municipal Action Plans do not show accurate descriptions for policy implementation, prioritizing actions based on procedures and tests that reinforce the centrality of attention in the male reproductive system. This study also highlighted that managers and professionals in direct care have little or no knowledge about this issue⁴.

It is worth noting that even if the creation of PNAISH is a big step towards the improvement of health care for the male population, generating a National Action Plan with implementation between 2009 and 2011, there are not effective changes in the Unified Health System (SUS) yet³.

Thus, despite the creation of this specific policy, health professionals, especially nurses, due to their direct contact with the patient, need to incorporate a qualified and focused

look that will make health care more efficient and effective in helping to reduce complications and appearance of disorders in the male population⁵.

In this sense, the health area needs to help for changes, especially in broadening equity and comprehensive care from the recognition of other health needs, in addition to those recognized by the services and policies areas aimed at increasing the quality of care health. Thus, it is a crucial discussion on masculinities for the services and health professionals as well as for the population, in order to break the paradigm of invulnerability of men and to give attention to the needs of this group, often forgotten and not embedded only by the health system, but the man⁶.

It is clear that there is a very big reflection to promote the construction of gender about the conceptions of masculinity. However, to reach the man with prevention and promotion of their health demands changes, especially cultural to be considered a challenge. With this challenge, some scholars point out that the organization and routine of services have significantly affected the insertion of men in services, since their presence is still very low, especially in regard to nursing consultation and educational groups^{1,7}.

There is no specific strategies in primary care directed to men in adulthood, especially with regard to prevention of diseases and promotion of health. Therefore, it is essential to sensitize the professionals who treat them, particularly nursing, encouraging them to listen to this demand in order to better understand it as the perception of their health^{6,8}.

Thus, it emphasizes the importance of considering the social relevance attached by the incidence of diseases and the increased vulnerability to diseases related to this population. In this sense, this study returned on preventive care, generating interventions that involve changes in the reception process and provide financial help for the planning of actions to men's health.

Thus, following this reasoning, the present study aimed to identify health needs, identify obstacles to meeting the health needs of man and present coping strategies for comprehensive and human to a group of men care.

METHOD

This is a descriptive and exploratory study with qualitative approach, which was developed in the city of Cuité - PB, located in Curimataú Paraíba, 230 km from the state capital. According to data from the Brazilian Institute of Geography and Statistics (IBGE), the municipality has a population of approximately 19,978 inhabitants, of whom 9,833 are male⁹.

Knowing the existence of a group of men of the Catholic Church in that city currently with 52 members, residing in

urban areas and mostly rural workers, this group was elected and ideal for the research. To this end, from the saturation of the speeches expressed by the subjects and meeting the inclusion criteria for the study, 10 of them were included in the sample, which is included on the following criteria: over 21 years old, be literate, assiduously attending the group - frequency of at least 50% of participation.

Data were collected in February 2012, using as instrument some semi-structured interview containing 12 questions organized into two parts, respectively: socioeconomic and educational questions, in order to characterize the subject, and pertinent to the objectives of the study specific questions.

A digital voice recorder was used in which the statements were recorded by the consent of the respondents, continuing availability of each subject in time and place that ensured their privacy. Moreover, it is noteworthy that there was the use of a diary, serving auxiliary instrument.

After data collection, transcription and thorough reading of the empirical data was done, analyzed by the technique of Content Analysis (CA), proposed by Bardin. According to the above author, the CA is divided into four phases which are necessary to analyze the data: phase of organization; exploitation or coding of the material; categorization and treatment; and interpretation of results¹⁰.

In the case of a research conducted with humans, the ethical principles established by Resolution No. 466/2012 of the National Health Council were observed¹¹, requesting the research participants to sign an informed consent form (ICF). The study was submitted to the Ethics Committee (CEP) of the Centre for Higher Education and Development (CESED) and approved on December 1, 2011, in Opinion Nº 2249.0.000.405-11.

RESULTS

Regarding socio-demographic aspects of the interviewed, it was observed that the age range was between 42-68 years old. Regarding marital status, 08 were married and 02 were single. Family income ranged from less than 01 minimum wage and more than 03 current minimum wages, associated with low educational level. Accordingly, 07 of the respondents reported having attended elementary school and only 03 reported having completed their high school education. With regard to the profession, 07 were farmers, working in the countryside, however, in the urban area were 01 retired, 01 mason and 01 merchant. The workweek described by them ranged from 20 to 52 hours.

Considering the data analysis, then, will be presented the three themes that emerged from the transcription and interpretation of interviewees' statements.

The real needs of men

In the presence of the considerations made by the research subjects, they were asked to better elucidate the real needs of men. It is clear, with the information obtained on the interviewees' statements, that the preventive health of man, is still linked to preventive screening for prostate cancer, which was cited by them as one of the main needs of men's health.

He needs everything, especially to do prostate exam, which requires more and many do not have the courage to present (11).

It's always because men neglect more, right? [...] about this prostate problem so you know what is happening (15).

In this scenario, other needs indicated by the research participants was the increased number of physicians to attend to all patients seeking the services consequently the insufficient number of professionals just overloading the environment and hampering the agility of service to attend the man who at the appointment is absent from their work activities.

I guess, you know what? More doctors, because a doctor just to meet a lot of people, of course is problem [...] (16).

[...] To have a doctor, having a team that attend at night, because then it would be better for men (18).

The obstacles presented by men in health services

This category discusses about the obstacles they found in health care. Among the obstacles referenced, it will be the shame of exposing and impatience by men, while waiting for care.

The term shame, used as a refuge by the study subjects is justifying male behavior of not adhering to prevention and health promotion:

I think many are embarrassed, ashamed, introverted, do not want to present (14).

It is because man is ashamed for the entire life of these things right (13).

[...] The shame that we have [...] we have that shame to go to certain things [...] (16).

In the same context, also it is highlighted as an obstacle to the male the impatience, as regards waiting for care:

It is because many people will not have the patience too, right? [...] When waiting for the doctors or for the record [...] and sometimes when we arrive in the health center already has the limitation of applications, so, if it is not today, then we won't go anymore (19).

It is because of such a grind, it is not for me. Man is different from woman. The woman can wait but the men cannot wait (14).

[...] And another thing is also when we arrive in the attendance, that we wait a long time in a queue, waiting to make an appointment, many people there... Look I'm a person that I'm like this, I like all of my stuff fast, I do not like waiting (16).

Another obstacle in the narratives was the lack of time to take with their health, given the system of work and the lack of resoluteness health needs:

First it is the problem of work, we cling very right to work, we work hard and forget the health [...] (16).

I think so, most men spend all their time working and they do not have available time to health care, but I think everyone needs to look for it (12).

[...] We go to do an exam, one thing, and we spent three months to receive it, and so we have this difficulty (13).

[...] Perhaps when we arrive to the health center that there is not attendance [...] if the person has a condition to spend, he is attended, today we have that option, this is the SUS problem, the limitation is big [...] (19).

The male point of view on coping strategies for adherence to primary health care services

Among the strategies presented in that category, there are: accessibility - by extending the hours of service and solution of the needs -; reception - through good service -; communication - through information -; and bond formation - through professional stability and home visits. In this context it is evident that the strategies exhibited by men, are all related to the humanization of health services.

It's the time of service. [...] Because most men work all day, we need evening option, right. To have a doctor, have a team that attend at night, because it would be far better for the men (12).

According to the speeches by the research subjects, the reception and communication are two strategies that should

be adopted by health teams so that users feel encouraged to seek the services:

If the person, if there is a good service, right. Sometimes we found it, sometimes not [...] if the person arrive and not be welcomed, there are many people that do not like that, you know, in the health center or in the hospital [...] (19).

More information [...] the information, for example, in terms of the health system to the man is still little. I think it's just in terms of information for the man (18).

It was also mentioned that the bond is another important strategy for health services. It presents the following speeches:

[...] We get there and meets other people, as the years go by and [...] are changing employee and stuff like that (19).

[...] Home visits, someone who works in healthcare can visit the houses. The is not... preventive for the women, then men should have too, for example, every year the woman can do that exam, so it should have the same for men. (18).

DISCUSSION

It is seen that most of the sample is inserted in the labor market, which impedes the way to these health care services due to the mismatch between the opening hours of services with availability after their labor activities.

It is estimated that most of the respondents is a provider of home and in their perspective cannot take time off work for health care. What we do not realize is that when their health is fragile, it will be a problem in the continuity of his role as a provider. Given the findings, it is necessary to conduct a strategy that addresses the unavailability of time between the workday and the opening of health services.

Corroborating the above, the study states that services provided in primary care are willing at times almost always not good to the exercise of work activity by the men. The need to meet the workload, as well as commitments justifies not looking for male health services¹².

In this research, respondents stated that the male population has health needs to be attended and are expressed in the discourse unanimously. This event is considered of great importance with regard to human health, because at this point they admit that they need to take care, which is not common among the male population, because the stigma attached to the prevailing masculinity culture in society.

Thus, the National Policy for Integral Attention to Men's Health (PNAISH) states that men have difficulty recognizing their needs, most of them mask their weakness, considering that the care is not a male practice^{3,8}.

With the speeches analyzed, they believe that men's health is mainly related to the examination of preventing prostate cancer, making the demand for health services, when it comes to other diseases or health promotion. It appears that one of several factors that interfere with male membership services, is this link that they do in relation to completion of the screening test for prostate cancer, which causes embarrassment, fear and prejudice.

Due to the hegemonic model of masculinity, the screening test for prostate cancer may be associated with the violation of masculinity, preventing these men to take care of their own health¹³.

In this perspective, it was also noted that men see only the figure of the doctor and the demand for curative services, preventive health and ignoring the role of nursing in primary care. The curative care model centered on the doctor still remains nowadays, especially in the view of the male population.

Therefore, it is necessary to educate and sensitize men to the importance of measures of disease prevention and health maintenance, so they can be their own caregivers¹⁴.

In hegemonic masculine culture, being a man is associated with invulnerability thus feel ashamed to seek for health care, since their perception would be a show of weakness^{3,8}.

It is noticed that the male cultural events, become an obstacle to be overcome. Thus, it is evident that the shame of looking for health services, as well as the impatience regarding the delay that men express to be treated, are related to cultural barriers.

Thus, men only look for health services when suffering from an illness, becoming demotivating the search for disease prevention services, when they need to live with the long wait for service, thereby generating circumvention of these same services, as well as the absence of return men after treatment, increasingly difficult to insert the male population in primary health care.

Confirming the above, some authors recognize that it is common to man does not see the need for the search of health facilities for prevention, as well as they do not like waiting for attendance^{8,15}.

It is understandable, given the position of the participants that work activities are always cited as a priority for the male population, leaving the health ever for later. These considerations are reflected in the reports submitted to the ideology of masculine identity, which is linked to the role of provider and implying the absence of men in primary care to take care of their own health through the promotion and disease prevention¹.

The man carries the responsibility of provider, a role historically assigned to them, making it a priority to them, by enabling the fulfillment of their obligations. Thus, they show inconvenience of looking for care of their health, citing lack of time related to work¹⁴.

The speeches analyzed also show as an obstacle to solving the lack of assistance from the difficulties in access to tests and the delay in treatment, both guided by the slowness of the SUS. In this perspective, the user's opinion is the best tool to assess the quality of care in public health, which may contribute to the reorganization of the system that needs to be done so that the demands and needs of users are attended¹⁶.

The resolution in health care involves different approaches, such as: Customer satisfaction, technology services, accessibility, human resources and cultural aspects¹³. Therefore, these difficulties in the health system with poor solving, contributing to the avoidance of users in the system. Men justify their absence in health facilities, reporting that the services provided in primary care are willing at times almost always inconvenient to those engaged in labor activity¹².

Studies see what had been identified in this research by claiming that in addition to gender issues, afraid to detect serious illness, insufficient number of records and lack of specialists are barriers to seeking health services^{8,13}.

After viewing so many obstacles, it emerges the need to identify and reflect on strategies for facing barriers referenced by men in effective primary health services. Therefore, the subjects surveyed mentioned the expansion of care, causing them to have more access to the services offered, as well as better resolution of their needs, which were previously reported as being obstacles to overcome them.

In this sense, it was explicitly stated that the lack of a welcoming service, as well as ineffective communication, complicates the membership of men in primary care services. To corroborate the above, the authors highlight that the lack of communication in health care, affect relations between professionals and users, interfering with the dynamics of the service. It is through communication that they can understand the uniqueness of each individual, identifying their weaknesses and facilitating the resolution of their needs¹⁷.

The reception and communication in health services entail the transformation of how the population has had access to health care. This communication should inform and advise on the actions and services for health holistically, since it is proposed as one of the principles guiding of PNAISH¹⁸.

To meet the peculiarities of the male population, it is necessary the training of health professionals, discussing the reality of each Primary Care and Family Health, together with managers envisage operationalize and inclusive service strategies^{8,13}.

The ability of professionals and reception services, translating and build a continuous and proper care for the health needs of this audience is crucial for the value in use of health care work being recognized that men recognize themselves as subjects of their care and needs⁶.

The man needs encouragement to feel more motivated to attend the Family Health Units (FHU). Therefore, it is important to develop specific actions to human health, whether individual or in group; establishing specific to this public service, so that makes possible and facilitates access to health services schedules. It is understood that from the time that the professional search the user is promoting a rapprochement between them, and this is part of creating a bond, being a way to focus more on the male figure.

It is known that bond formation is not built with ease, we must gain the confidence of the community through respect and commitment to it, so the professional's turnover hampers this binding and consequently the demand for the service.

The bond formation between users and staff, provides building new relationships and consequently the access to health services, and home visits exceptional to allow a connection between users and the FHU. It is important to highlight that the professionals who make up the FHU should seek strategies to improve the relationship between staff and users^{17,18}.

Thus, the lack of humanization in health services is characterized by lack of access, openness, communication and bonding, being explicit for interviewees' statements and lying as coping strategies for the effectiveness of men in primary health services.

It is undeniable that the humanization of health prevails as a coping strategy through access, reception, communication and bonding. The humanization through the above resources favors the relationship between professionals and users, facilitating the expansion of adherence to health services. And therefore critical for the actions to be more agile and resolving^{13,15}.

CONCLUSION

This research provided an opportunity to hear the men during the interviews and understand a bit of the male universe, from their point of view on health through their needs, the obstacles found in the health services and the coping strategies of the barriers.

The assumption that guided this study was ratified highlighting the need for disease prevention and health promotion of man, which represents a step forward from male superiority, often masculinity feature that associates the man to be an invulnerable.

However, it was identified that the creation of PNAISH was not enough to enter the man in the context of health, since it had a slated to be effectively deployed until December 2011, going against that demonstrates the reality.

The results emphasize that the team that makes up the FHS holds strong influence policy in order to make this happen in everyday practices, especially the nurse who holds autonomy when acting at FHU. However, several factors are characterized as barriers for professionals even aware of needed changes that may sensitize men about their self-care.

In this context, it is necessary to intensify transformations, since exposed the subjects' researched strategies are part of the PNAISH that despite recent, is the oldest line policies such as the National Primary Care Policy (BANP) and the National Humanization Policy (NHP). In this sense, demonstrating that the FHS has not progressed as it should, that it has not yet achieved the efficiency towards the guiding principles of the FHS, the HNP and BANP hindering the quality of services provided by not always able to offer a comprehensive and human care for fundraising and membership of the male population to primary health care services.

It is believed that vocational training and increasing the quantity of professionals can determine this change, while achieving improved reception to this public so unique, through a humanized service, as well as the solution of their health problems. Thus seeking assistance in the resolution, which will certainly bring positive results, leading to greater insertion of the male population to primary health services.

Given the absence, according to the authors, some limitations of this study, it is expected that the results of this research can add grants to the organization of services and planning of health actions directed at the man, that in fact the policy is implemented, which the same part of the context of primary care and thus there are changes in the male mortality profile found in the country.

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