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annaneryrevista@gmail.com
Universidade Federal do Rio de Janeiro
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Pereira Storino, Luisa; Ventura de Souza, Kleyde; Lara Silva, Kênia
NECESSIDADES DE SAÚDE DE HOMENS NA ATENÇÃO BÁSICA: ACOLHIMENTO E VÍNCULO COMO POTENCIALIZADORES DA INTEGRALIDADE
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# MEN'S HEALTH NEEDS IN PRIMARY CARE: USER EMBRACEMENT AND FORMING LINKS WITH USERS AS STRENGTHENERS OF COMPREHENSIVE HEALTH CARE

## Necessidades de saúde de homens na atenção básica: acolhimento e vínculo como potencializadores da integralidade

## Necesidades de salud de los hombres en la atención primaria: acogida y vínculo como impulsores de integridad

Luisa Pereira Storino[1], Kleyde Ventura de Souza[2], Kênia Lara Silva[3]

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## ABSTRACT

**Objective:** This study aimed to assess the health needs of males who were service users of a primary healthcare center in the city of Belo Horizonte in the state of Minas Gerais, Brazil. **Methods:** This is qualitative research and has health needs as its category of analysis. Interviews were held with 27 men aged 20-59 years old in the period March - June 2012. The data was subjected to thematic analysis. **Results:** The results showed that embracing and forming links with service users stood out as strengtheners of comprehensive health care and recognition of the health needs of the group studied. **Conclusion:** The ability of professionals and services to embrace users, translating, and building seamless and appropriate care for this public's health needs is fundamental for the value of the use of the health work to be recognized, and for the men to recognize themselves as agents of their care and their needs.

**Keywords:** Men's Health; Health policy; Masculinity; Comprehensive Health Care.

## RESUMO

Este estudo teve como objetivo analisar as necessidades de saúde de homens usuários de uma unidade básica de saúde, na cidade de Belo Horizonte/Minas Gerais. **Métodos:** Trata-se de uma pesquisa qualitativa e tem como categoria de análise as necessidades de saúde. Foram entrevistados 27 homens na faixa etária de 20 a 59 anos no período de março a junho de 2012. Os dados foram submetidos à análise temática. **Resultados:** Os resultados mostraram que o acolhimento e o vínculo se destacaram como dispositivos potencializadores da integralidade da assistência e do reconhecimento das necessidades de saúde do grupo estudado. **Conclusão:** A capacidade dos profissionais e dos serviços de acolherem, traduzirem e construírem um cuidado contínuo e adequado para as necessidades de saúde desse público é fundamental para que o valor de uso do trabalho em saúde seja reconhecido e para que os homens se reconheçam como sujeitos do seu cuidado e de suas necessidades.

**Palavras-chave:** Saúde do homem; Política de saúde; Masculinidade; Assistência integral à saúde.

## RESUMEN

**Objetivo:** El trabajo tiene como objetivo analizar las necesidades de salud de los usuarios hombres de una Unidad Básica de Salud en la ciudad de Belo Horizonte/Minas Gerais. **Métodos:** Se trata de una investigación cualitativa y tiene como categoría de análisis de las necesidades de salud. Entrevistamos a 27 hombres, entre 20 y 59 años, en el período de marzo a junio de 2012. Los datos fueron sometidos al análisis temático. Resultados: Los resultados mostraron que la acogida y el vínculo se destacaron como dispositivos impulsores de la integralidad de la asistencia y del reconocimiento de las necesidades de salud del grupo estudiado. **Conclusión:** La capacidad de los profesionales y los servicios de recepción, traducción y construcción del cuidado continuo y adecuado para las necesidades de salud de este grupo, son fundamentales para que el valor de uso del trabajo en salud sea reconocido y que los hombres reconozcan a sí mismos como sujetos de su cuidado y sus necesidades.

**Palavras-clave:** Salud del Hombre; Política de Salud; Masculinidad; Atención Integral de Salud.

[1] Universidade Federal de Minas Gerais. Belo Horizonte - MG, Brazil.
[2] Universidade Federal de Minas Gerais. Belo Horizonte - MG, Brazil.
[3] Universidade Federal de Minas Gerais. Belo Horizonte - MG, Brazil.

**Corresponding author:**Luisa Pereira Storino E-mail: lulitorino@gmail.com

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## INTRODUCTION

Epidemiological studies have shown that the male population has a shorter life expectancy than the female, all around the world. According to the World Health Organization (WHO)[1], the mean male and female life expectancies, worldwide, in 2009, differed by five years: the women were living, on average, for 71 years, and the men, 66.

In relation to mortality, in Brazil, the difference between men and women is significantly greater between 15 and 39 years of age; in 2010, a 22-year-old man was 4.5 times more likely to die than a woman of the same age. The external causes are the main causes of death for Brazilian males in this age range[2].

This data shows that men have specific characteristics which need to be understood, taking into account how they are integrated in society. Thus, it is possible to visualize the different profiles and patterns, typical for health and illness, which are manifested in this social group, and understand the determinants which operate upon it[3].

In this conception, men's life expectancy - in comparison with women's - is configured as only one parameter which, articulated with the social, cultural and political processes, contributes to understanding the different degrees of vulnerability which can be manifested in the male population.

This perspective contributes to extending and qualifying the health care based on the individual and collective health needs, allowing the pursuing of comprehensiveness. This is because comprehensiveness is defined as a principle of the Unified Health System (SUS), which takes into account the service user's biological, cultural and social dimensions, and guides health policies and actions which are able to meet the requirements and needs through accessing the network of services[4].

It is important to emphasize that, in order to think about comprehensiveness in healthcare, the subject of need needs to be represented in the daily construction of the health work at the individual level, as well as in the organizational and political ambits in which health needs are socially recognized[5].

However, in considering this requirement, in relation to the recognition and meeting of men's health needs and of the construction of a care based on the principle of comprehensiveness, the task has only been begun. Therefore, it still needs to be extensively discussed. It is a fact that the vulnerabilities of groups other than men - such as children, women and the elderly - have been historically prioritized in the actions of the health sector.

From the viewpoint of social medicalization, in the construction of public health policy in Brazil, specific groups have received the particular attention of the State, with the aim of "cleansing the social body". These groups - women, children, the elderly, homosexuals, criminals and the mad - were the target of special attention. The women, for their responsibility to reproduce a strong and healthy race; the children and elderly, because they were considered to be weak before diseases and misfortune, and the homosexuals, criminals and insane because they were thought to represent a social danger[6].

Another argument which explains this historical construct is that knowledge from the biomedical areas and from the shaping of public policies is anchored in elements considered to be masculine, and tend not to problematize the man as a subject of care, and the masculinity as the object[7]. Thus, these cultural, political and economic questions culminate in a non-recognition of men's specific vulnerabilities, represented in the public policies and in the reality of the health services[8].

In spite of this, some accumulations have occurred in the last two decades, in which, in various spaces, there has been debate on the importance of gender relations for discussing social questions, including health, raising contradictions which are inherent to the health practices and to the processes of health and illness in men. Public health policies worldwide[9,10] and in Brazil were impacted by these changes.

In Brazil, men's health has been slowly integrated into the agenda of public health, since the launch of the National Comprehensive Healthcare Policy for Men (PNAISH)[11], formalized on August 27th 2009.

However, a study which explored the implantation of the PNAISH in five Brazilian municipalities concluded that the Municipal Action Plans did not present precise descriptions for the implantation of the policy, prioritizing actions based on procedures and tests which strengthen the centrality of the attention on the male genital apparatus. The study also emphasized that managers and health professionals in the direct care have little or no knowledge of the policy[12].

It must be borne in mind that the PNAISH is a recent formulation and needs to be widely discussed and implemented, although it has already received many criticisms: for not incorporating discussions of gender, for "victimising" men, who need to be the subjects of a specific policy because they need to be protected from themselves, for representing yet another step in the "medicalization" of the male body, and for being overly focussed on the prostate[12].

It is accepted that actions for men's health should not be treated purely in the ambit of the health services. Issues such as the death of young men through violence, alcohol and drug abuse indicate the need for intersectorial efforts, involving the media, justice system, education and employers, among other institutions in society.

However, the health sector needs to engage with the changes, principally in relation to broadening equality and comprehensiveness of the care, based on the recognition of other health needs, besides those already recognized by the services and policies of the area. As a result of this, it is fundamental for the services/professionals and population to discuss masculinities, so as to break with the notion of male invulnerability and to draw attention to this group's needs.

Considering this context, and the perception that these phenomena are reproduced, including in the context of the primary healthcare services, in Brazil, it was decided to deepen the discussion on the health needs of male users of this type of service, based on a theoretical framework coherent with the perspective that the subjects construct needs based on how they are integrated in society[13].

Thus, this article aims to analyze the health needs of male users of a primary healthcare center. It is an excerpt from a master's dissertation titled: "Health needs of male users of a primary healthcare center in Belo Horizonte"[14] and presents one of the study's empirical categories, emphasizing user embracement and user attachment as means of strengthening the comprehensiveness of the care and the recognition of their health needs.

## METHODOLOGY

This is an exploratory, descriptive study with a qualitative approach. The theory of needs[13] was adopted as the theoretical-methodological base. In this perspective, the needs are understood as the product of the social practices of subjects and groups occupying a social class at a historical time. These practices are defined by the culture constructed by the morality and customs of past generations, which includes frameworks of masculinities. Therefore, the needs take shape unequally for individuals from different social classes and cultures, as the access to the products which meet their needs is unequal[3].

The theory of needs enables the comprehension of the mediation between micro- and macro-social processes, taking into account the mutual and complex interaction between structure and subjects[13]. However, meeting the health needs of groups and individuals is a process which takes place at the heart of a complex society, and has determinant structural factors. In this way, the subject's action in exercising autonomy is fundamental to mobilize his way of living, in the sense of viabilizing the meeting of health needs which can qualify life[15].

Empirically, the health needs can be analyzed based on the social actors' discourse on their relationship with the objects of their needs, which may be material or external to the human being (housing, food, or a way of life); or they may be internal, free or spiritual (knowledge, faith, or feelings motivated by the social relations). In relation to the health services, the professional practices and the health technologies are considered. In this way, the professionals and their acts being interwoven in this process, the mutual recognition in the relationship between health professionals and service users, based on user embracement and forming links with the user, is also configured as an object of these needs.

The study was undertaken in the city of Belo Horizonte in the state of Minas Gerais (MG) in a Primary Care Center (PCC) in the north district of the city, in which there are four Family Health Strategy (FHS) teams, the teams' user embracement occurring by spontaneous need during the daytime period, five days per week. 27 men participated in the research, aged between 20 and 59 years old, of fixed residency in the area covered by the PCC for at least one year, recruited randomly in the health service's daily routines and approached when they attended the PCC with personal needs or accompanying others.

Semi-structured interviews were held for production of the empirical material, until data saturation was reached, in the period March - June 2012. In the preparation of the instrument used, it was sought to delineate the object studied, covering opportunistically the issues which could cause the health needs to emerge. In addition to the interviews, records were kept by the researcher in a field diary, in which it was sought to reconstruct situations related to the health/illness process of the subjects of the study.

The subjects' views expressed on the objects of their health needs and their actions in regard to qualifying "way of living", were analyzed in a sequence coherent with the thematic content analysis[16], which foresees: pre-analysis, exploration of the material, treatment of the results, inference and interpretation. Emphasis is placed on the data which, semantically, refer to the themes covered in the Taxonomy of Health Needs[15].

This taxonomy is composed of four major groups of health needs, which include: good living conditions; guarantee of access to all the technologies which improve and prolong life; user embracement or attachment with a health professional or team; autonomy and self-care in the choice of the way of "leading one's life"[15].

For undertaking this study, all the ethical requirements proposed by resolution 196/96 of the National Health Council were met. It was approved by the Research Ethics Committees of the Federal University of Minas Gerais and the Municipal Prefecture of Belo Horizonte, in accordance with Decisions CAAE-0650.0.203.000-11 and 0650.0.203.410-11. The participants received individually all the guidance referent to the research, and signed the Terms of Free and Informed Consent.

## RESULTS AND DISCUSSION

As with any product, in order to have value for use for the individual, health equipment and practices need to necessarily meet the individual's needs. The value of use is also related to the characteristics of the "product", and to the human work applied in its production[13]. The study's results indicate that the link and the embracement are elements of the meeting of the study participants' needs in relation to the health services, confirming the findings of other studies[15].

The data shows that the men manifest satisfaction with the services provided when they have a link with a professional or team, exemplifying the situation in which they were embraced well:

> *I really like coming here... I see that clinic down there (referring to another service). God Almighty, that must be awful. Here, no! My mother was ill, and I received a lot of support, you know? I really like coming here. The people are great, polite. M(22).*

> *As we know that the attendance is good here, when I really need it, I come here. M(24).*

The expression "really need", in the second account, may signify very specific, restricted or little-varied situations in which this subject requires the services of the PCC, such as, for example, situations in which he has acute symptoms of some illness. In the second case, the link with the team is able to give support to other needs, such as, for example, the support for the family. Based on this, it is possible to infer that for the first subject, the service meets his needs more comprehensively.

In the account below, the man expresses satisfaction with the new health technology, which is better adjusted to his needs. This was made possible by the health team/service user relationship, in which both sides participated, producing as a result care based on the recognition of a health need which qualified the subject's life.

> *The insulin gives me security, you know?! I was taking four metformins, and even so I was losing my balance. Sometimes, my vision was a bit blurred. After I started taking insulin, things improved M(22).*

Therefore, to the extent that the health services offered correspond to the variety of the men's health needs, the more the men become attached to these services. This relationship is visible when one observes, more frequently, the existence of the attachment that men who know of the diagnosis of their chronic health condition have with the health professionals.

Thus, as this type of need is more recognized in the structure in which the service is organized, the health practices certainly have a higher probability of having value for the service users who present these needs than for other individuals, or they have chances of corresponding in a less fragmented way to their needs.

This relationship, however, does not exclude the importance of the participation of the health professional and the subjects in the consolidation of the continuity of the treatment, allowed by the link and by the construction and reconstruction of health needs. In this way, having a health professional or team with specific responsibility, within the system, could be a necessity, based on the construction of the link[13].

In the case below, the interviewee wishes always to be attended by the professional whom he trusts, and who produces work individualized to his health needs. This man recognizes that the fact of the doctor "being in the know", regarding his needs, makes the work better adapted to meet them.

> *Seeing as how I've already started with Dr. X, why would I deal with Dr Y? No way... Dr. X is already more "in the know" M(6).*

One cannot say that the link on its own guarantees an attendance which leads to comprehensiveness in the health team/service user care relationship, much less considering the meeting of the health needs, which is possible only in a complex network which extrapolates the health system. However, without the relationship of mutual recognition of the individuals in their positions as subjects, it is not possible to think about comprehensiveness. In this way, for there to be comprehensiveness, it is necessary for the subject's needs to be perceived in all their variety, and for this to occur, the community made possible by the link is fundamental[17].

The reality for the majority of men, however, is not similar to those of the subjects cited. The products of the professional practices of Primary Health Care (PHC) are not often used by the majority of men, for various reasons, which include structural issues in the configuration of the services and in how the men recognized themselves socially. These issues culminate in barriers which hinder the recognition of these men by the health professionals as carriers of health needs, as well as hindering the recognition of the professional health practices as products of needs on the part of the service users.

In the next statements, it may be perceived that one of the paths for the health professionals to invest in the reduction of the barriers so that men will access the health services is to make themselves available in a careful way, so as not to lose the opportunity to construct the link.

> *You have to have empathy. For example, the elderly, when they go somewhere, like a health clinic, are received well, it's another thing. But when you go to the health clinic and you are not well received you're not going to want to go back M(4).*

> *Sometimes the person is arrogant, and doesn't have that patience with us, so sometimes I think that, because the person treats us badly, we end up, how shall I put this, becoming distant M(17).*

The ability to listen, and the sensitivity of the person who receives the subjects and their needs in the health services, are fundamental for the real needs to be understood and met in the most comprehensive way[17].

However, for the user embracement and link to really take place and to become an indication of value of the practices in Primary Health Care (PHC) for the subjects does not depend only on the health professionals showing themselves to be available and listening to the men's needs. It is necessary for the health practices to be constructed with a view to broadening the products of health care for this public.

In the cases below, one can infer that these men, in spite of recognizing their health needs, do not recognise their vulnerabilities and judge the conditions not to be favorable to these needs being met.

> *I need to get some dental treatment so I can work. I've got pains in my ankle and I need to go see the doctor, so off I go today and it takes so long to be seen. They'll schedule the test. Then the test'll take 6 months to get done, and when the tests finally comes along you don't need that test, the pain has already gone away M(9).*

> *Coming to the clinic already takes enough time... when you're sick, for you to do preventive tests... well, it'll take even longer [...]Do a complete check-up here? I didn't know! M(20).*

However, in the first case, the person hadn't even gone to the PCC to resolve the complaint mentioned, having judged the service to be unable to meet his needs in a satisfactory time. The notes recorded in the field diary regarding this man showed that he was at the service not to be seen, but, rather, accompanying his daughter. In addition to this, in spite of being aware that he had a serious chronic illness, he was denying himself treatment and a link with the PCC professionals.

> *I might be diabetic and have high blood pressure, but I've never taken these medications. I never needed this. And if I did go to the doctor, he'll tell me to take them every day. Why am I going to take this? M(9).*

In the second case, the subject shows that he is not aware of the services offered and does not have a link with the professionals. In spite of being a confirmed smoker and having a history of arterial hypertension, he does not present a need to check his health through undertaking routine tests.

One can perceive these men's difficulty in recognizing their difficulties and taking responsibility for their own care. They place themselves in an alienated situation in relation to care for their health, creating a barrier which stops them expressing their qualitative needs in relation to their health. It should be emphasized that the subjects' qualitative health needs may not necessarily relate to products and services offered by the services.

In these cases, the way how the professional makes him- or herself available, in the sense of meeting these subjects' "conscious" needs, is fundamental for them to be able to be offered opportunities to develop other needs. In spite of the health professional's action having a clear limit, it is through the embracement and empathy that the contradictions which distance them can be overcome.

It should be noted that the health professional needs to be aware of his or her ability to induce demands. Because of this, it is fundamental to discover paths to a practice which recognizes the subjects' need for autonomy. Respect for the autonomy of men, "in the way of leading one's life" can mean care work.

The flexibility of the work, to allow access through good embracement and the availability of hours which are compatible for the workers reduces other barriers, and may also mean opportunities for health professionals to build links with the men.

In the account below, the interviewee suggests solutions for the reduction of the barriers which he recognizes, for accessing the health services:

> *In my case, depending a bit on the hours we work, I think that if it were a little more favorable, or was open on Saturdays... Because we work from Monday to Friday, sometimes we even work on Saturday, so... Yes, it may be the difficulty of the schedules too, I think that our schedules are a bit complicated. Sometimes in the afternoon we can't get an appointment, sometimes it is the only opportunity we can get... to come here, and we can't manage M(17).*

In the next account, the same man demonstrates that the satisfactory embracement contributed to him feeling the need to continue with the treatment.

> *Now, at the moment, I am going to the clinic, I'm getting familiar with it, and when I've been seen here before, the clinic gave me all the attention I needed... that's really why I'm returning, and I want to come more often... I want to come and get treated here M(17).*

What is most important in this process is the health work's potential for constructing with the men conditions such that they may recognize their vulnerabilities and be active in meeting their needs. For this to be possible, it is necessary for there to be the intention to recognize health needs, to build less prescriptive practices, taking into account the subjects' agency in the health-illness process, as well as these individuals' social integration.

It is important to remember that, in order to ensure the pursuance of comprehensiveness in a perspective which considers the meeting of the population's needs as fundamental, one cannot think of the bond between health professional and service user and the embracement as characteristics only of the care provided in primary health care. The link with the professional and good embracement are needs which accompany the subjects in their itineraries throughout the care network, and meeting these is a condition for pursuing comprehensiveness of care.

The dissatisfaction with some services, at other levels of health care, when the men already needed it at some point, suggests that embracement and attachment - besides being extremely important for the construction of the therapeutic process - are also indicators that a particular service either corresponds or does not to some health need of the group in question. In the accounts below, one can perceive that for the service user, the shortcomings in the embracement and the difficulties in building a link at other levels of care disqualify the health care.

> *I wish the treatment were more serious and efficient... You arrive there and get the answer, for example: the clinic refers you, and you go to the other department and they attend you, and don't send you all over the place M(7).*

> *I waited two years for the consultation with a prostate specialist. When I was referred to the specialist center, they asked for a test which the SUS doesn't do. M(26).*

> *I think the attendance here is good, I can't complain. It depends, some things you have to do privately, you have to wait for them to call you and so on... I'm waiting to see the urologist M(27).*

The difficulty of making possible attendance in which the embracement and a link are present in the actions which make up the health care network influences the ability to provide care in which the pursuit of comprehensiveness is present.

Embracement and link need to be sought in the relationship between health professionals and service users throughout the health care network. The PHC cannot, on its own, change health care through humanization and comprehensiveness. Attachment and embracement are tools which have functioned as a channel for other needs, which, like these, accompany the people wherever they go to satisfy them.

It must be taken into account that the doctor is much mentioned by the study's subjects, and that the work of nursing is invisible to them. This absence of link with the nurses may indicate various inferences, among which is the fact that the product of these professionals' work may not be corresponding to this public's health needs - at least, not at the moment.

The nurses, in this PCC, concentrate their activities in attendances which normally establish links with women - such as ante-natal care, attendance of women within protocols which aim to prevent cervical or breast cancer, progress or developmental check-ups for children up to two years of age, and educational actions. Another study observed the same fact in other scenarios[8]. In addition to this, consultations arranged for other groups, such as, for example, service users who have chronic illnesses, which, in the study scenario, are those which men use most, are punctual, there being no process of care which makes it possible to build links.

There is, however, a contradictory issue, which is the fact that nursing is on the front line of embracement. It is through this that men have greater access to the services. In spite of this, the male service users are unaware of this professional category's work, which implies the reiteration of the centrality of the demand for services in the figure of the doctor and the doctor's appointment.

Another issue to investigate would be: does the fact that nursing professionals are women influence their recognition of the needs? Does this hinder the recognition of the product of the nurses' work by the service users, taking into consideration that nursing does not occupy a hegemonic place in the production of health care and in gender relations?

Nursing, however, as a profession of care, can collaborate much for the recognition of health needs and of men's position of subjects of care. This contribution, based on a critical knowledge of the aim of health work, is essential for overcoming contradictions which reiterate the invisibility of men in the health service, strengthen medicalizing professional acts and deepen the abyss between men and the social practices of care.

This article revealed some elements and contradictions which are manifested in the dimension of the encounter between health professional and service user which may indicate paths for the work of nursing in this regard. It is understood, however, that aspects which touch upon this phenomenon can be recognized only based on closeness to the context, which includes, in the most complete way possible, the practices and the professionals involved in listening to, and caring for, this group. It is therefore considered that the fact that only men were investigated is a limitation of this study.

## CONCLUSION

The undertaking of this study allowed the conclusion that, in the contact with the objects of their needs related to the health services, the men may recognize in the professional's work, or in another technology, the response to their health needs, as well as perceive the importance of their own agency in the health-illness process, and of their participation in the construction of a health system able to give them visibility.

In the same way, the health professionals, in work with intentionality, have the potential to change their practice so as to produce care able to recognize this group's health needs more comprehensively. Thus, the subjects' relationship of mutual recognition, permitted by the link, has great potential for qualifying men's health needs and the health professionals' work, particularly that of the nurses, who make up the front line in the recognition of these subjects at the individual level.

This study indicates routes for the construction of health practices which are more efficient in the identification and interpretation of health needs, particularly regarding the embracement of the various subjects who seek the health services. Creating possibilities for embracement and attachment for men, throughout the health system, is the first step for it to be possible to break men's invisibility so as to evidence the principles of equality and comprehensiveness of the care.

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