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Experience of men in the context of Primary Health Care

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Experience of men in the context of Primary Health Care

Objectives. To know the experience of male users' in the primary health care and to build data based theory that represents this experience. **Methodology.** This is a qualitative study, in which was used the reference of Grounded Theory and Symbolic Interactionism, respectively, methodological and theoretical. We interviewed 33 male users of three units of primary health care. **Results.** After comparative analysis of data was built the data based theory feeling excluded, which includes: living with prejudice; living with the limitations of infra-structure services; reflecting on the health service environment. The analysis showed the need for a change in logistics services and professionals' attitude guided in respectful and effective communication, the problem solving in readiness in attendance, in addressing gender issues. **Conclusion.** For to take care of men users of the Unified Health System and/or preserve their health, the construction of another rationality in health is imperative, based on reflection and respect for the autonomy and individuality of the male gender.

Key words: health policy; masculinity; primary health care.

Vivencia de los hombres en el contexto de la Atención Primaria de Salud

Objetivo. Conocer la vivencia de los hombres usuarios de la atención primaria en salud y construir una teoría substantiva representativa de esta experiencia. **Metodología.** Se trata de una investigación cualitativa, en la que se utilizaron los referenciales de la Teoría Fundada y del Interaccionismo Simbólico, respectivamente, metodológicos e teóricos. Fueron entrevistados 33 hombres usuarios de tres unidades de atención primaria en salud. **Resultados.** Después del análisis comparativo de los datos se construyó una teoría substantiva: *sintiéndose excluido,* compuesta por: conviviendo con los prejuicios; conviviendo con las limitaciones de la infraestructura de los servicios; y reflexionando sobre el entorno de los servicios de salud. Se señaló la necesidad de un cambio en la logística de los servicios y en la actitud de los

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profesionales basada en la comunicación respetuosa y eficaz, en la prontitud y resolutividad en la atención, y en el enfrentamiento de las cuestiones de género. **Conclusión.** Para que los hombres usuarios del Sistema Único de Salud cuiden y preserven su salud, es imperativo la construcción de otra racionalidad en la salud, basada en la reflexión y en el respeto a la autonomía y a la individualidad del género masculino.

Palabras chave: política de salud; masculinidad; atención primaria de salud.

Vivência de homens no contexto da Atenção Primária de Saúde

Objetivo. Conhecer a vivência de homens usuários da atenção primária à saúde e construir uma teoria substantiva representativa desta experiência. **Metodologia.** Trata-se de uma pesquisa qualitativa, utilizaram-se os referenciais da Grounded Theory e do Interacionismo Simbólico, respectivamente, metodológicos e teóricos. Foram entrevistados 33 homens usuários de três unidades de atenção primária à saúde. **Resultados.** Após análise comparativa dos dados construiu-se a teoria substantiva: sentindo-se excluído, composta por: convivendo com o preconceito; convivendo com as limitações da infraestrutura dos serviços; e refletindo sobre o ambiente do serviço de saúde. Assinalou-se a necessidade de uma mudança na logística dos serviços e na atitude dos profissionais pautada na comunicação respeitosa e eficaz, na prontidão e resolutividade no atendimento, no enfrentamento das questões de gênero. **Conclusão.** Para que homens usuários do Sistema Único de Saúde cuidem e/ou preservem sua saúde, é imperativa a construção de outra racionalidade na saúde, baseada na reflexão e no respeito à autonomia e à individualidade do gênero masculino.

Palavras chave: política de saúde; masculinidade; atenção primária à saúde.

Introduction

The comprehension of the socio-cultural and institutional barriers is an important measure to propose strategies that will promote access of men to the services in Primary Health Care (PHC) in Brazil, aiming to ensure the prevention of risks and diseases and the promotion of health as necessary and fundamental axes of intervention. The implementation of the National Policy of Integral Attention to Men's Health, based on the gender approach, will certainly lead the country to change for better and at an accelerated way their standards in terms of morbidity, mortality and sociocultural aspects.[1] The adequacy of health services for demands of men is one of the challenges for the public health system.[2] One of the pathways to achieve this adjustment can be qualified hearing of men who seek health institutions. Several studies point to different profiles for men and women morbidity.[1,3,4] In general, men are exposed to greater risk of injury and death from external causes, mainly related to violence and traffic accidents.[1,4] The abuse and alcohol dependence are also higher in males than in the females.[1,5,6] Men also have higher smoking rate than women, which causes higher risk of cardiovascular disease, cancer and chronic pulmonary disease.[1,5]

Data of the year 2010 of Vigitel (Surveillance of risk and protective factors for chronic diseases through telephone survey) show that in Brazil, there is an increase of overweight and obesity in the adult population, indicating a prevalence of 48.1% of adults in capitals, being 52.1% males.[5] Despite increased male vulnerability to illness and a shorter life expectancy than that of women, there is a lower presence of men in PHC services.[7] This makes that the access of men to health services occur in the medium and high complexity services, leading to worsening morbidity by late detection or treatment.[1] Some authors associate this phenomenon to the own

socialization of man, in which the care is not seen as a male practice.[1,8] Therefore, there is a need for reflection on masculinity to an understanding of health impairments associated with gender.[1,9] To progress in this reflection, among other points, it is essential to give voice to men to better understand the their experience in the PHC.

Given the complexity and the subjectivity of the theme that involves the perceptions of men, we ask: how men experience care in PHC? How do men are attending in PHC perceive the health care service provided? The aims of this study were to know the experience of male users of primary health care and build a representative substantive theory of this experience.

Methodology

This is a qualitative study; were used the references of Grounded Theory and assumptions of Symbolic Interactionism, respectively, methodological and theoretical. Symbolic Interactionism has as approach the nature of the interaction and the dynamics of social activities that occupy the space among individuals and consist of cause of the behavior. The individual interacting, behaving, perceiving, interpreting, acting again, and therefore, actor and reactor in the unpredictable and active process in the world.[10]

In Symbolic Interactionism, the social world is created and recreated by interactions that give rise to an adjustment of the social actors in relation to each other. Social norms and rules are subject to constant reinterpretation, a social renegotiation. Participants are considered actors interacting with the social elements and not passive agents suffering the imposition of social structures, system or cultures that they belong.[11] The Grounded Theory aims to understand reality from the perception or meaning that a certain part or object has for the person, generating knowledge, increasing understanding and providing a meaningful guide for action.[12] The study took place at three basic health units (BHU) located in the southern area of São Paulo, Brazil. These BHU have teams of Family Health Strategy. The first BHU has four health teams to serve 4 071 families registered, with 6 926 men. The second BHU has five teams to assist 5 362 families registered, with 7901 men. The third BHU works with five health teams to serve 4,595 families registered, with 7,177 men. The opening hour of the three BHU is 7 am to 5 pm.

The research project was approved by the Research Ethics Committee of the Municipal Health Department of São Paulo, with the number 442/09, CAAE nº 0254.0.162.251-09. For each participant, before interview, was given a consent form provided in accordance to the regulations of research involving human subjects, in order to protect the anonymity of the participants and the dissemination of data collected by the researchers. Its execution was previously authorized by BHU managers. As inclusion criteria, was adopted: men over the age of 18, and registered users of one of the studied BHU.

Based on the principles of participants in qualitative research, the focus was on male user, considered in enough number to make possible the saturation of senses, that is, the moment that unveiled the researched phenomenon, predicting the possibility of successive inclusions of subject until be possible a dense discussion of the research issues.[13]

Data were collected between September, 2010 and January, 2011, using interviews compounded of two parts: the first, a script with the finality to define the participants of the survey (age, skin color self-reported, education, income, current job and reason for seeking treatment in BHU); and the second, consisting of open questions concerning the experiences of users in health care at the primary level. The interview was previously scheduled by phone, held at home and recorded after release, with an average duration of 40 minutes. There was the formal presentation of research at the residence of the participants, in regard to ethical criteria. In total, the theoretical sample consisted of 33 in-depth interviews with

users of the PHC. To survey participants were given fictitious names, starting with the letters C (BHU I), J (BHU II) or A (BHU III) in order to ensure anonymity and confidentiality of information.

The interviews were transcribed and analyzed using the constant comparative method of data, in which similarities and differences are identified, bringing out the categories and seeking theoretical conceptualization.[14] Interpretation of data was achieved with the inductive-theoretical development of categories. The steps of the method included the coding, in which were searched the meanings for all information units, codes revision, aggregating and grouping them into theoretical categories.

The second level of coding and analysis, axial coding, involved a manufacturing category system, as their properties and dimensions as well as its relations with other categories, until theoretical saturation was reached. For the axial coding, ie, the theoretical coding were used two types: the first called "six C" (cause, context, contingencies consequences, conditions and co-variants), which should be the first general coding model that a researcher should focus. It helps to expand the analysis, so that the presentation of the data is not be confined to a code list or categories.[14] The second type used was to determine the strategies, which allows to think of different ways to organize the mechanisms, strategies and compositions that people use in their socials interactions.[12] The final stage of the analysis involved the construction of conceptual definitions for the categories. This stage is characterized by the challenge of integrating categories, in order to form a Grounded Theory.[12-14] In preparing substantive theory, the categories should be able to offer a greater focus than that of a personal experience.

This is a substantive theory, as we tried to reflect the complexity of social life, limited in scope, rich in detail and applicable only within the limits of a given social context, ie, the PHC environment, without concern for a statistical generalization beyond their substantive area, sought further explanation of a particular scenario, built from the experiences of a particular social group, in this case men who experience the service in the PHC and; is a grounded theory because it was built from empirical data collected and analyzed systematically through the research process. Thus, allowed the construction of a data based theory, in which the central phenomenon experienced by participants was: feeling excluded, consisting of three categories: living with prejudice; living with the limitations of infrastructure services; and reflecting on the health service environment.

Results

Participants of the study

We interviewed 33 users, 11 participants in each UBS, the places of this study. The characteristics of these men who participate of the study were: aged 30 to 77 years, with an average age of 50.2 years. Regarding marital status, most were married. Regarding education level, 19 men had less than nine years of study. Highlights were older men, married and with low education. Regarding income, eight respondents reported monthly income over $1,530, 13 reported receiving between $765 and $1,530, and 12 received between $255 and $510. In relation to work, 12 men reported being employed under the Brazilian legislative policy related to labor law - Consolidation of Labor Laws (CLL), seven in informal employment, 12 reported being retired and two were unemployed. Among the activities performed, the highlights were mason, servant, painter, owner, and driver, master of operational, mechanical and attendant. With regard to skin color, 10 reported they were white, 12 mulatto and 11 niggers.

Regarding the reasons that led users to seek the BHU, there was a predominance of medical consultations related to complications related to arterial hypertension[11] and diabetes mellitus[9], corresponding to a total of 21 men, followed by congestive heart failure, chronic obstructive pulmonary disease, dyslipidemia, deep vein thrombosis, chronic atrial fibrillation.

It was observed that, in general, the reasons referred to treatment and control of diseases,

indicating that these participants did not seek the service of PHC for preventive measures, confirming the prevalent trend of traditional hegemonic curative practice that dominates and determines the usage profile of health services, according with other studies.[9]

Substantive theory

From the intense and constant interaction with the data from this study, as well from reflections, interpretations and observations, beside the assistance of comparative analysis as envisaged in the Grounded Theory was constructed substantive theory: "feeling excluded."

The identified categories and theoretical connections, resulted in an explanatory paradigm of the experience of the man on the care received in PHC, represented by the substantive theory "feeling excluded" (Figure 1).

<table>
<tr><th>Causal conditions</th><th></th><th>Action strategies</th><th></th><th>Consequences</th></tr>
<tr><td>Facing with the need of care/service.
Recognizing the limitations of service organization.
Finding a non-conducive environment for their care.</td><td>→</td><td>Assessing the need to take care always.
Faced with the delay in treatment, opening hours of BHU.
Recognizing the need for a welcome service</td><td>→</td><td>Weakening in front of the need of care.
Leaving seek care in PHC.
Not finding spaces to exchange experiences.</td></tr>
<tr><td colspan="5">Intervening conditions: capacity or not to reflect on the care received in PHC</td></tr>
<tr><td colspan="5">Background characteristics: PHC unprepared to attend the needs of male users</td></tr>
<tr><td colspan="2">Living with prejudice</td><td colspan="2">Living with the limitations of services infrastructure</td><td>Reflecting on the health service environment</td></tr>
<tr><td colspan="5">The central phenomenon feeling excluded represents the experience of men on the care provided to them in PHC</td></tr>
</table>

Figure 1. Description of causal conditions, context, intervening conditions, action/interaction strategies, central phenomenon and consequences from the experience of men on the care provided to them under the Primary Health Care

The figure, elaborated by the authors, is composed of rectangles that represent the phases experienced by men: causal conditions; intervening conditions; context; strategies of action/interaction and consequences. These phases represent the symbolic meaning of human experience, as components of a process that occurs in the context of PHC. The analysis of the phases, as well as their categories, and how they interact in the experience of man permitted to identify the process called as "feeling excluded." Each of the phases experienced by man consisted of challenges for which he needs to take action in order to overcome them, in a continuous flow of action.

Thus, the Symbolic Interaction describes the human being as unpredictable and active in the world.[11] The decision making depends, in part, on the possible future consequences. As action/interaction strategy the man just assessing the need to take care always, recognizing the need for a welcoming service, because he lives encountering with the delay in treatment, BHU opening time. The man knows that the decision, whatever it may be, has consequences and ends up weakening in front of the need for care, failing to seek care in PHC, because he does not find place to exchange experiences, as pointed out in Figure 1. Thus, "feeling excluded" represents a process experienced by men on the care provided to them under the Primary Health Care, consisting of "living with prejudice", "living with the limitations of the infrastructure of services" and, "reflecting about the health care environment".

Living with prejudice

The statement of respondents of the survey shows that there is, on the part of health professionals, an apparent and represented prejudice by the ideal male of virility and strength. This prejudice has negative effects on assistance offered by health professionals, contributing to the lack of acceptance in the male patients and their demands: *I was building the slab of a colleague and I ended up slipping and had this big cut here in the leg, I had to take tetanus vaccine [...] the assistant nurse made fun because I am afraid of needles ... came out laughing and making little joke by the unit, for everyone hear* (C11)*. I started a new job that required my vaccination card were updated, so I went to the BHU I needed to take two vaccines, but I am afraid of needle, dread ... everyone was laughing at me because I cried [...] heard so that man does not cry, like my father usually to spoke, I am ashamed to this day, not going back there anymore* (A9).

Disregard of subjectivity and user experience of life implies a number of negative consequences for the interaction between the professional and the user. In this sense, the assumption of fragility and vulnerability do not need to imply submission. After all, before a barrier to health, we need a re-discovery of a weakness to be careful, that does not have to be opposed to aspects of assertiveness of the subject. In this perspective, the statements below show that aspects of nonverbal communication were identified as the look and facial expression of impatience of health professionals: *In the last visit the doctor was angry, impatient even [...] I'm stuttering [...] he was drumming his fingers on the table, fidgeted in his chair [...] they attend badly who have a problem* (A1)*. My experience at the BHU is very bad [...] there are people there that when I get in, make scowl [...] has no patience with crippled elderly* (C2). The health team must be careful when using verbal and nonverbal forms of communication, to attend the population's health needs, seeking an assertive communication, with coherency between feelings, thoughts and attitudes.

Living with the limitations of infrastructure services

Men revealed that the opening hours of PHC services is presented as an important limitation of care experienced by them as users, because it coincide with their working hours. As, usually, the work takes a prominent place in the cast of male concerns, the search for health services is in the background, as pointed out in the speech: *It is very hard for people who work and do not have enough time. The opening hours is the same time that work, public health excludes people who work during business hours [...] does not work on weekends [...] I feel excluded* (A5). *I think it would need to create home visit at night to meet people who work on average twelve hours a day* (A3). *The service is lengthy, I can't miss a day of work, it is difficult for those who have to work all day, they should work late, at least a couple of days a week, for those who work outside* (J7).

Respondents pointed out others limitations in organizations of PHC services*: We spend hours waiting for our appointment with the doctor, it takes months and the day is also longstanding, I have to miss a day of work, it is difficult for those who have to keep the family and my last visit finished without solving my pain* (C8). *You get hours and hours to be attended [...] it should work 24 hours* (J1). *What I experience here is a very poor care, because the medical consultation is very fast, you come in with a problem and go out with two problems, because there is still a absence in the work [...] and also has health professional who attends slowly and with a grudge* (A11). The lack of reception and waiting lines without solving guarantee their demands are evidence of the need for reorganization of PHC services.

Reflecting on the health service environment

BHU men users of the surveyed are faced with an environment that does not recognize its uniqueness, which points to an invisibility of men as target audience for promotional health interventions and preventive risk in PHC services.

This invisibility is expressed mainly in the failure of programs and attendances directed to men: *My experience in the health service is a basic service, I am hypertensive, come in the appointment, I get the prescription [...] but only has groups and monitoring for children and woman, the tracks shows of woman cancer prevention, breastfeeding, the wall of the reception room is pink* (J9). *Look, public health is focused on the health of children and women, man is in the background, I feel a fish out of water, and all warnings are for women* (A2). *The unit is geared towards women and children, the wall of the reception room is pink, did you see? [...] They should have a team to attend only men* (J5). *I feel like a stranger in the health unit, few men, only women and children, I wen when I really need, it's everything for them* (C1).

Discussion

The presented substantive theory offers a vision of how can work the limits of men in PHC and demonstrates the reciprocity between these limits and decision making. Thus, have been emerged the integrant phenomena of the central category "feeling excluded." First, emerged the process in which the man was faced living with prejudice, in testimony, to be a man was associated, by health professionals, to invulnerability, strength and virility, incompatible characteristics with the demo signs of weakness, fear and insecurity, reinforced by reference to the masculinity of users, bringing them closer to the femininity representations. The speeches have left disclose the importance of interpersonal interaction, effective communication, as well as their difficulties, related to the little assertive care of health professionals. It is noteworthy that, in nonverbal communication, facial expressions may denote happiness, sadness, anger, indifference, contempt, prejudice, interest, fear and all these expressions can help to understand the interaction process between health care professional and PHC user.

Aiming at the humanization of health actions, respect to dignity and integrality of citizens, professionals must take a dialogic interaction, respecting the needs and fears to voice the anxieties experienced by each individual. Contrary to this, users can choose to remain in silent and accept passively what is imposed, what, sometimes, can lead to harmful effects to health.[9,15] Communication tends to be unsatisfactory when there is insufficient preparation of the professional to listening and dialogue with the user. In the aforementioned speeches were perceived that is fact the existence of hard interaction between health professionals and users, generating direct consequences in care.

When the health worker understands that the exchange process and empathy are beneficial for assistance, starts to use this interaction as an important working tool. Dialogue is essential to establish flatter and symmetrical interactions between health professionals and users, grounded in the care, trust and freedom of expression. The opening hours of PHC services performed as an important limitation to attendance experienced by men, while users of the service, due to the opening hours coincide with their working hours. Within the work, the male social identity is expressed in the figure of the provider, the household head, than rarely gets sick. Through the work, men can adopt certain behaviors and attitudes that drive for recognition and social respectability, but also to be justified by the difficulty to take care of their health.

Culturally there is a disincentive for the man absent from work for health care. Already paid work of women is not seen as a socially justified way so it does not take care of her health, there seems to take care for her health is a representation of a feminine characteristic, suggesting a greater tolerance of employers to release women to take care for her health or her family.[16] Its hard to find BHU or ambulatory open after 5 pm, much less on weekends, leaving out the economically active population, which, in this study, undermines the demand from men for health care, remaining for them the urgency and emergency services. Studies show that the adequacy of the PHC services to man's demands constitutes a challenge for the

public system saúde.[9,15] In this sense, is believed to be possible an inclusive assistance in PHC services if there extension in time opening of health services to at least 10 pm. The waiting time to get treatment is another cause of dissatisfaction, appointed by participants, and is related to the organization of institutions, and contribute to the low frequency with which the male community enjoys such serviços.[9,16]

The information collected by survey participants refer to the logistics of public health services in the context of BHU. Logistics involves the efficient management of the flow of goods and services to provide resources, equipment and information in the implementation of all activities of a health institution or another sector. Result, the effective management of goods and services offered to the user's health - citizen, the creation of time and/or place utilities, in turn, are key factors for the logistics functions. For public administration, both resources and organizational target audience are scattered in areas of different sizes, in addition to socio-cultural diversity of local residents.

Offer to population health care with quality, safety and at the right time required by the citizen is one of the greatest challenges of public management, the federal, state and municipal levels. The results of this study indicate that there is to meet the health units attending to the principles of legality, quality, economy and speed, at the right time and in the right quantity, to effectively offer health. Working with a model of health care user-centered,[19] is not an easy task, as it requires a view toward the individual needs of specific social groups and of the community; assumes a breakdown of the walls of health services, reorganization of the BHU and, above all, a high degree of complexity of knowledge. In addition, health care is with co-responsibility, incorporating the therapeutic act of valuing the other, respecting their world view, their social context and their dignity.[18] This is an assertively way to change health care aiming the quality of life in community.

The environments of the surveyed services are seen by men as places that do not favor their presence or stay, as they present as markedly feminine spaces. Topics such as the promotion of breastfeeding, prenatal care, STD prevention and HIV/AIDS are common in everyday health services and present great feminine approach. The approach of men relationships with institutions and health professionals is still young. The woman familiarity with health care, leading to association of health institutions as a female space was a result of the woman's body appropriation process, seen as a reproductive body and thus, control object of medical knowledge. The male body left the reproductive function, not the subject of health practices for many years.[17]

The statements corroborate studies describing that men consider themselves as excluded in the BHU environment, have a sense of not belonging to that space,[9,15,17] until the point of indication of having a team just to attend men, emphasizing the space of gender domination. Becomes essential the wake up of National Health System (NHS) workers, in the essential way of to create a welcoming and inclusive environment for all, with spaces for experiences exchange among users. We conclude that this study portrays the care provided from the perspective of NHS users' men in PHC, presents a substantive theory about the experience of men in BHU. The theory is classified as substantive because it is limited to a specific situation and context. A formal theory can be generated when the experiences of men is studied in multiple contexts and municipalities.

The experience of man occurs in a context of interpersonal relationships that affect emotions, beliefs, behaviors and decisions. It is necessary to understand the logic that the PHC users men use to define what is good health care, from different barriers, pointed by them. It is necessary to understand that many of their grievances are general citizens' rights. It was also observed in this study, a preponderance of questions about the actions offered in health and how to give, expressed by some participants, by the lack of organization in the system and services and by the ineffective or disrespectful communication by health professionals. Were reinforced the

differences between a male and female user in contemplation of the institutional environment, in the tendered shares and developed programs. These results point out aspects that favor the non-adherence of man to health care and the frequency with which seek to PHC services, because the waiting time was a strong reason for not demand for health services in BHU.

The results show that, to improve the adherence of man to primary health services, one of the interventions is based on reflection and respect for the autonomy and individuality of the male gender. So the policies implemented for specific groups or the community should include people management, to print important directionality in training and continuous development of health professionals to manage the care and services with more resolution and integrated into the NHS. For males users of the SUS take care and/or preserve their health, is imperative the construction of another rationality in health, from which the commitment with the suffering of another is able to shift the focus of the disease to give evidence to the life that produces even in illness and life that produces itself by promotional health actions in the quality of life. It is vital to recognize the importance of relational dimension professional/user in the health daily and change the ways of this know-how, including subject and collective in a smoothly, humane and ethical way.

It is worth noting the limitations of the study because, although covering the experiences of men in PHC, this is not an absolute reality for all men who frequent public health in Brazil, the unpredictability of the way of assistance to men might bring other charges and conflicts which should be considered and evaluated by health professionals.

References

1. Ministério da Saúde (Brasil). Secretaria de atenção à Saúde, Departamento de Ações Programáticas Estratégicas. Política Nacional de Atenção Integral à Saúde do Homem: princípios e diretrizes [Internet]. Brasília (DF): Ministério da Saúde; 2008 [cited 2014 Jan 22]. Available from: http://www.unfpa.org.br/Arquivos/saude_do_homem.pdf
2. Silva DM, Souza TO, Lima MV, Yarid SD, Sena ELS. Acessibilidade do homem aos serviços da atenção básica: uma aproximação com a bioética da proteção. Cogitare Enferm. 2013; 18(3):573-78.
3. Knauth DR, Couto MT, Figueiredo WS. 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. Ciênc Saúde Coletiva. 2012; 17(10):2617-26.
4. Andrade-Barbosa TL, Xavier-Gomes, L M, Barbosa V A, Caldeira AP. Mortalidade masculina por causas externas em Minas Gerais, Brasil. Ciênc Saúde Coletiva. 2013; 18(3): 711-9.
5. Ministério da Saúde (Brasil). Secretaria de Vigilância em Saúde, Secretaria de Gestão Estratégica e Participativa. Vigitel Brasil 2010: vigilância de fatores de risco e proteção para doenças crônicas por inquérito telefônico [Internet]. Brasília (DF): Ministério da Saúde; 2011 [cited 2014 Jan 22]. Available from: http://bvsms.saude.gov.br/bvs/publicacoes/vigitel_2010.pdf
6. Ministério da Saúde (Brasil). Secretaria de Vigilância em Saúde, Departamento de Análise de Situação de Saúde. Plano de ações estratégicas para o enfrentamento das doenças crônicas não transmissíveis (DCNT) no Brasil 2011-2022 [Internet]. Brasília (DF): Ministério da Saúde; 2011 [cited 2014 Jan 29]. Available from: http://actbr.org.br/uploads/conteudo/918_cartilha_dcnt.pdf
7. Brito RS, Santos DLA, Maciel PSO. Olhar masculino acerca do atendimento na estratégia saúde da família. Rev Rene. 2010; 11(4):135-42.
8. Reis LM, Martins BF, Gavioli A, Mathias TAF, Oliveira MLF. Saúde do homem: internações hospitalares por intoxicação. Esc Anna Nery. 2013; 17(3):505-11.
9. Gomes R, Rebello LEFS, Nascimento EF, Deslandes SF, Moreira MCN. A atenção básica à saúde do homem sob a ótica do usuário: um estudo

qualitativo em três serviços do Rio de Janeiro. Ciênc Saúde Coletiva. 2011; 16(11):4513-21.

10. Charon JM. Symbolic interacionism: an introduction, on interpretation, on integration. NewJersey: Prentice Hall; 1989.

11. Le Breton D. L'interactionnisme symbolique. 3rd ed. Paris: Puf; 2012.

12. Backes MTS, Erdmann AL, Büscher A, Dirce SB. Desenvolvimento e validação de teoria fundamentada nos dados sobre o ambiente de unidade de terapia intensiva. Esc Anna Nery. 2011; 15(4): 769-75.

13. Fontanella BJB, Luchesi BM, Saidel MGB, Ricas J, Turato ER, Melo DG. Amostragem em pesquisas qualitativas: proposta de procedimentos para constatar saturação teórica. Cad Saude Publica. 2011; 27(2):388-94. 14. Strauss A, Corbin J. Bases de la investigación cualitativa: técnicas y procedimientos para desarrollar la teoría fundamentada. Medellín: Facultad de Enfermería, Ed. Universidad de Antioquia; 2002.

15. Gomes R, Moreira MCN, Nascimento EF, Rebello LEFS, Couto MT, Schraiber LB. Os homens não vêm! Ausência e/ou invisibilidade masculina na atenção primária. Ciênc Saúde Coletiva.2011; 16 (Supl. 1):983-992.

16. Machin R, Couto MT, Silva GSN, Schraiber LB, Gomes R, Santos FW et al. Concepções de gênero, masculinidade e cuidados em saúde: estudo com profissionais de saúde da atenção primária. Ciênc Saúde Coletiva. 2011; 16(11):4503-12.

17. Toneli MJF, Souza MGC, Muller RCF. Masculinidades e práticas de saúde: retratos da experiência de pesquisa em Florianópolis/SC. Physis. 2010; 20(3):973-94.

18. Viegas SMF, Penna CMM. O SUS é universal, mas vivemos de cotas. Ciênc Saúde Coletiva. 2013; 18(1): 181-903