Revista de Pesquisa Cuidado é Fundamental Online
E-ISSN: 2175-5361
rev.fundamental@gmail.com
Universidade Federal do Estado do Rio de Janeiro
Brasil

de Araújo, Mércio Gabriel; do Nascimento Cassiano, Alessandra; Freire de Lima, Gleyce Any; Miranda de Holanda, Cristyanne Samara; Bittencourt Leite de Carvalho, Jovanka
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Revista de Pesquisa Cuidado é Fundamental Online, vol. 5, núm. 4, octubre-diciembre, 2013, pp. 475-484
Universidade Federal do Estado do Rio de Janeiro
Rio de Janeiro, Brasil

RESEARCH

ACCESS OF THE MALE POPULATION TO THE HEALTH SERVICES: PERCEPTION OF THE FAMILY HEALTH STRATEGY PROFESSIONALS

ACESSO DA POPULAÇÃO MASCULINA AOS SERVIÇOS DE SAÚDE: PERCEPÇÃO DOS PROFISSIONAIS DA ESTRATÉGIA SAÚDE DA FAMÍLIA

ACCESO DE LA POPULACIÓN MASCULINA A LOS SERVICIOS DE SALUD: PERCEPCIÓN DE LOS PROFESIONALES DE LA ESTRATEGIA SALUD DE LA FAMILIA

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ABSTRACT

Objective: To know the perception of the Family Health Strategy professionals (FHS) about the men's access to the basic health services. **Method**: It is an exploratory and qualitative study developed with 16 FHS professionals, with the approval of the Research Ethics Committee from the State University of Rio Grande do Norte (REC/UERN - n ° 052/11). The data were discussed through the thematic analysis technique of MINAYO. **Results:** The labor is considered a barrier for the access of this population to the health services or for giving continuity to already established therapeutic procedures. The health professionals blame the male population for its absence in the service at stake. The non-participation of men is related to the lack of planning and organization in the FHS scope, lack of intersectoriality, as well as assistance exclusively guided on outpatient care shares. **Conclusion:** it is possible to identify the lack of strategies to attract men to the BHU scope. The challenges become evident before the invisibility of practices that foster the demand for health services. **Descriptors**: Men's health; Access to the health services; Family's health.

RESUMO

Objetivo: Conhecer a percepção dos profissionais da Estratégia Saúde da Família (ESF) acerca do acesso do homem aos serviços básicos de saúde. **Método:** Pesquisa exploratória e qualitativa desenvolvida com 16 profissionais da ESF, com aprovação no Comitê de Ética em Pesquisa da Universidade do Estado do Rio Grande do Norte (CEP/UERN - n°052/11). Os dados foram discutidos através da análise temática de Minayo. **Resultados:** O trabalho é considerado uma barreira para o acesso dessa população aos serviços de saúde ou a continuidade de tratamentos já estabelecidos. Os profissionais responsabilizam o homem pela sua ausência no serviço em questão. A não participação do homem está relacionada à ausência de planejamento e organização na ESF, falta de intersetorialidade e assistência pautada exclusivamente em ações ambulatoriais. **Conclusão:** identifica-se a ausência de estratégias que atraiam o homem a UBS. Os desafios tornam-se evidentes diante da invisibilidade de práticas que favoreçam a procura pelos serviços de saúde. **Descritores:** Saúde do homem, Acesso aos Serviços de Saúde, Saúde da Família.

RESUMEN

Objetivo: Conocer la percepción de los profesionales de la Estrategia Salud de la Familia acerca del acceso del hombre a los servicios básicos de salud. **Método:** Investigación exploratoria y cualitativa desarrollada con 16 profesionales de la ESF, con aprobación en el Comité de Ética (CEP/UERN - n°052/11). Los datos fueron discutidos a través de análisis temático de Minayo. **Resultados:** El trabajo es considerado una barrera para el acceso de esa población a los servicios de salud o la continuidad de tratamientos ya establecidos. Los profesionales responsabilizan al hombre por su ausencia en el servicio. La no participación del hombre está relacionada a la ausencia de planeamiento y organización en la ESF, falta de intersectorialidad y asistencia pautada exclusivamente en acciones ambulatorias. **Conclusión:** se identifica la ausencia de estrategias que atraigan al hombre al UBS. Luego, los desafíos se tornan evidentes delante de la invisibilidad de prácticas que favorezcan la búsqueda por los servicios de salud. **Descriptores:** Salud del hombre, Acceso a los Servicios de Salud, Salud de la Familia.

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INTRODUCTION

The need for the inclusion of males in the public health policies emerged from the dissemination of gender discussions in the health sciences. Due to it being the main target of deaths from external causes, it becomes imperative to search for providing a better life condition to male gender, through the inclusion of men into reproductive and sexual health actions, as well as enabling their participation in health promotion practices.[1]

Health promotion should be understood as an essential and guiding concept of the Family Health Strategy (FHS), thereby favoring the enhancement of local micro-cultures and walking towards the autonomy of subjects, given that health promotion might be employed as a guiding tool for individuals who independently assume the responsibility for their health conditions.[2]

Studies on men, masculinity and their inclusion in health services, especially in the primary care scope, reveal the concern of the aforementioned services towards this group, given the difficulty that they have for getting into such spaces.[3-4]

The gender discussions identify values and ideas contained in the social imaginary that prevent that the individual self-care in the health-related issues. Being a man is still synonymous with not be afraid, not crying, not having feelings, risking itself before various dangers, showing courage and being active, and these situations strongly interfere in the health-disease process.[4]

Based on the above, it is perceived that men consider the basic health units as feminized environments, where there is a predominance of actions aimed at serving women, children and elderly subjects. Another obstacle is related to the fact that the health staff is mostly comprised of female professionals, which makes males invisible in such spaces.[5]

In order to minimize this fragility, man was brought into the discussion field of reproductive health, becoming co-responsible for family planning and responsible parenthood. Nonetheless, male participation in the pregnancy-puerperium cycle is still shy. The access of the pregnant women during this period takes place in an isolated way, i.e., in most cases with no participation of their spouses. Men consider themselves as providers and not co-participants in such a process. Before this understanding, males become a challenge for health services, since the intrinsic values and concepts inserted in the building of the masculine identity are obstacles in formulating actions to ensure their citizens' rights.

However, the development of strategies for health promotion and disease prevention, the discussion about the spaces that contribute to the males' insertion, as well as their permanence in these services, are facilitator axes for solving this issue. Accordingly, the primary care is an efficient tool that strengthens the bonds between service and population, in addition to contributing to the universalization of access and to warranty of the completeness and fairness of care shares. It should be understood as an interconnected set of actions and services that allow a direct access of users to the health field.[6]

By setting the rights of men against the ones won by women, it should be perceived a large gap when it refers to the health-related issues, because women over the years managed to gain access to policies and programs that could serve them in a special manner, being that they are currently considered the predominant group in the primary care actions - while the male gender remained untouched and unseen or, even,

unnoticed by public health policies until the year 2008.

Based on these assumptions, the present study aimed at knowing the perception of FHS professionals about the males' access to basic health services.

METHODOLOGY

It is an exploratory and descriptive study with a qualitative approach, which was conducted in the Basic Family Health Units (BFHU) that compose the primary care at the municipality of São José do Seridó, located in the hinterland from the Rio Grande do Norte State, Brazil. The study population consisted of sixteen (16) health professionals who are part of the minimum staff of the municipal FHS, which is comprised of physicians, nurses, nursing technicians and community health workers (CHW).

We have included professionals registered in the FHS who were developing their working activities. This sample does not cover the workers who were on vacation or were removed from their activities, besides those who refused to sign the Free and Informed Consent Form (FICF).

The data collection was conducted from November 2011 to January 2012 from semi-structured interviews comprised of a script organized in two parts, containing questions related to the characterization of the participants and questionings directed to achieve the proposed objectives. The obtained information were analyzed and discussed through the thematic analysis technique of Minayo.[7]

The ethical opinion was issued by the Research Ethics Committee from the State University of Rio Grande do Norte (REC-UERN) under the protocol number 052/11. The study was guided by the ethical and legal considerations proposed by the Resolution nº 196/96, which regulates the researches involving human beings.

RESULTS AND DISCUSSION

CHARACTERIZATION OF THE PARTICIPANTS

The study subjects were characterized according to age, gender, marital status, schooling, occupation, years of professional experience, years of experience in the ESF, length of stay in the BFHU and qualification in the FHS or associated area. The results aimed at revealing the profile of the participants included in the survey.

Regarding the age, it is perceived that 68,75% of the interviewees were aged between 20 and 50 years, which denotes the presence of young professionals in the FHS scope. This profile might influence in the consolidation of this strategy, given the changes that have occurred in the last few decades in the curricula of graduation health courses, allowing the inclusion of new ways to conduct health practices.[8]

With respect to the gender, 81,25% were women, which reveals the predominance of this group in the primary care context. This demonstrates the strong presence of females in this space and the low participation of male professionals in this level of care, causing some resistance from male users, who idealize this space as a purely female environment. As to the marital status, 62,50% were in a stable relationship, being that it is a factor that has relevance to the study, because these subjects, in most cases, live together with the male population, thereby facilitating in the daily living with the peculiarities inherent to this group.[9]

The schooling showed 50% with average level (complete high school), reflecting the predominant number of community health workers and nursing technicians, representing respectively 62,5% and 12,25%. This percentage demonstrates the search for educational improvements. Even with the increased schooling, many of these

professionals remain in the profession, thus contributing to the consolidation of employment links.[10]

It is observed that 87,50% have from 0 to 25 years of professional experience, referring to a transformation in the health services assistance that took place with the onset of the Brazilian Unified Health System (SUS), allowing the insertion of professionals with profiles aimed at dealing with several situations in the context of the health/disease process of individuals, families and communities.[8]

Concerning the years of experience in the FHS and in the BFHU, it is realized that the subjects hold from 0 to 10 years of activity, which represents about 62,50% of those involved. 87,50% have revealed that were trained in the FHS or in an associated area. Thus, these professionals know the uniqueness and relevance in building spaces in the ESF that might favor the improvement of the quality of health of individuals and of the community context. In this light, despite the training being a tool for improving the technical competence, it does not imply the warranty of quality care.[11]

The formation of the male subject, built from the perspectives of invulnerability, strength and virility has historically contributed to the absence of males in health services. These characteristics are inconsistent with demonstrations of weakness, fear, anxiety and insecurity, represented by the pursuit for such establishments (health institutions), endangering masculinity and pushing the male gender towards the representations of femininity.[12]

The speech of the surveyed subjects highlights the concept that the male gender has when it speaks of the need for health promotion and prevention, unveiling the female gender as the main subject subjected to health-related issues, being that women are forced to take care of themselves, while men, due to their socially built figure, have no need of such care shares.

> *[...] they think they do not need a doctor, do not need to go to health services; they think they are totally healthy. Some of them have already told it me: women are only the ones who need care. I say: we, human beings, men and women, have to take care of ourselves in an equal manner. (CHW 01)*

> *[...] The difficulty is that the adult man, because of his own culture, does not have or seek the doctor for solving its health problems. (PHY 02)*

Through the professionals' speech, it is perceived that the conceptions prevalent in society require that access to health services by men preferentially takes place through outpatient clinical care, because their speeches emphasize the medical consultation when they mention *"they (males) think they do not need a doctor" and "they (males) do not seek the doctor for solving their health problems"*. This demonstrates the lack of knowledge about the relevance of health promotion.

The presence of men in health services has been evidenced by the challenges that the primary care is facing, whether by the cultural issues belonging to the male imaginary, which understands the BHU as a feminized space, or by his "non-belonging" to such a space, since it has no available actions, programs and activities aimed at serving the male population.[9]

The absence of men is perceived by the cultural aspect, seen by reference to a gender identity, while it offers to the woman a specificity grounded on the biology linked to reproduction, contraception and pregnancy. The cultural approach is associated with a male type, reinforcing an idealized model of masculinity (strength, virility, objectivity, emotional distancing, risk behavior), as opposed to being a

woman, which is identified with fragility and sensitivity.[13]

The surveyed professionals have also highlighted that one of the barriers to the men's access is the shame generated by the lack of habit of searching for health professionals such as physicians and nurses. This is a factor that is understood as a consequence of a training founded on the premise that it is not necessary to search for solutions to their health problems.

> *[...] They do not seek the health station because of shame and also say that is a women's thing the fact of going to the health station; in addition to having no patience to wait in line, they feel ashamed of doctors and nurses. (CHW 06)*

> *[...] Many men still have that prejudice relating to shame, sometimes, many times, they have a problem does not mean that they feel like this, did you know, [...].(NURS TEC 02)*

Another statement identifies the fact that the health professional belongs to the opposite gender is an obstacle to the insertion of the male population in the activities undertaken by the service.

> *[...] The fact that I am a woman partially inhibits this demand, it is basically like this. (NURS 01)*

This perception was already highlighted by another study that discussed the profiles of professionals working in the FHS. The survey has revealed a predominance of females, which significantly contributed to the failure of men to access health services focused on primary care. Another great problem is the predominance of actions targeted to women, children and elderly subjects, i.e., there is a shortage of spaces for providing activities for men.[9]

Some barriers should be considered before the hegemonic model of masculinity and the health practices that are offered, namely: the fear of men to seek medical care and be understood as weak and vulnerable, the traditional association between self-care and femininity, the perception of invulnerability of the male body and the assessment that the health services are spaces intended for females.[14]

The work is also considered a barrier to men getting access to health services or continuing the already established therapeutic procedures. Lack of time, inability to stop the activities, or having fear that the disclosure of any health problem and the absence for medical treatment might harm them, resulting in loss of work places, are some of the concerns in men who become ill at work, whether it is due to occupational diseases or not. This has made impossible to perform several actions towards this public and, consequently, has led professionals to abandon activities of health prevention and promotion targeted to this group.[15]

From the professionals' statements, it is perceived that the men made use of their commitments in order not to participate in health activities. The barriers are imposed for work-related issues or even for not having interest in searching for the health services. This reflects the low demand, and it is imperative realizing the need to offer actions that encourage men's access to such services. The permanence of eventual activities makes fragile the possibility of men in winning access to services.

> *[...] When we call, they never want to come. We stand, they are too busy, it doesn't matter, doesn't have anything to do. (CHW 03)*
> *[...] but demand is the actual problem; demand is very small, leaves much to be desired. Because of that, we did not serve a great number of men, which would be ideal [...]. (NURS 01)*

Another justification for non-insertion of men into health services is the priority of working activities to the detriment of their health conditions. The work comes first in the list of

male concerns, which also demonstrates that the opening hours of health facilities is not always reconcilable with the schedules of individuals included in the labor market, regardless of being male or female.[16]

There are services that use the strategy of expanding its care shares beyond the usual schedule, serving 24 hours, on Saturdays or on a third shift, demonstrating a greater male participation in the health actions. This reinforces the questions directed to the labor as an aspect that restricts the access and use of health services by such individuals.[6]

The subjects have revealed the existence of specific schedules to meet the laborer public, and these times include both men and women. However, it should be understood that this is not a planned and specific service, i.e., designed to meet the male audience, but rather to meet the entire laborer population, regardless of gender.

> *[...] I do a work here – worker's time -, through that, those people who do not have access to the health unit during the day, they might have access at night to be attended. (PHY 02)*

> *[...] The man who says he doesn't have time or I'm working [...] we have to deal it with the man, ok! Even with the employees, a way, here, for example, the city even has a schedule in which we organize the worker's time in order to attend this situation, but, until now, I didn't meet any man on the worker's time, only women [...]. (NURS 02)*

It is observed that the professionals use a service offered in a different time from the proposed by the FHS to justify the existence of actions performed to the male audience, however, one of the surveyed people reveals that never met a man: *"I didn't meet any man on the worker's time, only women"*, which demonstrates the lack of specific activities directed to this audience.

Therefore, it should be realized the difficulty of dealing actions for the male audience, given that the health professionals do not develop strategies to facilitate the participation of the male population in the FHS. Thus, the statements are guided by the challenges of performing actions that ensure the accessibility of this group in the establishments and, consequently, turn these subjects into customers of such a service.

Based on the above, we have identified that the health professionals blame the men for their absences in the service. Nonetheless, it is noteworthy mentioning the need for engagement from FHS for planning and implementing health actions that include men as co-participants in their health conditions.

One of the surveyed professionals describes the need for commitment and the pursuit for overcoming imposed barriers by understanding that access is essential for strengthening actions that improve the health conditions of men.

> *[...] it's very difficult for us to bring him; I think if we strive and achieve this goal, it'll be something of great importance. (CHW 07)*

It should be considered the importance of commitment and responsibility inherent to the multiprofessional staff that comprises the FHS, because one cannot just blame the male audience. The health professionals should develop strategies to allow the inclusion of the male population in the BFHU scope through the conduction of an active search and the intensification of actions to facilitate and make accessible the men's access to health services. The invisibility of men in health services is linked to an alleged lack or non-recognition of the male uniqueness, realizing the absence of actions aimed at serving this audience, which requires health

policies that recognize and incorporate the male gender as a protagonist of such actions.[17]

Accordingly, the professionals' statements have stressed the absence of the male gender in the primary care, which reaffirms the responsibility of men for not being inserted into the demands from the FHS, not considering the need for actions, strategies and implementation of policies that allow demands and services for an improvement of the access of these individuals.

> *[...] men have practically no access to health care buildings [...]. (CHW 01)*

> *[...] We rarely see some man here in the health sector. (NURS TEC 02)*

Nevertheless, one of the respondents points out that the male gender was forgotten over time, which allows us to hold a reflection on the building of the health model of the country, which has prioritized health policies of several groups, but has excluded the men's health, perhaps because of the dominant reference of their gender assignments embedded in multiple sectors of the society at large. Furthermore, it seems that cultural issues are prevalent in the subjects' speeches, since the same professional believes that machismo is a feature of the men's invisibility.

> [...] The male gender was forgotten over time, but I don't know if it was due to sexism [...]. *(NURS TEC 01)*

The gender discussions are present in the processes of illness and death that surrounds the man. Thus, the creation of health policies enables an improved access of these individuals to health services, in addition to allowing the provision of programs and services.

The men associate the frequency to the health service with the possibility of illness and death, considering this place as a space for treating diseases and their consequences, and not as a place of life and health care. A shy male participation in the primary scope collaborates with the conception of an environment of sick people in which the actions of health promotion and prevention are forgotten.[18]

The testimony of a subject of the study makes clear a striking characteristic of the male gender - the uncertainty of the disease -, unveiling the need to develop coping strategies with the purpose of raising the awareness of this subject in relation to pathologies, especially those ones related to sex, since men impose barriers for the condom use.

> *[...] men don't even believe that there is a disease, ok! In my daily life coexisting with men, they've started to come to me to say that AIDS doesn't exist! So I think there has to be a gathering with men, in order to explain them about the reality of the disease; they could be more aware. (NURS TEC 01)*

At the beginning of the AIDS epidemic, with the definition of risk groups, heterosexual men were excluded from the prevention actions and from the risks inherent to such a disease, thereby occurring the denial of risks, as well as the perception of immunity in relation to this group, given that it was early related to the male stereotype of invisibility and fearlessness.[19]

The non-participation of men in the health services is also related to the lack of planning and organization on the part of the FHS, which does not establish actions in conjunction with the various primary care professionals. Therefore, we see the lack of intersectoriality, the non-compliance with the FHS precepts and a care service exclusively guided on outpatient shares.

In the speech below, one of the surveyed professionals stresses that it is not due to ignorance, inability or lack of skills that they prevent the development of strategies to insert the male audience in the FHS scope, but rather due to the lack of commitment from health

professionals, which are not articulated to formulate and implement joint actions, thereby basing themselves only in individual activities.

> *We have the knowledge, need more support of the staff, physicians and nurses [...] we work very lonely and [...] cannot bring the men here to the unit [...]. (CHW 02)*

The actions developed by professionals in the FHS scope should not only be individual, since the multiprofessional labor enables deployment of activities, practices and actions in these services that favor the men's access, not only to health services, but rather to the widely understood health, because a man should be seen as a subject who has singularities and subjectivities that require a comprehensive care.

The invisibility of the male population in the FHS services, as well as the lack of programmatic actions, are identified in the affidavit from the subject below, considering only the individual under medical consultation as a tool for the formation of a bond between the male patient and the health service, reaffirming that practices of health promotion and prevention do not take place in this environment.

> *[...] I think the difficulty is to convince the male population to seek the health unit, because, in the male imaginary, he only comes to the unit when he is really sick. Then, he will seek the doctor, thus the preventive part leaves much to be desired. (NURS 01)*

The challenges of planning actions targeted to men in the primary care scope are mainly raised due to the building of values and to the gender issues and historicity that have been impregnated in the formation and imagery of this subject over time, however, the lack of building of links and strategies on the part of professionals, most often contributes to the invisibility of male gender in this environment.

The absence of a continuous qualification for FHS professionals in relation to the specificities of the men's health is attached to the lack of effective actions to facilitate the access of this group. Moreover, it is worth mentioning that the deficiency in the process of approach and assisting/care of men on the part of health professionals, being that it is crucial to make use of tools to get closer to the male population. Accordingly, it should be highlighted that the lack of welcoming, or the existence of an unattractive welcoming, is related to the weak professional qualification to deal with the male audience.[20]

For ensuring the access of the male population to the health services, it is imperative that the health professionals delve themselves into the men's reality, knowing their singularities, developing strategies aimed at serving this group, recognizing it as a set of individuals who need attention and care, besides promoting actions to sensitize men in quest for a quality health.

CONCLUSION

The estrangement of men from the health sector was caused by the social building of masculinity grounded in values that prevented the access of the male gender to the health field in its various contexts. Hence, the pursuit for the men's access to these services is the main challenge for the primary care scope in nowadays, including through the provision of new demands that might widen and improve the access and the quality of such a service, because the men usually access the health services by means of the specialized care.

From the subjects' speeches, it is possible to identify the lack of strategies to attract men to the BHU scope, besides the need for performing actions that allow the access of this group. The challenges become evident before the invisibility

of practices that foster the demand for health services.

It becomes necessary that actions of health promotion and prevention are introduced by the FHS professionals by means of a multiprofessional labor, intersectoral actions and health education practices, given that the health care activities do not allow the formation of a bond between the health service and the male patient. The health professionals should enable moments of conviviality and exchange of skills with those individuals, seeking to know their realities and their singularities.

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Received on: 08/12/2012
Reviews required: no
Approved on: 17/06/2013
Published on: 01/10/2013