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Difficulties of the man in primary healthcare: the speech of nurses

Dificuldades de inserção do homem na atenção básica a saúde: a fala dos enfermeiros

Dificultades de inserción del hombre en la atención básica a la salud: voz de los enfermeros

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Abstract

Objective: To know the difficulties faced for the nurses in the men's health context in the primary healthcare in João Pessoa - PB. **Methods:** It is an exploratory-descriptive research with qualitative approach and content analyses. 28 nurses that developed heath actions at least for one year were interviewed. **Results:** The finds showed that the difficulties experienced for the nurses are: Absence of men; behavior deficit of self-care; feelings of fear related to work; deficit in the capacity of the professionals in heath and in the knowledge about the National Politic of Integral Men's Health Care; feminization of these services; incompatibility of schedules. **Conclusion:** The efficacies of the strategic actions by the nurses depends on factors that cross among the others aspects, by gender questions, instrumentalization of health professionals, adjustments in the care spaces in this level of care and the adequacy of the working process of the professionals involved.

Keywords: Primary Health Care; Gender; Masculinity; Heath's men.

Resumo

Objetivo: Conhecer as dificuldades enfrentadas pelos enfermeiros no contexto da saúde do homem na atenção básica no Município de João Pessoa - PB. **Métodos:** Trata-se de uma pesquisa exploratória-descritiva com abordagem qualitativa e a análise de conteúdo. Foram entrevistados 28 enfermeiros que desenvolviam ações de saúde há pelo menos um ano. **Resultados:** Os achados revelam que as dificuldades vivenciadas pelos enfermeiros envolvem principalmente: Ausência do homem; déficit de comportamento de autocuidado; sentimentos de temor vinculado ao trabalho; déficit na capacitação dos profissionais em saúde do homem e no conhecimento sobre a Política Nacional de Atenção Integral à saúde do Homem (PNAISH); feminilização desses serviços e incompatibilidade de horários. **Conclusão:** A efetividade das ações estratégicas referidas pelos enfermeiros depende de fatores que perpassam, entre outros aspectos, pelas questões de gênero, instrumentalização dos profissionais da saúde, readequações nos espaços cuidativos neste nível de atenção, bem como pela adequação do processo de trabalho dos profissionais envolvidos.

Palavras-chave: Atenção Primária à Saúde; Gênero; Masculinidade; Saúde do Homem.

Resumen

Objetivo: Conocer las dificultades enfrentadas por los enfermeros en el contexto de la salud del hombre en la atención básica de João Pessoa - PB. **Métodos:** Investigación exploratoria-descriptiva con abordaje cualitativo y análisis de contenido. Fueron entrevistados 28 enfermeros que desarrollaban acciones de salud durante al menos un año. **Resultados:** Los resultados mostraron: ausencia del hombre; déficit de comportamiento de autocuidado; sentimientos de temor vinculados al trabajo; déficit en la capacitación de los profesionales en salud del hombre y en el conocimiento sobre la Política Nacional de Atención Integral a la Salud del Hombre (PNAISH); femenilización de estos servicios; incompatibilidad de horarios. **Conclusión:** La efectividad de las acciones estratégicas referidas por los enfermeros depende de factores que parpasen las cuestiones de género, instrumentalización de los profesionales de salud, readecuaciones en los espacios de cuidado en este nivel de atención y la adecuación del proceso de trabajo de los profesionales envueltos.

Palabras-clave: Atención Primaria a la Salud; Género; Masculinidad; Salud del Hombre.

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INTRODUCTION

The themes involving "men and health" have been increasing, especially by health professionals, in order to better intervene in a lot of health demands related to men as well as in health services in primary care and thus contribute to the reduction of morbidity and mortality indicators that reflect the health profile of Brazilian men.

Men's health care has been neglected by the different sectors of health of various governmental levels. However, contemporaneously with the adoption of the National Policy for Integral Attention to Men's Health, there is the increasing occurrence of discussions involving the health-disease process of the male clientele.

The established issues in this policy show on the one hand the challenges faced by managers and health professionals, especially, and on the other hand, the urgency to be viable nationwide represented the necessity of that population and the recognition of risks to health that are big public health problem.

It is possible to conclude that recognizing and addressing the health needs of the male population are linked to the basic principles of the SUS, in particular the concepts of completeness, feasibility, coherence and feasibility, being guided by the men and the quality of care, principles which must underlie all these actions[1].

It must be noted that the construction of masculinity directly influences vulnerability to severe and chronic diseases and especially with early death. Despite this vulnerability and high rates of morbidity, more men die than women during the evolutionary lifecycle and many of these deaths could be prevented if male would search health services more, particularly primary care[2].

In this regard, the morbidity and mortality are highlighted that contributed to set the National Policy for Integral Attention to Men's Health, in 75% of cases, are focused on five major groups of disease entities, involving: Injury; Diseases of the Circulatory System; tumors; Diseases of the Digestive and Respiratory Diseases. It is worth remembering that the External Causes, Traffic Accidents, the Intentional self-injury and aggression are responsible for a large percentage of deaths in the male population, whereas deaths due to external causes are the primary cause of mortality in the population group aged 25 to 59 years old[1].

It is verified therefore, that men access health services through tertiary care, when there is already a clinical morbidity installed, requiring high social costs, particularly for men and economical for the state. In this sense, PNAISH also highlights that 80% of male admissions in the SUS are motivated by external causes, with a preponderance in the age group of 20 to 29 years old and reinforces that in 2007, 39.8% of hospitalization were men, and 48% of these occurred in the population aged 15 to 59 years old. The traffic accidents were the causes of greater magnitude[1].

The expression of such indicators has intensified in recent years, discussion forums about health and self-care of the male population, both in the university and in the context of management of local and national health services. In these discussions it is highlighted among other aspects, the investigation of factors that to a greater or lesser extent, distanced male users of primary health care services, the need to adapt these services, the need to provide tools for professionals in the area, and strategies for implementation of the National Policy for Integral Attention to Men's health defined in 2008 by the Ministry of Health[1] whose objectives underlie health promotion and disease prevention.

Before the recognition of this scenario which translates as an important public health problem, the Ministry of Health of Brazil established the National Policy for Integral Attention to Men's Health, which aims to describe the health of the male population in the lines-care safeguarding comprehensive care, strengthening and upgrading of primary care to ensure health promotion and the prevention of avoidable health problems in this population[1].

Then, including men in primary health care is a challenge to public policies, because they do not recognize the importance of health promotion and disease prevention as issues related to their health. The care of themselves and the recovery of the body towards health issues are not placed in the socialization of men[3]. As a result, it can be stated that this sociocultural construction of the men has produced behaviors and attitudes that influence negatively the determinant of the health-disease process.

Therefore, given the morbidity profile that characterizes the state of health of man and the possibilities of recovery of their health demands, this study aims to answer the following questions: What are the difficulties faced by nurses for effective health care to the man in Primary Care?

To answer these questions the study has a general objective that is to know the difficulties faced by nurses in primary care within the health care of the man.

METHODOLOGY

This is an exploratory-descriptive study with a qualitative approach. Its exploratory character shown by the ability to increase familiarity with the topic of study - Man in primary health care - a systematic manner, seeking after description of the phenomenon and its relationship between variables, clarify concepts related to the theme and identify issues for inclusion in this man's level of health care.

The research was conducted in the Integrated Health Units (IHU) of the Health Districts I, II, III, IV and V that are part of the network of health services in the city of João Pessoa, Paraíba state in the period of May to August 2013. This scenario was selected because it shares the National Policy for Integral Attention to Men's Health.

The population of this research consisted of 28 (twenty eight) Nurses, whose participation was conditioned upon their express consent of the Term of Consent (Appendix A). The sample was accessibility, considering inclusion criteria nurses who develop actions in units selected for the study for at least one year.

The research project was approved on April 23, 2013 by the Committee of Ethics in Research, Health Science Center, Federal University of Paraíba, with protocol Nº 0114/13 and CAEE 13597213.0.0000.5188, and then underwent assessment of the Municipal Health Department of the city of João Pessoa - PB and managers of the districts involved in the research. So after it is approved by those bodies and signed the Informed Consent Form (ICF) by the study participants, the survey was started. They were identified with the letter N, nurse, followed by a number.

Data were collected through interviews subsidized by a semi-structured, recorded by recording and later transcribed for analysis.

Information analysis was accomplished using the technique of content analysis proposed by Bardin[4]. In this process, the three stages of content analysis were operationalized: 1) pre-analysis 2) exploration of the material, and 3) treatment of the results, inference and interpretation.

The pre-analysis constituted the operationalization and systematization of the initial ideas. Readings were enforced in order to identify the theoretical concepts that support the analysis of information about the nurses about the difficulties of the men in APH.

The exploration of the material stage consisted of coding operations to identify the core meaning of the stories and reveal the Thematic Units, subcategories, due to their similarities resulted in the construction of categories.

Regarding the stage of treatment of the results, inference and interpretation based on the reference that characterizes the state of the art against the subject, the meaning of the reported range was sought, thus providing interpretation.

RESULT AND DISCUSSION

Difficulties experienced by APH nurses in man health care

The analysis of the thematic units derived from the reports of nurses in the research revealed a wide range of difficulties for the man in the actions of primary health care, represented by three categories and eight subcategories, which are presented in Table 1, and discussed based on the literature involving the construction of masculinity and health, primary care and PNAISH.

According to the table, the integration problems of men in APH, experienced by nurses are reflected in three aspects: the man himself; the professionals and services of this attention level.

The similarity of the reports linked to men enabled the construction of the category difficulties entering the APH linked to the man who had the basis for their identification subcategories: Absence of man in primary health care; Deficit preventive behavior of self-care; Feelings of fear to work.

It is known that the adoption of practices that encourage the participation of men in primary care should be developed and prioritized in primary health care, in the primary health units and/or in actions with the community of the area and developed through strategies that can insert this population in other health actions. However, the absence of men in these services has hindered their integration strategies. In this study, this phenomenon is revealed from the reports: [...] the difficulties appear because they do not come (N3)/[...] they do not come to the unit (N8)/[...] an obstacle to not come in the unit (N9)/[...] their absence (N18), which enabled the identification of the subcategory Absence of male in primary health care.

Regarding the association of the absence of men, or their invisibility in these services, to a characteristic of masculine identity related to their socialization process, it can be seen that men prefer to use other health services, more than emergency care, such as pharmacies and emergency rooms, that would respond more objectively to their demands, being attended faster and exposing his problems with ease[5].

By analyzing the relationship between masculinity and health care, it is observed that the perception of men on health rests is in the necessity and difficulty in seeking the services, making them to delay for seeking care and only go when they cannot solve by themselves with their symptoms[6].

Putting the man in health actions at the level of primary care and implement interventions aimed to meet their specific demands, is a huge challenge. However, it is an important step to ensure that these users are viewed by health professionals as beings with needs to be included in these actions, whether for health promotion and/or disease prevention.

In subcategory deficit of preventive self-care behavior, the speech of the nurses revealed that men do not recognize their health needs in the preventive context. Then, it can be stated that they think that they do not get sick and they seek primary care when the disease is already present, as it can be identified from the reports: [...] they come when they have

Table 1. Categories and subcategories related to difficulties in the integration of men in APH, João Pessoa, 2013

Categories	Subcategories
Difficulties entering in the APH related to Man	• Absence of man in primary health care • Deficit preventive self-care behavior • Feelings of fear related to work
Difficulties of man in the APH related to Professionals	• Deficit training in men's health • Lack of knowledge about the PNAISH
Difficulties of man in the APH related to services	• Feminization of APH services • Incompatibility of schedules • Excessive demands on primary care

some health problem [...] to prevent they do not come at all (N5, N22)/[...] they already come with the (N10, N12, N13, N14, N18, N22)/[...] they say they do not need, they are not feeling anything (N13)/[...] they come when they are in the last degree of necessity (N16, N25, N27)/[...] they do not come with prevention (N14).

Health professionals recognize the difficulties of male users of primary care to seek preventive health care, revealing that the construction of hegemonic masculinity model hinders seeking for health services, perpetuating the healing vision of the health-disease process and ignoring the measures prevention and health promotion, available within primary care. The society imposes to the man a position of invulnerability, not giving him the right to disclose their weaknesses. The man is not allowed to cry, to experience emotion, to show fear or anxiety. Then, to seek for a health service for treatment or prevention of risks is an act of weakness that goes against the views of this androcentric society[7].

These reports reveal the reflection of the absence of men in the context of primary care and reaffirm that they access specialist health services with morbidity and often chronically problems, causing overloads in costs in health, without any evidence without having care and attention networks of care recommended by the Unified Health System (SUS).

In the difficulties of insertion of the men in APH, another important concept that emerges refers to the fear of losing the job. This is also mentioned as a problem, because the world of work devalues male absence motivated by health/illness, so men avoid taking this quest for fear of revealing weaknesses in their social context[8].

Then, the subcategory Feelings of fear related to work, the speech of nurses reinforced the fear of man to hurt at work is a major reason that favors the lack of interest in this population demand for health services, according to the reports: [...] work, he undermines [...] (N9)/[...] fear of losing the job [...] (N18, N26)/[...] afraid to give medical certificate [...] (N26).

Even contributing to the reflection opposite relationship work and health care, it can be stated that the requirement to practice a daily workday and the obligation to perform the tasks within the prescribed time that normally coincides with the opening hours of services health, make them to not seek for such assistance[3].

It can be stated that the influence of socialization on the construction of masculine identity in the work context and its influence on health-disease process has been a challenge in the context of primary health care, since, PHU is organized for the operation schedules incompatible with the workday of the man, so it is necessary to structure health services in terms of organization and work process in order to take the specificities of this population, providing easy access to services, adapting opening hours for foster quality care and inclusive. So, we can highlight ideas from studies with professionals and users of PHU, pointing work as one of the main aspects that could explain the lack or difficulty of users accessing services[9].

The difficulties of insertion, as mentioned above, also involve aspects related to healthcare professionals and according to the nurses, are related to Deficit training in men's health and deficit of knowledge about PNAISH, subcategories identified that lead to the construction of the category Difficulties of man in the APH related to Professionals.

In the subcategory deficit in training in men's health, it was observed that the practice of health education in the context of men's health are restricted to report that no training/instrumentalization facing this area, thus hampering the assistance for these patients, according to the reports below: [...] they do not have a training [...] if we were trained it would be much better [...] (N17, N22) [...] the training are not good [...] we had no training for men's health [...] (N23).

Continuous training of professionals active in Primary Care Nursing is the responsibility of health institutions with the aim of promoting the update of concepts, to deal with social issues and techniques inherent to this new dynamics of work[10].

The scenario of lack of professional qualification in man's health care may be contributing to the low participation of men in the actions of APH and at the same time reaffirming the need for exploitation of these professionals.

Still contributing to this reflection, it is highlighted the need to pay attention to the profile and needs of the worker to be trained[11]. Thus, to qualify the nurses is a challenge, whose roots have their origin even in academic and continuing education, and therefore lifelong learning an instrument to minimize/resolve these gaps contributing to raising the visibility of the man in primary care.

According to the Ministry of Health and Education (2007), the gap between the academic world and the real delivery of health services has been considered worldwide as one of those responsible for the health sector crisis, especially in health man, where it shows high rates of morbidity and mortality and the presence of chronic diseases[12].

The Deficit of knowledge about PNAISH while subcategory related to the difficulties of professionals were identified by the reports: [...] we have to have material, that we do not have to work men's health [...] (N23) [...] it has nothing related to men's health [...] (N27) [...] services do not offer a service [...] lack of services for them [...] (N24).

It is worth noting that the aforementioned deficit of nurses related to PNAISH turns directly to its all-inclusive proposition, i.e., the policy was made and disclosed so that the actions of health promotion and disease prevention in the male population occurred from APH actions instituted there. One of the guidelines is to reorganize the PNAISH health actions, through an inclusive proposal, in which men consider health services as well as masculine spaces and in turn, the health services recognize men as subjects who need care, seeking to implement inclusion strategies of the male population, and meeting their needs[2].

Thus, it is observed a gap between the knowledge of nurses about the services and actions aimed at male customers in PHU. Maybe this fact is due to the expertise of these professionals and managers in the area about the policies, and its action plan deficit.

It is understood that the implementation is of utmost importance that the deficits are minimized in the care of men's health and the SUS to meet its principles. Thus, their proper understanding is essential for the actions of professionals to become effective and results that prove efficacy.

The difficulties of integration in APH related services were based for their identification subcategories: Feminization of APH services; incompatibility of schedules; excessive demands on primary care that are discussed below.

The predominance of female professional and actions for women and/or children identified in the statements of nurses, enabled the construction of subcategories Feminization of APH services presented in the reports: [...] most of the time the services has a lot of women [...] (N20) [...] because I'm a woman [...] (N21).

It is known that men, particularly those aged prioritized in PNAISH (20-59 years old), are afraid to attend health services, reflecting their low frequency in APH, for they do not feel part of it, since most actions are designed for women, children and elderly, which ends up reinforcing the hegemonic model of masculinity socially constructed and rooted for centuries.

The gender perspective characteristic of scenarios of PHUs needs to be rethought, since the feminization of these spaces is a hindrance to healthcare for the man. Several studies, like Gomes (2009) reaffirm that the perception of man about the context of primary care, as a feminized environment makes difficult their integration in the services offered[3,8].

The presence of male's health professionals, including nurses, may contribute to a better integration of the actions of men in APH. However, this scenario needs to have characteristics of masculinity that men can feel welcomed, generating bonds and thereby becoming participants of the construction of the health-disease process. These aspects are fundamental and structural that will surely help professionals in adopting new attitudes to accommodate the demands of health care delivered by men in everyday services.

However, for the welcome and the link really happening and become a brand value of health practices of Primary Health Care (PHC) for the subject, is not only depending on health care professionals being available and listen to the demands of men. It is necessary that the health practices are constructed aiming to expand the products of health care for this public[13].

In the perspective of identifying the difficulties experienced by nurses for insertion of men in APH actions, the speech of these professionals expressed the hours of operation as an important aspect linked to services that hampers the access and retention of male users at this level attention. Thus, we identified the subcategory Incompatibility of schedules with labor activity, as shown in the reports: [...] working hours [...] (N10, N12, N13, N16, N20, N22, N25)/[...] men who work all day, it is difficult to come to the unit [...] (N11, N19) [...] he does not come because he is working [...] their work is usually at the time that we are attending [...] (N16, N25) [...] there is not more service on the unit at this time (night) [...] (N19) [...] the great majority of men are in the workplace during working hours [...] (N20).

It is noticed in these statements that the hours of operation of the APH services, to coincide with the shift work activities of male customers, hinders the search for these users actions

for health promotion and disease prevention, impacting significantly on indicators of mortality cited in PNAISH. Thus, it appears that the work comes first in men's priorities, getting healthcare relegated to a lower place.

Health services can be regarded as little able to absorb the demand by the men, because their organization does not encourage access to this segment[14]. In this perspective, it is realized that there are few health facilities that provide extended care, in shifts of 24 hours, on weekends or on a third shift, at night[15]. Thus, people who are working in the formal market, with strict working hours, cannot be absent with the frequency required, hampering their job security.

It is necessary to adjust the supply of healthcare services from APH with a schedule that prioritizes the specific functioning of men in order to insert them into actions for health promotion and disease prevention at this level of attention. The organization of work needs to be flexible, i.e., having more possibilities for action, not fragmented, trying to concentrate as much care at the same times and places in order to promote quality and inclusive care[16].

The subcategory Excessive demands in primary care shown by nurses as one of the difficulties of integration of men in primary care was constructed from the reports: [...] here the demand is very large [...] impossible to perform activity [...] (N22) [...] the great demand for consultations [...] all come to the unit [...] a lot of acute cases and not meeting the prevention [...] (N28).

The organization of services in the APH puts nurses and other professionals, faced with the challenge of fulfilling the goals of productivity, which results in difficulties in planning and implementing relevant to the health of the male, customer actions and thus not adopt important aspects recommended by the National Policy on Primary Care[17].

Excessive demands on primary health care is an aspect which has been valued in several studies by the reflections of the same dynamics of the daily work at this level of attention. The FHS is designed to expand access to primary care and coordinate the integration with the networks of attention to health[18]. However, in practice, the access dimension remains low because of excess demands for health services.

CONCLUSION

The difficulties of integration of men in APH, experienced nurses are translated into three contexts: the man; professionals and services this level of attention. In the context of man are revealed: the absence of men in APHS, deficit of preventive self-care behavior and feelings of fear. In the professional's context, we identified: deficit in training in men's health and knowledge about PNAISH. Within the health services, we include: feminization of APH, incompatible schedules and excessive demands as factors that interfere negatively in healthcare for the man.

The unveiling of these difficulties demonstrate that the men's health in the context of primary health care is a challenge that involves many different facets. However, it is expected that the resulting contributions to this study in the context of education, research and care process, which will surely produce reflexes to minimize the problems presented.

In teaching and research ambit, it is expected that the aspects disclosed herein are incorporated in the planning of the disciplines that deal with the subject, among them gender and men's health, and thus their reflections subsidize more focused assistance actions in reality experienced by nurses forward to assist the male clients in health services.

In the care of the male customer in APH, it is expected that the contribution of this study is of great importance, favoring closer this clients with professionals and health services, generating new possibilities in this context and a new scenario for men's health. Moreover, the contributions emerge from the researcher to enable the expansion of their knowledge and definition of new practices in this field of knowledge.

It can be said that the difficulties revealed by the APH nurses in health care man express weaknesses that need to be overcome for the SUS to become a reality for this population group.

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