

Men in primary healthcare: discussing (in)visibility based on gender perspectives

O homem na atenção primária à saúde: discutindo (in)visibilidade a partir da perspectiva de gênero

El hombre en la atención primaria a la salud: discutiendo (in)visibilidad a partir de la perspectiva de género

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ABSTRACT

This paper presents an ethnographic study on the relationship between men and primary healthcare in eight clinics in four Brazilian states. The objective was to comprehend the (in)visibility of men within the daily routine of care, based on gender perspectives, with discussion of the mechanisms that favor inequalities in healthcare work. Different dimensions of male (in)visibility were identified within this context: targeting of men in interventions within the field of public healthcare policies; male users who faced difficulties in seeking attendance; difficulty in stimulating effective participation among men; and male subjects of care (for themselves and for others). The paper emphasizes the importance of gender studies and their relationship with health, while discussing the production of social inequalities that are (re)produced by the gender inequalities that are present in the social imaginary and in healthcare services.

Keywords: Men's health. Men. Primary healthcare.

RESUMO

Este trabalho apresenta estudo de caráter etnográfico acerca da relação entre homens e a assistência à saúde na Atenção Primária, realizado em oito serviços de quatro estados brasileiros. Seu objetivo é compreender a (in)visibilidade dos homens no cotidiano da assistência a partir da perspectiva de gênero, que discute os mecanismos promotores de desigualdades presentes no trabalho em saúde. Foram identificadas, nesse contexto, diferentes dimensões desta (in) visibilidade: os homens como alvo de intervenções no campo das políticas públicas de saúde; como usuários que enfrentam dificuldades na busca por atendimento e no estímulo à sua participação efetiva; como sujeitos do cuidado (de si e de terceiros). O trabalho reforça a importância dos estudos de gênero e sua relação com a saúde, na medida em que discute a produção das iniquidades sociais (re) produzidas pelas desigualdades de gênero presentes no imaginário social e nos serviços de saúde.

Palavras-chave: Saúde do homem. Homens. Atenção primária à saúde.

RESUMEN

Este trabajo presenta un estudio de caracter etnográfico acerca de la relación entre hombres y la asistencia a la salud en la Atención Primaria, realizado en ocho servicios de cuatro estados brasileños . Se objetivo es el de comprender la (in)visibilidad de los hombres en lo cotidiano de la asistencia, a partir de la perspectiva de género, que discute los mecanismos promotores de desigualdades presentes en el trabajo de salud. Se identificaron en tal contexto diferentes dimensiones de esta (in) visibilidad: los hombres como objeto de intervenciones en el campo de las políticas públicas de salud; como usuarios que afrontan dificultades en la busca por atención y en el estímulo a su participación efectiva; como sujetos del cuidado (de sí mismos y de terceros). El trabajo refuerza la importancia de los estudios de género y su relación con la salud, en la medida en que discute la producción de las iniquidades sociales, (re)producidas por las desigualdades de género presentes en el imaginario social y en los servicios de salud.

Palabras clave: Salud del hombre. Hombres. Atención primaria a la salud.

INTRODUCTION

Studies on the relationship between men and healthcare are increasingly being produced, directed especially towards topics such as access to and use of services (Figueiredo, 2005, Pinheiro et al., 2002), morbidity-mortality profiles (Laurenti, Mello Jorge and Gotlieb, 2005) and representations relating to health and becoming ill in specific social groups (Figueiredo, 2008; Gomes, Nascimento and Araújo, 2007; Nardi, 1998).

Although these studies indicate that there are high mortality rates among men at all ages, in relation to almost all causes (Laurenti, Mello Jorge and Gotlieb, 2005; White and Cash, 2004), analysis on morbidity rates, self-perceived health and use of services shows that women present higher indicators than men do. This has been attributed to greater incidence of health problems among women and/or the greater heed taken by women in seeking healthcare (Aquino, Menezes and Amoedo, 1992).

Pinheiro et al. (2002) outlined the panorama of reported morbidity and access to and use of healthcare services in Brazil. Using age and sex categories, they showed that with regard to self-assessed health status, 23.5% of the women and 18.2% of the men declared that their state of health was deficient. Their study also showed that there were marked differences between the sexes regarding reasons for seeking healthcare services, even after excluding childbirth and prenatal care. The women sought healthcare services more often for routine and preventive examinations (40.3% of the women versus 28.4% of the men), while the men sought healthcare services more often because of illnesses (36.3% of the men versus 33.4% of the women).

Nonetheless, with regard to the type of service sought, primary healthcare was the type most cited by both sexes (32.6% of the women and 30.2% of the men). It was highlighted that the men predominantly sought emergency services, pharmacies and trade union outpatient clinics, while the women predominantly sought specialized outpatient clinics.

Although the results from Pinheiro et al. (2002) are corroborated by other findings in the literature from Brazil and elsewhere, for example that men's self-reported health is better than women's (White and Cash, 2004) and that women use healthcare services more than men do (Schofield et al., 2000), attention is drawn to that study because of the observation of notable presence of men in primary healthcare services. This finding is reinforced by those of Schraiber and Couto (2004) in São Paulo. Complementing this, qualitative studies such as those by Schraiber (2005), in 12 units guided by the Family Healthcare Strategy (FHS) that geographically covered the city of Recife, and by Figueiredo (2008), in two healthcare units in São Paulo, showed that the use made of healthcare services by men differed from women's use. Men's use was concentrated on seeking care for pathological conditions, accidents, injuries and dental problems, and on pharmacy use.

More recently, the relationship between masculinity and healthcare has been analyzed based on a gender perspective, focusing on men's difficulties in seeking healthcare and the ways in which healthcare services deal with men's specific demands, which may amplify the differences.

With regard to men seeking healthcare and their representations of health, becoming ill and healthcare, some qualitative studies have identified barriers to male presence in healthcare services. According to Valdés and Olavarría (1998) and Gomes and Nascimento (2006), men's difficulties are related to the structure of gender identity (the notion of invulnerability and seeking risk as a value), which would make it difficult for men to put their healthcare needs into words within the context of the healthcare services.

Recent investigations on men's perceptions relating to primary healthcare have shown that they believe that such services are destined for elderly people, women and children, and they consider that these are feminized spaces. This perception gives rise to a feeling that men do not belong in such spaces (Figueiredo, 2008; Gomes, Nascimento and Araújo, 2007).

Taking into consideration the way in which these services are organized and their routines, it has been pointed out that healthcare institutions have an important influence on the (re)production of the social imaginary of gender, which in turn has repercussions on the attendance provided for the population. According to Courtenay (2000), healthcare services destine less of their professionals' time to men and provide few and brief explanations regarding changes in risk factors for diseases to men, compared with what is provided for women. These actions reinforce the social patterns of masculinity and femininity associated with healthcare notions.

On the one hand, addressing the social values that influence men's behavior in relation to healthcare and seeking it, and on the other hand, organizing the care and professionals' practice in primary healthcare units implies adopting an analysis reference point that takes gender (here understood to be the conditions that historically and socially construct and establish social relationships between the sexes, which are permeated by power and inequality (Scott, 1990)) to be a principle that creates order and rules regarding social practices. Gender, in association with other reference points such as generation, class and race/ethnicity, shapes stereotypes and expectations that are (re)producible at institutional levels (the healthcare system) and ends up making men's (and women's) healthcare needs invisible, thereby also denying them the possibility of acting as subjects with rights in relation to the healthcare services.

Invisibility is regarded here as having a social origin. Within the healthcare sector, it has been discussed from the starting point of complex and sensitive topics such as gender violence (Dantas-Berger and Giffin, 2005; Schraiber et al., 2003) and abusive use of illicit drugs (Lima et al., 2007). In recognizing that individuals' own care practices and practices towards other people are constructed from the relationships between people, both within the private/domestic sphere and within the public/institutional sphere, the recognition and reception of male (and female) demands and needs would be expanded. This would break up the vicious circle of invisibility and exclusion of subjects, and make it possible to recover equity and improve healthcare and attendance.

These findings form the starting point for the present study, taking into consideration that primary healthcare units (PHUs) are the preferred gateway to the healthcare system in Brazil. PHUs represent an effort towards consolidation of the National Health System (SUS), thereby making it more efficient, strengthening the links between the service and the population and contributing towards universalization of access and assurance of comprehensiveness and equity of attendance. Thus, the aim of the present study was to gain an understanding of the (in)visibility of men in and caused by PHUs, based on gender perspectives. Taking the platform of day-to-day relationships within healthcare services, the dimensions of men's position as users and the relationships that they establish with professionals within the contexts of activities and attendance are explored.

Methodological features

The present study formed part of a multicenter study that had the aim of investigating the characteristics of the relationship between men and healthcare services in cities in four Brazilian states: Pernambuco (Recife and Olinda); Rio de Janeiro (Rio de Janeiro); Rio Grande do Norte (Natal) and São Paulo (São Paulo and Santos)(Couto et al., 2009). The project was submitted to and approved by the National Research Ethics Committee and by the respective committees in the academic institutions that were the partners in each of these states, as well as by the health departments of the participating municipalities. In this survey, only the PHU services were analyzed: these totaled eight fields, which were coded according to the state to which they belonged, respectively as: PE1 and PE2; RJ1 and RJ2; RN1 and RN2; and SP1 and SP2. The following requisites were taken to be the criteria for selecting the units: duration of functioning greater than ten years, with the currently active healthcare team functioning for at least two years; demand volume greater than or equal to 1000 attendances per month; and presence of a multiprofessional team.

In terms of theoretical methodological reference points, an ethnographic perspective was used. This method has a long tradition within Anthropology and its fundamental basis consists of interpreting symbolic and cultural characteristics within the social contexts in which they occur (Geertz, 1997; Peirano, 1995). Using this perspective, the gender issues present within day-to-day actions at the PHUs were mapped out and expressed in terms of: issues that emerged, how they were presented, the way in which the work teams at the units understood the issues as pertinent to healthcare work, and how they faced these issues. We sought to reveal mechanisms that potentially promoted gender inequality in day-to-day situations of healthcare and attendance.

The reference point for the broader investigation was an assessment proposal using triangulation between methods (Minayo, 2005), making use of the following instruments: ethnography on the units, semi-structured interviews with higher-level professionals, focus groups with middle-level professionals, semi-structured interviews with users, examination of the medical files of users who were interviewed and analysis on the production records of the units.

Here, we will focus on the ethnographic analysis on the units, which was done in two stages. The first stage comprised mapping of the day-to-day activities of the units, in which it was sought to identify how they were organized and were functioning, and how the services were provided during typical weeks, over an approximately one-month period in each unit. The second stage comprised observations on the attendance flow and the decision-making processes while care and attention were being provided in the different care activities inside and outside of the units, over a two-month period for each unit. All the observations in the eight units were made by two local investigators with ethnographic skills, supervised by the study coordinator for the state. The observations were described in field diaries and, later on, reports were compiled from the observations jointly with the local coordinator, and with participation from the general coordination office for the project. In order to illustrate and clarify the results that were indicated, we will present some passages from these diaries, in which the respective unit is indicated when the notes came from direct observations or comments by the field investigators, and the origin of the discourse is indicated when it came from the words of a subject (either a professional or a user) who was present at the observation locus.

The ethnographic analysis and interpretation followed the principles of the sense interpretation method (Gomes et al., 2005). It was sought to unravel the logic and meanings underlying the actions, and to compare these actions with the plan of intentions and concepts within its context. The course followed in the analysis and interpretation consisted of four stages: (a) exhaustive reading of the descriptions in the observation records (field diaries); (b) identification of the meanings attributed to the actions; (c) elaboration of analytical lines, through breaking down what was described into structural elements of the observed actions, taking into account the symbolic aspects of these actions; (d) interpretation, in which we produced a synthesis from what was analyzed in the second stage, through dialogue between actions and context; intentions and attainments; and empirical material and the theoretical gender perspectives on which the investigation was based.

Mapping the healthcare services and men's presence

Although the eight units analyzed were orientated as PHUs and were therefore characterized as gateways to the care network, they presented diversity of models and professional teams. In the states of Pernambuco and Rio Grande do Norte, the units had been functioning since the end of the 1980s along the lines of the Family Health Strategy (FHS), with a core group of professionals (doctor, nurse, dentist and nursing auxiliary) and community health agents (CHAs). It can be highlighted that there was a regionalized physiotherapy referral service at RN2. In Rio de Janeiro, the units had been functioning since the 1970s and could be classified as PHUs without FHS, given that they provided healthcare in a programmed manner to a given population, with three basic specialties (general clinical medicine, pediatrics and gynecology-obstetrics), while others had dermatology and pulmonology. Occupational therapy, psychology, speech therapy, dentistry, social service and nutrition professionals were also available in these units. In the state of São Paulo, the unit in Santos is very longstanding (1948), and it functions as a PHU, with attendance for general clinical medicine, pediatrics and gynecology-obstetrics. Moreover, it has been a reference center in Santos for STD/AIDS, leprosy and tuberculosis since the end of the 1980s. The service in the city of São Paulo (the state capital) has been a teaching unit since the middle of the 1970s and has a multiprofessional team composed of doctors (public health specialists, clinicians and gynecologists), nurses, nursing technicians and auxiliaries, CHAs and social workers. It also has subsectors specializing in mental health, speech therapy and oral health.

After taking into account the particular features of the units in terms of length of functioning, care guidelines, team makeup, size and comfort, all of them were functioning with sufficient installations and had different spaces for providing care. There were always individual rooms for attendance (consultation, examination and medication-vaccination rooms) and collective assistance area (waiting rooms, reception and places for educational activities).

In characterizing the units, attention was drawn to the way in which the environments were not welcoming to men and did not favor their continuing presence, considering that all of them had spaces that were markedly feminine. These observations stood out in all the field diaries. For example, in the common areas and areas with many people passing through, such as the reception area and waiting room, there are always a lot of posters from the Ministry of Health, carrying health promotion messages. Topics like promotion of breastfeeding, prenatal care and prevention of STD and HIV/AIDS often appear, and many of them have a string female connotation, except for those about correct use of condoms and about leprosy.

In addition to this, it can be seen that the feminization of the environments within the units is reinforced both through health education material and through purely decorative materials that are produced within the unit (by the employees). Thus, although a relative change in the patterns of communication from the Ministry of Health can be perceived through the inclusion of references to gender, generation and race/ethnicity, this intention has not yet reached the teams at healthcare services regarding their local production. In short, personal marks influenced by gender imaginary are visibly transposed to the public/institutional environment of healthcare:

“In the corridor, three murals are laid out, in the form of a little house with drawings of blue, pink and orange flowers: another trait making the environment feminine. In the sterilization room, in a space not destined for attending patients, attention is drawn to the decoration, which consists of small stickers bearing images with childish and feminine themes”. (RN1)

“One pediatrician observed that the Ministry of Health has been changing its own communications, and showed me consultation office posters on breastfeeding, which presented photos of a heterosexual couple, and no longer just the mother with her baby”. (SP2)

Men were seen to be present within the day-to-day routine of the units investigated: men in different age groups; alone or accompanied; as users or accompanying persons; as the son, father, spouse or partner; or with episodic participation or continuous use of activities. Thus, men were present in the units in a variety of capacities.

In configuring this presence, elderly people and children predominated. This was easily correlated with the focus of CHAs, which was historically directed towards the mother-child segment, but started to incorporate the segment of elderly people more noticeably from the 1980s onwards. Over the last few years, through programs aimed at chronic diseases, such as the *Hiperdia* program (arterial hypertension and diabetes mellitus), elderly people have had more space for their requirements.

The presence of men has increased in certain activities, especially in medical consultations, dental care and activities made available in some of the units, such as physiotherapy in RN2, the tuberculosis and leprosy program in SP2, and mental health in SP1. In the other units, male presence is still very halting, like in RJ1, where men have been brought in through adaptation of certain strategies that were originally created through the Full Women’s Healthcare Program (PAISM). For example, in the Family Planning Program, through greater stimulation of practices like vasectomy, slight growth in interest and participation has been noted among men (and couples). Men participated less in nursing consultations, which are especially orientated towards prenatal and childcare follow-up, and in educational activities. It is interesting to note that even in relation to the elderly clientele, which includes significant numbers of men, there was little male presence in educational groups. In short, the following passage can be taken as a reference point for the other units:

“Characterization of the presence of men in the units indicates that they tend to prioritize curative issues: restoration of body integrity and adequate functioning”. (RJ2)

In relation to use of the pharmacy in the units, men had a notable presence, particularly in one of them (SP1), which points in the same direction as observed by Figueiredo (2008). The number of men seemed to be greater in the pharmacies of some of the units, when only the demand for condoms was considered. This appeared most clearly in SP2, where a specific day of the week was destined for this activity.

Some of the units investigated had expanded their opening hours beyond the usual range (7 am to 5 pm), through making attendance available in 24-hour shifts (RJ1), on Saturdays (RJ2) or in a third shift in the evenings (SP2). We noted that there was greater presence of men in these units at the extra times that had been created, and also in other units that kept activities functioning across lunchtime. This consisted especially of men who seemed to have gone there from their workplaces, which endorses the discussion about work as a factor that restricts access and use of healthcare services by men (Gomes et al., 2007). This relationship was constantly recalled in the words of the users and professionals through the argument that work is a reason why men do not seek healthcare services:

“Even with the backing of medical certification, workers have the intuition that absences from work arouse disapproval. Hence, they postpone seeking healthcare for as long as possible. Thus, one of

the explanations for the low presence of men in the healthcare units relates to this, according to informal reports from nursing and administration”. (SP2)

“This culture of ours is a culture of employee and employer; a culture of not being absent from work; one of not taking care of yourself. Men don’t take care of themselves. Me too: I’m a man, I’m doctor and I neglect my health so that I’m not absent from work”. (Doctor, RN1)

The concentration of men at these times also points towards the potential efficacy of a strategy for creating alternative attendance hours, especially for workers. It should be borne in mind that although this clientele includes large numbers of men, it is not restricted to men, given that women work under similar conditions, except for greater tolerance by some employers towards releasing them to seek care, according to reports from some users and professionals at the units.

The relationship of working users with healthcare services takes on an inverted direction in the specific case of vaccination, for which companies participate actively in this relationship. Some work establishments encourage and/or require vaccination and make room for healthcare professionals (generally CHAs) to guide employees regarding this activity and invite them to go to the units. Consequently, men were observed in some of the units (RN1 and SP2), singly or in groups, seeking the vaccination rooms. However, no expansion beyond this use to other care possibilities provided by the units was observed, either because of lack of initiative among these users or because the units missed the opportunity to welcome them and integrate them into other activities.

Comparison between men and women’s presence and use of the services showed that the clientele consisted more of women than of men, in terms of both frequency and familiarity with the space and organizational logic. Like Figueiredo (2005) and Schraiber(2005), we observed greater presence of women in all the units. Female predominance was observed in most activities and in almost all the physical space of the units. Women represented the majority in consultations, waiting rooms, queues, groups, circulation areas, etc.

However, going against this trend, the activities of some units stood out because equal numbers of men and women, or even greater numbers of men, were attended, for example the dental care provided at some units (RN2 and SP2) and activities relating to vaccination, curative action and the pharmacy.

The observations regarding the way in which men and women presented themselves and behaved in the units revealed that women got to grips with these environments better than men did. Female users tended not only to be more at ease in communicating with the professionals, using the space and creating interactions, but also to be better adapted to the way in which the services functioned. The passages below illustrate this difference well:

“In the waiting room, it was observed that the women were more at ease, talked to each other and sat closer to each other. On the other hand, unless the men came accompanied by someone, it was rare for them to talk to each other or with other users. There were men who did not even sit down, but remained restless, walked around or stood while waiting. (SP2)

“The men more often sought the external areas of the unit, and usually kept quiet without much interaction”. (PE1)

Invisibility

The ethnographic study on the organizational logic of the units and the day-to-day work routines made it possible to grasp different linked dimensions, among which the invisibility of men (users and accompanying persons) and their issues stood out.

a) Men as targets of healthcare interventions

This first dimension referred to the structuring of programs and activities in the PHUs, in which there was low incorporation of men in relation to women. It is worth noting that in the PHUs, the emphasis is on health problems that are considered to be simpler and more customary, and also on linking cure and prevention, thereby making the attendance differ from direct, more episodic action on diseases. The lack of attention to the male public reflects disqualification of men from this care perspective. In this respect, no value was placed on targeting men in interventions within the organizational logic of the PHUs, nor was this seen as appropriate or pertinent. This implies disqualification within the field of public healthcare policies, which we take to represent a form of invisibility for this population.

Within the logic of segmented services for the clientele, it can be highlighted that women's healthcare programs exist, put into practice through a diversity of activities, whereas no programs or activities are aimed towards care for men and, in particular, for young men of reproductive age. This worsens the perspectives of comprehensiveness of care, and even forms critical opposition to the historical segmentation of programs. The requirements of these young adult men are partly attended through a variety of programs that are directed towards other segments of the clientele, such as elderly people, hypertensive individuals and/or diabetics, as shown by the observation below:

“Regarding the specific demands of the male population, no formal structures for recognizing this segment's social needs for healthcare were identified, thus differing from the position for women, children and adolescents. In other words, there are no specific activities for the male clientele. It should be emphasized that men are diluted in the attendance logic of the units, since they appear in emergency service consultations, return consultations and the logic of the programs”. (RJ2)

This invisibility is present in the way in which the strategies and organization of care are thought out by managers, and in the professionals' stance, as illustrated by the following situation, which was observed in an educational group aimed at contraception:

“At the stipulated time, the nurse responsible for the group came up with 28 medical files. The investigator commented that there was only one file relating to a man. The nurse thought this was strange and went to check. Later on, she commented that it was a mistake. One file had been brought up wrongly from pediatrics, and she explained: ‘the contraception group is a women's group, a group directed towards female users; sometimes a few husbands come as accompanying persons, but men are not enrolled to participate in this group’. [...] However, while the group meeting was being conducted, the following discussion took place:

Nurse: – And I'd like to say one thing to you: whose responsibility is it to avoid the child?

User A.: – Ours.

Nurse: – Is it the woman's?

User A.: – The man's too.

Nurse: – The man's too. Everyone agree? [...] Or do you think it's just the woman's or just the man's? What do you think?

User B.: – Both.

Nurse: – Both? And why would it be that men don't come to this group? Could it be that we don't invite them? (laughing)

[...] At the end of the group meeting, the nurse asked the female users which of the alternatives they would choose, among the contraceptive methods offered. In this manner, she restricted the decision just to the woman”. (SP1)

On this occasion, we saw an activity that not only was aimed at women and expressed an understanding of reproduction as an exclusively female area, but also was a simplistic debate on possible stimuli for making men responsible for reproduction and contraception, thereby making this activity inaccessible to men, in cases in which they sought it.

b) Men as users of the unit

Invisibility within this dimension is envisaged as incapacity among the professionals to note the presence of some men as service users, or the issues that they brought. In this respect, the words of some of the professionals regarding their perception of the presence of men indicate lower frequency than was observed by the investigators. In some units, in the light of the presentation of the project to be developed, the professionals made estimates that demonstrated exaggerated perceptions of the differences between the sexes among the clientele of the service:

“If only the women were present, you’d have 90%!”. (Doctor, RN1)

“The professionals argued that men didn’t go to the unit and that it would be difficult to carry out this study. Over the course of the observation, this point was gradually attenuated, and men started to become more visible, both to the investigators and to the professionals”. (PE2)

The invisibility that was the product from the historical feminization of the PHUs reiterates and reproduces, in new and current terms, the continuation of this direction within the organizing of service predominantly for women. This legitimizes the process, even in new models and strategies for organizing the PHUs. Consequently, now that a strategy for expanding the coverage of primary services to the entire population is being considered, this study has revealed the difficulty faced by men in this regard. The words of an employee presented in the following passage are illustrative.

“[...] The pharmacy assistant came into the conversation [between a user and the investigator]. The user went away and I [the investigator] added that he had been facing the problem for three years. Making an expression of denial and doubt, she said: ‘For three years? But he never came here to treat this. I never saw him here. His wife, yes, I’ve seen her here.’ I did not tell her that I had previously seen him there. I remember that, when I met him, he said that he had only been able to make an appointment through his partner’s intervention, and that on his own, he had no value there. This was in line with the employee’s claim that she had not even seen him there”. (RN1)

Some beliefs about the presence of men in the units are constructed based on perceptions that are biased by this invisibility, as shown by the investigation in relation to the idea that men rarely went to the unit, to get condoms. Although without unanimity among the professionals, this idea was frequently reproduced in most of the units:

“Although we observed a significant number of men going to get condoms, some professionals insisted that few men did so. According to the professionals who worked in the pharmacy, the demand from women was greater: they were getting condoms for their partners”. (PE1)

The observations on how the units functioned made it possible to see that the distribution of condoms to men and women tended to take place along different routes. Men got them only through free dispensation at the pharmacy within the unit, through spontaneous request or, in some cases, through stimulation from the professionals. In general, this activity was formalized through specific registration, which also did away with opening a medical file. On the other hand, male condoms were also handed out to women in connection with family planning activities, in which systematic distribution was made, tied to their participation in this activity.

It makes sense to understand the observed difference as a reflection of men’s association with sexuality and women’s with reproduction, thus confirming the questions that have already been raised in this respect by Leal and Boff (1996). This reinforces gender asymmetry in the units, given that in PHUs there is generally, and in keeping with their tradition manner of functioning, greater concern regarding reproduction than regarding sexuality.

In this dimension, there is therefore a deficiency in welcoming the male public and their demands. If PHUs become the preferred gateway to the healthcare system (especially for the popular strata), through the current healthcare policy and especially through the FHS, but this policy of gender

perspectives is not worked on (through seeking to criticize and modify the traditional gender concepts relating to the health-illness process, either among managers or among the professionals), it will be difficult to fulfill the right to expansion of coverage through this primary care strategy in the case of men. Some users find that no one in the units listens to their requirements, especially if they are expressed differently from the ways that have become recognized within the context of traditionally female care provision. The following example expresses a situation in which receiving male users required professional effort towards new possibilities for listening to them:

“A male user who had cut his wrist in a work situation came into the bandaging room. [...] The nurse pointed out that some stitches would be needed at the site of the cut, which caused an immediate response from the user, complaining that this was going to hurt. [...] The user’s fear of injections and of the entire procedure that was to be carried out was clearly perceptible. This caused a lot of comments about being a man and being afraid. [...] The nursing auxiliary commented: ‘There’s no need to shit yourself, you know?’ (laughing)”. (RN2)

This invisibility was also expressed in the representation of male presence that is qualitatively ineffective. It was common for the professionals to take the view that not only were the men less present and less keen, but also they were more resistant to invitations to go to the unit, they failed to keep appointments for consultations and they did not adhere to the treatment in the way that they were supposed to. As pointed out by Schraiber (2005), the low frequency of men in the units was attributed to their resistance, while the low inclusion of men in care proposals was unrecognized. Along the same lines, a trend towards holding men responsible for low levels of seeking the services was observed. It also has to be borne in mind that the users reproduced these representations and were also responsible for impasses in the relationships with the units. However, we emphasize that it was unusual for the professionals to pay attention to the characteristics of service setup or functioning that caused difficulty for men or even impeded their access to or use of such services. Likewise, the professionals did not perceive that, through this, the strategy of expansion of coverage was not being accomplished, and that furthermore, this was divergent from comprehensive care from a gender perspective. In other words, the professionals were unaware that the issue of comprehensive care was a problem at the PHUs, and this was in relation not only to men but also to women. We can say that in this sense, the professionals and managers ended up mandating the continuation of the historical gender culture in healthcare because they did not place value on situations in which, objectively, a change was already taking place.

c) Men as care subjects (gender stereotypes)

The imaginary that, on the one hand, attributes caring for one’s health with being female and, on the other, non-care with being male was constantly present in the units (Figueiredo, 2008; Gomes, Nascimento and Araújo, 2007; Couternay, 2000). Surrounding this, there were various gender-related representations and stereotypes, such as: “men are stronger”; “women’s bodies have particular features that require more care”; “women are naturally carers”, etc. These ideas were reproduced in the professionals’ discourse and even by the male and female users, as shown by the following passage:

“[The professionals] emphasized that male participation was limited not through direct responsibility of the unit or the professionals, but because of factors ‘intrinsic to men’, who did not seek services as a consequence of their (de)motivation through macho culture, lack of time or non-attribution of value to health-related issues”. (PE2)

According to this imaginary, invisibility is produced through an expectation among the professionals that men will not take of themselves or other people and therefore either will not seek services or will do so in a less authentic manner. Based on this premise, the professionals’ actions within the day-to-day routine of care provision end up reinforcing this dimension of invisibility.

When they do not recognize men as potential care subjects, they fail to stimulate preventive and health promotion practices among men, or do not recognize cases in which such behavior is demonstrated. The following examples indicate this:

“A CHA commented that it was interesting that when she went to someone’s home, she never asked the man anything, especially if he had already undergone some prevention”. (PE2)

“The nurse asked whether the woman was giving the medicines [to her sick husband] at the right times, and the woman answered that she did not know, because her son was responsible for giving the medication and he was not at home. This response made the nurse visibly irritated and she went on to explain, without much patience, the importance of giving the medication at the correct times. [...] The nurse complained [to the investigator] that the wife seemed not to understand the severity of her husband’s problem, because she had not been keeping an eye on the times for the medicines and had left the task to her son”. (RN1)

This dimension of invisibility generally incorporates the image of female carers and, from a gender perspective, is linked to the image of men as non-carers that is constructed (Figueiredo, 2008; Gomes, 2008). In this manner, female figures, generally as mothers or female partners, dominate the care field and thus mediate the relationship between male users and the services, or between men and general healthcare. Many scenarios of attendance provided for men have a woman as the protagonist:

“In contacts with a public of elderly men, it could be seen that they were concerned and were taking care of their health, but it was easy to catch professionals addressing their wives using phrases like: ‘make sure that he takes the medicine’, ‘control his food.’”. (PE1).

Possible visibility: men as potential carers

Despite the observed dynamics through which men became invisible in the units, these users’ presence and incorporation has been seen (even if little recognized) as an important element for constructing care provision that, in line with the premises of SUS, attends to men and women as subjects with the right to healthcare.

In this respect, some visibility for men as potential carers and service users seems to be underdevelopment, albeit still haltingly. It cannot be neglected that some of the discourse and actions among the professionals gave visibility to male users and stimulated them towards practices of self-care and care for others. Thus, it can be reported that cracks existed in the trends indicated and, moreover, there were some innovative actions as strategies for attending to men and incorporating them within the context of the units:

“One man also came to accompany a childcare consultation for his baby. According to the nurse, he asked whether he could come in, and she said that he could and that this was good”. (PE1)

“Another concern among the management is the need for the healthcare professionals to be qualified to attend to the male population. Such qualifications need to focus on development of communication with this population in general and development of skills for dealing with issues specific to the segment of young adult males, among other issues”. (RJ1)

“Nevertheless, [...] physical specie destined for both men and women is being created within the unit. This has taken shape through provision of two chairs (instead of just one, as had been the practice in the unit) in the doctor’s consultation room, and creation of an event exclusively for attending to men, which was done during the year preceding the present study. At this event, which was conceived by a dentist and the technical coordinator of the unit, the activities scheduled included distribution of condoms and publicity leaflets on the community’s streets, educational talks and a day dedicated to attending to male requirements”. (RN1)

“Another initiative that can be highlighted with regard to creating space for male users was the recent development of a specific group for discussing men’s health. In this respect, users were invited to participate in this group and discuss issues relating to their healthcare needs and how to develop self-care. It is interesting to note how, over the course of other activities, users who demonstrated ‘concern for healthcare’ became defined as good candidates for this group”. (SP1)

Final remarks

The analyses undertaken demonstrate that it is essential to recognize that gender, among other categories, places order on social practices and thus conditions perceptions of the world and thinking. In this way, it functions as a sieve through which the subject perceives the world.

Hence, attributes relating to masculinity, such as invulnerability, low levels of self-care and adherence to healthcare practices (especially with regard to prevention) and impatience, among others, which are reset within the day-to-day activities of the healthcare services both by the professionals and by the users themselves, make these spaces “genderified” and add to social inequalities, thereby making men’s needs and demands invisible and reinforcing the stereotype that PHUs are feminized spaces.

It should not be forgotten that men’s low presence and little connection with the activities provided by the units are not solely the responsibility of the professionals who provide the services, given that when men respond to the shaping of traditional patterns of masculinity, they (re)produce the social imaginary that distances them from prevention and promotion practices (Gomes, Nascimento, 2006).

From the experience of some units (RJ1, SP1 and RN1), day-to-day presence of men with their healthcare demands and needs has made it possible to create cracks in the dominant classifying pattern that attributes to women a role of caring for their own and others’ health and to men, the place of those who demand mediation regarding healthcare. However, before such situations break down the invisibility, they may reinforce it. Insofar as the social imaginary of gender still conceals the emergence of such needs and demands, it makes them “strange”, complex and difficult, and consequently impedes their incorporation as issues appropriate for PHU services. Thus, the sense of men’s (in)visibility in PHUs from a gender perspective (Schraiber, D’Oliveira and Couto, 2009; Dantas Berger and Giffin, 2005; Schraiber, 2005) represents a technological refusal to incorporate new subjects with their specific characteristics, within the healthcare services. Furthermore, the persistence of traditional attendance patterns impedes the renovation of healthcare services towards progressively comprehensive care, thereby making it difficult for gender issues to be addressed and brought into healthcare comprehensiveness.

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