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Perspectives of primary care professionals regarding male adherence

Perspectivas de profissionais da atenção primária quanto à adesão do homem

Perspectivas de profesionales de atención primaria sobre la adherencia masculina

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This is a descriptive and exploratory study with a qualitative approach, conducted in a district of São Luis, in the state of Maranhão, Brazil, in 2018. It aimed to describe and analyze the adhesion and adherence of users to men's health programs from the perspective of professionals who work in care primary. Data were collected through semi-structured interviews with 15 health professionals and analyzed using thematic content analysis technique. From it, three categories emerged: "*Male user - looking for health units*"; "*Health service: bureaucratic purposes and biological aspect*"; and "*Men's health program*". There was a reduced search for services by men, as well as the lack of knowledge of professionals about the *Política Nacional de Atenção Integral à Saúde do Homem* (National Policy for Comprehensive Attention to Men's Health), which is necessary for managers and health managers offer actions that aim to train them in relation to the content of this policy, in addition to interventions that can better include the male universe in primary care, with a view to increasing adherence and adherence and reducing morbidity and mortality.
Descriptors: Men's health; Primary health care; Public health.

Este é um estudo descritivo e exploratório com abordagem qualitativa, realizado num Distrito de São Luis - MA, em 2018, com o objetivo de descrever e analisar a adesão e aderência dos usuários aos programas de saúde do homem na perspectiva de profissionais que atuam na atenção primária. Os dados foram coletados através de entrevista semiestruturada com 15 profissionais de saúde e analisados pela técnica de análise de conteúdo temática, emergindo três categorias: *"Usuário homem - procura pelas unidades de saúde"; "Serviço de saúde: fins burocráticos e aspecto biológico"; e "Programa saúde do homem*". Verificou-se a busca reduzida pelos serviços por parte dos homens, assim como a falta de conhecimento dos profissionais a respeito da Política Nacional de Atenção Integral à Saúde do Homem, o que se faz necessário aos gestores e gerentes de saúde ofertar ações que visem capacitá-los em relação ao conteúdo dessa política, além de intervenções que possam melhor incluir o universo masculino na atenção primária, com vistas a ampliar adesão e aderência e reduzir morbimortalidade.
Descritores: Saúde do homem; Atenção primária à saúde; Saúde pública.

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Descriptores: Salud del hombre; Atención primaria de salud; Salud pública.

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INTRODUCTION

The special attention directed to men in the field of public health was boosted in the 1980s onwards, by the outbreak of HIV, initially among men and, later on, in the 1990s, associated with the the feminization of the epidemic among heterosexual women[1].

The recognition of this peculiarity and the physical or psychological vulnerability of the male population brought the need for men to be included in Public Health Policies, and being preceded by several discussions, involving various social actors, institutions and civil entities, unlike the National Policy for Comprehensive Care to Women's Health, it did not correspond to a motivation in the social field, since the male population is not considered to be excluded or abstracted in the social environment[2].

From the point of view of the history of health policies aimed at "specific populations", the Ministry of Health created the *Política Nacional de Atenção Integral à Saúde do Homem* - PNAISH (National Policy for Integral Attention to Men's Health), as a significant moment in the long and paradoxical process that unfolds around the medicalization of the male body, therefore "men" now have a place alongside other subjects, older focuses of specific health actions: in addition to "women", "adolescents and young people", "elderly", "people with disability ", “users of mental health services” and “individuals in the custody of the State”[3].

PNAISH wwere principles and guidelines created in 2008 and sanctioned by the Ministry of Health through Decree No. 1944[4]; which emphasized that its previous health actions were mainly directed at young adult men[5]. This was the first step towards a series of transformations in the public health network, seeking to detect the demands of the population in order to build actions and policies aimed at health issues and aimed at its actors[5].

This policy is considered to be the result of broad processes of analysis and discussion between sectors of civil society, health professionals, managers of the *Sistema Único de Saúde* - SUS (Unified Health System), researchers and scientific societies, aiming to direct health actions to sensitize men to take care of themselves , as well as reducing the high rates of male morbidity and mortality[6].

Men still seek less health services and, when they do, it is through medium to high complexity, thus, conferring the greatest vulnerability and aggravation of chronic diseases, which often present at a stage when there is no more cure, such as prostatic neoplasms, generating demand at a higher cost for SUS[7]. A study[8] shows men's difficulties in recognizing that they are sick, as well as the fear of discovering serious illness.

Historically, in Primary Health Care Units, care is generally focused on women and children, even though these places are intended for the entire population[9].

In this context, health professionals are fundamental in health promotion, therefore, the good relationship between professional and user is a fundamental strategy that enables the sharing of thoughts, beliefs, values, in addition to the possibility of respecting and understanding the countless situations that involve their health.

Thus, this study aimed to describe and analyze the adherence and adherence of users to men's health programs from the perspective of professionals working in Primary Care.

METHODS

This is a descriptive and exploratory study with a qualitative approach[10], developed with health professionals in Primary Health Care units located in the District of Itaqui-Bacanga, São Luís, in the state of Maranhão.

Interviews were carried out, with the inclusion criteria of being a Family Health Strategy (FHS) professional with at least one year of experience, and signing a Free and Informed Consent Form to participate in this research. Exclusion criteria referred to professionals who were on vacation or leave during data collection.

The number of participants was defined by the saturation sampling criterion, which consists of the suspension of the inclusion of new participants when the interview data start to present redundancy or repetition, and it is not relevant to persist in the collection[11].

For data collection, semi-structured interviews were carried out, with a script prepared by the researchers in the Microsoft Word program, version 2016. This script consists of sociodemographic data (gender, age, profession, education, training in men's health, length of experience in the FHS). As questions, it was considered: a) "*Tell me about your experience in assisting men being cared by your team*"; b) "*Tell us a little about the man's demand for the Family Health Strategy*"; c) "*In the health unit, are there any actions aimed at integrated attention to men's health?*"; d) "*Do you know the programs focused on men's health?*"; e) "*What are the factors that facilitate or hinder human health care?*"

The interviews were conducted between October 2016 and March 2017 with each participant individually in a reserved place, respecting their privacy and the time scheduled by them. The interviews were recorded with a mobile phone, and later transcribed in full and double checked to ensure the accuracy of the transcript.

Data were analyzed with the thematic content analysis method, which consists of identifying nuclei of meanings present in a communication, by verifying the presence or frequency of these nuclei for articulation with the research objective[10]. Three stages were considered: reading of the interviews, which enabled the correction of interpretive directions or the emergence of new questions; exploration of the material, as well as the search for categories; and basing the results with the theoretical frameworks[10].

To guarantee the anonymity of the participants, letters were used to represent the professional categories: D (doctors), N (nurses), CHA (community health agents), followed by the sequential number of the interviews.

This research was approved by the Ethics Committee of the Universidade Federal do Maranhão, in accordance with Opinion No. 1,627,922 of 2016, CAAE 5.0000.5087, respecting the ethical precepts of Resolution 466/12 of the National Health Council.

RESULTS

In the surveyed region, seven health units were considered, in which 36 professionals worked. Data saturation was possible with 15 professionals, represented by: three doctors, four nurses, three nursing technicians and five community health agents. Five participants were male and ten were female. The age group ranged from 28 to 56 years (Chart 1).

Regarding the level of education, seven of the participants had a university degree, three had a technical level degree and five had a Elementary level degree (Chart 1).

As for training, 15 of the participants reported having received training in men's health, such as: HIPERDIA - program focused to the care of patients with hypertension and diabetes mellitus (6 professionals); partner's prenatal care (2 professionals), prostate cancer (2 professionals), penile cancer (1 professional), sexually transmitted diseases (2 professionals) and men's health (2 professionals) (Chart 1).

As for the length of experience in the Family Health Strategy, nine of the participants had been working there for more than ten years, while six of the professionals had been working there for five to ten years (Chart 1).

Chart 1. Sociodemographic profile of health professionals. São Luís - MA, Brazil. 2018.

	Gender	Age	Educational level	Profession	Training in Men's Health	Time in the Family Health Strategy
1	Female	30 years	University	Doctor	Partner's Pre-Natal Health - Men's Health	5 years
2	Female	55 years	University	Doctor	HIPERDIA	Over 10 years
3	Male	48 years	University	Doctor	HIPERDIA	Over 10 years
4	Female	28 years	University	Nurse	Partner's Pre-Natal Health	6 years
5	Male	35 years	University	Nurse	Men's Health	8 years
6	Female	40 years	University	Nurse	Sexually Transmitted Diseases	10 years
7	Female	52 years	University	Nurse	Prostate Cancer	Over 10 years
8	Female	35 years	Technical	Nursing Technician	HIPERDIA	5 years
9	Female	50 years	Technical	Nursing Technician	Sexually Transmitted Diseases	Over 10 years
10	Female	52 years	Technical	Nursing Technician	Penile Cancer	Over 10 years
11	Female	56 years	Elementary	Community Health Agent	Prostate Cancer	Over 10 years
12	Male	50 years	Elementary	Community Health Agent	HIPERDIA	Over 10 years
13	Female	48 years	Elementary	Community Health Agent	HIPERDIA	Over 10 years
14	Male	37 years	Elementary	Community Health Agent	Men's Health	8 years
15	Male	49 years	Elementary	Community Health Agent	HIPERDIA	Over 10 years

After the transcription of the interviews, the organization and thematic analysis of the material, three categories emerged: *Male user - looking for health units*; *Health service: bureaucratic purposes and biological aspect*; and *Shortage of health actions aimed at men's health*.

Male user - looking for health units

In this category, it is observed in the reports of participants that there is still little demand for men for assistance in the FHS, and they only do so as a last resort, which may be related to poorer prognosis:

Men come infrequently and are usually accompanied by their wives. Those who come through HIPERDIA request a prescription. The most common cases are those with tuberculosis and leprosy. (N 1)

Men only come as a last resort. The highest frequency is women and children. Male presence is much more difficult, even. Hypertensive and diabetic patients are the most frequent, whether for consultation or to exchange prescriptions and medicines. The others appear quite sporadically, only in cases of mandatory vaccinations. (CHA 1)

The low demand for health services by men may be related to the feelings of fear of discovering some serious illness:

What makes it difficult, often, is fear. (CHA 2)

What makes it difficult is the fear they have when talking about their symptoms, in this case women are more open, when they feel something they are not afraid to express it or come to the Unit. (N 2)

Furthermore, to justify the low demand for men in the FHS, participants point out that there is still a "taboo" regarding this, since men are still resistant to seeking health services:

Men considers the BHU as an environment geared towards female care, that is, this user sees the health service aimed at the most "vulnerable" public, like women, the elderly and children. (D 1)

There is a big "TABOO" in relation to their health, when they look for a Unit it is because they are already very sick. Our consultations are carried out with the presence of doctors and nurses. (CHA 2)

What makes it difficult is the question of the prejudice of the man himself. (CHA 3)

Another important factor would be that the men are usually not comfortable with female professionals:

What hinders the greater male presence in the Health Unit is the fact that men do not feel comfortable when being attended by a doctor, here, for example, there are two more (male) *doctors so there is a greater demand for care with them.* (D 2)

Health service: bureaucratic purposes and biological aspect

In this category, the demand for health services by men is related to bureaucratic purposes, such as going after a letter of medical justification when they are absent from work or even for vaccination required by the company they work for:

The frequency is still low, but they are enjoying to be included in prenatal care, including, in addition to the invitation at the first moment, we inform those who work with a formal contract that we make the certificate of the day so that the absence is paid. The patient who works in these conditions is concerned with leaving his work [...]. (D 1)

The frequency in the Health Unit is low, but there is a greater demand in the vaccination sector, mainly beccause some vaccines are required by companies. Now, with the Yellow Fever outbreak they come more. (NT 1)

Many men do not seek health services due to the economic aspect, lack of time due to work, and the importance of carrying out activities aimed at this public out of their working hours:

What makes it difficult is the economic situation, as many live in low income communities, in addition to supporting their household, so they need to work full time. (N 3)

What makes access difficult is work, we would need to do something out of their working hours. (D 3)

Most participants pointed out that assistance to men is more focused on the biological aspect and instead of other aspects such as psychological, cultural and social:

Usually, men tend to self-medicate, when they make the decision to seek us out, it is because the problem is already much more serious. Assistance is greater in the biological scope. (N 4)

What makes it difficult here is the lack of proper approach and welcome, when arriving, the man is lost without knowing how to proceed. (CHA 4)

What makes it difficult is not having specialists to take care of men in the Units. (CHA 5)

Shortage of health actions aimed at men's health

In this category, it is evident in the reports that there is no specific comprehensive program for men's health aimed at expanding their access:

Although we provide assistance to men's needs, there is nothing more specific and directed to this audience, so we developed a work with the medical students at internship, they spend three months here and at the end they have to present an intervention project. In the end, many are interested in doing work aimed at the male audience. We work here with community health workers. That month, we did a job at a fair close to the Unit addressing prostate cancer and other diseases, drawing attention to the need for proper treatment, but it is not some specific plan aimed at men. (N 4)

There is no specific day for the care of men, we serve everyone together. (D 3)

However, few professionals reported knowing any program aimed at men, and these participants mention the programs of HIPERDIA, HIV and Prostate Cancer:

Yes, the issue is mainly leprosy and prostate cancer prevention. (NT 2)

No, what we have is just a campaign in which nurses do hepatitis and HIV tests, but we do lectures in Blue November, whose most frequent audience is hypertensive and diabetic people. (NT 3)

DISCUSSION

Including men in health services, especially those in primary care, is still a challenge for public policies, as they do not value health promotion and disease prevention as a way of taking care of themselves. They seek services of this level of health care in cases of campaigns and vaccinations[12].

In one study[13], the presence of men in primary care was found in certain activities, such as: medical consultations, dental care and activities available in some of the services, with emphasis on physical therapy, Tuberculosis and Leprosy Program and mental health. However, in the services of the Family Planning Program and in the nursing consultation, men tend to participate less.

One of the factors that can lead men to avoid seeking health care may be related to the

feeling of fear in discovering that they are a serious disease, or even by the hegemonic model of masculinity, which culturally places them in the condition of providers, representing synonymous with strength, invulnerability and virility. Showing signs of weakness could put "masculinity" at risk and bring you closer to representations of "femininity", "fragility" and "sensitivity"[14].

Thus, the resistance of men to seek health services, especially those of Primary Health Care (PHC), indicates that many deaths could be avoided. This is because, when they go to the health services, the disease is already advanced, which leads to reflections on the construction of masculinity as a factor with direct influence on the vulnerability to serious, chronic diseases and early death[15].

Also, men have the perception that health units are directed to women and children, a feminized space, and, thus, they do not feel they belong[9,16].

A research[13] points out that, in health services, there is a feminization of the environment, since health education materials are generally decorative, although the Ministry of Health emphasizes the importance of including references to gender, generation and race/ethnicity .

The female figure of the health professional can be an impediment in care, since, as a woman, this professional may not convey confidence to the male user, as men tend to be embarrassed and/or doubtful of women's ability to provide guidance. them regarding the resolution of their problem, often of a sexual nature[17].

This information can be observed in work[18], which found that participants felt more comfortable when attended by male doctors in relation to the female doctors, especially when it came to sexual health issues.

In this context, although it is possible for health policies aimed at the female public to integrate with men's health, the specifities and diversities within the scope of social relations need to be considered. Thus, it is considered that there is a lack of equity in meeting the health needs of men, which evidences the precarious attention of health services[19].

The bond between professional and patient is important, since the male user feels more at ease when he is attended by a professional who values integrality. However, for this to be possible, it is necessary that this subject's needs are perceived in his diversities[20].

With regard to the demand by men for health services for the purpose of bureaucratic services, it was found: to go after a letter of of medical justification, an exam required for work or even an evaluation on why they missed work[21]. When it comes to work, male users do not see the need to be absent to go to a Primary Care Unit, since the working hours of public services work in limited shifts and coincide with their working hours.

It is added that the male user is identified in a negative way, as he reveals little patience in waiting for care in contrast to the female posture of being "patient"[21]. Thus, there is a need to restructure the working hours of the basic unit, especially at night, since men have little flexible hours as they are inserted in the job market.

In most of the participants' reports, assistance to men is more focused on the biological issue and other aspects are not observed, such as psychological, cultural and social. With this, assistance still prioritizes the biomedical model, in which many professionals give higher priority to individual health problems than to collective ones, and disregard the psychological, affective, historical and cultural factors of human illness[14].

Furthermore, most professionals reported that there is no specific program for the health of integral men, despite the fact that the Ministry of Health has already implemented, in 2008, the PNAISH[4], aiming at expanding this user's access to health services.

Many health professionals are not aware of this policy, emphasizing that the lack of in-service education actions is an obstacle and, many times, the policy's dissemination materials are the only source of information that professionals have[23]. The few professionals who know PNAISH emphasize that the policy advocates attention to men's health without creating the necessary mechanisms to carry it out in practice[23]. In the study presented here, few

professionals reported knowing about a program aimed at men, with emphasis on: HIPERDIA, HIV and Prostate Cancer.

It should be noted that PNAISH, within the scope of the document, aims to break down the category "man" into a series of subcategories: indigenous, blacks, gays, cross-dressers, disabled, among others[3].

As for issues related to gender identity and non-hegemonic sexual orientations, an investigation highlighted that access to health by the LGBT population (lesbians, gays, bisexuals and transgenders) has been considered as a health promotion strategy and aimed at combating discrimination, since this population may have basic human rights violated due to the non-adequacy of gender with biological sex or to non-heteronormative sexual identity. However, although the PNAISH base document emphasizes the importance of incorporating men into reproductive health as a means of changing gender stereotyped patterns, it is noted that there is a small space reserved for this theme[24].

PHC institutions have great influence on the social view of gender and health, causing this view to reproduce and have an impact on the model of care offered to the population, so there is a failure in health services in activities aimed at the public male, as evidenced in a work that found in PHC the lack of favoring the presence and permanence of men, due to the fact that most actions are aimed at women, such as: breastfeeding, prenatal care, STI prevention and HIV/AIDS[13].

Given this context, it can be mentioned that the thematic promotion of men's health in PHC is still little addressed in academic circles. Despite the well-known relationship between morbidities associated with this audience, such as obesity, hypertension and diabetes and others, it is known that most studies on health include the female population, in addition to children and the elderly. Thus, despite the structural issues in PHC that make it difficult to promote health to the male population, there is also a reluctance of men to seek PHC units.

One of the clues to the non-attendance of men in PHC units is that this environment is often organized for the care of women and children, being perceived by professionals as an element that makes men "uncomfortable"[21].

CONCLUSION

The data obtained in this investigation showed that low demand for men at the FHS health service, in the view of the professionals, is related to the user's feeling of fear of putting his "masculinity" in question and the taboo that involves considering the health environment as a feminized place (predominance of female professionals and actions aimed at women and children) that hinder their insertion in it.

As for the cause for the search for men by the BHU, the participants pointed out bureaucratic ends of the service (letter of medical justification and vaccination), due to the deterioration of their health status and, when they seek the health service, they end up being tended by professionals only in the biological aspect, not taking into account other aspects that involve their health.

The interviewed professionals showed lack of knowledge about PNAISH, which is worrisome, since it is important to know all the necessary actions for an adequate assistance to men to influence or motivate the demand for health services.

The PNAISH is not disseminated efficiently in the PHC Units surveyed, which may compromise the offer of health programs aimed at assistance regarding health promotion and disease prevention, which may affect the male population. This shows the importance of health managers and managers in training professionals who work within PHC with themes that involve the male universe.

The limitation of this research concerns the fact that it is carried out only with professionals. Thus, it is necessary to carry out future research that also involve the participation of male users so that the vision of the reasons that lead them not to seek health

services can be broadened, in addition to other aspects that can be taken into account to expand service offerings for that audience.

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Francisca Bruna Arruda Aragão, **Elaynne Silva de Oliveira**, **Jacira do Nascimento Serra**, **Caroline Cunha Fontoura** and **Emanuel Péricles Salvador** contributed to the conception, collection and analysis of data, writing and review. **José Henrique da Silva Cunha** participated in the writing and revision.

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