

The male genre and health care: the experience of men at a health center

O gênero masculino e os cuidados de saúde: a experiência de homens de um centro de saúde

El género masculino y los cuidados de salud: la experiencia de hombres en un centro de salud

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ABSTRACT

The aim was to understand how the men of a Health Center behave concerning health care. Qualitative study in a Center for School Health that selected by convenience and interviewed 15 individuals that were adults of male gender and the data organized according to the Discourse of the Collective Subject. Four central ideas emerged that portray the reasons for seeking the service, health problems, attitudes towards these issues and participation in the activities of the unit. These individuals are assiduous, care to follow the advice received and used the individual attention, preferably, for lack of time, but show an interest in participating in group activities. This should be used by the services as an opportunity to enhance their participation in specific groups that are already existing for men, offering a welcome space and offer listening to several problems, being a form of reintegration of these individuals with the health service.

Keywords: Men's Health; Health Centers; Nursing; Delivery of Health Care.

RESUMO

Compreender como os homens de um Centro de Saúde se comportam quanto aos cuidados com a saúde. Estudo qualitativo, realizado em um Centro de Saúde Escola que selecionou por conveniência e entrevistou 15 indivíduos do gênero masculino, adultos e organizou os dados conforme o Discurso do Sujeito Coletivo. Emergiram quatro ideias centrais que retratam os motivos para procurar o serviço, problemas de saúde, atitudes diante desses problemas e participação nas atividades da unidade. Esses indivíduos são assíduos, se preocupam em seguir as recomendações recebidas e utilizam o atendimento individual, preferencialmente, por falta de tempo, mas demonstram interesse em participar de atividades em grupo. Isto deve ser utilizado pelo serviço como oportunidade de intensificar a participação deles em grupo específico já existente para homens, que oferece um espaço de acolhimento e escuta de problemas diversos, sendo uma forma de reintegração desses indivíduos junto ao serviço de saúde.

Palavras-chave: Saúde do Homem; Centros de Saúde; Enfermagem; Assistência à Saúde.

RESUMEN

El estudio buscó comprender cómo los hombres de un Centro de Salud se comportan cuanto a los cuidados con la salud. Investigación cualitativa, realizada en un Centro de Salud que seleccionó y entrevistó, por conveniencia, a 15 hombres adultos y organizó los datos de acuerdo con el Discurso del Sujeto Colectivo. Emergieron cuatro ideas centrales que retratan las razones para la presencia del hombre en el servicio: problemas de salud, actitudes delante de estas cuestiones; y participación en las actividades. Son asiduos, se preocupan en seguir las recomendaciones recibidas y utilizan la atención individual, preferencialmente, por falta de tiempo, pero muestran interés en participar en actividades de grupo. Esto puede ser usado como una oportunidad para mejorar su participación en el grupo específico para los hombres, que ofrece un espacio para recibir y escuchar a problemas diversos, siendo una forma de reinserción de estas personas con el servicio de salud.

Palabras-clave: Salud del Hombre; Centros de Salud; Enfermería; Prestación de Atención de Salud.

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INTRODUCTION

The launch of the National Policy for Integral Attention to Male Health (PNAISH) in 2009 with the overall objective to improve the health of the male population, envisioned to reduce morbidity and mortality, focusing their attention on risk factors for this population following as well as provide conditions for increasing access to health services and integral health actions¹. This study is calling attention to this issue, stimulating the development of this research, as well as to other studies²⁻⁷.

According to recent data from the Brazilian Institute of Geography and Statistics (IBGE), with reference to the 1st of July 2014, it is estimated that currently Brazil has 202.7 million inhabitants; life expectancy, overall, increased from 74.1 years in 2011 to 74.6 years in 2012 and, in relation to sex, for men it increased from 70.6 (2011) to 71 years (2012) and for women it rose from 77.7 to 78.3 years over the same period⁸.

Regarding mortality, aged between 20 and 59 years, the leading causes of death in Brazil were external causes, cardiovascular diseases, cancer, digestive diseases^{2,9}. Men die in accident situations and violence leading them to premature death, with no time for illnesses to develop, compared to women, who die from cancer, blood disorders, endocrine disorders, among others⁹. Internationally, the disparity between the health of man and woman, is also observed, as in Singapore, where men die earlier and suffer from diseases like cancer, heart disease, cerebrovascular disease, sexually transmitted diseases. The mental health issues were also significant, with men having higher suicide rate than women. These conditions result in years of productive life lost and, in addition, men more than women have unhealthy life, which predispose them to chronic diseases¹⁰.

As to the unhealthy lifestyle habits and presence of chronic diseases, in Brazil there was a significant increase in the prevalence of obesity, overweight, insufficient physical activity during leisure time, physical inactivity, hypertension and diabetes with increasing age². This way, it can be said that men are entering the health system through specialized attention, resulting in increasing morbidity by delaying the attention and greater cost to the National Health System (SUS). It is necessary to strengthen and upgrade primary care, and this way ensuring health promotion and prevention of avoidable health problems¹.

There are several studies that have sought to understand the motives of these men come to services already installed with chronic diseases. From a professional view, one realizes the valorization of women in detriment of men, since they would be more likely to healing practices and less able to prevention¹¹. There are several representations and stereotypes related to gender, such as: "Men are stronger"; "The female body has particularities that require more care"; "Women are naturally caretakers". This way, the invisibility of the male gender is produced through an expectation by professionals that men do not take care of themselves or even other people and therefore do not seek the

services or do it in less authentic ways. When professionals do not recognize these individuals as potential subjects of care, they fail to encourage them to practice prevention and promotion of health or do not recognize cases in which they demonstrate these behaviors³.

However, when men are asked about the reasons that lead them not to seek care for basic health, issues arise that are not associated only to gender, such as inappropriate hours of operation of services that occurs during working hours, fear of be a carrier of a serious illness, lack of specialists, delay in treatment. These factors can be minimized if the services offer new strategies for follow-up care for this population⁴⁻⁶.

Thinking about the theme man vs. health, the question that guided this study was: how men have behaved in relation to caring for their health?

The research objective was to understand how men of a Health Center behave towards health care.

METHOD

This research is embedded in a qualitative line, with data organized in the form of the Collective Subject Discourse (CSD). It was performed in the Center of School Health Auxiliary Unit of the University of the State of São Paulo, interconnected with the network of Municipal Health as a Basic Health Unit (BHU). According to the last census, this municipality has about 130,000 inhabitants and said BHU is responsible for approximately 25,000 inhabitants mostly living in its coverage area.

The constitution of the sample was convenience and based on the saturation of the responses 15 male subjects were selected aged over 18 years who agreed to participate in this research and who attended at BHU for a possible service or for a pre-scheduled service in the period July to September 2010, when the data was collected. The necessary ethical procedures were applied, this work has been approved by the Research Ethics Committee, in April 2010, with protocol number 3479-2010. All participants signed a consent form, in duplicate, as recommended.

To collect data individual interviews were conducted by one of the researchers, recorded on electronic device, lasting about 30 minutes, which were transcribed verbatim and were erased after this step. Three guiding questions were asked that stimulated the subjects to talk about: the reasons that made them look for the service, which care they have or do not have in relation to their health and how the return attendance is at scheduled appointments, whether as an individual or in a group mode, for monitoring of proposed treatments.

The data was organized based on the proposal of the DSC, a methodological strategy that proposes organizing them using four figures¹²: Central idea: is the statement that reflects the summary of the explicit speech made in the statements; Key Expressions: allow to recollect the essence of the content of speech, through the literal transcription of portions of depositions.

One must return to the survey questions when selecting such expressions. The construction of the DSC is based on this figure; Collective Subject Discourse (DSC): not using the grouping into categories. This figure attempts to revive the speech, using the speeches themselves. There is no unifying category, but we search to "rebuild, with pieces of individual speeches, as in a puzzle, as many synthetic discourses as deemed necessary to express a given figure, i.e., a given thought or social representation of a phenomenon"^{12:19}.

The construction of the DSC parts from the selection of the main core ideas that are selected through the key expressions, originating in the speeches of each individual, being concluded, in summary form, as if the various speeches were one. The grouping of several speeches on a DSC should be made based on the similarity of the discourse. When there are different ideas the separation in different discourses is mandatory¹².

RESULTS AND DISCUSSION

The speeches made by the participants, based on the questions that guided the research were organized using the methodological strategy of the Collective Subject Discourse (DCS), and four central ideas emerged.

Central Idea 1: Reasons that led them to seek the services: health care, doing exams, follow-up consultation, extra and routine consultations.

Collective Subject Discourse

It is the benefit that the poor has to take care of health. For me it has been a great treatment. I sought to be attended to improve my health. In this sense, if we try not to take care of health we will go for the worse. I had two heart attacks, now I do follow-up consultation here, to treat me to get better and also to try to stop my addictions. I was referred by my doctor to order do tests to continue my treatment of asthma and bronchitis. I return to nursing to monitor my conditions of high pressure, to follow-up on this, see how my health is, as to my heart, to measure triglycerides, cholesterol, in short, the general thongs, in order to give a good service to the body. I came to monitor my diabetes, knowing the result of examinations, routine visit. To see the pressure, if it is under control. I went to the appointed consultation group. And today I tried to see what is really going on, because they sent me here, in an extra query, because yesterday I was really bad, I felt bad in my head and suddenly gave me dizziness, it turned my mouth and I fainted. I always come to consultations. I do my best not to lose one. Once in a while one forgets. Every time the query is marked, I come. Go to my geriatrician; go to the nurses to do blood tests and urine, whenever requested. Every time it was marked I participated (E1, E2, E3, E4, E5, E6, E7, E8, E9, E10, E11, E12, E13, E14, E15).

The motives for men to seek the service, are related, in most of the discourse, to procedures for monitoring diseases like diabetes, hypertension, cardiovascular disease, respiratory disease, blood pressure control, chronic diseases that are already installed and that require constant monitoring. They demonstrate commitment to return visits in their speech, they appear for the exams, the control of blood pressure levels, these are important aspects for the control of risk factors and disease prevention, one of the strengths of PNAISH¹ and seek care when they are not well. According to the chronic diseases already present, these findings are consistent with literature that bring that, when a man comes to health care, he already arrives with demands for levels of expertise¹.

It is emphasized that the health team has a key role in this service, so that these men continue with this commitment of caring for their health, because as found in another work³, if they are not recognized by professionals as responsible for their care, the team will not provide the necessary tools for the improvement of the practices of health promotion and prevention.

The link with the healthcare team and the attendance are important aspects for men to feel fulfilled in their needs. Whether for a very specific need, to the manifestation of an already established disease, or to give support to their family, or even satisfaction with a new health technology that has improved their quality of life⁷. For men to change their behavior on issues of the health-disease process, professionals can interfere adopting strategies that stimulate this demand through a more effective attendance⁴.

Another study¹³ that examined the participation of males with the Primary Attention raised the lack of time as one of the difficulties mentioned by the men not to participate, including specific campaigns for them, as in the case of screening for prostate cancer. Consider this point is important for the planning of health actions, since the basic units generally operate in daytime, coinciding with the hours of work of these individuals^{4-6,13}.

Despite not having been the object of this study to evaluate the service and staff, this DSC treatment offered by the service is considered optimal. In the literature, studies that had assessed the services contained suggestions from male users: na increased supply of care, more attention from the professionals, ease in making appointments and better remuneration of health professionals, to improve the quality of care. There were also some claims as to improve service to male users in campaigns, realization of meetings clarification, creation of separate sectors for care of women and children, attendance of urology, revealing that there is not an equal concern, as in the cases of women who have gynecological monitoring specialist⁶.

Central Idea 2: Health problems that affect men: respiratory problems, orthopedic problems, hypertension, diabetes and dyslipidemia.

Collective Subject Discourse

I have more breathing problems. Because the heart, all the doctors say it's good, that my problem is the lungs. That's it, thank God that's all. I think the problem is my high blood pressure, nervous system problems, had an ulcer problem, but I was already healed, lost a sight, broke the femur and the leg shortened, the rest was normal. I am having a normal life. High pressure, which is being controlled, monitoring prostate that is super controlled, although I am not taking any medicine, but only with the food intake it is lowering the PSA and well the rest is normal. The pressure remains normal, but occasionally rises. We forget to take the medicine, often gives a problem, but that's it. Have high blood pressure. Little cholesterol, diabetes. Cholesterol, I have a bit (E1, E2, E4, E5, E6, E7, E8, E9).

By participants' report, it is noted that there are already installed and chronic diseases diagnosed, and role of Primary Health Care (PHC) offer health actions, both individually and collectively, rooted in the promotion and protection, and disease prevention, diagnosis, treatment, rehabilitation and maintenance of health¹⁴. Often the society is unaware of how to access the actions and health services, and what the population does not know, has no way of to be defended by it. The Primary Care has a capacity for society to define their rights, and incorporate its concepts and can receive the same kind of health care. When services are completed by the APS, based on the principles of the NHS, it directly reflects on the costs of the Union, reducing hospitalizations, consultations for the same health problem, additional tests, allowing the increase of prevention that will influence the better treatment adherence and satisfaction of the population¹⁴.

Mindful of the growing number of chronic diseases, the Ministry of Health has implemented various policies to fight these diseases, including the Health Promotion Policy, which intensifies actions in the sphere of healthy eating, physical activity, tobacco use and alcohol prevention, aiming at their prevention, as well as their risk factors¹⁵.

The causes of death from chronic diseases in Brazil, in general, are: diseases of the circulatory system (31.3%), cancer (16.3%), chronic respiratory disease (5.8%) and diabetes (5.2%)¹⁵. Based on these data, we highlight the importance of inclusion of participants in this research on insertion of care activities, as well as encouraging this participation with the health service, seeking thereby the prevention of diseases and premature death.

These results are in agreement with some of the data from another study, which found that the main health complaints of men, according to the professionals, are related to acute and perceived symptoms and that hinder the work activities, as well as cardiovascular disease, hypertension and diabetes

and issues in order of sexuality. The approach in the service of man is not a difficulty, but to change the male attitude towards their own health¹⁶.

Central Idea 3: Following the recommendations for treatment in relation to nutrition, physical activity and medication use.

Collective Subject Discourse

I always try to come and do what the doctors tell me to. I can not eat salt, there are many things I can not eat. But for the rest, I do what I can, I'm not exaggerating anything, the part of greasy food is very little that I do, a lot of salad, enough vegetables, white meat, fish, finally, it seems that food is, in my view, within the standard. I always try to take care of myself in relation to food, because I'm already at an advanced age. Not before, now I'm being careful. I'm avoiding eating fat meat, fat, salt. Things I ate, drank, I let go off. I try to do the follow-up just right. Avoid sweet food, the use of sugar. Every day I do some physical activity. Anything they call me: hiking, biking, playing ball, running, walking, anything I do. Take care of diabetes, take medication according to medical orders. Try to have health care as much as possible. I take the medication just right and I feel very good (E1, E2, E3, E4, E5, E6, E7, E8, E9, E10, E11, E12, E13, E14, E15).

Participants mentioned some health care that are preventive and health problems common to some chronic diseases¹⁵, whereas in DSC 2 they cited health problems such as hypertension, diabetes, dyslipidemia, respiratory disease. They said they stopped with some behaviors, especially those related to food, for surely they were told by professionals that assisted them to do so, after the diagnosis of these diseases.

In 2011 the Strategic Action Plan for the Fight of Chronic Noncommunicable Diseases (NCDs) was launched by the MH with the objective to prepare the country to encounter and stop the following diseases: stroke, heart attack, hypertension, cancer, diabetes and chronic respiratory diseases. These diseases account for about 70% of deaths in Brazil and reach with greater emphasis the poor strata of the population with low income and education. Over the past 10 years there has been an approximate 20% drop in mortality rates for NCDs, which may be related to the expansion of primary care that covers about 60% of the Brazilian population, improved care and lower consumption of tobacco since 1990¹⁵.

According to data from MH, some risk factors for cardiovascular related to lifestyle diseases as well as diseases that may worsen in their presence, are more prevalent with increasing age of the men, being: insufficient physical activity in free time, sedentary lifestyle, hypertension and diabetes. On the other hand, the improper consumption of alcoholic beverages, soft drinks and saturated fat decreased, and smoking and some dietary habits

(low consumption of fruits, vegetables and beans) remained unchanged^{1,2}. Another MH study (Vigitel, 2010) detected that in Brazilian capitals in the general population, 15.1% were smokers and 14.9% of supporters with regular physical activity, 34.2% of consumers of meat with fat, 29.9% of regular consumers of fruits and vegetables, 18% of consumers of alcohol, 48.1% of people are overweight and 15% with obesity already installed¹⁵.

In the DSC 3 we note that the men in the study have been more attentive over the practice of physical activity and increased food intake as vegetables, contrary to the data of MH^{1,2} and in agreement as to the care with diet rich in fats and intake of alcoholic beverages.

Another study found the opposite behavior of the one presented here, since men who visited health facilities for some already installed problem, revealed to maintain the habit of smoking and drinking, poor eating habits, lack of or insufficient physical activity and a small demand for health services¹⁷.

Because this service offer group activities for men who attend the unit, during the interview one question was asked related to inserting these individuals in this type of assistance mode.

Central Idea 4: Participation in individual and group consultations.

Collective Subject Discourse

Group I am participating in is the second time. The rest, I come for individual consultations. What is being done is too good. I'm always here attending the service because it solves and improves things in our life. Our life is a school. And learning from each other, properly, it is time we come up here and feel more confidence in each other. Share, follow health care. I think now is the time to really take care of health. Do not participate in the group. Really got my life a lot of running to do, I'm always traveling, I go to a lot of places I visit relatives out of Botucatu. I did not want to make any compromises to be missing them afterwards. In addition to the consultations, do not participate in anything. No Time. Work all week. Only participate in individual consultation. Interest in participating in group up there, the problem is I can't reconcile the time of the company with the hours of groups here (E6, E7, E8, E9, E11, E12, E14, E15, E2, E3, E4, E10, E13).

As observed in the statements of the respondents they indicated that the two types of support are employed and there is no restriction to the group as to not to take an interest in this type of care, but rather, the lack of time and the difficulty of reconciling ones commitments to schedules. The operation of these groups is based on a specific number of meetings that may occur weekly or monthly, depending on the individuals who compose it. As for the individual queries, these end up being the preferred strategy, as they will occur in a period of more spaced time depending on the demands of these men, thus causing less hassle especially

for those who work. However, this is a modality that is very much used in primary care, seeking to facilitate the understanding of the health-disease process, through guidelines.

According to the literature, the use of the educational process should be geared to the needs of the individual, valuing their prior knowledge and stimulating the quest for understanding the health-disease process. This for them to be able to prevent possible complications and make appropriate treatment, to participate actively in this process and becoming responsible for their health and the decisions of changing lifestyle or not¹⁸.

It is understood that it is up to the health professional to perceive this when performing the group sessions or individually, taking into account the individuality of the demands and possibilities of the user. One way to facilitate this participation may be offering this type of assistance in alternate time, which facilitates the access of these men, mainly because they have shown interest in participating, as observed in DSC 4.

As with this service, innovative public health strategies with men, formed by an understanding of the genre, are being developed, allowing for successful and creative way to involve men in health promotion activities¹⁸.

When comparing young men with the elderly, the latter are seeking more care for their own health due to diseases already installed. Promotion and prevention remains key aspects of men's health that needs to be explored and should be encouraged at all ages.

FINAL CONSIDERATIONS

Human health is gaining prominence, timidly, but some initiatives of federal agencies have demonstrated the importance of studying and thinking about strategies that focus on males.

To seek understanding of men in view of caring about their health, this work brings a slightly different behavior than expected compared to men, according to the literature presented, as the discourses that emerged from their speeches reflect individuals who use the health service, are assiduous and care to follow the recommendations of professionals. This brings the practice of healthy habits such as adequate food with reduced fat and increased intake of vegetables, physical exercises, behaviors that contribute to the control of chronic diseases already present in their lives.

Regarding participation in service activities offered by the service, participants reported that individual care was the most used. They demonstrated some availability and interest in participating in other strategies, such as group. Others, however, reported difficulties in organizing their work commitments, since activities in groups, in their opinion, take more time.

It is believed that this interest in participating in the strategy group mentioned by them, must be used by service as an opportunity to strengthen an initiative that is already being put

into practice: the group service for men seeking the service. This group was created by the high demand of new cases occurred in the study unit, consisting of members of the male gender who were separated from the unit for dropping out of treatment, for new cases of individuals belonging to the area or transferred from other areas of coverage. This group has been working as a reception and the listening to problems of various spheres, as well as to reintegrate these individuals with the health service. The flexible hours outside the conventional may increase this participation, since this unit already offers some night calls, which would not bring great difficulties, especially in relation to human resources and would be a facilitator to encourage these individuals.

Regarding the discrepancy of the findings with the literature, mainly because of the difficulties that man has to take care of his health did not appear in this group, perhaps related to the guiding questions of the interview, this issue should be further explored with further research. Another aspect that should be considered is to make an assessment of the trajectory of these men within this health unit, based on their medical records. Evaluate their participation in this already existing group, will surely bring contributions to the health issues in this genre.

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