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DISCOURSE OF MEN ABOUT ACCESS TO HEALTH IN PRIMARY HEALTH CARE

DISCURSO DE HOMENS SOBRE O ACESSO À SAÚDE NA ATENÇÃO BÁSICA

EL DISCURSO DE HOMBRES SOBRE EL ACCESO A LA SALUD EN LA ATENCIÓN PRIMARIA

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Objective: getting to know the discourses of men about the access to health care in Primary Healthcare. Method: descriptive study carried out December 2016 with 20 users from the Primary Healthcare of the city Cajazeiras, Paraíba, Brazil. The Discourse Analysis was the methodological resource adopted. Results: the following categories emerged from the discourses: difficulties in discerning the functions of Primary Healthcare; praise for the biomedical model; practice of medicalization; factors related to service leave; absence of actions and programs destined to men; and differences between masculinity and femininity. Conclusion: male discourses ratified that knowledge and practices of health services need to be re-oriented to broaden the access of the male population to Primary Healthcare.

Descriptors: Primary Health Care. Masculinity. Gender. Men's Health.

Objetivo: conhecer os discursos de homens sobre o acesso à saúde na Atenção Básica. Método: estudo descritivo, realizado em dezembro de 2016 com 20 usuários da Atenção Básica do município de Cajazeiras, Paraíba, Brasil. Adotou-se como recurso metodológico a Análise de Discurso. Resultados: dos discursos emergiram as categorias: dificuldade em discernir as funções da Atenção Básica; exaltação do modelo biomédico; prática da medicalização; fatores de afastamentos do serviço; ausência de ações e programas destinadas aos homens; e divergência entre masculinidade e feminilidade. Conclusão: os discursos masculinos ratificaram a necessidade de reorientação de saberes e práticas dos serviços de saúde para ampliar o acesso da população masculina na Atenção Básica.

Descritores: Atenção Primária à Saúde. Masculinidade. Gênero. Saúde do Homem.

Objetivo: conocer los discursos de hombres sobre el acceso a la salud en la Atención Primaria. Método: estudio descriptivo realizado con 20 usuarios de la Atención Primaria de la ciudad de Cajazeiras, Paraíba, Brasil, en diciembre 2016. El Análisis del Discurso fue el recurso metodológico adoptado. Resultados: las siguientes categorías

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emergieron de los discursos: dificultad en reconocer las funciones de la Atención Primaria; exaltación del modelo biomédico; práctica de medicalización; factores de distanciamiento del servicio; ausencia de acciones y programas destinados a los hombres; y diferencias entre masculinidad y feminidad. Conclusión: los discursos masculinos ratificaron que es necesario reorientar saberes y prácticas de los servicios de salud para ampliar el acceso de la población masculina a la Atención Primaria.

Descriptores: Atención Primaria de Salud. Masculinidad. Género. Salud del Hombre.

Introduction

Men's healthcare has been increasingly present as a part of the actions promoted by Primary Healthcare (PH), which leads to the broadening of discussions with regards to this new perspective. However, despite this recent advance, shortcomings are still observed in health actions offered to this part of the public, especially due to the lack of understanding of specific care for these social actors.

Since the needs of this public often go unperceived in PH services, that means that a part of the population is excluded from the routine of assistance. This setting ends up encouraging men to seek health services only when health problems and diseases are already set in, especially in emergency and/or urgency situations, requiring specialized and high-complexity care[1-3].

It also stands out that the unequal construction of gender, which gives support to the social belief that men are stronger than women and, as a result, do not get sick nor need care, interferes in their access to health services[4]. This explains the high rates of morbidity and mortality and health problems in men when compared to women[5].

Considering this perspective, the Ministry of Health implanted, in August 27, 2009, the National Policy for the Integral Care to Men's Health (PNAISH)[6], which aims to recognize the need for the individual to be integrally represented in the PH setting, reducing the risk factors responsible for the high rates of male morbidity and mortality. This policy takes part in issues about gender concepts, aiming to offer better health conditions for this public.

Discussions about men's health reflect the extreme need to seek improvement in the validation of the precepts reinvigorated by the PNAISH. The insertion of this public in healthcare actions implies, directly and positively, in the modification of mortality and morbidity rates, and in the gender signification which historically and culturally is in effect in our society.

The relevance of this study is in the fact that it brings forth the need for offering integral healthcare to men, in a context capable of bringing the male population to the health setting, with support of staff, management, teaching, and research, encouraging explanations that aim to solve or minimize this problem.

As a result, the guiding question of this research emerges: What are the discourses of men about the access to health in the field of Primary Healthcare? This study aims to get to know the discourses of men about the access to health care in Primary Healthcare.

Method

This is a descriptive, qualitative study, with 20 users from the Primary Healthcare of the city Cajazeiras, Paraíba, Brazil. Data collection took place in December 2016, through the application of a semi-structured interview in a reserved room within the health service facility itself. Were included men who were registered for at least one year in the Family Health Strategy (ESF). Were excluded men who were seeking the service as the companions of other users.

The information found by this study was examined using Discourse Analysis (DA).

This interpretative aspect enables better understanding of man as individuals who are capable of producing meaning and producing the meaning they have themselves[7]. The DA has consistent features, such as the way in which data is interpreted, which can attend to the objectives of the research and seek the meanings that are produced and immersed in the social and historical context. It has three stages: going from the linguistic surface to the object of the discourse; going from the object of the discourse to the discursive process; and going from the discursive process to the ideological formation[7].

The anonymity of participants was kept using alphanumerical codes built using the letter M, for man, followed by a number. The study started after approved by the Research Ethics Committee of the Universidade Federal de Campina Grande, campus Cajazeiras, under Protocol 1.844.255. The ethical precepts that direct the stages of the study are in accordance to Resolution 466/2012, from the National Council of Health[8].

Results

The enunciations that are part of this study are firmly based on the discursive formations shown below, which go towards an ideological formation that acts as backdrop and base of the discourses of social actors. Forged within these representations, the biomedical model revokes the guidelines that generate and structure the practices that focus on the process of becoming ill and on the person as a subject. Considering this context, it is possible to see, in the discourses, the understanding of users with regards to the functions of the PH for the male public:

> *Man, I think the unit here is very good, they attend well* [Who is attended well? Men? Women?] *People come here and register and are well attended, I don't have anything bad to say about the unit. Yeah... I think the unit is very good and deserves an A.* (M3).

> *We come here to the unit. I can't complain about anything at all. I have nothing to complain about. Look here, I've already been attended.* (M5).

The presence of polysemy can be noted, as it manifests a contradiction around the understanding about the setting that makes up the PH for the male population.

> *To prevent some disease, right? Actually, I've been visiting the health unit a lot in the last six years. I came to this one, here, about ten times.* (M10).

> *For men? I think that not only for men, but for everyone, it's to help, right? An institution that offers support to the others, for instance, in the case of the UPA. There they offer more urgent care; here the attention you get is to measure blood pressure, this simpler type of attention. As far as I understand, right?* (M14).

Throughout this investigation, it became clear, through repetition, which was anchored in paraphrastic, or even metaphoric discourse, that the PH setting was a space for assistance in cases of health deterioration. The search for alternative methods was mentioned as a justification to not seek care.

> [...] *God helps me. And I worry more about the others, too. Then in these cases I sometimes don't like to come to the health unit so much. I just take a pill for the headache at once, I take. Once they showed a charm to stop headaches on television, for migraines, right? You drink the water of the beans with no seasoning three Fridays. Oh! I wanted, I did it.* (M17).

> *Man, it's when the case is bigger, right?* [What cases would that be?] *A bigger health problem. When it's something small we shrug it off. When it's something bigger, blood pressure things, then the doctor has to see it, right?* [...] *Shrugging it of I mean, the person avoids being on the doctor's neck, takes a med here, other things, right? So you're not on the doctors neck all the time. Being at the doctor's neck all the time is good, but they say it's good, but when you don't seek the doctor, sometimes a bigger health problem is there, right? Then the bloke* [the person] *starts to care and it's late. That's how I've been me whole life, right? I never liked breathing on the neck of the doctors.* (M16).

The discourse of participants denotes the resonance of factors that directly interfere in their going to the service.

> *What bothers me is how long it takes. The waiting. A lot of time, the bloke* [the person] *drinks his tea cold. If the bloke* [the person] *doesn't wait, you feel like leaving.* (M4).

> *It's time, and it's also work, and there's work too, and the bloke* [the person] *who doesn't care about it doesn't have it... Leave it* [health] *behind, right? And comes when the disease comes, when they feel bad.* (M9).

Ingrained in these problems, in this research, is the lack of actions targeted at the male population that stands out, which directly interferes in the accessibility and presence of this population group in this field of assistance.

> *I think it's not much. Yeah... I think if it you think from a hundred percent, ninety are women. Cause they need it more* [Why do women need it more? And men, don't they have the same needs?] *I mean the women they seek more the health units. We, not that much. Sometimes we do, and when we do they don't have what we want. Sometimes a medicine, something. And then you have to use your money, sometimes even if you can't. Take it from your table, the mouth of your child, from a business, a grocery day, from the gas, the cooking gas, so you can keep yourself. Because the government doesn't offer good health.* (M2).

> *Man that's more the prostate thing, that, right? That old cataract they do in these actions. The virus of AIDS, tuberculosis, that's it.* (M4).

The divergence between masculinity and femininity must be considered, which is highlighted in the health field and in the interposed gender relations and connotations, configuring the absence of the masculine in the health unit.

> *Women are better attended* [Why are they attended better?] *Always, everywhere, women have privileges* [What would be these privileges available for women?] *And in the health units especially. I mean, let's imagine... If the treatment was the same to the women, but for the men* [What should be equal in the attention?] *Because there is always that problem* [What problem?] *because... Change, right? This atmosphere* [What atmosphere?] *right? Men, women. That everyone should treat, everyone the same, equally. The great treatment. It's like they say: the medicine, as soon as it arrives, we make your form, you're attended, take the medication at the right times. But it's hard for us to find that.* (M2).

Discussion

The discourses enable the apprehension of the meaning the men attributed to the PH, to the goings on of their relations with the service, and to understand which actions enable this population group to get involved in the health environment. The explanation allows to show the results that have a common focal point: the subversion of the hygienist model of discourses.

As an initial characteristic, there is a restrict vision about the principles that corroborate the function of the PH in the health field[3-4,9], since the service ends up not being understood by the population as a first instance resource. However, researches assert that it is specifically the first place for population attention and support, in addition to their capacity of effectively dealing with a high demand for health[10]. It is also a base where the flow of network care and the complexity of activities that each network setting involves are founded[10].

Even as a prelude for the understanding about the service, the medical and biological paradigm resonate in the social perception of health and PH, which refer to the assistance chain that still reverberates and interferes in the vision and formulation of the concept whose relation to the practices of care is observed. Therefore, the traditional biomedical model has central demarcations in the uni-causality of the process of health and disease, promulgating a service that is rooted in fragmentation, prescription, reductionism, and in a curative focus with regards to the aspects of health[11].

The focus on the biomedical model is directed towards the prevalence of technical efficiency in regards to a therapeutic practice that can answer to the demands presented[12]. In this traditional chain, a mechanistic point of view is considered superior, according to which the body is treated practically in both objective and study terms, having solidity in an "embrace" which involves and domesticates men, conditioning them to a certain posture defended by them, by the professionals and the management with regards to the services that need to be offered to this public.

Anchored in this conception are reflexes concerning the presence and/or search for the service by the male population. In this setting, a dialogue between methods emerges and justifies the absence of thesea men from the spaces of health, as observed in the reports according to which they resort to other means to seek health. They also structure the ideal of cure through non-professional recommendations, referring to other resources that materialize their distancing from the service and that, in their imaginary, echo the same effect that could be obtained with professional help. In consonance to this result, the study found that the participants used teas and self-medication as alternative resources so they would not seek health attention[4].

Therefore, it stands out that men prefer other health services, among which are: emergency

attention, pharmacy, and urgency[13-14]. These correspond more objectively to their demands, and there they are cared for faster when it is a problem that can be solved easily.

It should be noted that the time, the wait, and work directly interfere in the presence of this public in the attention settings. The difficulty these individuals have seeking services stand out, since they only do so when the signs and symptoms tend to aggravate and compromise their daily life activities[14-15]. Authors have listed other elements that are involved in this framework, such as: working hours of the attention service, lack of patient vacancy, absence of exams, difficulties in receiving attention, and long lines[16-17].

From the discourses, it can be apprehended that participants externalize their (lack of) knowledge about the existence of actions that guarantee interventions in the field of men's health. This is noticed when they mention other programs and ministerial actions, in which masculine specificity and representativity are not evidenced and/or central[12]. The fact that participants cannot describe the actions offered to their own specific public is a reflection of their distance from the services. After all, the attention that targets men, oftentimes, is not a part of the PH daily scheduled activities, which are based on attention offered to the cycles of life and the conditions/state of the health of the individual[17].

From this same point of view, it stands out, from the statements of the participants, the praising of women as those who require more care, which highlights the symbolism of gender frailty. The deepening of the discourses shows the existence of a historical-dialectic relation reiterated with regards to the social stigma rooted in the conception about the masculine. This can be noted throughout the discourses, when other programs and ministerial actions end up being described, and in them, masculine specificities are not evidenced.

Understanding the models of masculinity and femininity that are prevalent in society and in gender relations gives potential to the instances of the government and their ability to produce and implement actions and programs in the field of public health, programs that can be more in line with the ways to act socially in accordance to gender relations[5]. Another option, to deal with this demand, is for professionals and managers to articulate health policies in which men are the protagonists, to encourage actions that recognize the specificities of this population group, aiming to offer integral assistance to it[18]. To this end, it is paramount to deconstruct the understanding of men as victimized and guilty for their diseases and, as a result, it is urgent to restructure and organize health settings[19].

Finally, it stands out that, despite the consistent permanence of a curative model in the health sectors, the main conjuncture, which can help promote or attract males to the health settings, involves thinking the service as a space for the production of care, which can add new possibilities of actions and services to the biomedical model, and act as a structuring axis for light technologies.

The results of this study are limited, since it was developed in the ESF of only one city, and cannot be generalized, since they strongly depend on the health dynamics of the region studied.

Conclusion

The analysis of male discourses showed that knowledge and practices of health services need to be re-oriented to broaden the access of the male population to Primary Healthcare. The aspects that resonate in the access that the masculine population has to the PH service, as expressed by their discourses, evidenced gaps with regards to the understanding of the function of said health service, the preponderance of the biomedical paradigm, and search for alternative methods such as quality in health, the absence of actions targeted at the male public, and the connotation of the social-historical-cultural process with regards to gender differences in health attention.

The need for offering integral healthcare to men's health, in a context capable of bringing the male population to the health setting, stands

out in such a way that workers, managers, and users understand and think of the service as a space to produce care. It is also important to add new possibilities and actions and programs, as a framework of structuring axes for attention technologies and under presuppositions that reiterate the philosophy of SUS.

Collaborations:

1 – conception, design, analysis and interpretation of data: Bruno Dias Batista, Mayara Evangelista de Andrade and Marília Moreira Torres Gadelha;

2 – writing of the article and relevant critical review of the intellectual content: Jéssica Mayara Almeida Silva, Petra Kelly Rabelo de Sousa Fernandes and Marcelo Costa Fernandes;

3 – final approval of the version to be published: Bruno Dias Batista and Marcelo Costa Fernandes.

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