

# Male access to health services in primary care: utopia or reality?

Acesso dos homens aos serviços de saúde da atenção primária: utopia ou realidade?

*El acceso de los hombres a los servicios de salud de la atención primaria: ¿Utopía o realidad?*

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## Abstract

**Introduction:** The National Policy for Comprehensive Men's Health Care was implemented in 2009 and intends to reducing barriers to the access of the male population to health care services.

**Objective:** This study aimed to analyze men's access to health care services belonging to Family Health Strategy in the countryside of Bahia, considering organizational and technical dimensions.

**Methods:** This is qualitative study, carried out in Family Health Care Units in a district of Bahia, in which 4 health care providers and 10 health service users participated. The data was collected by semi-structured interviews and analyzed by thematic analyses of content. The research was in accordance with Resolution n. 466, from December 12, 2012, and n. 580, from March 22, 2018. It was approved by Certificate of Presentation for Ethical Review (CAAE) N.01439012.1.0000.0053.

**Results:** The results reveal that male seeking of health care services in primary care is still low. There is a lack of planning for actions directed towards men by the health team, which is limited to addressing spontaneous demands, with occasional campaigns such as "Blue November". The workers reported difficulties in establishing a relationship with users, especially with young men.

**Conclusions:** The study shows that male access to health care in Family Health Care Units falls short. This happens because: the team's lack of planning around the needs of this population group, little understanding of men's health-illness process, geographical access difficulties, incompatibility between unit's opening times and working hours, inadequate reception and lack of bonding between patients and workers. So, 15 years after the establishment of the Policy, assistance gaps still persist when it comes to male health.

**Keywords:** Primary Health Care; Male health; Health services accessibility.

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## Resumo

**Introdução:** A Política Nacional de Atenção Integral à Saúde do Homem implementada em 2009 visa diminuir barreiras de acesso da população masculina aos serviços de saúde. **Objetivo:** Este estudo objetivou analisar o acesso de homens aos serviços de saúde da Estratégia Saúde da Família em um município do interior da Bahia, sob as dimensões organizacional e técnica. **Métodos:** Estudo qualitativo, realizado em Unidades de Saúde da Família de um município da Bahia, do qual participaram quatro trabalhadores de saúde e dez usuários. Os dados foram coletados por entrevista semiestruturada e analisados por análise de conteúdo temática. A pesquisa obedeceu às Resoluções nº 466, de 12 de dezembro de 2012, e nº 580, de 22 de março de 2018, e foi aprovada sob Certificado de Apresentação para Apreciação Ética (CAAE) nº 01439012.1.0000.0053. **Resultados:** Os resultados revelam que a procura dos homens pelos serviços da atenção primária ainda é baixa. Existe falta de planejamento de ações direcionadas aos homens pela equipe de saúde, resumindo-se ao atendimento da demanda espontânea, com campanhas pontuais como “novembro azul”. Os trabalhadores revelaram dificuldades de estabelecer vínculo com os usuários, principalmente os jovens. **Conclusões:** O estudo mostra que o acesso dos homens aos cuidados em saúde nas unidades de saúde da família é pequeno. Isso se dá pela falta de planejamento das equipes de saúde com relação às necessidades desta população, pouca compreensão do processo saúde-doença pelos homens, dificuldades de acesso geográfico, horário de funcionamento das unidades incompatível com a jornada laboral dos homens, acolhimento inadequado e não estabelecimento de vínculo entre equipe e usuários. Assim, passados 15 anos da aprovação da política, ainda persistem as lacunas assistenciais a esta população.

**Palavras-chave:** Atenção Primária à Saúde; Saúde do homem; Acesso aos serviços de saúde.

## Resumen

**Introducción:** La Política Nacional de Atención Integral a la Salud del Hombre implementada en 2009 tiene como objetivo reducir las barreras de acceso de la población masculina a los servicios de salud. **Objetivo:** Este estudio tuvo como objetivo analizar el acceso de los hombres a los servicios de salud de la Estrategia Salud de la Familia en un municipio del interior de Bahía, según las dimensiones organizativa y técnica. **Métodos:** Estudio cualitativo, realizado en Unidades de Salud de la Familia en un municipio de Bahía, participaron 4 trabajadores de salud y 10 usuarios. Los datos fueron recolectados mediante entrevistas semiestructuradas y analizados mediante análisis de contenido temático. La investigación cumplió con las Resoluciones nº 466 de 12 de diciembre de 2012 y nº 580, de 22 de marzo de 2018, aprobadas bajo CAE N.01439012.1.0000.0053. **Resultados:** Los resultados revelan que la demanda de servicios de atención primaria por parte de los hombres aún es baja. Falta planificación de acciones dirigidas a los hombres por parte del equipo de salud, que se limita a servir a la demanda espontánea, con campañas específicas como el “Noviembre azul”. Los trabajadores revelaron dificultades para establecer vínculos con los usuarios, especialmente los jóvenes. **Conclusiones:** El estudio muestra que el acceso de los hombres a la atención de salud en las unidades de salud de la familia es limitado. Esto se debe a la falta de planificación por parte de los equipos de salud con relación a las necesidades de esta población, poca comprensión del proceso salud-enfermedad experimentado por los hombres, dificultades de acceso geográfico, horarios de apertura de las unidades incompatibles con las horas laborales de los hombres, recepción inadecuada y falta de establecimiento de vínculos entre el equipo y los usuarios. Así, a 15 años de la aprobación de la política, aún persisten brechas en la atención a esta población.

**Palabras clave:** Atención Primaria de Salud; Salud del hombre; Accesibilidad a los servicios de salud.

## INTRODUCTION

The National Policy for Comprehensive Men’s Health Care (PNAISH), implemented in 2009 in Brazil, aims to ensure men’s access to Primary Health Care (PHC) services and, consequently, reduce access barriers. It is important to highlight that this demographic group has a socio-historical background characterized by low demand for health services.<sup>1,2</sup>

Access to health services can be analyzed from various dimensions; the organizational dimension encompasses the point of entry, the flow of care, geographic barriers, and regulation/referencing/counter-referencing. On the other hand, the technical dimension focuses on the comprehensiveness of care, reception, relationship-building, competence/skill, commitment, and quality of care.<sup>3</sup>

Historically, women’s and children’s health care has specific policies, in contrast to the topic of male health, which only began to be discussed with the implementation of the PNAISH.<sup>2</sup> Thus, it is evident that

men's health is still rarely addressed and largely unknown to society, creating gaps in assistance within health services.<sup>4,5</sup>

It is important to highlight that there are various factors contributing to the low demand for health services by men; however, this deficit should not be attributed solely to men's lack of responsibility for their health, but also to the (dis)organization of health care models, especially PHC. Studies show that most men do not understand the health-disease process.<sup>6,7</sup>

The Unified Health System (SUS) considers PHC as a reference for coordinating and organizing care. In this context, the Family Health Strategy (FHS) is the main point of health care, and its expansion can be regarded as an important policy for increasing access to health services.<sup>8-10</sup>

However, when it comes to men's health care, access may be affected by the inadequacy of the PHC units' structure, as well as a lack of motivation and the development of promotional actions against the most common health issues in this population.<sup>5,10-13</sup>

Furthermore, in many places, health workers are unaware of the PNAISH and have limited knowledge about the relationship between men and health services, which leads to discourses by the health team that blame men for the weak ties with the FHS. This can compromise the effectiveness of care and the comprehensiveness of attention.<sup>10,12</sup>

In light of the above, this study aimed to analyze men's access to health services offered by the FHS in a municipality in the countryside of Bahia, focusing on the organizational and technical dimensions of access.

## METHODS

This is a qualitative study, and the *Consolidated Criteria for Reporting Qualitative Research* (COREQ)<sup>14</sup> was used to write this research. The study was conducted in a large municipality in the countryside of Bahia, where the main cause of mortality is diseases of the circulatory system, followed by neoplasms (IBGE).<sup>15</sup> The data were collected in two rural Family Health units and two urban Family Health units. The urban units serve approximately 2,500 families each; one of the rural units serves 2,475 families, while the other serves 2,366 families. However, the coverage area of both is extensive, with villages located far from the Family Health Units (FHU).

As a technique for data collection, semi-structured interviews were chosen, using a specific guide for health workers that includes questions directed at the work process and health care for male users, as well as a specific guide for male users with questions about access to services (facilitators and barriers), relationship with the health team, and reception. The study sample was intentionally defined and consisted of two groups: Group I – composed of health workers active in the FHS for more than six months (doctors, nurses, and nursing technicians), represented in the text by the letter T followed by an ascending ordinal number according to the order of the interviews; and Group II – made up of male users over 18 years old, residing in the coverage areas of the studied USF, registered for more than six months, represented by the letter U followed by an ascending ordinal number using the same criteria. The total number of participants was 14, comprising four health workers and ten service users, and this number was determined through data saturation.<sup>16</sup> Table 1 presents the socioeconomic characteristics of the study participants.

The data were analyzed using the thematic content analysis method.<sup>17</sup> The research adhered to Resolutions No. 466, dated December 12, 2012,<sup>18</sup> and No. 580, dated March 22, 2018,<sup>19</sup> and was approved under the Certificate of Presentation for Ethical Review (CAAE) No. 01439012.1.0000.0053.

**Table 1.** Socioeconomic characterization of the study participants.

Participant	Gender	Age	Schooling	Profession/Occupation
W1	Female	51	Complete Higher Education	Nurse
W2	Female	34	Technical Education	Nursing technician
W3	Female	26	Technical Education	Nursing technician
W4	Female	28	Complete Higher Education	Nurse
U1	Male	29	Incomplete elementar school	Carpenter
U2	Male	82	Illiterate	Retired
U3	Male	27	Complete high school	Merchant
U4	Male	45	Incomplete high school	Farmer
U5	Male	54	Incomplete elementary school	Farmer
U6	Male	55	Complete elementar school	Wall painter
U7	Male	38	Complete high school	Driver
U8	Male	44	Complete high school	Salesperson
U9	Male	40	Complete high school	General services assistant
U10	Male	51	Complete elementar school	Farmer

## RESULTS

From the analysis of the data, two thematic categories emerged: 1) access of the male population to the Family Health program: they only seek care when they are ill; 2) the establishment of relationships and reception: to what extent can frequency foster closeness?

### Access of the male population to the Family Health Strategy: they only seek care when they are ill

The reports from health workers reveal that the demand for health actions/services from the FHUs is predominantly female, despite the strategies employed by the team to change men's perspectives on the functionality of the health unit. In this case, only the workers from one unit reported offering specific services to engage this population, enabling them to attend the FHU regularly, such as hosting sports activities and scheduling events outside of regular working hours.

The implementation of specific actions to attract male audiences to health units represents an important tool for achieving this goal. However, such activities were not common across all the studied units, and none of them had a strategic plan for actions aimed at men's health; the activities carried out were sporadic and took place in only one FHU.

Regarding the operating hours of the health unit, a factor that presents a difficulty for men's access to health units, the interviewees describe that:

*The schedule often does not coincide; sometimes they arrive at 4 PM to get a tetanus shot, but it closes 15 minutes earlier. The clinic closes at 4 PM, so they can no longer be assisted (W2).*

*I work all week; I'm only here on the weekend (U2).*

*Some of the men here in the countryside work in the municipality's headquarters, so often they do not have the opportunity to come to the unit. Unless they miss work, the vast majority do not come (W4).*

The above statements highlight difficulties for men's care due to the operating hours of the unit, which coincide with their work activities.

On the other hand, older men with chronic diseases, likely retirees, participated more actively in activities at the FHU through groups aimed at hypertensive and diabetic patients.

However, these groups do not focus health education on preventing health issues exclusive to men, as they concentrate more on hypertension and diabetes. Thus, this type of health education activity assists in the management and treatment of these diseases for men who are already ill, but it does not encompass the male population in general in terms of preventing these conditions:

*We hold groups for hypertension and diabetes; men participate, but it is not exclusively targeted at men. When we organize activities specifically for men, we have low attendance (W1).*

Among the few activities offered for men are waiting rooms and health campaigns, such as "Blue NOvember", which are sporadic educational activities conducted by the teams focused on themes like the prevention of sexually transmitted infections and prostate cancer. However, workers report little receptiveness from men towards preventive activities, especially health education:

*They come for the appointments they scheduled, but to sit and listen, no (W1). No, they do not like preventive activities. They don't like lectures; they're impatient and do not participate (W2).*

Thus, as there is a lack of planning for the execution of actions directed at the male population by the health team, the offerings are limited to addressing spontaneous demands, with no organized activities aimed at men's health, except for occasional campaigns.

In general, men only seek the FHU when they are ill. This statement is prevalent in the majority of the responses from the interviewed subjects, regardless of whether they are users or health workers.

*They come like this, when they are ill; they don't come for prevention. They only come for curative care, not for prevention (W4).*

*They come when they need to [...] according to their needs, when they feel high blood pressure, or something with their prostate, fever, something like that, but nothing that has a reserved time slot or is part of the organized demand of the service (W2).*

*Because men only tend to seek the doctor when they are very ill. I speak for myself, as I only go to the doctor when I am really sick and can't take it anymore (U1).*

Ultimately, the demands are related to health needs, where symptoms perceived as significant lead to the search for services. Thus, men's demand for health units is primarily characterized as being free or spontaneous.

When it comes to organized demand, such as scheduling appointments and exams, it is usually the men's family members, such as partners or parents, who make the arrangements:

*If he cannot come to schedule, he has the option to send someone to make the appointment for him, so he doesn't have to lose two days (W3).*

*The convenience is that when I'm at home sick, my father comes over and makes the appointment for me (U6).*

*It's usually a family member who makes the appointment, like a mother or wife. They come more at the time of the appointment, then they see the doctor, get the exams done. Sometimes, when it's time to submit the results, the patient doesn't even come; it's the mother who comes. 'Look, doctor, so-and-so did the exams and brought them for you to see his results' (W4).*

Regarding geographic access, all the men reported having no difficulties getting to the FHU. They usually use motorcycles, bicycles, horses, or, depending on the distance, they walk. However, in the rural units, where the coverage area is larger, the distance to reach the unit can represent a barrier to access:

*Some come walking, others come by bicycle, some come by motorcycle, and others by car. Public transport here is very difficult because this is a rural area, and some people live far away. The vast majority walk (W2).*

*For me, it's not difficult because I live close by. But for the general population here in the countryside, many live far away. There's only one unit for all of this (U7).*

## **Relationship and reception: determinants for male users' access to the Family Health Strategy.**

The relationship and reception are essential components of PHC. Regarding reception, health workers believe that they treat men and women equally. However, since the demand for services by men is lower, some workers understand that there is no reception specifically directed at men. The relationship between the team and users emerges when discussing the establishment of bonds in the FHU. In this regard, the relationship with the health team was considered good by the interviewed users, especially those who frequented the unit more regularly, such as those with some type of chronic illness.

On the other hand, among younger men, the bond with the team is practically nonexistent. This situation may occur because this demographic visits the unit less frequently due to work schedule issues or does not feel attracted to the actions and services offered, in addition to not having a chronic illness diagnosis that requires continuous follow-up.

The difficulty reported by workers in establishing a bond with male users is generally related to subjective issues, such as the perception that men are more reserved. This hinders the creation of bonds, especially with the health team, which is predominantly female. This is reflected in their statements:

*They feel withdrawn, and we don't do much to welcome them either (W1).*

*In terms of care, we can already see the issue with men; we can sense their shame and their feelings about themselves, so we try to be welcoming to help make them feel at ease (W3).*

In light of this reality, it is essential to recognize that reception is a powerful tool that facilitates the establishment of relationships.

Cultural issues are considered barriers to access. This is because, from the statements, we can gather that men seek the health unit less frequently and only do so in the presence of illnesses.

*I don't go; I only go when I'm really bad, like about to collapse (U3).*

*Men don't really like to come to the clinic. They only come when they need to due to illness (W2) . You have to work; we forget about our health, just going through life thinking, 'I'm fine.' Just going on. Working, working, and when I really can't take it anymore, then my wife takes me to the doctor (U6).*

Some characteristics, such as shyness and embarrassment, are noted by health workers and considered obstacles to establishing a bond between the health team and men:

*I wouldn't even say there's interest; you can see it's more like insecurity. I don't know if it's a masculine trait, but you can see there is insecurity and embarrassment (W3).*

*I think some men have that cultural idea of wanting to be seen by a male provider. They feel embarrassed discussing certain things with me as a woman. When I notice that he is shy about talking to me about certain intimate subjects, I refer him to the doctor (W4).*

*On the other hand, when men seek the service, they feel welcomed by the team:*

*For me, I am well received. Not just for me, but for everyone as well, as I have seen. I pay attention to that; everyone is welcomed. The people who come just don't know how to organize themselves (U6).*

*I was embarrassed, but after I came the first time and the staff welcomed me well, I come whenever I need to (U8).*

## DISCUSSION

There are numerous factors that can influence access to health services by the population, including those related to the morbidity and severity of the illness, socioeconomic and cultural factors, the services offered, service providers, among others.<sup>20</sup> Historically, the male population has not been among those most served by PHC, and in this context, the FHS has primarily focused its actions on women and children, even with the approval of the PNAISH in 2009.<sup>1</sup>

Regarding the organizational dimension of access, factors such as the team's workflow, the provision of services demanded by the population at convenient times for them, the geographical location of the unit, and comprehensive care for health needs can negatively and/or positively impact men's access to health units.<sup>3</sup>

It is important to highlight that the geographical access barrier is strongly connected to economic factors. Thus, social vulnerability and living in areas far from the unit can be attributes that hinder men's search for health units, thereby affecting their effectiveness.<sup>21,22</sup>

The results of this study reveal that men's demand for services offered by the family health teams in the studied municipality is still low, particularly among young adults who are still of working age, and it is limited to assistance for health issues and illnesses perceived by them. Similarly, other studies conducted in Brazil have identified the same profile of service demand, emphasizing the search for treatment of sexually transmitted diseases, erectile dysfunction, and specialized care for other health issues.<sup>2,5,21,23-25</sup>

In fact, men typically do not have a culture of self-care and, therefore, do not visit health services as frequently as women, especially in PHC. This often leads family members to take on the role of seeking care and scheduling appointments.<sup>2,5,22,24</sup>

An existing cultural reality is that some men who visit the FHU are brought in by their partners, especially for consultations/interviews regarding tubal ligation or vasectomy as part of family planning

activities. Studies show that a small number of men access the unit to seek services such as blood pressure measurement or male condoms, and during these moments, health workers take the opportunity to provide them with guidance on disease prevention in general.<sup>20,23</sup>

Implementing specific actions to attract this audience, such as educational and recreational activities and offering other procedures, can be a strategy to overcome the access barriers faced by men.<sup>2</sup>

However, the lack of planning for the execution of actions aimed at the male population by the health team is a reality, and activities targeted at this group are limited to addressing spontaneous demands, without an organized focus on men's health. The exceptions are occasional campaigns, such as "Blue November", concerning prostate cancer prevention, and the distribution of condoms. Similar results have been found in various regions of the country<sup>22,23,25,26</sup> and point to the limited knowledge of health workers regarding the PNAISH. They also show that activities related to the care, prevention, and promotion of men's health developed in Primary Health Care (PHC) and the processes for implementing men's health care are in their early stages, with existing gaps in assistance. This has hindered access to health services for the male population, moving away from the goals of the Policy.<sup>27,28</sup>

Thus, the difficulties in devising strategies to change the pattern of non-seeking behavior and, consequently, the integration of men into Primary Health Care (PHC) services are evident. This is because certain characteristics contribute to building this barrier, such as fear, lack of time, machismo behavior, and the lack of training among the health team<sup>22,25,29</sup> However, there are successful experiences aimed at attracting men to health units, such as the creation of men's health pamphlets that provide information on issues pertinent to this population, promotion by micro-area to form operational groups with interdisciplinary activities, and training Community Health Workers to implement popular health education strategies.<sup>30</sup>

The technical dimension of access focuses on the comprehensiveness of care, meaning it directs actions to meet the health needs of users and should be accompanied by care tools such as reception, relationship-building, competence/skill, commitment, and quality of care.<sup>3</sup>

Therefore, for health services to provide comprehensive care, it is necessary to implement reception in the practices and actions of health services. This strengthens the bond between health workers and the population, which can facilitate service utilization and ensure effective solutions that achieve comprehensiveness.<sup>31</sup>

Thus, reception primarily aims to reorganize the service to ensure universal access, effectiveness, and humanized care. Always providing a positive response to the health issue presented by the user embodies the core idea of reception, which has been established as an operational guideline.<sup>32</sup>

In this aspect, workers revealed difficulties in establishing a bond with male users, particularly younger ones, as this age group visits health units less frequently. However, they did not express any plans or strategies to make the unit more attractive and accessible to this population, including the implementation of promotional actions against the most common health issues facing men. Other studies show that the discourse of blaming men for the weak ties with the FHS is present among health team workers, as well as the invisibility of men's needs and demands in PHC due to gender stereotypes.<sup>22,23,25,26</sup>

Thus, the historical and social construction of machismo is a structural element that influences men not to seek health services, neither for general care nor for health promotion and prevention activities. Additionally, organizational issues in PHC, such as operating hours, contribute to this situation.<sup>25</sup>

The organizational models of health services that lack flexibility and operate under a vertical approach perpetuate the hegemonic model and do not reach new perspectives, which in this case are strategies that can truly encompass the male reality while also seeking the engagement of this population. In light of this, new forms of health planning must be considered, especially in PHC.<sup>8,9,33</sup>

This study had limitations regarding the number of units analyzed in relation to the total number of units within the studied municipality; however, it included units from both urban and rural areas.

## CONCLUSION

The study shows that men's access to and participation in the actions and services provided at Family Health Units are still limited. The reasons for this absence include a lack of awareness and planning by health teams regarding the health needs and demands of this population, men's misunderstanding of the health-disease process, geographic access difficulties to health units, operating hours that are incompatible with the routines of economically active men, inadequate reception, and the failure to establish a bond between health workers and users.

The findings indicate a reality similar to that found in other regions of the country, thereby contributing to the debate on the weaknesses of men's health care in Primary Health Care (PHC) in Brazil — which seeks to motivate health workers to reassess their practices within the framework of the PNAISH and contribute to reversing the morbidity and mortality rates of this population.

Thus, 15 years after the approval of the PNAISH, gaps in assistance for this population in PHC still persist. This reality demands critical reflection from family health team workers regarding their ability to welcome and meet the real demands of these health system users.

## CONFLICT OF INTERESTS

Nothing to declare.

## AUTHORS' CONTRIBUTIONS

LCFO: Concept, Data Curatorship, Formal Analysis, Fundraising, Investigation, Methodology, Project Administration, Resources, Supervision, Visualization, Writing – First Draft, Writing – Review and Editing. JALL: Concept, Data Curatorship, Formal Analysis, Fundraising, Investigation, Methodology, Resources, Supervision, Visualization, Writing – First Draft, Writing – Review and Editing. MCS: Concept, Data Curatorship, Formal Analysis, Investigation, Methodology, Visualization, Writing – First Draft, Writing – Review and Editing. MFFO: Data Curatorship, Formal Analysis, Investigation, Visualization, Writing – First Draft, Writing – Review and Editing. ALNJ: Data Curatorship, Formal Analysis, Investigation, Visualization, Writing – First Draft, Writing – Review and Editing.

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