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O acesso do homem ao serviço de saúde na atenção primária

Man's access to health services in primary care

Acceso del hombre a servicios de salud en atención primaria

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ABSTRACT

Objective: To investigate the factors that influence man's access to health services in primary care. **Method:** It is a descriptive and exploratory study, with a qualitative approach, carried out with eight men through focus group in October 2010. The data was analyzed based on the technique of the Collective Subject Discourse. **Results:** The users expressed precarious investment in the service organization from a gender perspective, reinforcing common sense that men are not the primary users, and remain subsidized by a patriarchal ideology. **Conclusion:** It is necessary to think about determining socio-historical-cultural ways of life, illness and death of the today's man, and to establish a new paradigm men's health in modern life.

Descriptors: Men's health, primary health care, gender identity, nursing.

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RESUMO

Objetivo: Investigar os aspectos que influenciam no acesso do homem ao serviço de saúde da atenção primária. **Método:** Trata-se de um estudo exploratório descritivo, com abordagem qualitativa, realizado com oito homens por meio de grupo focal em outubro de 2010. Os dados foram analisados com base na técnica do Discurso de Sujeito Coletivo.

Resultados: Os usuários expressaram pouco investimento na organização do serviço numa perspectiva de gênero, reforçando o senso comum de que os homens não são usuários da atenção primária, tendo ainda uma ideologia subsidiada pelo patriarcado. **Conclusão:** É preciso pensar nos determinantes sócio-históricos-culturais dos modos de viver, adoecer e morrer do homem na atualidade e instaurar um novo paradigma acerca da saúde do homem na vida moderna.

Descritores: Saúde do Homem, atenção primária à saúde, identidade de gênero, enfermagem.

RESUMEN

Objetivo: Investigar los factores que influyen en el acceso del hombre a los servicios de salud en atención primaria. **Método:** Se trata de un estudio exploratorio descriptivo con enfoque cualitativo, realizado con ocho hombres a través de grupos focales en octubre de 2010. Los datos fueron analizados sobre la base de la técnica del Discurso del Sujeto Colectivo. **Resultados:** Los usuarios expresaron su poca inversión en la organización de servicio a partir de una perspectiva de género refuerza la creencia convencional de que los hombres no son los principales usuarios, e incluso subvencionados por un patriarcado ideología. **Conclusión:** Ha que pensar en la determinación de los modos de vida socio-histórico-cultural, enfermedad y muerte del hombre de hoy y establecer un nuevo paradigma sobre la salud del hombre en la vida moderna.

Descritores: Salud del hombre, atención primaria de salud, identidad de género, enfermería.

INTRODUCTION

The male population has been blamed for damage to their health throughout time, suffering from gender inequality that strongly influences the construction of male identity preached by contemporary society. In this scenario, the current lifestyle appears as a predisposing factor of man's mortality, marked by alcohol abuse, smoking, sedentary lifestyle, stress. These factors constitute a multifaceted context that impacts man's ways of living and dying nowadays.

Among the possible difficulties of access and male participation in primary health care is the role of society itself, which creates this conflict and is directly related to gender issues.

Gender is the social construction of masculinity and femininity. It does not necessarily imply inequality between men and women. Often, the hierarchy is only presumed. This inequality suffers influences of patriarchy, which is in permanent transformation.¹

Thus, the fact that men do not adopt healthy living habits and, in turn, do not seek health services is related to the historicity of contemporary man. Therefore, it can be noted that hegemonic masculinity generates harmful behaviors to male health. The demand ends up being something quite

rare, restricted only to cases where men are prevented from carrying out their daily functions due to limitations that disable them.²

Patriarchy is conceptualized as "the hierarchical relations between men, as well as the solidarity between them, which enable the category consisted of men to establish and maintain control over women."^{1:104} Such definition marks this link and hinders man's quality of life at this juncture.

Cultural norms used to maintain the social power of men and the sense of masculinity hinders the adoption of habits and healthier beliefs. This power is linked to masculinity – men, to feel strong, tough and invulnerable, neither assume preventive behavior nor access health services. It is clear also that the presence of men in primary health care services is quite rare.³

Culture has a tremendous ability to model individual and collective imagination. In the scope of the researched subject, it represents a confluence of men's lives and health care, since due to the socialization of men, care is not seen as a male practice, which creates obstacles in the change process.⁴ It is necessary to overcome the prevailing ideology and rethink new paradigmatic bases.

Therefore, the actual access of man to health programs is a challenge, since healthcare is not seen as a male practice for different reasons. One of them refers to the fact that, in general, when socialized, the man learns that to care for himself, to value his body, as well as to take care of others are not issues inherent to masculinity. Feelings such as fear and shame, tied to the overwhelming feeling of fragility and industrial activities justify to them the distance from health services.

According to the principles and guidelines of the Unified Health System (SUS, in Portuguese), equity and integrity subsidize the healthcare process, since this population in focus requires health professionals' plural and complex knowledge, along with a gender approach that may include the evolution of man historicity and the emergence of diseases, aimed to seek a special attention. Public services are often perceived as a feminized space, mainly frequented by women and composed of a professional team also formed mostly by women. This situation causes in men the feeling of not belonging to that space and establishes a barrier.⁵

The implementation of primary care as a health systems organization strategy is undoubtedly important in this discussion. There is evidence that countries in which health systems are organized based on the principles of primary care achieve better health outcomes, lower costs, greater user satisfaction and greater equity, even in great situations of "social inequality."⁵

The year of 2009 constitutes a historical and legal framework to male access to primary care services, due to the launching of the National Comprehensive Care Policy for Men's Health. This policy emphasizes the need for paradigmatic shifts in relation to the perception of men and the care of both their own and their families' health. But it has

not been implemented yet in most of the country, because it is a new initiative, which demands a slow process of gradual introduction. Furthermore, there is also the financial part that restrains its development, because somehow there must be a great investment since it requires strengthening mechanisms and the qualification of primary care.⁴

To advance this discussion, among other things, it is fundamentally important to give voice to men themselves to better understand the issues involved in access to health services. This constitutes an obstacle, since verbalizing their feelings and talking about their health issues can be interpreted as a sign of weakness and feminization. This need for approaching emerges as inherent to those who, in most cases, are unaware of their own ways of accessing healthcare and health services.²

The choice of subject emerge from the following question: *What are the reasons that influence men's low demand for healthcare at the primary level, since this is considered the gateway to the health services in the Unified Health System (SUS)?*

It is assumed that the male users look for health services at the primary level due to the influence of man's historical and cultural process, along with gender dimensions and patriarchal ideology.

Thus, it will be exposed the results of the research, which goal was to investigate the factors influencing men's access to health services in primary care.

METHOD

This is a descriptive and exploratory study, with a qualitative approach. A qualitative study expresses an ensemble of methodologies, involving several epistemological references.⁶

The research technique used for data collection was the focal group. Considered by some as a strategy by which the researcher brings together, at one place and in a certain period of time, a determined amount of people who are part of the target audience of their investigations, aiming to collect, through dialogue and debate among them, information about a scientific topic.⁶

Its organization and systematization adopt a didactic-pedagogic guideline that involves the presentation pre-selected topics, followed by the explanation of its features. It should not be forgotten that, since it is a technique which aims at collecting qualitative data, the number of focus groups to be held is not rigidly determined by mathematical formulas, but by the depletion of discussed issues. It does not sticks itself, therefore, to the sampling relation.⁷

Moreover, they highlight the importance of the mediator for the conduction of the meeting, along with a script for debate, which has flexible character composed of key issues that will guide the discussion and was built based on the objectives of this work. The script has respected the

proposed duration of one to two hours each session. As it has an open character, throughout the meeting other issues can be inserted. We tried to respect the parameter of at least four and a maximum of 12 people to compose a focus group session.⁷

The researched site was a Basic Health Unit (UBS) at Mossoró-RN. Comprised of a team of Family Health Strategy (ESF, in Portuguese), eight community health workers, it has 1472 ascribed families. Currently, the basic unit does not provide any program aimed at men's health. The nurse of the unit reports that this demand is incipient.

The researched population was composed of eight male users of the target unit service selected by Community Health Agents (CHA), who composed the focus group. The subjects were informed about the research objectives by reading the Consent Form and agreed to participate in the study by signing the document.

The selection of participants took into account the following inclusion criteria: men; aged between 20 and 59 years; users of primary care services; identified by CHAs.

The focus group discussions were recorded on a MP4 electronic device and later transcribed, stored and analyzed. The gathering took place in October 2010.

For data analysis, we used the technique of the Collective Subject Discourse (CSD). The CSD is a set of individual speeches, which are composed by central ideas, key expressions and anchors. The CSD is an aggregation of isolated statements, combined to form a whole discourse, in which each party is recognized as a constituent of that whole.⁸

Study developed in accordance with the ethical principles of research involving human subjects required by Resolution 196/96 CNS/MS and Resolution 311/2007 of the Federal Council of Nursing. Reviewed and approved by the Research Committee of FACENE Protocol 99/10 and CAAE 2986.0.000.351-10.^{9,10}

RESULTS AND DISCUSSION

The use of debates was adequate to allow the rescue of subjectivity, since speech reveals values and belief systems. Thus, starting from the key expressions, it was possible to identify the main ideas and the formulation of the CSD, which will be presented.

IC/CSD I – The difficulty is huge

There are no conditions, is a tremendous difficulty. It's complicated, we try but do not succeed. Honestly, I do not like going to the doctor, I just look for a doctor when I'm feeling something serious, because I do not have much patience to wait. The difficulty is great because we arrive at 1 in the morning and still can't get to see a doctor, there are too many people. I'm tired of arriving at 4 p.m. and

seeing no record files to fill out, one cannot spend the whole night waiting there. When I arrive at a healthcare center they send me to another us and then again and again. When I can finally set an appointment within 30 to 60 days, I get pissed. It would be nice if someone made a news story to tell it like it is.

The CSD I shows the wait as an obstacle to the health services at the primary level.

Several studies have highlighted dissatisfaction with the waiting time for assistance, which relates to the long period of waiting in lines to be assisted by the service and to the long interval between scheduling an appointment and solving the problem.¹¹

The difficulties of network operation emerge as another factor for male distance from the concerned services. The formation of queues contributes to the users' evasion, since this should not be the reality of primary care services, let alone of units with teams working in the perspective of the ESF. Demand grows, and the services are not organized for this change, which creates a burden on the units.

Also, basic health units were organized to operate at times often incompatible with "working man" hours, so it is a challenge to assist them by expanding the hours of operational service.¹²

In this context, still within the explanations anchored in the culture, men are identified in a negative way by revealing impatience in service waiting. This guideline is based on pillars such as ensuring universal accessibility and qualification of relations, in which listening and attention to the needs are fundamental to the process, so that the service provides an always positive response to the problems presented by users.¹³

The ESF was created to reorient the healthcare model through the presence of multidisciplinary teams and an interdisciplinary approach. Therefore, there is a need for devices to change the dynamics of the healthcare process making the ESF a favorable space for the construction of new practices covering the social health needs of the population.¹⁴

IC/CSD II – Men are always on the margins

I believe men were not informed enough, women have received investment (education, information, media and government), and men were always on the margins. They are starting to invest, but sporadically, so the assistance given to man is different. It does not have a focused strategy in relation to human health. There is the day of the prevention exams for women, is there the day focused on preventive examinations of men? No, there is not. There is a lack of strategy focused on human health.

The CSD II reveals the gap in the organization of health services in men's healthcare is related to the lack

of investment in this direction and in the absence of comprehensive strategies.

The approach of the relationship between men and health from the perspective of institutions and health professionals is more recent. It is, partly, based on reflections about the traditional structure and organization of services, as well as the provision of educational and health practices to hygiene and childcare that, historically, favored mother and child, and eventually established a significant influence on how gender relates to health care. The logic of service, the organization of this care towards the mother-child axis is the result of a historical process that articulated the production of medical ideas along with political action focused on the female body or on the institutions designed for these purposes.¹⁵

According to some studies, users point out that the healthcare organization has historically been designed to value the healthcare of women and children, demarcating the differences in approaches of assistance by gender promoted by the health services and health policies.²

Criticism is extended to when the focus is the lack of programs for men's health, which coexists with the idea that primary care does not offer professionals that comprise to the health care of men, especially urologists. However, even if a particular specialty is claimed with the justification that the general does not account to meet the specificity of man, it is necessary to avoid a reductionist view or fragmenting primary care by circumscribing man's specificity only to urology.¹²

IC/CSD III – Men do not care to adopt healthy habits or to take care of his health

Men do not care to adopt healthy habits and to take care of his health, except in cases in which they are dying. Most men have this custom.

According to the CSD III, men do not have a concern about their health and a healthy life, therefore using health services only when reporting acute conditions.

The models of masculinity and how the male socialization arises can weaken or separate men's concerns from self-care and the pursuit of health services. The perspective of male healthcare can become positive when it incorporates the idea that men are also allowed to care for themselves.¹⁶

The male population has the habit to seek health services only when they are in a more advanced health condition. This is characterized by an ideology influenced by patriarchy. The cultural aspect associated with being a man tends to reinforce an idealized masculinity model (strength, virility, objectivity, emotional detachment, risky behavior).¹⁵

It is important to remember that the male image of "being strong" can result in reckless attitudes towards men's own bodies, making them vulnerable to a series of situations.¹⁵

The fact that men do not seek PHC services implies that they are deprived of the necessary protection to preserve

their health and continue to make use of procedures which would be unnecessary had they sought assistance earlier. Many injuries could be prevented if men performed, regularly, primary prevention measures. Male resistance towards primary care not only increases the financial burden of society, but also the physical and emotional suffering of the patient and his family, in the fight for the preservation of health and quality of life of these people.

IC/CSD IV – Many men report the issue of working hours, but women also work, and still manage to look and care for their health

There are people who come tired from work, but it depends a lot on the kind of work. For me, it's not a problem. Many men report the issue of available time, but women also work, and still manage to look after their health.

The CSD IV expressed men's recognition that work is not a reason for the male absence at the primary level care.

Although the work is mentioned as a problem, either due to the fact that the units do not have a wider opening hours (third shift) for the service, the existence of a social and work culture that devalues male absence motivated by health/disease or male fear of revealing weaknesses in their social context.¹⁵

Low male demand also appears associated with the lack of welcoming assistance or an unattractive assistance, which may be related to weak professional skills to deal with the male segment. In this reasoning, the adoption of strategies that focus both on expanding campaigns as well on sensitizing men to take care of their own health would be necessary. Thus, a possible strategy to be adopted would be the qualification of the gateway, focused on receptiveness and resolution, which would result in the construction of a network of attention to effective healthcare.²

The absence of men in PHC services can be described through the field of culture, understood through gender identity, while it is attributed, by contrast, a specificity to women rooted in biology related to issues of reproduction, contraception and pregnancy. So women's work, even when paid, is not seen as a socially justified way to explain a possible unavailability for seeking healthcare. The flexibility of women's working hours to attend the services indicates, in the minds of employers, the presence of the social imagination that women have to be careful but men don't.¹⁵

IC/CSD V – I do not seek the unit

Sometimes I come in angry, I do not even seek for it, if I need it I just go to the private hospital. Because if there is an appointment, it is within a year or two.

CSD V affirms a devaluation of the public service in relation to the private sector to provide health services such as the hospital.

It would be fitting to reflect on the quality of ideas that bring the symbolic debate between the NHS and the health insurance offered by private enterprises. It is necessary to reject the idea that quality is expressed in the simple possibility of consuming goods and health services. The desired quality should be guided by ensuring adequate and timely access to health campaigns and services that have the power to respond to people's needs, according to these needs.¹⁷

One should be reminded that the objects (technologies), practices (programs, proposals) and intentions (speeches, laws) are not good or bad, outside the relations and the problematic field which generated them and can produce them. Thus, it is necessary to follow them in their exercises, production of meanings and connections; evaluating ethically and politically their opening levels to social multiplicities and what they promote and update as reality production.¹⁸

Improving the quality of health services in order to provide comprehensive answers which produce practical success over suffering strongly tenses the coexistence of the private health sector and therefore should instigate a backlash. Thus, the transformation of SUS practices guided by its principles and guidelines opens a perspective of a radical reversal of the symbolic image of superior quality health supplement.¹⁷

IC/CSD VI – Man is seen as self-sufficient

This is not new, it's very ancient, it follows a long tradition, people like to follow old customs. So my grandfather would not seek for a doctor, my father also wouldn't, I follow my father's path and so on. Men, they are seen as self-sufficient, strong, so they just look for healthcare when they're almost dying. They do not know, because they do not seek for it, how are they going to know? Honestly, I don't like doctors, I would go to a doctor as a last resort, only if I have one foot in the grave and if someone else drags me there. I do not even know what it is.

CSD VI refers to evaluative aspects, which seek to interpret male behavior, placing it in a universe of relationships and values. Evaluative aspects mean the universe of culture and subjectivity, interpretation of phenomena and events related to the axis of the need for health are, within the framework of the differences in gender and generation.¹³

This type of behavior influences not only in the state in which the user comes to health care, but also in how he uses it. The explanation for this behavior is connected to the demands of hegemonic models of masculinities.¹⁹

In the family environment there is a socialization of ideas that do not stimulate a male behavior of self-care, as throughout the personal trajectory male healthcare is

usually mediated by female figures as mothers, partners and daughters.¹³

The big issue regarding health is that men often deny the existence of pain or suffering, vulnerability, to enhance the idea of male strength, demarcating their difference from women.

There is a socially constructed requirement in the idea that a man should be strong, unfolding the figure of a man who fears to take care of their health, delaying preventive treatments. Diseases and their possible association with the finiteness of life represent a danger and a threat to life. The association between frequency of health service and death is interesting, as if the proximity to this place reminds one much more of the disease treatment axis and its consequences, than of a place of caring towards life and health. This perspective seems to be tuned to the historic and socially shared representation that there is a discontinuity between health and disease, as though the latter interrupted the life cycle instead of being a part of it. This perspective makes it difficult to incorporate the experience of illness and the development towards self-care.²⁰

IC/CSD VII – It just depends on men

There is no solution, there is no point in giving suggestions for you, because I know that it won't solve anything. The thing that can improve men's health is their very will, it all depends if they go after it.

According to CSD VII, there is a disbelief in the continuity and the resoluteness of the services provided at the primary level in men's health. But the important thing is that, listening to this, it is possible to know the satisfaction or dissatisfaction of those users regarding the care provided to them. Moreover, it can be seen that men end up blaming themselves for not having guaranteed access to quality service and preventive care.

Primary health care must be the gateway to the health system. It is the space in which most of the demands can be solved, constituting a priority in the health care organization.¹⁹

It is common that men should seek health services at primary level when in need of something more immediate. Not always do they think about disease prevention or health promotion, but instead they seek a medical certificate or an examination required by their employers.

Other studies show that, although satisfaction surveys of users/patients about the quality of health care in primary care services are numerically significant, when men are the users, knowledge production is greatly reduced. Thus, studies on man's vision of access and quality to primary health care services are needed to tailor these services to male demands.¹¹

Other research results indicate that the dissatisfaction of participants with the reference and counter reference demands the reorganization of basic health units, in order to become more agile routing users to a level of attention of greater complexity. Besides, it is believed to restructure the basic health units in order to extend its service hours for nighttime, allowing the search for assistance. Thus, it is expected that the number of men seeking services at the primary level increases and, consequently, ensuring greater adherence to their treatments and preventive actions.⁸

CONCLUSIONS

This research has achieved its objectives, since it was able to express the aspects that influence male access to health services in primary care, highlighting through the speeches the gap in public policies for men and the disorganization of municipal service's flowchart, converging to a negative view of the public service, and the historical process of human socialization. Moreover, there is the recognition of women as workers who can maintain a frequent attendance to the primary health care services.

The comprehensive man's health care presents itself as an inclusive proposal in line with the principles and guidelines of SUS but, to be implemented, synchrony between health management and qualified professional practices is necessary.

Other studies to support the teams working on the APS and municipal technical staff towards concrete changes in the work process facing the citizens are suggested.

REFERENCES

1. Saffioti HIB. Gênero, patriarcado, violência. São Paulo: Fundação Perseu Abramo; 2004.
2. Gomes R, Nascimento EF, Araujo FC. Por que os homens buscam menos os serviços de saúde do que as mulheres? As explicações de homens com baixa escolaridade e homens com ensino superior. *Cad. Saúde Pública*. 2007 mar; 23(3):565-74.
3. Gomes R, Nascimento EF. A produção do conhecimento da saúde pública sobre a relação homem-saúde: uma revisão bibliográfica. *Cad. de Saúde Pública*. 2006 mai; 22(5): 901-11.
4. Carracas S, Russo JA, Faro L. A política de atenção a saúde do homem no Brasil: os paradoxos da medicalização do corpo masculino. *Physis: revista de saúde coletiva*. 2009; 19(3): 659-78.
5. Brasil. Ministério da Saúde. Política Nacional de Atenção Integral a Saúde do Homem: princípios e diretrizes. Brasília 2009. Disponível em: <<http://dtr2001.saude.gov.br/sas/PORTARIAS/Port2008/PT-09-CONS.pdf>>. Acesso em: 10 mai. 2010.
6. Severino AJ. Metodologia do trabalho científico. 23ª ed. São Paulo: Cortez; 2007.
7. Cruz Neto OC, Moreira MR, Sucena LFM. Grupos focais e pesquisa social qualitativa: o debate orientado como técnica de investigação. Minas Gerais; 2002.
8. Lefrève F; Lefrève AMC. O discurso do sujeito coletivo. Caxias do Sul: EDUSC, 2003.
9. Conselho Nacional de Saúde (BR). Comissão Nacional de Ética em Pesquisa. Resolução nº 196/96 de 10 de outubro de 1996. Aprova as diretrizes e normas regulamentares de pesquisa envolvendo seres humanos. *Bioética*. 1996; 4(2 supl.): 15-25.
10. Conselho Federal de Enfermagem (COFEM). Resolução Nº 311 de 08 de janeiro de 2007. Revoga a resolução COFEN Nº 240/2000 e aprova a reformulação do código de ética dos profissionais de enfermagem. Rio de Janeiro: COFEN; 2007.
11. Gomes R, Rebelo LEFS, Nascimento EF, Deslandes SF, Moreira MCN. A atenção básica à saúde do homem sob a ótica do usuário: um estudo qualitativo em três serviços do Rio de Janeiro. *Ciênc. saúde coletiva*. 2011; 16(11):4513-21.
12. Figueiredo W. Assistência à saúde dos homens: um desafio para os serviços de atenção primária. *Ciênc. saúde coletiva*. 2005; 10(1):105-09.
13. Brehmer LCF, Verdi M. Acolhimento na Atenção Básica: reflexões éticas sobre a atenção à saúde dos usuários. *Ciênc. saúde coletiva* 2010; 15(3 Supl):3569-78.
14. Paulino TSC, Valença CN, Germano RM. Processo de trabalho do enfermeiro: algo em desuso? *Rev. pesqui. cuid. fundam.* [on line] [citado 24 jul 2013]. Artigo no prelo (com confirmação para publicação).
15. Machin R, Couto MT, Silva GSN, Schraiber LB, Gomes R, Figueiredo WS et al. Concepções de gênero, masculinidade e cuidados em saúde: estudo com profissionais de saúde da atenção primária. *Ciênc. saúde coletiva* 2011; 16(11):4503-12.
16. Gomes R, Moreira MCN, Nascimento EF, Rebelo EFS, Couto MT, Schraiber LB. Os homens não vêm! Ausência e/ou invisibilidade masculina na atenção primária. *Ciênc. saúde coletiva* 2011;16 Supl 1:983-92.
17. Mattos RA. Princípios do Sistema Único de Saúde (SUS) e a humanização das práticas de saúde. *Interface comun. saúde educ*. 2009; 13 Supl 1:771-80.
18. Neves CAB. Que vida queremos afirmar na construção de uma política de humanização nas práticas de saúde do Sistema Único de Saúde (SUS)? *Interface comun. saúde educ*. 2009; 13 Supl 1: 781-95.
19. Teixeira RR. Humanização e Atenção Primária à Saúde. *Ciênc. saúde coletiva* 2005; 10(3):585-97.
20. Gomes R. Sexualidade masculina e saúde do homem: proposta para uma discussão. *Ciênc. saúde coletiva* 2003; 8(3):825-29.

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