Male demands for primary health care

Demandas masculinas para o atendimento na atenção primária à saúde

Demandas masculinas de atención primaria de salud

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RESUMO

Objetivo: caracterizar as demandas de atendimento à saúde de homens na Atenção Primária. **Método:** Trata-se de um estudo epidemiológico, descritivo com base nos dados secundário provenientes do E-SUS SISAB. Analisou-se os atendimentos dos homens na faixa etária entre 20 a 59 anos, residentes em um município do estado da Bahia, Brasil, realizados entre 2015 e 2019. Os dados foram organizados em tabelas utilizando o Stata. **Resultados:** Entre 2015 e 2019, foram realizados 4.630 atendimentos, sendo 79,9% realizados pela equipe mínima. A maior frequência de atendimentos ocorreu na faixa etária entre 50 e 54 anos. Houve maior frequência de atendimentos pela manhã na UBS e em consultas programadas. Estiveram em observação 92,5% e, dos atendimentos realizados pelo NASF, prevaleceu a prescrição terapêutica 45,2%. Dentre os problemas/condições avaliados, foram mais frequentes a hipertensão arterial, reabilitação e saúde mental. Os procedimentos mais realizados foram a aferição de pressão arterial e administração de medicamentos endovenosos. As condutas adotadas foram: o retorno para consulta agendada e retorno para cuidado programado. Realizaram atendimentos odontológicos programados sob o acesso de consultas programadas e com demandas relacionadas procedimentos dentários, dor de dente. Foram assistidos por visitas domiciliares, não sendo compartilhada entre profissionais. **Conclusão:** As demandas por cuidado à saúde apresentadas pelos homens na APS refletem a diversidade e complexidade que provem do cotidiano de trabalho a partir dos territórios e direcionam a reflexão acerca da maneira como os serviços estão orientados, a lógica das práticas de saúde e a própria compreensão dos profissionais e sujeitos no processo de cuidar.

Descritores: Homens; Saúde do Homem; Atenção Primária à Saúde; Estratégia de Saúde da Família.

ABSTRACT

Objective: to characterize the health care demands of men in Primary Care. **Method:** This is an epidemiological, descriptive study based on secondary data from the E-SUS SISAB. The attendance of men aged 20 to 59 years, living in a municipality in the state of Bahia, Brazil, between 2015 and 2019 was analyzed. The data were organized in tables using Stata. **Results:** Between 2015 and 2019, 4,630 calls were made, 79.9% of which were carried out by the minimum team. The highest frequency of visits occurred in the age group between 50 and 54 years. There was a higher frequency of consultations in the morning at the BHU and scheduled appointments. 92.5% were under observation and, of the visits made by the NASF, the therapeutic prescription prevailed 45.2%. Among the problems / conditions evaluated, arterial hypertension, rehabilitation and mental health were more frequent. The most performed procedures were the measurement of blood pressure and administration of intravenous drugs. The conducts adopted were: return for scheduled consultation and return for scheduled care. They performed scheduled dental appointments under the access of scheduled appointments and with demands related to dental procedures, toothache. They were assisted by home visits, not being shared among professionals. **Conclusion:** The demands for health care presented by men in PHC reflect the diversity and complexity that come from the daily work from the territories and direct reflection on the way services are oriented, the logic of health practices and the very understanding of professionals and subjects in the care process.

Descriptors: Men; Men's Health; Primary Health Care; Family Health Strategy.

RESUMEN

Objetivo: caracterizar las demandas asistenciales de los hombres en Atención Primaria. **Método:** Se trata de un estudio epidemiológico descriptivo basado en datos secundarios del E-SUS SISAB. Se analizó la asistencia de hombres de 20 a 59 años, residentes en un municipio del estado de Bahía, Brasil, entre 2015 y 2019. Los datos se organizaron en tablas utilizando Stata. **Resultados**: Entre 2015 y 2019 se realizaron 4.630 convocatorias, 79,9% de las cuales fueron realizadas por el equipo mínimo. La mayor frecuencia de visitas se produjo en el grupo de edad entre 50 y 54 años. Hubo una mayor frecuencia de consultas por la mañana en la UBS y citas programadas. El 92,5% estaban en observación y, de las visitas realizadas por la NASF, la prescripción terapéutica predominó en el 45,2%. Entre los problemas / condiciones evaluados, fueron más frecuentes la hipertensión arterial, la rehabilitación y la salud mental. Los procedimientos más realizados fueron la medición de la presión arterial y la administración de fármacos intravenosos. Las conductas adoptadas fueron: regreso para consulta programada y regreso para atención programada. Realizan citas dentales programadas bajo el acceso de citas programadas y con demandas relacionadas con procedimientos dentales, dolor de muelas. Fueron asistidos por visitas domiciliarias, no siendo compartidos entre profesionales. **Conclusión:** Las demandas de atención a la salud que presentan los hombres en la APS reflejan la diversidad y complejidad que surgen del trabajo cotidiano desde los territorios y la reflexión directa sobre la orientación de los servicios, la lógica de las prácticas de salud y la propia comprensión de los profesionales y sujetos en el proceso asistencial.

Descriptores: Hombres; Salud de los hombres; Primeros auxilios; Estrategia de salud familiar.

ORIGINAL

Introduction

The national and international scientific production on men's health care has also privileged aspects of morbidity and mortality, risk factors, and the male distancing from institutional health services.[1] Despite this, the aspects that deal with health behaviors, care practices, and the demands presented informal health spaces, especially among adult men, still lack more space. In countries such as Brazil, even with the National Policy of Integral Attention to Men's Health instituted, men's search for health care has been permeated by relational gender dimensions, normative standards, stereotypes, and discrimination in health.[2]

Male access to Primary Health Care (PHC) faces structural challenges in care management, institutional service organization to meet the demands of men and athenalysis manifested by health professionals regarding the reception and production of male health care.[3] Producing care capable of looking at the singularities of individuals has been essential to achieve equity and integrality in care. Especially in the context of the production of nursing care directed to the male population, theoretical, conceptual and practical advances have been observed and direct the need for expansion and strengthening of nursing interventions in order to supply existing invisibilities and incipiences with regard to male health care.[4]

Primary Care has the potential to guarantee the resolution of a significant portion of the population's health demands and needs. Nurses and multidisciplinary health teams within the framework of consolidated PHC and with adequate working conditions can contribute significantly to the transformation of the health panorama of men and communities, ensuring health promotion actions, construction of health awareness and autonomy, social participation and control, disease prevention, treatment and rehabilitation.[4-5]

Despite the search for specific care for diseases, other demands can be presented by men in PHC, such as: environmental, oral, home, spiritual, mental, nutritional, sexual and reproductive health and others.[5-6]

Given the context presented, this study was guided by the following research question: What are the demands of men's health care in Primary Care in a municipality in the semi-arid state of Bahia? The aim of this article is to characterize the demands of men's health care in Primary Care.

Method

This is an epidemiological, descriptive study based on secondary data from E-SUS SISAB. We analyzed the care of men between 20 and 59 years old, living in a municipality in the state of Bahia, Brazil, conducted between 2015 and 2019.[7]

The municipality investigated has an estimated population of 8,972 inhabitants, with 3,785 households registered, is inserted in the state service agreement network, has coverage of 100% of PHC, and public funding from the federal government for health programs: Health Academy, School Health Program. It is structured by four areas and 22 microareas, with a greater extension of rural area, two Basic Health Units - UBS and two Family Health Units - FHU, with complete minimum teams and five health posts located in the villages and districts.

It has a team of 20 Community Health Agents - CHA and 10 Endemic Control Agents - ACE, a NASF team, a Mobile Dental Unit, health surveillance departments, laboratory collection for laboratory tests, vaccination rooms / cold room, and a pharmacy unit in Bahia, which performs free drug dispensing. Since 2014, the municipality has used the E-SUS system of the Ministry of Health, and has a health unit with an electronic medical record established since 2017. O banco de dados foi solicitado através do Sistema Eletrônico de Serviços de Informação ao Cidadão (e-SIC) e disponibilizado pelo MS em formato de planilha eletrônica através do *Microsoft Excel 2010.* Os dados foram extraídos em maio de 2020.

The variables about the characteristics of the visits were as follows: shifts of care, place of care, type of consultation, was under observation? and care by the Family Health Support Center - NASF. Problems/conditions, procedures and conducts were also evaluated. On the other hand, dental care, care shifts, types of care, type of consultation, procedures and problems/conditions evaluated, conduct and referrals were contemplated. In home and territorial visits, the variables of interest were shifts of care, shared visit, reason for visit and outcome.

Data analysis was performed in the second half of 2020. All variables of the study are categorical, therefore, absolute and relative frequencies were calculated. In the analysis, the period from 2015 to 2019 was considered due to the availability and completeness of the data due to the establishment of the E-SUS system in the municipality investigated. The data were organized in tables using Stata (version 13).

The project was approved by the Ethics and Research Committee under the protocol number: CAAE: 47814815.4.0000.5654 and n.1.208.304.

Results

Between 2015 and 2019, 4,630 visits were performed by men in basic health units in the city of Quixabeira (BA) and 79.9% (3700) performed by the minimum team (physician, nurse, nursing technician, dentist, oral health assistant and Community Health Agents and Endemic Control) and 20.1% (930) by the family health support center team - NASF. The highest frequency of visits occurred in the age group between 50 and 54 years (777/16.8%).

Regarding individualized care, there was a higher frequency of morning visits (2,466/53.3%), in the UBS (4,531/97.9%), scheduled consultations (3,133/67.7%), were under observation (4,281/92.5%) and, of the visits performed by the NASF, the therapeutic prescription prevailed (420/45.2%) (Table 1).

Table 1 - Characteristics of individualized care of men in primary care. 2015 to 2019. Bahia, Brazil.

Variables	n	%
Service shifts		
Morning	2.466	53,3
Afternoon	2.164	46,7
Place of service*		
UBS	4.531	97,9
Domicile	66	1,4

Mobile unit	7	0,1
Ignored	26	0,6
Type of query		
Scheduled	3.133	67,7
Spontaneous demand	1.453	31,4
Ignored	44	0,9
You've been under observation		
Yes	4.281	92,5
No	349	7,5
NASF Calls*		
Evaluation/diagnosis	190	20,4
Clinical/therapeutic procedures	320	34,4
Therapeutic prescription	420	45,2
Total	**4.630**	**100**

*** Percentage calculated considering only the individuals who performed care with the NASF.**
Source: E-SUS.

Among the problems/conditions evaluated, arterial hypertension (843/18.3%), rehabilitation (512/11.0%) and mental health (495/10.7%) were more frequent. On the procedures, blood pressure measurement (1,594 / 34.4%) and intravenous medication administration (01,704/36.8%) were the most performed. Regarding the conducts adopted, the return to scheduled consultation (2,633/56.9%) and return to scheduled care (1,547/33.6%) were the most prevalent (Table 2).

Table 2 - Problems/conditions evaluated, procedures and conducts performed in men in primary care. 2015 to 2019. Bahia, Brazil.

Variables	n	%
Assessed problems/conditions		
Hypertension	843	18,3
Rehabilitation	512	11,0
Mental health	495	10,7
Diabetes Mellitus	232	5,0
Sexual and reproductive health	122	2,6
Obesity	55	1,2
Asthma	41	0,9
Cardiovascular risk (screening)	13	0,3
Signs and symptoms of the lumbar region (CIAP 2)	92	2,0
Flu (CIAP 2)	51	1,1
Abdominal and epigastric pain (CIAP 2)	39	0,8
Other	2.135	46,1
Procedures		
Blood pressure measurement	1.594	34,4
Special dressing	122	2,6
Withdrawal of points	102	2,2
Quick Syphilis Test	190	4,1
Rapid HIV test	165	3,6
Hepatitis C Rapid Test	180	3,9
Administration of intravenous drugs	272	5,9

Intramuscular drug administration	1.704	36,8
Inhalation/nebulization	111	2,4
Other	190	4,1
Conducts		
Return to scheduled query	2.633	56,9
Return for scheduled care	1.547	33,6
Scheduling for NASF	42	1,0
Scheduling for group	5	0,2
Internal routing	13	0,3
Referral to specialized service	90	2,0
Referral to home care	15	0,4
Referral to urgency	9	0,2
Ignored	246	5,4
Total	**4.630**	**100**

Fonte: E-SUS.

Dental visits were more frequent in the morning (2,431/55.8%), scheduled (3,847/86.68%), return visits (58.9%), guidance as a procedure (1,435/1,435/86.68). 32.9%), toothache as the most evaluated condition (703/16.2%), return as conduct (3,670/84.3%) and only 2.7% (118) were referred to some complementary service (Table 3).

Table 3 - Dental care performed in men in primary care. 2015 to 2019. Bahia, Brazil.

Variables	n	%
Service shifts		
Morning	2.431	55,8
Afternoon	1.923	44,2
Types of service *		
Scheduled	3.847	86,8
Spontaneous demand	399	9,0
Urgency	184	4,2
Type of Consultation		
First	1.154	26,1
Return	2.566	58,9
Maintenance	285	6,5
Ignored	349	8,0
Procedures		
Orientation	1.435	32,9
Permanent tooth restoration	1.075	24,7
Scraping and polishing	1.065	24,5
supragingivals	779	17,9
Other		
Assessed problems/conditions	703	16,2
Toothache	67	1,5
Soft tissue change	52	1,2
Dentoalveolar abscess	3.532	81,1
Unspecified/No problems or conditions		

Conduct		
Return	3.670	84,3
Treatment completed	354	8,1
High after episode	217	5,0
Ignored	113	2,6
Referrals		
Radiology	101	2,3
Dental	17	0,4
No routing	4.236	97,3
Total	**4.354**	**100**

***** Total frequency 4430.
Source: E-SUS.

Regarding home and territorial visits, 22,780 activities were carried out, concentrated in the morning (14,020/61.5%), not being shared among professionals (22,356/98.1%), the reason for periodic visits (14,032/40.5%) and were performed (21,982/96.5%) (Table 4).

Table 4 - Characteristics of home and territorial visits performed with men in primary care. 2015 to 2019. Bahia, Brazil.

Variables	n	%
Service shifts		
Morning	14.020	61,5
Afternoon	8.716	38,3
Ignored	44	0,2
Shared visit		
Yes	424	1,9
No	22.356	98,1
Reason for the visit*		
Periodic visit	14.032	40,5
Guidance/Prevention	8.773	25,3
Invitation to collective activity/campaign	1.167	3,4
Active search	4.411	12,7
Accompaniment	6.182	17,9
Environmental control	43	0,2
Outcome		
Held	21.982	96,5
Refused	17	0,0
User absence	781	3,5
Total	**22.780**	**100**

* Total frequency 34,608.

Discussion

The data presented in this study indicate the male demand that arrives at primary care services, with a higher demand for men aged 50 years or older and more markedly in the morning shift. The role of the different technologies

available for care in PHC is emphasized, such as the NASF, which was responsible for promoting the reception of different male demands.

The recognition of barriers to men's access to health services permeates the assimilation of transversality from the gender perspective in the organization of care practices6, so that obstacles are evidenced and potentialities capable of modifying the reality of distancing, sense of non-belonging and low male engagement in actions and services of health promotion and care, overcome the common place of the difficulties already already pointed out. Above all, it implies the possibility of identifying from the PHC itself, the male demands and needs of the territory that may or may not be presented in these services.[8-9]

The results indicate a male insertion mostly for therapeutic follow-up, having remained more than 90% of them under observation by the teams, without much feedback to the information system of what this observation refers to, that is, it is not possible to verify an intervention to improve the organizational logic of the services to identify the needs in the territory, reproducing the query-complaint logic. This is tied to this, the low percentage of health education actions, which makes it difficult to overcome distancing, the weaknesses in access, the qualification of health information and ratifies the idea of non-correspondence between man and care, devaluing these subjects and their practices and consequently, sustaining weaknesses in the reception of the male public and their demands.[9,10]

Regarding chronic illness, the results corroborate the morbidity distribution profile in Brazil, which shows that approximately 70% of its population between 18 and 59 years old with at least one Chronic Non-Communicable Disease (NCD), reaching 80% after 60 years. Nursing teams have a great impact on the care of people with chronic conditions, since they are responsible for self-care guidance, care; by the management of demand within the unit and by the teaching process, both in popular education and in continuing education.[10-11]

Studies report that the care of nurses based on the nursing process, especially in the stages of detection of health situation diagnoses in validated taxonomy, planning and evaluation of actions with the patient has the potential to improve health behavior and give them a better quality of life. This evaluation should maintain a periodicity for the improvement of knowledge in patient health, improvement of the perspective of self-care and recognition of potentialities.[12]

However, nursing consultations are mostly directed to female reproductive planning, prenatal care and childcare, not encompassing, to a large part, men. Another viable strategy to improve the reception of these men in the health unit are the focus groups carried out only with them, with themes that associate the personal interest of service users and the need to build a knowledge in community health and accessible.[13-14]

Looking at the scenario of access to PHC unseen by the results also generates triggers in the field of sexuality, observing communicable diseases Looking at the scenario of access to PHC unseen by the results also generates triggers in the field of sexuality, observing diseases transmissible by sexual means. The screening of possible sexually transmitted infections, the availability of contraception and the direction of other methods for planning paternity and the strengthening on the importance of maintaining the updated immunization

card, with a special look at hepatitis, is important and challenging. The literature points out strategies based on the initial application of light relational technologies, aiming to know the principles of the man being cared for and the strengthening of treatment equity. In addition, improvements in the flow of the unit, from the disposition in the environment to interferences in the organizational culture, stimulating the participation of men parents of the community in the consultations of the children and co-responsibility of care are seen as favorable for the strengthening of primary care.[15]

This study presents as a limitation the fact that the sample is composed of primary data being taken from the electronic system of the SUS, which historically presents underreporting. Added to this is the fact that the city considered to be located in the interior of Bahia, and be small, with less than 60,000 inhabitants, currently.

Nursing practice in Primary Care is essential to reverse the situation of precarious health of men, as observed in the article with men and women with obesity in the USA, in which it would be necessary to understand the experiences of health care among populations at risk in order to obtain results that guarantee equity in health,[12] or in the article on the performance of community nurses by complementing the work of multidisciplinary rehabilitation teams, providing men with continuous evaluation, management and information on possible interventions and, when necessary, referrals to other health demands.[16]

As contributions to nursing, analyzed data are presented that support the construction of a possible diagnosis of the performance of primary care in the knowledge and meeting the demands of the male population. In addition, the gap in studies that measure the resolution of interventions to meet male demands in PHC is highlighted, so it is recommended that new searches be recommended to contribute to advances in this scenario.

Conclusion

The demands for health care presented by men in PHC reflect the diversity and complexity that come from daily work from the territories and direct reflection on the way services are oriented, the logic of health practices and the very understanding of professionals and subjects in the care process.

Moreover, the male demands go beyond what repeated studies have proposed as a production of men's health, broaden the look beyond the aspects of morbidity, sexuality and shed light on other issues that mobilize the time, attention and care of men with them and in this sense, these apprehensions become expensive to the reorganization of the care model.

It is essential to point out for the role and potential of PHC in the Brazilian context, with its singularities and penetration in the territories, in causing ruptures in the understanding and action of subjects and professionals and, consequently, contributing to the transformation of practices and beliefs about health, disease and care among men.

Therefore, the evidence of this study points to possibilities that allow us to look beyond the obstacles in male involvement in the health care arena and provide resources to capture paths for the construction of bonds, promotion of welcoming and thus guarantee the right to health for men.

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