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EPIDEMIOLOGICAL STUDY OF MALE POPULATION ATTENDED BY AN ITINERANT EXTENSION PROJECT

ESTUDO EPIDEMIOLÓGICO DA POPULAÇÃO MASCULINA ATENDIDA POR UM PROJETO DE EXTENSÃO ITINERANTE

ESTUDIO EPIDEMIOLÓGICO DE UNA POBLACIÓN DE HOMBRES ATENDIDA POR UN PROYECTO DE EXTENSIÓN ITINERANTE

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ABSTRACT

Objective: to outline the epidemiological profile of the male population served by a university extension project. **Method:** a descriptive exploratory study with quantitative approach, performed on 107 men who were attended by the Program "Laboratório Itinerante" at Universidade Estadual da Paraíba, after the research project was approved by the Ethics Committee of the Universidade Estadual da Paraíba, under CAAE No 0497.0.133.000 -11. Data were collected using structured questionnaires and analyzed using Epi Info® 3.5.2, displayed as figures and tables, also, the responses of mixed questions were grouped by keywords according to the frequency. The discussion was in accordance with literature. **Results:** the majority of men (53.0%) were overweight, drank alcoholic beverages (43%) and reported health problems (32.7%). Only 15.9% attended Primary health care last year. Geographical factors and socio-organizational (25.2%) were the major difficulties reported in the quest for Primary health care. **Conclusion:** the prevalence of overweight and risk habits in men was associated with the lack of Primary health care service. **Descriptors:** Epidemiological Profile; Men's Health; Gender and Health; Primary Health Care.

RESUMO

Objetivo: traçar o perfil epidemiológico da população masculina atendida por um projeto de extensão universitária. **Método:** estudo transversal, quantitativo realizado em 107 homens residentes nos municípios atendidos pelo Programa "Laboratório Itinerante" da Universidade Estadual da Paraíba, depois da aprovação do projeto de pesquisa pelo Comitê de Ética da Universidade Estadual da Paraíba, sob CAAE nº 0497.0.133.000-11. Os dados foram coletados utilizando-se questionários estruturados, entre outubro e dezembro de 2011 e analisados no software Epi Info® 3.5.2. **Resultados:** a maioria dos homens (53,0%) estava com excesso de peso, fazia uso de bebidas alcoólicas (43%) e referiu ter problemas de saúde (32,7%). Apenas 15,9% frequentou a atenção primária no último ano. Fatores geográficos e sócio-organizacionais (25,2%) foram as maiores dificuldades relatadas na busca pela atenção primária. **Conclusão:** a prevalência de sobrepeso e hábitos de risco foi associada à ausência homens ao serviço atenção primária. **Descritores:** Perfil Epidemiológico; Saúde do Homem; Gênero e Saúde; Atenção Primária à Saúde.

RESUMEN

Objetivo: analizar el perfil epidemiológico de la población masculina servida por un proyecto de extensión universitaria. **Método:** se realizó un estudio descriptivo exploratorio con abordaje cuantitativo, realizado en 107 hombres que participaron en el Programa "Laboratorio itinerante" en la Universidad del Estado de Paraíba, después de la aprobación del proyecto de investigación por el Comité de Ética de la Universidad del Estado de Paraíba, en CAAE No 0497.0.133.000 -11. Los datos fueron recolectados a través de cuestionarios estructurados y analizados mediante Epi Info® 3.5.2, presentada a través de figuras y tablas, también, las respuestas de las preguntas mixtas fueron agrupadas por palabras clave de acuerdo con las veces que apareció. La discusión estaba de acuerdo con la literatura. **Resultados:** La mayoría de los hombres (53,0%) tenían sobrepeso, hicieron uso de bebidas alcohólicas (43%) y reportaron tener problemas de salud (32,7%). Sólo el 15,9% asistió a primaria el año pasado. Factores geográficos y socio-organizativos (25,2%) fueron las principales dificultades reportadas en la búsqueda de la atención primaria. **Conclusión:** La prevalencia de sobrepeso y hábitos de riesgo se asoció con los hombres que carecen del servicio de atención primaria. **Descriptores:** Perfil Epidemiológico; Salud Masculina; Género y Salud; Atención Primaria de Salud.

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INTRODUCTION

Men's health is increasingly gaining prominence on the national and scientific scene and the high rates of morbidity presented by this group related to the low interest in services of primary health care associated with risky behavior adopted by the male subjects¹⁻². The difficulty in promoting health in the male population, coupled with high rates of mortality and dangerous behaviors guided the dictates of a hegemonic masculinity socially imposed, constitute human health as one of the main challenges faced by the current Brazilian health system³.

Men are dying in greater quantity and sooner than women⁴. In Brazil, the chance of a 20-year-old man dying before moving to the next age group (25-29 years), compared to a woman the same age group, rose from 1.1 in 1960 to 4.1 in 2006⁵. Currently, it is expected that a newborn male live 7.5 years less than a feminine newborn⁶. Some authors⁷ associate this framework construction of being male undoubtedly more difficult by the vicissitudes undergone by these individuals for such development. Since men should be providers, dominant, straight, start up sexually with prostitutes, protect their sisters and not show any trace of weakness, they find an obligation to meet the expectations imposed by the surrounding and suppressing social needs recognized as fragile by society⁸⁻⁹.

Since the concept of disease leads to weakness and consequently to fragility, it becomes the natural to men not to value their health. The traditional masculinity presupposes deficit of health³. So, sticking to this idea constitutes a costly risk for men, who suppress their needs and demands, which is reflected in the difficulty in seeking medical care. The issue of male resistance is compared here as being "a lot easier to have them check the status of their car, spending large sums of money, then to spend on some preventive examination"¹⁰.

Along with this problem, more effective measures aren't usual and health services designed specifically for the male population, which historically has been established as not necessary and specific to women, children and the elderly¹¹. Thus, Política Nacional de Atenção à Saúde do Homem has been created in order to explain and recognize the social determinants on the vulnerability of the male population to health problems, considering the social representations of masculinity. It was particularly created to articulate programs for gender with other health

policies in the country, as the National Primary Care Strategy (Política Nacional de Atenção Básica) in line with the Health Strategy for Family (Estratégia Saúde da Família)¹².

Efforts in this line should be highlighted so that the services of primary care are strengthened when using their results in the development of their schedule, this way they understand which aspects compromises them, the biological, non-biological, individual and collective aspects⁴.

It is believed that this study can contribute with data to enable a better understanding about the health of man, the specific profile of the served communities, as well as contribute to the establishment of strategies aimed on bringing this public to health promotion.

OBJECTIVE

- To outline the epidemiological profile of the male population served by a university extension project.

METHODOLOGY

Cross-sectional study, descriptive and exploratory, using a quantitative approach. The research was conducted in the cities of the state of Paraíba inserted in the visit script of Programa de Extensão Laboratório Itinerante (LABIT) bound to Pró-Reitoria de Extensão e Assuntos Comunitários (PROEAC) da Universidade Estadual da Paraíba/UEPB: Campina Grande, Esperança, Guarabira, Lagoa Seca, João Pessoa, Patos, Remígio e São Sebastião do Umbuzeiro.

LABIT is a PROEAC Extension Program, comprising outreach projects of Nursing, Physiotherapy, Dentistry, Physical Education, Industrial Chemistry, Law, Social Work and Journalism, which in scheduled days perform an action in a particular locality or institution which have previously requested their presence, in public squares, clubs, workplace or school, aiming to bring information, education, culture and promoting the health of the population by stimulating new perspectives enhancing the quality of life as an important strategy to promote the consolidation of these actions.

The population in the research consisted of men living and/or passersby in the areas covered by the project. The sample is non-probabilistic, consisting of accessibility by 107 men over 18 who went for the services of the Extension Project "Health and Quality of Life

for Men” (“Saúde e Qualidade de Vida para os Homens”).

Data collection was conducted from October to December 2011 in the environment of the service project. We developed a specific and structured questionnaire with 31 mixed and objective questions that addressed firstly sociodemographic aspects, and secondly the health profile (anthropometric measurements, blood pressure, blood glucose, smoking, alcohol consumption, demand for health services, preventive habits) and the difficulties in finding primary care. The instrument of research went through a pre-test in order to adjust the questions according to any difficulties that may be faced.

For the data regarding blood pressure and blood glucose it were used 04 (four) mechanical sphygmomanometers and stethoscopes Premium® and two (02) digital sphygmomanometers DXJ-630®. For glycemic indexes it were used three (03) G-Tech® glucometers and test strips for hemoglicoteste, lancets, cotton and 70% alcohol. For the measurements of height and weight it was used 01 (a) mechanical scale with adult anthropometer Welmy®.

Descriptive statistics were used in the data analysis process. These were transcribed into a database using Epi Info 3.5.2®. Figures and tables were developed in Microsoft® Office Excel 2007. Later, the responses of mixed questions were grouped by keywords as they appeared. The discussion was in accordance with literature.

Given the above and in order to preserve the ethical aspects, the project was referred to the Committee on Ethics in Research UEPB, according to Resolution 196/96 of the National Health Council, and was approved under CAAE 0497.0.133.000-11. It is also worth noting that the participants in this study were informed and were free to participate or not in it, and give up on any of the stages of the research, signing, if so, the term of consent. Along with this, it was requested to the coordination of LABIT, by letter, an allowance for this research.

RESULTS

The research involved 107 male samples aged 18-88 years and overall average of 35.67 years, with predominant age group 18-29 years (40.2%).

In a general sociodemographic characterization of the sample, detailed in Table 01, it can be stated that the predominance was of men who were married or in a stable relationship (49.5%), without children (52.3%), whites (48.6%), Roman Catholics (48.6%), with high school education (29.9%) receiving a monthly income of 2-3 minimum wages (34.60%) and whose main occupation is "employee of private company "(23.4%).

Table 1. Sociodemographic characterization of men enrolled in the Itinerant Laboratory (Laboratório Itinerante) program in cities in the state of Paraíba.

Characteristics	Specifications	n= 107	%
Age Group	18 to 29 years old	43	40,2%
	30 to 39 years old	21	19,6%
	40 to 49 years old	23	21,5%
	50 to 59 years old	9	8,4%
	60 or more	9	8,4%
	Ignored	2	1,9%
Ethnicity	White	52	48,6%
	Parda	45	42,1%
	Black	6	5,6%
	Others	4	3,7%
Education Level	Illiterate	4	3,7%
	Fund. Complete	5	4,7%
	Fund. Incomplete	16	15,0%
	Médio Complete	32	29,9%
	Médio Incomplete	4	3,7%
	Sup. Complete	15	14,0%
	Superior Incomplete	30	28,0%
	Ignored	1	0,9%
Marital Status	Single	49	45,8%
	Married	53	49,5%
	Widower	2	1,9%
	Divorced	3	2,8%
Income	Up to 1 wage	29	27,1%
	2 to 3 wages	37	34,6%
	4 to 6 wages	11	10,3%
	7 or more	4	3,7%
	Ignored	8	7,5%
	No wage	18	16,8%
Occupation	Government	23	21,5%
	Employee	25	23,4%
	Private Employee	22	20,6%
	Student	20	18,7%
	Freelancer	4	3,7%
	Retired	13	12,1%
	Others		

The study subjects live in average with 4.18 people. Altogether, 47.7% of respondents said they have children, with an approximate average of 2.84 children per man.

The origin of these individuals, itemized by Figure 01, followed the LABIT action

achievement, especially the city of Campina Grande, the second most populous city in Paraíba, with a population of 182,249 men and male stage of 50.5 % of care provided.¹³



Figure 1. Geographical distribution of men surveyed and serviced by the project "Health and Quality of Life for Men" tied to the Itinerant Laboratory program in the state of Paraíba.

The second part of the data collection instrument, now dedicated to the research of men's health profile, the first results were related to anthropometric measurements. It showed a mean weight of 76.55 kg and overall height of 1.72 meters.

When individually crossing values, we concluded that 53.0% of these subjects had body mass index (BMI) above the healthy parameters considered, ie, 41.1% of men were overweight, 8.5% obese moderate (Grade I) and 3.8% with high obesity (Grade II), as provided in Figure 02. It was considered as

overweight BMI between 25kg/m2 and 29.9 kg/m2, moderate obesity BMI between 30kg/m2 and 34.9 kg/m2 and obesity elevated BMI> 35kg/m2.

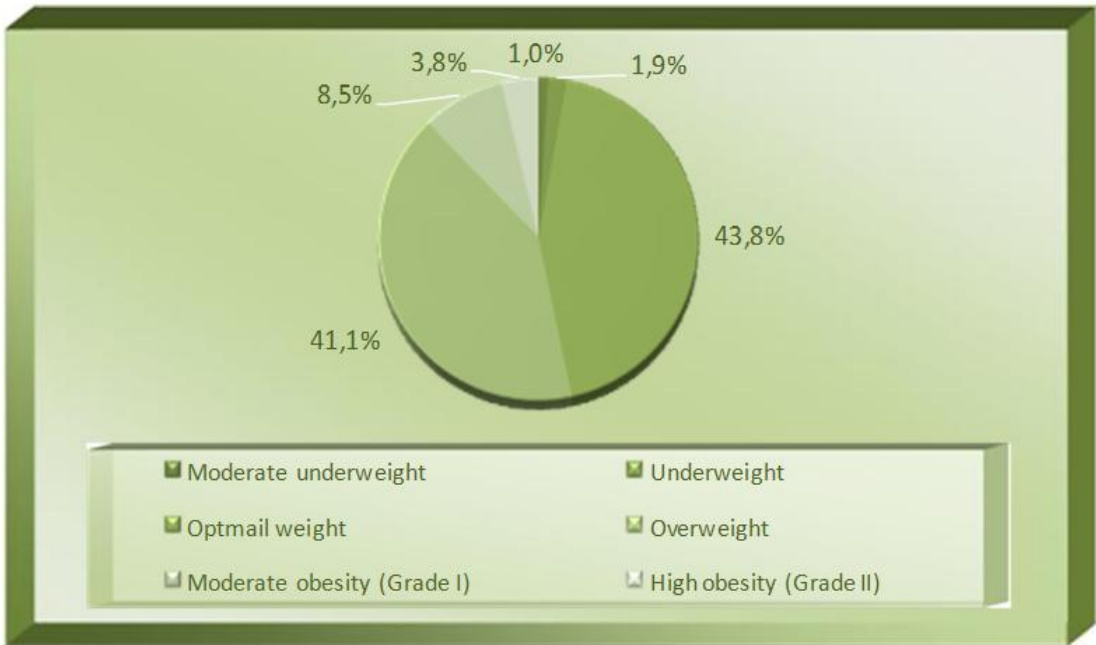


Figure 2. Graphical representation of BMI's of men surveyed and serviced by the project "Health and Quality of Life for Men" tied to the program Itinerant Laboratory.

Regarding clinical data, the participants' blood pressure was verified. There, 24.0% presented increased blood pressure levels at the time of collection, noting that it was considered as increased pressure values >130/85 mmHg. These values were proposed by *National Cholesterol Education Program Adult Treatment Panel III*.¹⁴

The blood glucose of 45 men was verified and the average blood glucose levels was 106.44 mg / dL which is considered normal, since it was not a prerequisite to be fasting. Fasting glucose> 110 mg / dL is considered high.¹⁴

Risk habits such as abusive intake of alcohol and smoking were investigated since they are socially tied to masculine behaviours. According to the respondents, 43% drink alcoholic beverages, 10.3% often, 31.8% occasionally and 0.9% always.

Altogether, 32.7% of respondents answered for how long they have been drinking alcoholic beverages and the average value

reached 11 years, showing that the drinking habit is acquired before or during adulthood. Regarding smoking, when asked, 14.0% of respondents answered yes.

When answering the question "How is your health today?", 17.8% of men reported being with excellent health, 51.4% good and 26.2% regular. Only 3.7% of men judged themselves with bad health and 0.9% very bad.

Most of the men surveyed (55.1%) considered themselves as being careful with their health because they prevented (26.7%), because they had good health habits (21.7%) or because they were conscious (11.7%). When asked how this precaution happened, the most frequent response was generally that they'd seek medical treatment in case of illness.

They were asked which health service they had used in the last year. It was known that 29.0% of men had ties with private health plans. Table 02 breaks down these results:

Table 2. Use of health services by men in the past year.

Health Services *	Specifications	n = 107	%
Clinical and laboratory tests performed?	Yes	58	54,2%
	No	49	45,8%
Required urgent care? (SAMU)	Yes	05	4,7%
	No	102	95,3%
Required hospitalization?	Yes	8	7,5%
	No	99	92,5%
Performed physical therapy?	Yes	05	4,7%
	No	102	95,3%
Attended a basic health unit?	Yes	17	15,9%
	No	90	84,1%

*More than one alternative could be marked

They were questioned how long ago they had last gone to a doctor or dentist in order to add value to the practice of prevention.

The result was that individuals did not attend doctors' offices in 19.77 months on average, and 5.7% reported never having had an

appointment with these professionals. It was also clear that in 22.93 months men did not visit the dentist as a means of routine, prevention or diagnosis and monitoring.

A total of 32.7% said they had health problems, the most frequently cited problem were orthopaedic problems (13.1%), followed by gastric (10.3%) and hypertension (7.5%). The worst of it all is that even claiming to have health problems, 79.4% of these individuals did not receive any treatment and 82.0% did not take any medication.

Only 15.9% of respondents attended primary last year, as shown in Table 02, which is a sensitive indicator of how prevention and male health promotion is being developed, precisely because it represents the point where such strategies are being proposed.

In the final part of the survey, we asked what was the biggest difficulty encountered by men in the search for primary healthcare, as shown in Figure 03. A total of 25.2% of participants responded that the biggest barriers were difficulties regarding the use of health services by geographical factors (unfavourable geographical location of the unit) and socio-organizational factors (the frequent use of tokens and waiting too long in queues).

Poor attendance / dehumanization figured as a response of 16.8% of men, followed by difficulties arising from the socially imposed model of masculinity, such as lack of time due of work, limited hours of the operation unit and the idea of 'I don't need a doctor', cited by 12.1% of the sample.

Finally, the lack of human resources. They cited that the professionals of the Family Health Strategy did not complete the full course load they were supposed to. This was a response of 11.2% respondents as being the biggest obstacle, which was characterized as a discouraging factor to the presence of men who thus prefer Basic Units.

DISCUSSION

The findings of this study converge to the existence of the practice of a socially imposed masculinity that is associated with risky behaviors and actions that make up a real man.

This masculinity profile is linked to ways of living and thinking of men and women, which grow in a cultural mix and the male construct characterized by dominance, heterosexuality and provision.^{8;15}

Our demographic profile translates into practice what once was theory. The 49.5% of married men, the 47.7% who have children,

and the 63.6% of employed men from the sample make up a profile of male household heads and they have in their jobs dignifying positions, which enables them to meet their obligations and undoubtedly reassures their masculinity.

This masculinity turns out to suggest risk habits in an attempt to adapt to a process of building expectations. Research^{16, 20} demonstrate these behaviors in male, highlighting, for example, that the number of smokers is higher among males (20.3%) than females (12.8%), as well as sedentary (39.8 % versus 20.1%) and people who abusively consume alcohol in which there's a tendency to be two times higher in men than in women (16.1% versus 8.1%).

Regarding alcohol consumption, biological and social aspects must be considered. Studies at the Universities of Yale and Columbia related the alcohol intake to the amount of dopamine released, which was higher in males, with an increase of this substance in areas of the brain associated with pleasure, addiction and affirmation, thus explaining the higher alcohol consumption in men.¹⁷

Considering the cultural context, the act of drinking falls still early among the young as a form of male social facilitation, enhancement of sexuality and a way of relaxing¹⁸. This develops in men the habit of drinking before or during the adult age, which is proved by the average duration of 11 years of alcohol intake found in our study, rather than the young age group.

The early use of alcohol demands attention since the sooner the young starts drinking, the more damaging will be the pattern of alcohol consumption in the future¹⁹. This is a major concern. The consumption of alcoholic beverages directly influences the profile of morbidity and mortality, not only with violence but also with the increased risk of chronic diseases like cancer, cirrhosis and hypertension¹⁸.

With regards to tobacco, our results (14.0%) are within the parameter of male smokers in Brazil, which reaches 14.8%, and also indicate that men are ahead of women in this regard²⁰.

Smoking is considered by the World Health Organization (WHO), the leading cause of preventable death worldwide. The WHO estimates that one-third of the adult population and 47% of the entire male population worldwide smokes²¹, entering the lung, trachea and bronchi, in this context, as the most frequent malignant type in males¹².

A sedentary lifestyle also more common in men, when associated with an inadequate dietary pattern results in greater vulnerability to overweight. It is known that excess weight reduces potentially the life expectancy²². Weigh a third more than the ideal, in countries like Britain and the United States, reduces the average life expectancy in three years²².

As detailed in Figure 02, 53.0% of men with BMI greater than what is considered healthy are among the national average of about 52.0% of men presenting overweight²⁰.

The 12.3% of obese patients in our study also are among the percentage of Brazilian men with obesity, in which between 2002 and 2009, the percentage increased from 9.0% to 12.4%. In Brazilian cities, this same index was 14.4% in 2010²⁰. Overweight and obesity are key factors to the development of type 2 diabetes, gout, sleep apnea, cardiovascular disease and male infertility¹⁴.

Regarding hypertension, it is known that the percentage of 24.0% of men with increased blood pressure levels indicated by our study do not correspond to reality, since they refer to a population of young age and diagnosis of this condition becomes more common with age, but equates to the percentage of Brazilian hypertensive men of 20.7%²⁰. A study conducted with 1,339 workers, where 803 were male, showed that the prevalence of hypertension was higher: 38.1% between men²³.

Despite the masculine characteristics, especially alcoholism, smoking, hypertension and obesity are significant in the profile of men's health, causing numerous health problems to these individuals. We noticed that there is not yet a habit of prevention among men, a fact proven by the average frequency in healthcare facilities and medical practices found in this investigation.

It is understood that the men definitely do not usually attend health facilities. The demand for primary care occurs mostly by elderly men, due to better understanding facing primary care often for dispensing drugs related to chronic diseases.

There is not a sense of belonging to that place. They consider the environment of health facilities feminized because they were oriented to be active, strong, productive and feel invulnerable²⁴. This speech is implicitly evident in 95.4% of the responses from men who considered themselves with good health, excellent or regular, rather than the percentage of men with health problems which reaches 32.7%.

Some authors¹ believe in a natural determination of invulnerability which is very comfortable and disclaims responsibility for men's behaviors and attitudes. And even when they have health problems, the search for medical assistance by men occurs from the recognition of symptoms thought to be serious. The 79.4% who received no treatment for their diseases and the 80.0% who did not take medication translate very well this framework.

Thus, there is reinforcement of the idea that men prefer actions that seek to solve their problems in an objective way. This happens in pharmacy counters or in emergency, which restricts the actions in care practices or in an emergency basis¹⁵.

There is a strong belief that health care is just treating disease. When asked whether they are careful with health, most said yes, because they went to the doctor when they got sick.

It is important to recognize in this context that the needs of men regarding their health is not confined to diseases. Thus, health care should include preventive measures and the implementation of educational activities to promote health, strengthening primary care.

However, in this study we observed a gap between these individuals and input services of the health system. An absence that inevitably compromises the expectancy and quality of life and could be reversed with preventive measures and health promotion for the thread³.

The idea of having a larger amount of programs that seek out an approach not of risk and harm but of health as satisfaction of human needs, integrated with other health strategies of the country is essential to act maximizing efforts and minimizing costs, not competing for investments aiming other policies nor creating isolated compositions.^{12;25}

Therefore, actions for the Health Care of Man (Atenção à Saúde do Homem) are required to promote the acceptance and accessibility of men in general and to be more attractive, not only answering the demands, but bridging the barriers to use of services such as difficulty reported by most men in our research. Some studies also share the idea that besides the difficulties in service entry, the lack of personnel to work with this the limited hours of operation are the major difficulties in the interaction of individuals with primary care service^{9; 26}, factors supported by our findings and presented in Figure 03.

Thus, it is important that men understand the difficulties of access to Basic Units and that this strengthens the distancing of them from the health service. Moreover, the lack of programs or strategies targeted to men, and the very concept of masculinity, results in a greater difficulty of interaction between men and health services⁸.

It is noteworthy to remember that the participants of this research even though they had flexible hours, since they had no formal job, and being able to get the help of basic units in the period established for its operation, choose not to do so, which reinforces the thesis that is necessary to understand the issue from the perspective of gender issues involved in this context.^{8;24}

CONCLUSION

Based on the data of this investigation, it was found a profile of risk adopted by the male subjects, and when combined with the conception of male invulnerability culturally imposed, these interfere in the promotion and health care of these individuals resulting in higher prevalence of avoidable injuries and the high rates of morbidity and mortality.

Also there's the lack of effective strategies and programs to improve the care for men. We noticed a lack of these individuals in primary health care, so we need to go where the men are. Thus, we need to start investing in the emergency as a place of prevention in a humane way, it is a great way to encourage men to take a second glance to their values and practices, promoting secondary prevention.

Harm reduction should be a basic principle in health actions, since we realized that men make up the portion of the population that consumes more alcohol and other drugs, it is essential to work with this segment, rejecting punitive and restrictive measures. We must implement strategies to reduce the damage brought by discussions on gender and masculinities.

Managers and health professionals need to review practices, concepts and values. This process must promote criticism of sexist attitudes that often do not allow men to realize that they also have specific health needs.

Information is the basis for any public policy. We know little about the health and illness of men. Therefore, studies like this are above all relevant in the generation and dissemination of systematic data on the key needs of men in terms of health, the main

causes of illness and death, and on accessibility of services to ensure that public health policies as a way of exercising citizenship and social control.

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