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ORIGINAL ARTICLE

MEN'S HEALTH: REFLECTIONS ABOUT THE ACCESS IN A FAMILY HEALTH UNIT SAÚDE DO HOMEM: REFLEXÕES SOBRE O ACESSO EM UMA UNIDADE DE SAÚDE DA FAMÍLIA SALUD DE LOS HOMBRES: REFLEXIONES ACERCA DEL ACCESO A UNA UNIDAD DE SALUD DE LA FAMILIA

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ABSTRACT

Objective: analyzing the access of men assisted by a Unit of the Family Health Strategy. **Method:** a descriptive, exploratory study of a qualitative nature carried out between October 2010 and August 2011. There were used participant observation and interview technique conducted with eighteen men in compiling the data. It was used the technique of Content Analysis to analyze the information. The study met the standards of Resolution 196/96, which approved the project at the Research Ethics Committee, CAAE n° 0395.0.133.000-10. **Results:** it was showed the invulnerability as a constituent of being a man; the biological focuses on self-care and the service organization as an obstacle to men's health. **Conclusion:** the understanding of issues involving the concepts of masculinity contributes to improve access of man to health services. **Descriptors:** Men's Health; Access to Health Services; Family Health Strategy.

RESUMO

Objetivo: analisar o acesso de homens assistidos por uma Unidade da Estratégia de Saúde da Família. **Método:** estudo descritivo, exploratório, de natureza qualitativa, realizado entre outubro de 2010 a agosto de 2011. Utilizou-se a observação participante e a técnica da entrevista realizada com dezoito homens na produção dos dados. Utilizou-se da Técnica da Análise de conteúdo na análise das informações. O estudo cumpriu as normas da Resolução 196/96, sendo aprovado o projeto pelo Comitê de Ética em Pesquisa, CAAE n° 0395.0.133.000-10. **Resultados:** demonstrou-se a invulnerabilidade como constituinte do ser homem, o enfoque biológico no autocuidado e a organização do serviço como obstáculo à saúde dos homens. **Conclusão:** a compreensão das questões que envolvem os conceitos de masculinidade contribui para melhorar o acesso do homem aos serviços de saúde. **Descritores:** Saúde do homem; Acesso aos Serviços de Saúde; Estratégia Saúde da Família.

RESUMEN

Objetivo: analizar el acceso de hombres asistidos por una unidad de la Estrategia Salud de la Familia. **Método:** un estudio descriptivo, exploratorio de carácter cualitativo realizado entre octubre de 2010 y agosto de 2011. Se utilizó la observación participante y la técnica de la entrevista realizada con dieciocho hombres en la compilación de los datos. Se utilizó la Técnica de Análisis de Contenido para analizar la información. El estudio cumplió con las normas de la Resolución 196/96, que aprobó el proyecto al Comité de Ética en la Investigación, CAAE n° 0395.0.133.000-10. **Resultados:** mostróse la invulnerabilidad como constituyente de ser hombre, el enfoque biológico en el autocuidado y la organización de servicios como un obstáculo para la salud de los hombres. **Conclusión:** la comprensión de las cuestiones relacionadas con los conceptos de la masculinidad contribuye a mejorar el acceso de los hombres a los servicios de salud. **Descriptores:** La Salud del Hombre; El Acceso a los Servicios de Salud; Estrategia de Salud Familiar.

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INTRODUCTION

The term << access >> refers to the possibility of inclusion of the subject in the health service focused on solving problems that affect health. This concept permeates the axis demand-supply; however, involves a network of interactions and multidimensional and dynamic contexts.¹

With regard to the access of people to health services, it is understood that there are aspects that reflect the limits and possibilities of comprehensive care. Such aspects may be related to geographical factors, organizational, social and cultural.² These factors have direct influence on how individuals access the service, leaving a reflection on offer, quality and continuity of care, this is including resoluteness of shares.³

Access can be understood even with an expanded perspective that makes possible to identify the factors that influence how individuals seek the service. In this sense, it assumes importance the social and cultural factors, like the gender relations⁴, which reflect differently representations of health and disease. As a product of these relationships, it attributes to women the role of care, while men are led to a model of masculinity that culturally is away from the care practice.⁵ From this perspective, it is understandable that there are differences in the way subjects live fall ill, access services and meet their health needs. Such differences should be considered for overcoming inequalities.¹

This understanding led to the expansion of man's health care line, especially from the National Integral Attention to Men's Health Policy (PNAISH) established in 2008. The PNAISH arises as a way to legitimize and extend the look the population of men, which in proportional terms, fall ill and die earlier than women and has high morbidity and mortality rates by preventable diseases.⁶

Man's morbidity and mortality profile is related to greater exposure than women to risk⁶ factors, which in line with a socio-historical construction and gender influences on material positions, symbolic and in care practices.⁷

In the midst of these barriers, there is the conception of care as something detached from the man who interfere in how this process understand their health and disease, which often presents incipient⁸, as well as interfere in the way accesses the service health in its different levels of care.⁵

Within the framework of primary health care, specifically in the Family Health Strategy (FHS), the gaps in health care consist of man from the inadequacy of the structure to meet the incipient motivation and development of promotional actions against the most common diseases in this population.⁹

Regarding the hegemonic concepts of masculinity, which are also candied in professional practices, attention to men's health has many weaknesses that need to be focused. The approach to man's health must be guided by the comprehensive care, to devise man's health beyond the genitility and/or paternity, who understands through a broad concept, focusing on masculinity, this is entering the reflections on man teenager, young, adult, elderly, the homoaffective.¹⁰⁻¹

The work developed by the FHS is configured as an important tool in creating bond with men, in identifying their needs, as well as developing strategies that facilitate access. The FHS, as capacity of care in an attached territory, has the challenge that involves integrating this population to care practices, considering all the social construction, organizing team work process to an audience that was not prioritized historically, when compared to population of women and children.⁵

Understanding the importance of care to man's health, this developed study had the following guiding question: How does the man access to health services? Therefore, this study aimed to analyzing the access of men assisted by a unit of the Family Health Strategy. It is expected to contribute to expansion of knowledge on this topic, especially for the incipient scientific literature on the subject. In addition, it is expected to direct some possible ways to implement the comprehensive care to human health.

METHOD

This article is an excerpt of the search results << Evaluation of primary prevention actions and control of Sexually Transmitted Diseases and HIV in men attending a basic unit of family health >>, under the Education Program for Working for Health, Health Action Line for Man, regulated by Ministerial Order 421/2010 of the Ministry of Health of Brazil.

This is a descriptive and exploratory study of a qualitative nature. This approach applies to the study of relationships, perceptions and opinions derived from interpretations that individuals make about how they live, feel and think.¹²

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The scenario chosen was a FHS called José Pinheiro I, Teams I and II, which belongs to the district Sanitary I in the city of Campina Grande-PB, which provide care for seven years. The mentioned FHS serves 1.923 families corresponding to 6.268 people living in the neighborhoods of José Pinheiro, Santo Antonio and Monte Castelo.

The territory of the FHS José Pinheiro I is divided into 12 micro-areas, ranging from 480 to 570 people per micro-area. The teams are composed of Community Health Agents (12), Physician (1) Nurses (2) Social Worker (1), Dentist (1) Oral Health Assistant (1) Nursing Assistants (2), Auxiliary of General Services (1) and Vigilants (2). There is also a Core Team to Family Health Support, composed of physical educator, physiotherapist, psychologist and nutritionist.

The population under study consisted of men between 25-59 years of age, belonging to the enrolled area served by the FHS José Pinheiro I. In both teams there are about 1.200 men in this age group. The sample consisted of 18 men, allowing for meaningful representation of the desired data from the criterion of saturation of answers. The men were randomly selected by lot. Inclusion criteria corresponded to the presence of registration of users in FHU José Pinheiro I, being from the age 25 to 59 years old, as recommended by the National Health Policy for Men⁶, and accept participating. Exclusion criteria were not desire participating and not be available to respond to the questionnaire by work schedule incompatibility.

Data collection was carried out during the period from November 2010 to August 2013, which followed a predetermined schedule consisting of two stages. The first stage corresponds to the application of an interview with men users, through a semi-structured instrument validated by pre-testing. The second moment corresponded to the participant observation, since the researcher is Nurse Service, so it was possible to document through the records, changes in professional work process, the host workshops, as well as changes in the structure on accessibility to the health service.

The study fulfilled the determinations issued by Resolution 196/96, in force at the time, being appreciated and approved by the Ethics Committee of the State University of Paraíba, under Presentation Certificate for Ethics Consideration nº 0395.0.133.000-10. Thus, it picked up the fundamental scientific and ethical requirements, guaranteed the respect for the autonomy of individuals and confidentiality of data collected by signing the

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Informed Consent. The transcribed words were identified by the initial letter of each name, then age at the time of the interviews.

Data collected in interviews were analyzed using content analysis technique in the thematic mode, because that way it is possible to encode the information, transforming them from a raw state in a possible representation of the content.¹³

In analyzing the data the following empirical categories were extracted: the invulnerability as a constituent of a man, the biological approach to self-care and the service organization as an obstacle. The categories were discussed in light of studies that discuss the themes masculinities, gender and access of men to health services.

RESULTS AND DISCUSSION

Respondents had corresponding education to higher education (03), high school (5), elementary education (6), and of them were illiterate (4). Concerning occupation, most held informal work (8), a lower proportion held formal work (4) and the rest were unemployed (2), were retired (2) or students (2). Household income amounted to three minimum wages (12), the other lived with help from parents and wife or with informal income (4) and the rest had retirement of one minimum wage (2).

The analysis of the profile variables did not refer to significant differences in access to health services. However, it reveals characteristics of the largest social and economic vulnerability, such as low per capita income, and shows the predominance of low education and the performance of activities that require less formal qualification and hence lower remuneration.

♦ The invulnerability as constituent of being a man

The correlation of care as opposed to the male takes shape when men do not see themselves as potential care subjects, when it cease to encourage them to promotion practices and preventive health care or do not recognize cases where they demonstrate such behaviors.⁸

It was found from most of the speeches of the participant men that care is understood as something that is not yours, as a practice that is not necessary.

No, because I don't need. (P. 48 years old)

Only boys who always will; I never needed, when I need to have to go, right? (F, 32)

No, no. People say it's good, when I need to I will. So far, I never needed. (P, 46)

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No, because I tried not know these things not. (G, 43)

This perception of invulnerability is also contemplated in the speech of others interviewed, when addressing that disease never had in life. Understanding the state of non-illness relates to adopt isolated preventive habits and the absence of signs and symptoms.

Because of this perception of invulnerability, the man becomes more susceptible to diseases that could be avoided through preventive measures. Several studies point to a correlation between high rates of mortality among the male population due to delayed search to health care.⁹

In the field of human health, research indicates that men in general are more exposed to unhealthy work situations¹⁴ and seek confrontation with the risk situations as a structural feature in the construction of male identity, combined with a feeling of invulnerability, which implies high death rates from violent causes.^{15,16}

Only one of the respondents reported accessing the service as a way of routine assessment and disease prevention. In fact, the actions developed involving men's health are punctual and restricted therefore ineffective.¹⁷

It appears from an important aspect that relates to access to the service and the opportunity for comprehensive approach by the health team. The FHS was set up as the closest to the user access via the best means of potentiating a preventive attitude, and by encouraging awareness of the importance of health promotion and prevention practices. Therefore, the user by the service drive should be considered as an opportunity for the FHS staff can implement man raising actions for the activities of prevention, promotion, protection.

Men's access to health care, extended care in perspective in its various senses may appear as secondary and logistical support. The man sees himself as the one who takes the wife, son and/or mother ill for official health services.¹⁷

In this sense, it is relevant to gender perspective about the subject of relationships and its influence to understanding care. It emphasizes the importance of mainstreaming this approach in care actions, but also through critical reflection together with managers and professionals⁸ for designing promotional strategies to men's health.

In the context of traditional conceptions of gender, hegemonic notions of male and

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female outline the concepts, attitudes and practices of the subjects regarding the processes of health and disease and in determining the care; you see the association of care and illness as unattainable positions to men.

The imagery that associates, in polo, women's health care and on the other, the male to non-care, is reflected negatively in demand for health services. According to this imaginary produces the expectation of individuals and of society that men do not take care of themselves or even other people and therefore do not seek services or make less authentic way.^{8,18}

Based on this premise, the actions of individuals and health professionals can, in day-to-day assistance to strengthen this dimension of male invisibility in demand for services⁸. Therefore, there is an emerging need for the mainstreaming of action to understand the social construction of gender, both for professionals, which is reinforced in PNAISH⁶, but also in health education actions the population, which can lead to the empowerment of men about their living conditions, health and illness.

The male empowerment is linked to the autonomy of the subjects and forms an essential part for comprehensive health care and points to a health dimension as a project, which involves self-determination with interdependence to build decision-making processes, communication dialogue and development of therapeutic projects of individuals in care management.

This care management is understood by some authors as the degree of adjustment needed for the reform of health and society, which depends on the agreements and disagreements between projects of health professionals, policy makers, managers and users.¹¹

In this dimension, it is understood that to achieve the full health care in the male population, there should be considered other relational aspects, beyond gender relations, such as age, socio-economic status, social determinants of health, cultural contexts and forms of life, understanding health as a multiple and complex social production⁶, with a portion of people's lives, and starting from the position that masculinities are constructed historically in a constant process of transformation.

♦ The biological approach of self-care

When asked about the demand of the health unit of the family of the neighborhood, a considerable part of the respondents

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reported that the search for health services came to performing procedures.

Once. I went to remove the stitches from surgery. (M, 45)

It's been a long time since I looked for a health service, only to take vaccines last year [job requirement]. (G, 36)

I went only once to the Health Center because of a dog bite. (P, 48)

Some studies indicate that the demand for men is higher for performing procedures and in clinical dentistry and related to vaccination services, curative and pharmacy.⁸

This perspective is emphasized in the common search to dental service as one of the priority forms of access to BFHU of the neighborhood:

I searched many times. Only for dentist. (F, 32)

The motivation to access the service is still strongly linked to a health approach to the interventionist point of view and not facing a comprehensive and preventive care.

In this way, it should encourage interdisciplinary approach to care, which can be valued by the search for interaction and integration of men who are captured by performing procedures and the provision of dental care in service with other team members. That way, you can offer it so the service menu available through the multidisciplinary care.

Such access, even if initially focused on this approach can through listening and acceptance, resize new forms of care and generate greater linking of man to team members, in addition to strengthening demand for care prevention, promotion, protection and health treatment.

However, it is clear in the speeches of some respondents that there is a weakness in the understanding of the motivations for seeking the FHS, which, in turn, reflects the fragility of the service.

Yes, but appoints when we're not sick anymore, cannot afford. (G, 40)

Only once. Longer needed urgent examination of urgent medical attention, then we have to score and passes 3, 4 days to be served, then in my case does not, 'll go private. (M, 45)

Yeah. When I was shot, it was the only time I had to, just go when I need to, but as I did not need was not. (C, 32)

Understanding the service as a space for care of illness states, these are including acute cases, denotes the appreciation of staff for the care and the community's relationship with the same, but also highlights the incipient knowledge of the user to the

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organization's network services offered, especially about actions that need to have their resolution of character at each level of attention.

When the user comes to the search for unity when it was gunshot victim, this denotes ignorance because the specter of action of BHU professionals to these situations is restricted, while the assistance to small emergencies.¹⁸ At the same time, leads to reflection about the importance of accepting the individual in cases of illness and make them aware about the solvability limit the team's actions in ensuring their care.

The FHS is one of the components of the health care network this user and it is up to the rest of this network, continuity of care, to ensure the integrity and the universality of access to the various care levels in its complexity, in all care levels.¹⁹

One should reframe care, providing a better understanding of the work in the FHS, understood as a collaborator of shared care between the team and the man, leaving both the incentive for these practices.

On the demand for health services, some studies indicate that young men are those who have higher rates of hospitalization and death from external causes such as homicide, violence and drug abuse.⁶ Such health problems are directly related to socialization processes, which generally encourage risky behavior at the expense of caring for themselves and others. An offshoot of this social practice is the greater presence of men in urgent and emergency services for primary health care in health in Brazil, according to the own Brazilian Ministry of Health.²⁰

In the context analyzed, you can see the frequency of access of men with Chronic Noncommunicable Diseases (NCDs).

There several times already. High blood pressure, diabetes and headache. (J, 59)

Already. Heart trouble, fatigue, gastritis and on a recipe I've been taking because some time ago I was taking prescription drug to sleep. (D, 26)

Access is presented as one of the elements of the health system, among those linked to the organization of work processes, which concerns not only the entrance, but the continuity of care, as in the case of care provided to individuals with NCDs. The model of care that grievances of group-anchors on improving the quality of care to the subjects through a proactive approach, able to predict and anticipate possible complications and exacerbations of the disease and present the involvement of patients, their families and community.²¹

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The speech of the men interviewed reveals the ease of access, at least with a more organized flow, by virtue of being inserted into continuous care logic as in care programs to hypertension, diabetes and mental health programs that have a history of construction, service organization and direction of the previous PNAISH care.

Another dominant perspective in looking men at the service took place by seeking care for illness states, as seen in the following lines:

Yeah. Just a normal consultation it, it was flu, only throat. (G, 40)

I'll come soon. So I feel a pain here inside, as if it were burning. (R, 48)

This understanding enhances the search services taking place predominantly through the care model centered on disease and not on the individual, with a booster for a biological self-care approach.

It is noticed the biological approach of the transverse mode care in different lines, since the search service reasons anchor primarily on procedures and disease. The focus of curative medicine, outdated in terms of policy, is crystallized in understanding the subject, in the arrangement of services and professional practices. However, the reorientation to health care model with the SUS implementation, demand the extension of care approach, in order to guarantee universal access and comprehensive care.

♦ The organization of the service as an obstacle to health

The organization of the health service should provide qualified and humanized care listening in order to accommodate the demands of the population. In the speeches of some respondents see that this dimension is presented fragile:

The difficulty is to make an appointment for the consultation, right? It's been over a month since I cannot make an appointment, when it has there is no more place. The only thing I have to say here is that because doctors are too good. (J, 68)

Difficulty is great, because the service is bad; the service is there bad, very bad. You get there by 5 am in the morning when my wife was stood in the queue; in time to get the plug the receptionist says that over the passwords. Give two or three passwords to one person, there is the other people with no password, then she says is so many people with a number of chips, then gives 3 records to a single person, that is three people back there that did not receive there back, then I do not seek that post for it. (M, 45)

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Some authors mention the difficulty of users' access to health services, as one of the major obstacles to generate assistance²² and organizational barriers as influential and/or generating these barriers.²³ Therefore, you should invest in a multidimensional understanding of access with attention to social and cultural aspects necessarily present in the formulation and implementation of health policies.

Weaknesses access are reinforced in the speech of two users, when highlight the difficulties in solving the service, the structuring of the service network, but also in work management professionals that make up this network:

The difficulty is if you have the product [medicine, condoms] to give us, because then we leave empty-handed. The difficulty is if there is a strike, because no one works without receiving. (G, 36)

There are times that have many difficulties within hours they hinder. (A, 36)

Now you have some tests there is to do, you know, but it's been two months that I fight to get the results and collect my exams that did not come until now. If you can afford to make particular and can take it is better. (G. S., 53)

The multidimensional nature must be motivating for organizing services in order to enable greater accessibility and suitability as the population's needs through quality care in order to legitimize the acceptance of this population.³

Speech of GS (53 years old) refers to a strand of accessibility, which is the resoluteness of actions within the Primary Health Care (PHC), including the FHS as an important component within the Health Care Network (RAS). Ensure the realization of tests and procedures, within the network, is part of the guarantee of accessibility, which refers the need for an organization of the whole system, in order to allow universal access.

Discussions concerning advances and limits are needed to guarantee this access within the public health system, since the limits are associated mainly to socioeconomic factors and the expansion of supply of services in the primary care network, which is still restricted.³

As regards the valuation of the private sector over the public health system, the autonomous private sector, generally known as the sector linked to health plans, it appears, however, represented in the social imaginary as reference assistance best quality of risks and the unforeseen health problems. Marketing strategies conveyed through the

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media undoubtedly contribute directly to the promotion of design for greater efficiency of supplementary medical attention, emphasizing their speed and resolution.²⁴

An important aspect reported by men relates to the reasons for difficulties in accessing considering opening hours in service.

I work, I have to arrive an hour this afternoon's lost. If it was faster was better service. (G.S, 53)

One perspective this speaks refers to ways of working that men fall that, in a sense, can weaken this understanding of care. Some authors^{20,25}, the work is an integral part of masculinities. So consider this variable in the organization and functioning of primary health care facilities in health is needed. However, this consideration is not only related to men and, yes, to all persons in the labor market.¹⁷

So to better targeting and health care strengthening is needed to understand the different meanings of being a man and what services roster of devices offered by FHS the individual needs use.²³

The organization of the service and the welcoming attitude of the professionals is vital to structure an appropriate service to people's needs. It emphasizes the importance of analysis of the services offered by BFHU, verifying if they are consistent with the needs of the male population, since the access organizational barriers may be present due to lack of demand study, the type of service offered, the waiting time and scheduling needs.

A relevant aspect about the work process in health care from the perspective of access, related to the issue that some users do not find the services listening their demands, especially if these are expressed in different ways those already enshrined in assistance context traditionally female.^{24,25}

The low frequency of men in service is usually given by professionals as related to the strength of men coming to services. But generally it does not recognize the low inclusion thereof in care proposals.¹⁷

It can be seen a relative change in the communication standard of the Ministry of Health, by the inclusion of gender references, generation and race/ethnicity in health education materials produced. However, still have weaknesses with the work process of the FHS teams in their local productions, due to have little scope in terms of ambience and promoting health. It can be seen very strong personal brands influenced by gender imagery that are implemented in public

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environment/institutional health, with enhanced feminization, such as the use of decorative figures.⁸

Because of these aspects, health services have little ability to build a man host culture and need further review, the dictatorship of heteronormativity in the construction of professional attention.²⁶

The distance service in daily human health practices is evident in the interviews, when most of the men reported that the main route of access to information comes from the media, printed materials reading and other sectors.

I have already received, on television, posters on the wall, we always see and learning. For health professionals not. (G, 36)

The organization of the service should include access to popular education initiatives in health, so that the population in this by inserting man, can be perceived as part of the care process and that this care denote sense for it.

♦ A proposal for a change on men's health practices

The study scenario consists of two teams, had own work forms. In both practically nonexistent care to men, these being recorded only in the care of people with chronic diseases, such as: hypertension, diabetes mellitus and mental disorders. In most, the profile of care was predominantly geared to women in their various life cycles and children.

Sporadic cases of men who came to the service aimed to spontaneous demand and we schedule the male population, the exception of men with systematic monitoring of NCDs, were made by their wives, daughters or mothers who came to the service performs them and most of the time, they did not attend.

The demand for inputs for this population also happened by women, whether they are partners or mothers, as demand for condoms and drugs. Few accessed the service in search of immunization and were restricted to those who had obligation to update the vaccination schedule for admission to employment, procurement, training or because they would travel to other states. Was looking sharper men for withdrawals points and making dressings.

The agenda of the staff endorsed operative reflection of female predominance in the unit, with no specific time reserved for man, nor easing receptivity of immediate demand, in

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case of appearance thereof, without scheduling.

The appearance of the unit did not make it a neutral environment for purposes of any individual but was overloaded with images of flowers or child objects, which directed a more feminine connotation and child to the environment. There was little information on ways to access, opening hours and channels for complaint demands, such as availability of contacts of local and national ombudsman, and suggestion box.

In the process of working with professionals there was an active listening and an understanding of the historical process of social construction of man on health care and so the speech of professionals did not value the time gold of a few men who sought the service, not valued them as individuals with rights of their health, so that associated the designation of someone's husband, someone's son and father of someone and not be unique, with right of access and individuality.

The invisibility of man also extend to home visits from health community agents that addressed the predominantly women of the household, even to know information about men's health, even the man being at home and being the person who opens the door.

Regarding the active search for the evaluation of health status, this was camouflaged, when it came on human health, since professionals resigned in speeches that men did not like these things, when in fact professionals not allowed reflect on the reasons for the poor access of men to the services provided by BFHU and ended up playing a barrier, built of social order, historical and cultural, working process of almost all professionals.

From this context, some strategies have been designed and developed by the team, including: The creation of a specific time for the man in the scheduling of teams, flexible spaces for spontaneous demand calls, should they come to the unit for emergency situations the integration of the entire staff in order to improve the capture of this man-golden moments on the drive, as in immunization, in dentistry, in procedures or for information at the reception in order to capture it and perform his schedule for consultations subsequent or other services available from the FHS menu.

It was also thought on the availability of more easily in obtaining condom and without identification, as before, with the same available in all halls of the unit, at the front

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desk, waiting room and auditorium, tote bags, facilitating access to thereof.

In order to improve the ambience, there were taken images that direct specific groups. The teams decided to make the welcoming environment without infantilisms and feminization, but instructive guidance for any individual seeking the service.

As a way to improve the reception were held several workshops that addressed topics such as risk rating, self-care, professional ethics, active listening and teamwork. From all this redefinition, some suggestions have emerged in addition to the establishment of the welcoming attitude of all professionals. It was thought in the shared and more direct accountability of all, by creating the shift welcoming figure, where all professionals in the FHS take turns to perform listening and help with directions individuals who seek the service.

It was up to the cozy provide clear, direct to individuals in various sectors of the unit, reception, immunization, screening, pharmacy. For this was also thought identify them with a robe with the inscription can I help? As was also performed the preparation of a manual support with reference service information, contacts, flows by lines of care and general observations. Due to professional attitudes, the shift welcoming the proposal did not materialize and the manual could not be implemented.

The comings and goings of construction and reconstruction of these roads, it prepared an educational brochure explaining important aspects of the prevention and the importance of self-care that were given to the CHAs, in order to be distributed in home visits to men as a way to capture them.

From all these actions, the access of men to service increased significantly. Previously the average service the male population, via Tab data of the acts served the medical and non-medical calls (AVEIAM) was around eight weekly, except for men with NCDs, this average rose to about 20 weekly visits. In addition, the guidelines have been implemented on immunization, preventive care and participation in educational activities across in waiting rooms and other moments of health care.

From the idea of the medical teams, together with other professionals, created a health project in the territory (PST) facing the male population, while naked cup. This is a football tournament, which in 2013 added men of the entire east side of the city for 15 Sundays of the month from September to

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December. From that event materialized if the project is Sport Health, which took place prevention guidelines and health care, delivery of condoms, weight check, blood pressure, and waist and blood glucose. Men raised in this health action were referred for further consultation on the drive when necessary.

FINAL REMARKS

From the initiatives men were captured and became aware of the care of their health, increasing the demand for them for the service. The change of men's practices reinforced the importance of welcoming attitude by the professionals, through active listening, as crucial to break the paradigms relating to low demand of men to health services or their little interest.

The organization of the work process of the FHS teams, with the conduction of an effective host, understood as a working guideline, facilitated the adherence of men to care about their health. Associated with these factors, understanding by professionals and users about the influence of the issues surrounding the concepts of masculinity in gender approaches, contributed considerably to make access as the primary man as the other groups.

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