ABSTRACT
Objective: to investigate the therapeutic itinerary of men to the hospital with a diagnosis of encephalic vascular accident (EVA).
Method: exploratory and descriptive study, with qualitative approach, conducted with 14 hospitalized men at a large hospital in Belo Horizonte/BH due to the diagnosis of EVA. The data were obtained from an interview with a semi-structured guide and from the analysis of the medical records.
Results: the results show that the routes are quite diverse and are all marked by the logic of the user who does not always make the route recommended by the protocols. The men’s autonomous route is determined by access difficulties and solution of their problems. This logic is marked by aspects of masculinities socially shared by men, such as being strong, unwavering, protector and provider.
Conclusion: there is need for advancing the functioning of the health care network, considering the men as unique subjects and with health needs.
Descriptors: Delivery of Health Care; Men’s Health; Therapeutics; Masculinity.

RESUMO
Objetivo: investigar o itinerário terapêutico de homens até a internação com o diagnóstico de acidente vascular enCEFálico (AVE).
Método: estudo exploratório e descritivo, de abordagem qualitativa, realizado com 14 homens internados em um hospital de grande porte em Belo Horizonte/BH, devido ao diagnóstico de AVE. Os dados foram obtidos a partir de entrevista com roteiro semiestruturado e da análise dos prontuários.
Resultados os resultados revelam que os itinerários são bastante diversos e todos são marcados pela lógica do usuário que nem sempre faz o percurso preconizado nos protocolos. O percurso autônomo dos homens é determinado pelas dificuldades de acesso e resolução dos seus problemas. Essa lógica é marcada por aspectos das masculinidades socialmente compartilhadas pelos homens tais como um ser forte, inabalável, protetor e provedor. Conclusão: há de se avançar no funcionamento da rede assistencial, considerando os homens como sujeitos singulares e com necessidades de saúde.
Descritores: Assistência a Saúde; Saúde do Homem; Terapêutica; Masculinidade.

RESUMEN
Objetivo: investigar el itinerario terapéutico de los hombres al hospital con un diagnóstico de accidente cerebrovascular (ACV).
Método: estudio exploratorio y descriptivo, de enfoque cualitativo, realizado con 14 hombres ingresados en un hospital grande en Belo Horizonte/BH debido al diagnóstico de accidente cerebrovascular. Los datos fueron obtenidos a partir de la entrevista semiestructurada y el análisis de los registros médicos.
Resultados: los resultados muestran que las rutas son muy diversas y están marcados por la lógica del usuario que no siempre hace la ruta recomendada en los protocolos. La ruta autónoma de los hombres está determinada por las dificultades de acceso y resolución de sus problemas. Esta lógica está marcada por aspectos de la masculinidad socialmente compartidas por hombres como ser fuerte y firme, protector y proveedor.
Conclusión: hay necesidad de avanzar en el funcionamiento de la red de atención de la salud, teniendo en cuenta a los hombres como sujetos únicos y con necesidades de salud.
Descritores: Prestación de Atención de Salud; Salud del Hombre; Terapéutica; Masculinidad.
INTRODUCTION

The encephalic vascular accident (EVA) is defined by the World Health Organization as a focal (or global) disorder of the brain function of rapid evolution. It is considered as the health grievance with the highest rates of morbidity and mortality worldwide.¹

It results from systemic complications, often related to conditions of chronic noncommunicable diseases. Properly monitoring these conditions and the change in the related risk factors can prevent acute conditions as EVAs.²

Brazil has been changing its epidemiological profile, with noncommunicable chronic diseases leading the causes of morbidity and mortality. Hospitalizations from encephalic diseases, in 2009, recorded 160.621 cases. Of that number, about 115.808 were considered causes sensitive to primary care.³

The concept of conditions sensitive to primary care⁴ is a set of health problems for which effective action of primary care may reduce the risk of hospitalization, such as disease prevention, diagnosis, early treatment and monitoring of chronic diseases.

Men and women share the same traditional risk factors for EVA. Due to attitudes and lifestyles, the men are the leaders of risk factors indicators for encephalic diseases, have the worst rates in the protection measures and use less health care. Therefore, they are most vulnerable for EVA.¹⁵

Most studies find higher rates of mortality from EVA in men when compared to women. The life expectancy of men compared to women can be understood as only one parameter that, added to social, cultural and political processes, enables understanding the different degrees of vulnerability that may be present in the male population.¹²⁶

From these findings, in the last twenty years, the debate about men’s health has gained more notoriety in the spaces of knowledge production in health services and the public policy agenda. In the country, it is noteworthy, in 2009, the launch of the National Policy of Comprehensive Care to Men’s Health (PNAISH - “Política Nacional de Ação Integral à Saúde dos Homens”), with the objective of improving the men’s health conditions with actions that seek to break the men obstacles in using the health services.⁷

Despite recent, it is observed that the implementation of PNAISH has occurred very differently across the country. Health professionals and managers do not always have the knowledge necessary for implementing the recommended actions, making it difficult to improve comprehensive care for the male audience. In addition to this, there’s the policy’s that brings no further discussion of gender, placing man in a marginal position, who must be saved from himself or reducing him to prostate disease.⁸

Barely visible regarding the ESF, the men are quite noticeable in emergency scenarios, a concerning fact for this study’s researchers. A study that analyzed the Brazilian reality points to this male prevalence in emergency scenarios. In these spaces, these individuals are often attended more quickly and can expose their problems more easily.⁹

The therapeutic itinerary was chosen as a tool to know the ways and strategies adopted by men affected by EVA, for it enables understanding the coping with health issues and disease, modeled from the context in which individuals live, as well as economic, social and cultural aspects that organize collective and biological life, resulting in a space of action and social interaction.¹⁰

Still considering the therapeutic itineraries, it is observed that, in most studies, the medical, care or therapeutic itineraries are highlighted, corresponding to the sequence of care resources to health, from the onset of a problem or illness to its cure, stabilization or death. There are few studies with the objective of knowing the men’s itineraries in sickening situation.

Given this context and the gaps in the scientific literature about the behavior of men regarding disease situations, it was decided to further the discussion about therapeutic itineraries of men and the choices and behaviors in managing situations of chronic conditions.

OBJECTIVE

- To investigate the therapeutic itinerary of men to hospitalization with diagnosis of encephalic vascular accident (EVA).

METHOD

Exploratory and descriptive study, with qualitative approach, conducted at the Hospitalization Unit of the Medical Clinical of a large hospital reference in attending the clinical and surgical emergencies in the city of Belo Horizonte. This unit is known as EVA unit, as it is reference, within the institution, for the care of patients suffering from this injury. In this sector, patients receive care of the multidisciplinary team (doctors, nurses, psychologists, physiotherapists, occupational
therapists, etc.) that act mainly in the health promotion of these individuals and in the rehabilitation process.

The hospital has 481 beds and constitutes a reference for urgencies and medical and surgical emergencies in the city of Belo Horizonte and in its metropolitan area, with an average attendance of 420 attendances/day.

The study included 14 men who were hospitalized at the mentioned unit of this hospital, from March to April 2012, and that met the inclusion criteria for the study: age over 18 years, diagnosis of EVA in his hospital tab, be in physical and psychological conditions to attend the interview and confirm acceptance by signing the Informed Consent Form (ICF). It was guaranteed the confidentiality of information and the freedom of these men to refuse or leave the study at any time, without that entailed some kind of injury. The number of hospitalized men in the period exceeded the 30 patients, but many of these had no approach conditions in the search due to sequelae and clinical conditions that made it difficult to interview them.

The data were collected through semi-structured interview. While formulating the used instrument, the objective was to clearly contemplate the research’s theme and clarify the choices and behaviors of individual until the time of his hospitalization. Besides the interviews, the medical records were consulted in order to collect socio-demographic information and supplementary information. The interviews were conducted at the hospitalization unit, after identifying men with primary diagnosis of EVA, by daily searching in the bed control list of the unit.

The recorded interviews were fully transcribed and, later, exhaustively read. These were analyzed in a coherent order regarding the thematic content analysis11; pre-analysis, material exploration, treatment of results, inference and interpretation. From the speeches, the themes were learned and each therapeutic itinerary, prepared. These were subsequently presented to participants and their companions to validation and possible adjustments. To identify the statements, it was adopted as code the letter “E”, followed by the number of the performed interview.

The study was approved by the Research Ethics Committee of the mentioned hospital, on 15/09/11, Protocol number 459121, respecting the resolution number 196/96 about researches involving human beings. The study has not received funding from any institution.

RESULTS AND DISCUSSION

Among the 14 interviewed men, the age ranged from 39 to 89 years, with the age group between 50-70 years (nine) having the highest frequency, most (eight) lived in Belo Horizonte, four living in cities of the metropolitan area, and two, in cities beyond the state capital surroundings. As for the working condition there was a slightly similar division between those working in the formal or informal sectors (eight) and those who were retired (six). Only two respondents were diagnosed with hemorrhagic EVA; all the others were affected by ischemic EVA. All respondents had some kind of sensorimotor sequelae, requiring specific care during hospitalization and after discharge.

From the respondents’ statements, several ideas stood out, which were organized into three categories: the first refers to the initial demand for care concerning the onset of symptoms; the second refers to men and their network care; the last category regards the therapeutic itineraries described by this group.

◆ The disease’s emergence

By questioning the men about the onset of symptoms, that made them seek care, it is observed that the disease in question happens suddenly, and does not always have uniform symptoms, varying from individual to individual as the following reports:

"I felt, suddenly, my right arm and my left leg without communication, they stiffened. When I realized, I was laid down, I got up and asked a friend of mine help to call the ambulance, then I fell and realized I was with problems." (E6)

"[...] I got up early in the morning and there was a pouring rain.[...] I got up to put the clothes on the clothes line, and when I was going back, my eye sights got dark and so did my house." (E12)

The time between the first visit at the health services and the onset of first symptoms also varied. Some men said they postponed this search because of the first symptoms of neurological disorder:

"[...] At night, I told my wife I was feeling my tongue kind of heavy, so she told me I had to go to the doctor, but I said: no, it’ll get better!" (E1)

A common phenomenon is also observed in other studies about man’s health, which is the difficulty in seeking care concerning the health problems6,8,12-15. The men in this study,
even reporting that the symptoms left them worried, were still resistant to seek help.

The attitude of these men corroborates the findings of authors\textsuperscript{12} that, when reviewing the health behaviors of men, identified a common phenomenon in this group, called the “wait and see”. Faced with symptoms such as typical chest pain, acute neurological deficit or serious infection and signs of inflammation, the male population does not consider seeking help from health professionals as a first option for solving their problems. They decide to wait as if their symptoms would get better for themselves, often leading to the worsening of their health condition.

This fact is closely related to the construction of socially shared masculinities: the man’s representation is that he is strong, invulnerable and healthy, playing the role of protector and provider for his family. This type of identity contributes as a barrier to the process of seeking the health services.\textsuperscript{5,8,12-5} When looking for the service, this man stands in a different position, subjecting himself to other’s knowledge and power, a situation that is not always comfortable and accepted.

The following reports demonstrate that the search for health services due to early symptoms was marked by the logic of easy access, without worrying about the level of attention demanded by that situation or any connection with the service. It is explicit that quickly solving the problem is the key element in the malaise situations for this group.

[...]. When I realized I wasn’t talking right and I had a awful headache, I asked my son to take me to the neighborhood health center (E5).

[...]. Since my daughter was at home, I asked her to take me right away to this hospital, for I knew we would get here faster (E8).

\textbullet Men and their care network

Although EVA suddenly occurs, it is known that the correct monitoring of chronic issues can positively impact on the quality of life and prevention of this disease.

In the surveyed group, it was identified the presence of risk factors such as hypertension, diabetes mellitus type 2, dyslipidemia, smoking, obesity and dyslipidemia. Once identified, these individuals were asked about how to monitor their health. Some men report they do not have a specific place for monitoring, moving between health centers, private clinics, emergency units and hospitals or they even do not go to any place.

I go for medical consultation at least once in a month, I go to the Polyclinic, when I can’t, I go to Santa Casa (hospital) or to the health center [...]. (E8)

\textbf{Therapeutic itineraries of men affected by...}

I don’t have a specific place, I go here, in Belo Horizonte, I go in Sete Lagoas and there, in Pompeu. (E12)

The absence of frequency and systematic monitoring of chronic conditions strongly contributes to worsening and deteriorating conditions, since the continuity and monitoring of individuals are vulnerable.

Those who reported having a specific place for the monitoring of their health condition are divided into two groups: those who use primary care and those who use the emergency units.

Studies have revealed the invisibility of male population in primary care and investigated the reasons for not seeking the services.\textsuperscript{06,12-13} Among these, the shame of exposing their bodies to professionals, fear of discovering something serious, gender stereotypes that complicate self-care attitudes, lack of specific activities for the male population and difficulties in access are the main reasons. Some of these reasons have emerged in this study.

[...] My follow-up is at the health center near home, but it’s difficult because it takes too long for me to schedule a consultation, you have to get up early, go through the receptiveness, and then, the girl (Community Health Agent) takes us the consultation day. (E7)

Now that I’m already registered, the consultation doesn’t take too long, I get out of there with the next one already scheduled, but if I have to go back, I have to be lucky to find another date. (E3)

I go to my neighborhood’s health center, but it takes too long there! It takes long to schedule, to get attended and to undergo the exams. [...] Exam, only blood and feces! (E9)

Besides considering the mentioned access barrier as the delay for the service, men demonstrate discredit in the provided care, regarding primary health care, due to lack of technological resources in health care procedures and lack of consultation with a specialist. None of these individuals mentioned participating in activities to promote health and disease prevention, making it clear that the medical consultation becomes the only used service. It is inferred that, for the male audience, the activities offered at health centers are still limited to healing.

The following reports show that once the secondary care is used for consultations and/or procedures of specialists, it is positively evaluated by men’s vision. Another aspect to be highlighted is the gap between the levels of care in the follow-up of the
users’ clinical condition, making it difficult to primary care to perform its role of coordinating care and ordering network.

I went to the health center and they referred me to Domingos Vieira (Medical Specialties Center). I am followed-up by the cardiologist and the rheumatologist. I already do there everything they tell me [...]. That’s the only place I go to, I do not go to another place! (E10)

Other participants also mentioned using the emergency units and hospitals for monitoring chronic conditions, reinforcing the logic of demand for the service only when they have acute clinical conditions or worsening. It reveals the “un”concern with necessary care in the daily management of their health.

I go for consultations at UPA on May 1st, I feel sick and I go there, they already follow me up, I’ve been tom many times, they already have my records there! (E11)

[...] We remember health when we feel sick! (E11)

The reports above exemplify the male perspective found in this study: men see themselves as individuals who need care when they feel a change in their condition. When they feel they no longer fit the hegemonic pattern of strong and invincible man, it seems to be the time to take care of their health.

These reports confirm the findings of a study\(^\text{16}\) that investigated the reasons for the low demand for health services between low and higher education men. These two groups report that the demand for health services was due to severe illness situations or to fulfill bureaucratic requirements of business employers; there is a close relationship between the search for health service and maintenance of the role of a man in society.

Therapeutic Itineraries

The therapeutic itineraries revealed by the men joining the study were unique, yet marked by similarities. Thus, it was possible to group them into two types, represented in Figures 1 and 2.

![Therapeutic itinerary type 1](image)

**Figure 1. Therapeutic itinerary type 1**

The itinerary type 1 (Figure 1) is characterized by the comings and goings of the user in health services, without solving their problems, reinforced by the following statements:

I started to feel sick on Sunday, but, on Monday, I searched for UPA. There, they told me they couldn’t attend me, so they referred me to the health center where I belong to. When I arrived there, a doctor of mine gave me a medication to take away the pricking I was feeling in the leg and arm and sent me home. But, at night, I got worse, so my wife took me to UPA, where they realized it was serious and took me here, to the hospital. (E11)

I began to have my mouth twisted and asked my friend for help, who put me in the car and took me straight to the medical center (Health Center) there, in the neighborhood, I got there and they were wondering of which team I was. I said I didn’t know, my friend got nervous because I was feeling sick. They said I had to go to the UPA for they didn’t attend these things. We attended at the UPA and I was discharged. After about three days I got worse, I already asked to bring me here (Hospital). (E14)

It is noticed that the demand for health services due to early symptoms were not always accepted and duly answered according to the assumptions of the comprehensive health care. These men were often informally referred and without any warranty of service to solve their health problems. They weave their care network according to their logic and condition, from their experiences with health services.

It was also possible to identify that, sometimes, users travel from neighborhoods, or even cities, performing real marathons in different health services for the resolution of their grievances.
Castro MA, Silva KL, Marques RC.

Therapeutic itineraries of men affected by...

Figure 2 represents the second type of therapeutic itinerary described by the interviewees.

![Therapeutic Itinerary type 2](image)

In this type of therapeutic itinerary, the users report having directly sought the emergency room of the hospital with the onset of symptoms. It is noteworthy that, between the onset of symptoms and arrival at the hospital, there were several reports of secondary paths as visits to pharmacy, asking the family and friends for help and looking for actions linked to beliefs and religiousness for the relief of the illnesses.  

[...] It was already night when I felt sick, I felt my blood pressure high, I felt a lot of pain in the neck, so I went to the neighborhood drug store. They usually check the blood pressure and helped me. (E7)

The pharmacy is important as people's access door to the consumption of drugs, prescribed or not, and the procedures aimed at restoring health. It is noteworthy that, due to being a place with few protocols or criteria, attending the individuals' complaints happens faster and without much exposure as in traditional health services. These features may contribute to men for accessing these sites as places to satisfy their health needs.  

The search for friends and family, considered as a support network of individuals, was a recurring attitude in this study, and already mentioned in other studies about therapeutic itineraries. The support of this network goes from an orientation of which service to choose, due to successful previous experience of care, to an informal prescription of medication or homemade preparations (teas, juices, etc.) that could be useful for the relief of symptoms and disease control.

We ran to Dona Ana, our backyard neighbor, to ask for help, she fought a lot with her husband when he was alive because of blood pressure problems. She was just saying: Take him to the hospital right away [...] (E12).

[...] She (neighbor) indicated me eggplant water, which helps to lower blood pressure and cholesterol (E9).

Another issue found in the reports was the use of religious apparatus as healing resources. In the popular representations of the disease, the breaking image of the spiritual balance is perceived as causing the illness. The cure will depend on restoring that balance. Thus, the healing systems that focus on this aspect were also present in the study group.

He felt sick the whole day, so we decided to go to the worship to ask God for health. (E4)

[...] I even went to Jorge when I saw the things I was feeling, he usually prays for us. There's a strong pray, you know. (E10)

[...] I asked God a lot for me to get cured. (E9)

From an analysis of the context of each individual itinerary, it was observed that, for the most part, they were all covered with the presence of a female figure (wife, daughter, sister) playing a key role in the choices and decisions made to solve the mentioned health problem. These women are also mentioned as accompanying of the subjects during hospitalization. The men reported, at various times during the interviews, the key role these women had in each itinerary: they are seen as those who often insist the search for a service, when facing barriers, or often decide which resource to access.

This finding is confirmed by other studies, which point to a strong contribution of female figures in the men's life for accessing the health services, regarding their clinical condition, referring to the maternal action in childhood.

CONCLUSION

There are several logics that guide the choices and paths of men in the search for assistance. Individual aspects, socio-cultural representations related to being sick and...
being a man, socio-economic and structural conditions were essential for each choice made, indicating that the therapeutic itineraries are unfolding of a process. The influence of the relational aspect of gender was also identified as a constitutive element of the choices made by each subject and his family.

The plurality of paths, characters and places evoked from each report shows that men draw their itineraries from their experiences and knowledge. These choices do not always follow the protocols and formal health system pacts.

The study allows us to rethink health actions, which little consider men as autonomous and unique subjects in their health and disease processes, as well as the functioning of health services as a network able to accommodate the health needs of these individuals.

It is believed that considering the uniqueness of each man in the management of their health and including them in the agenda of health actions can contribute to advancing the establishment of a network of services able to more comprehensively serve this group.

REFERENCES


Submission: 2015/10/20
Accepted: 2016/05/27
Publishing: 2016/07/01

Corresponding Address
Marcelo Augusto de Castro
Rua Jose Cleto, 1715, Bloco 07, Ap. 304
Bairro Santa Cruz
CEP 30530-280 – Belo Horizonte (MG), Brazil