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Barriers to self-care among men: discourses of men participating in a health education group

Dificultades del autocuidado masculino: discursos de hombres participantes en un grupo de educación para la salud

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ABSTRACT The objective of this study was to analyze men's discourses regarding difficulties related to their participation in health services and their self-care practices in the health-disease process. In order to do so, a health education initiative was implemented with men living in the area covered by a Basic Health Unit (UBS) in a municipality in Northeastern Brazil. The initiative was designed by professionals at the UBS, and its third stage consisted of five group meetings that addressed issues related to men's health. For the analysis of discourses, a content analysis strategy was used. The experience allowed us to reflect on the importance of developing strategic actions oriented towards promoting men's engagement with health services and the self-care of users, particularly in primary care settings. This is considered within the framework of the National Policy for Comprehensive Men's Healthcare (PNAISH). Re-signifying actions oriented towards men's health and changing the perspectives of professionals attending to this population can create a sense of belonging in men with respect to spaces of health promotion, protection, and recovery.

KEY WORDS Gender; Men's Health; Primary Health Care; Health Promotion; Health Education; Brazil.

RESUMEN El objetivo de este estudio fue analizar las dificultades de la participación masculina en los servicios de salud y sus prácticas de autocuidado en el proceso salud-enfermedad. Para ello, se realizó una intervención, a la luz de la educación en salud, con hombres que vivían en el área de cobertura de una unidad de atención primaria, en un municipio del nordeste de Brasil. La intervención fue diseñada por profesionales de la unidad y la tercera etapa consistió en cinco encuentros grupales que abordaron temas relacionados con la salud masculina. Para el análisis de los discursos se utilizó la estrategia de análisis de contenido. La experiencia permitió reflexionar sobre la importancia del desarrollo de acciones estratégicas con el propósito de promover el acercamiento del público masculino al servicio de salud y el autocuidado de los usuarios, especialmente en el escenario de atención primaria, en el marco de la Política Nacional de Atención Integral de Salud para el Hombre (PNAISH). Resignificar las acciones que involucran a la salud del hombre y el cambio de actitud profesional para atender esta población puede desencadenar en el público masculino la sensación de pertenencia al espacio de promoción, protección y recuperación de la salud.

PALABRAS CLAVES Género; Salud del Hombre; Atención Primaria de Salud; Promoción de la Salud; Educación en Salud; Brasil.

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INTRODUCTION

Evidence suggests that men's participation, in every level of health care, is significantly lower than that of women,[1] including in health promotion activities, such as healthy practice groups and physical activity groups offered in primary care settings. Another factor related to this situation is that the greater demand for health care made by the male population takes place in the context of acute diseases, that is to say, that the demand primarily comes from people suffering from acute diseases.[2] Other factors related to male absence in primary healthcare services have to do with the large proportion of female healthcare professionals, cultural issues,[2] and the lack of encouragement from health teams through actions and programs specifically aimed at men.[3] This situation may often cause diseases to be detected in advanced stages, debilitating the recovery process and increasing the risk of death.[4]

Considering that the predominant social construct of masculinity in Brazil still does not encourage men to take care of themselves or others,[5,6] in 2008 the Ministry of Health, in an attempt to stop this situation, created the National Policy for Comprehensive Men's Healthcare (PNAISH) [*Política Nacional de Atenção Integral à Saúde do Homem*], which has as one of its principal objectives the promotion of health-related actions that contribute to understanding male characteristics in socio-cultural and political-economic contexts, aiming to increase life expectancy and reduce morbidity and mortality rates due to preventable and avoidable causes within this population.[4]

To accomplish the objectives proposed by the National Policy for Comprehensive Men's Healthcare, certain programs and actions offered to the community seek to satisfy the specific needs of this population.[7] One of the strategies implemented was the incorporation of health education actions in primary care settings, which cover three segments: healthcare professionals dealing with the prevention of ailments and health promotion; managers that support these professionals; and the population that needs to build knowledge and increase its autonomy in self-care and collective wellbeing.[8] In this way, to treat men, to provide the needed health care, and to consider their characteristics, health education may be helpful in the sense of facilitating engagement of this population with health services, especially primary care services.

Health education as a political and pedagogical process requires the development of critical and reflective thinking on the health-disease process, which helps individuals to unveil their situation and propose transformative actions, in terms of historical and social subjects capable of acting and expressing their opinions on health-related decisions for self-care and the wellbeing of their family and the community.[9] For several educators, permanent health education derives from popular education, based on certain principles and/or guidelines developed by Paulo Freire such as education as the practice of freedom and the pursuit of meaningful learning.[10]

Taking into account that primary care works as a gateway to health services in Brazil and that the actions developed must go beyond the scope of curative care to also include preventive and health promotion actions, focusing even on Brazil's male population, the objective of this article was to analyze male discourse in relation to the barriers to self-care through narratives of male participants in a health education group, centered on men's health.

METHOD

This is an exploratory-descriptive, qualitative, interventional research study, implemented between August 2016 and January 2017, in a Basic Health Unit (UBS) [*Unidades Básicas de Saúde*], located in the municipality of Sobral, Ceará, in the Northeastern region of Brazil.

The Basic Health Unit in which the initiative was implemented had two family health teams, one oral health team and one

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Family Health Support Team. According to the data provided by the last Weekly Territorialization Report from the Municipality of Sobral in 2016, that specific Basic Health Unit had 1,711 registered families, amounting to a total of 5,902 individuals.

The initiative was implemented in four stages: 1) introduction to the professionals of the Basic Health Unit, 2) analysis of the community's view on male participation in healthcare settings, 3) creation of a men's health group, 4) impact of the initiative. Figure 1 shows the stages of the initiative and their respective procedures, whereas Figure 2 presents the logic model of the initiative, stating the relationship among objectives, inputs, activities, outputs, outcomes, and influential factors. For this research study, only the narratives of the men who participated in stage 3 of the initiative, which was related to the cultural aspects of masculinity and male self-care, were taken into account.

The total duration of the initiative was six months, three of which were used for group meetings of the health education group centered on male self-care, carried out in the

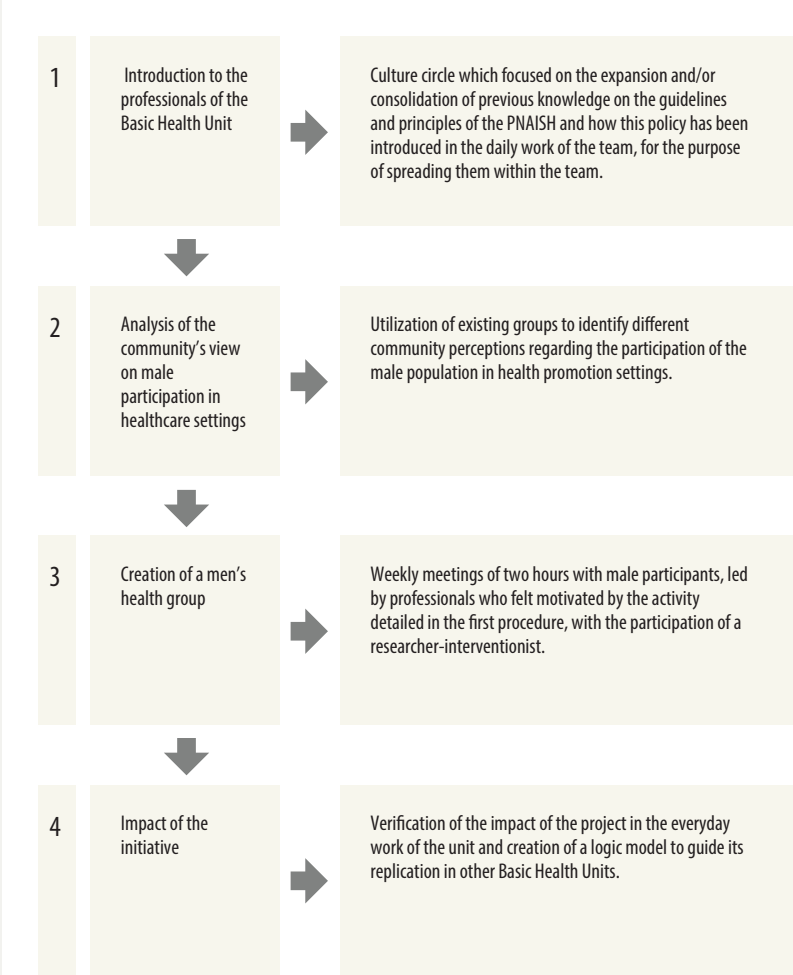

Figure 1. Stages of the initiative and their respective procedures. Ceará, Brazil, 2016-2017.

Source: Own elaboration.

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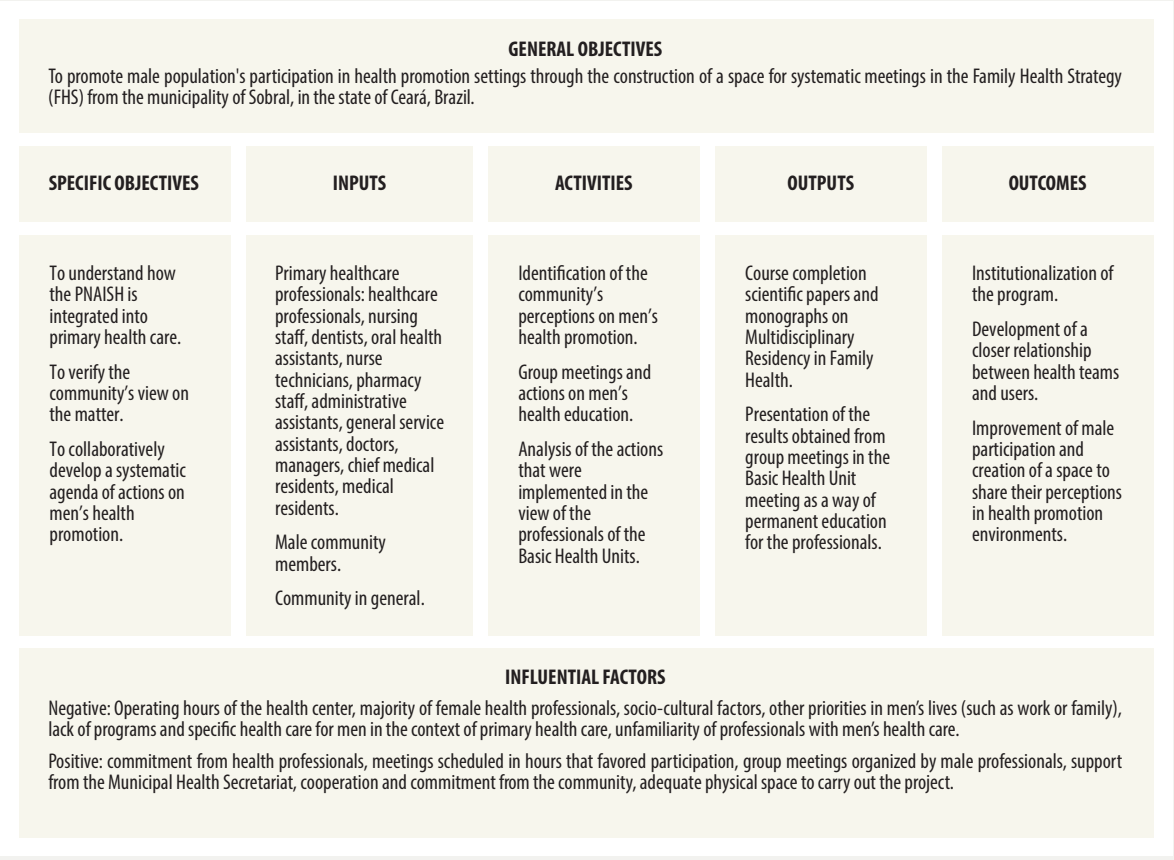

Figure 2. Logic model of the initiative: relationship among objectives, inputs, activities, outputs, outcomes, and influential factors.

Source: Own elaboration.

auditorium of the Basic Health Unit, every two weeks, on Wednesdays from 6 p.m. to 7.30 p.m. The decision to schedule the first meeting after business hours sought to promote the engagement of the working participants. The decision was accepted by the participants and the meeting time maintained until the end of the initiative. It should be noted that only the first group meeting covered a topic suggested by the professionals, whereas the other topics were chosen by the men who participated in the first meeting. Each meeting had a title taken from songs performed by male artists of popular Brazilian music, which contained lyrics that helped men reflect on matters related to masculinity. The researcher in charge of the initiative considered that the songs that were chosen to start each meeting worked as a strategy to open up a discussion among the group of men.

Table 1 shows the order, title, health-related topic that was covered, and the number of participants in each meeting.

To be eligible for the group of men, the individuals had to be male users and live within the area covered by the selected Basic Health Unit. The men who participated in the initiative received a printed invitation at their addresses, which was delivered by community health workers or by a family member that frequently visited the Basic Health Unit. The invitation was written by healthcare professionals and contained information regarding the objective of the group, the date, and

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Table 1. Order, title, health-related topic that was covered, and number of participants in each meeting of the research. Sobral, Ceará, 2016.

Order	Title of the meeting	Song title and authors	Topic covered	Number of participants
1	"I lived with the illusion that being a man was enough"	*Super-Homem- A canção* (Gilberto Gil)	Prevention of prostate cancer	21
2	"Men don't cry, not for pain, not for love"	*Homem não chora* (Alvin L / Frejat)	Relationship with the health service	20
3	"That man is me"	*Esse cara sou eu* (Roberto Carlos)	Prevention of cardiovascular diseases	18
4	"Being a feminine man does not affect my masculine side"	*Masculino e feminino* (Baby Consuelo / Didi Gomes / Pepeu Gomes)	Leprosy: how to identify and prevent it	19
5	"I'm a man with M and the way I am!"	*Homem com H* (Antônio Barros)	Oral health	20

Source: Own elaboration.

the time of the first meeting. Due to structural matters, lack of space, and in order to preserve the quality of the results obtained from the initiative, it was decided to open only 20 positions for male community members.

Data were collected using the "culture circle" method, proposed by Monteiro and Vieira,[11] based on Paulo Freire's pedagogy. The culture circle was used as a space management tool and as a strategy for data collection to encourage participants to share their narratives. This method includes the principles of health care with a focus on health promotion and seeks to provide tools for professionals to develop educational actions related to health matters and to provide autonomy for users in the health-disease process. The narratives from the group participants were digitally recorded to ensure an accurate transcription and analysis of the obtained material.

After collecting all the data, the narratives were analyzed based on a content analysis method, using a thematic analysis technique, in which the text is separated into meaning units.[12] For practical purposes, the analysis of the discourses was divided into three stages, which are detailed below.

1) Pre-analysis: after collecting the data, the narratives were heard, two or three times on average, to make their complete transcription possible. Then, the documents that were going to be analyzed were selected, which helped resume the objectives of this research study. Finally, the indicators that guided the final interpretation of the analyzed material were developed.
2) Exploration of the material: in this stage the process of meaning detection took place. First, we selected recording units from the transcribed text: a word, phrase, or event.
3) Classification of data: the data were divided into theoretical and empirical categories that guided topic specification. Next, those categories were grouped according to their significance, resulting in two meaning categories: cultural aspects of the lack of male visibility and the promotion of male self-care.

This research study was reviewed by the Human Research Ethics Committee at the Universidade Estadual Vale do Acaraú (UVA) and approved by Protocol No. CAAE 62963316.9.0000.5053. All participants gave their free and informed consent, in compliance with Resolution 196/96 as issued by the National Health Council, and data anonymity and confidentiality were ensured. To prevent the identification of the authors of the narratives, the names of the participants were replaced with letters.

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RESULTS

During the five group meetings that were carried out, the minimum number of male participants was 18 and the maximum number was 21. Taking into account the characteristics of the 21 participants, the average age was 44 years old (standard deviation = 15.7 years old). The majority of the participants had a background education ranging from five to nine years (71.4 %), did not have a partner (57.2 %), reported that they suffer from one or two diseases (42.8 %), were overweight (61.9 %), and have lived for more than 10 years in the neighborhood (71.4 %). The sociodemographic characteristics related to the group participants' health status are detailed in Table 2.

Many of the participants' narratives show the stereotype of a "strong man," of disease as a sign of weakness (despite the fact that, in the narrative that expose this latter idea, this point of view is connected with something from the past) and the lack of self-care "habits":

> *Men are wild beasts difficult to tame! To me, a man is like a hunting dog... He works all day long and doesn't take care of his health and that's why he ends up dying at a young age.* (Man B)

> *In the past, people believed that a man who got frequently sick was a weak man and that he wasn't good enough to get married.* (Man D)

> *Oh, you know how it works, don't you? We didn't grow up with the habit of taking care of our health.* (Man C)

One of these narratives indicates that the principal cause of this situation has a cultural/educational origin, placing at least part of the responsibility on (male) parents:

> *It is usually passed down from father to son that a man shouldn't cry, shouldn't get sick, shouldn't talk about his feelings and those things get stuck in our head.* (Man L)

In several narratives, participants highlighted the importance of overcoming the stereotype that hinders men's self-care:

> *We must pay a lot of attention to health care, and I do! But that doesn't make me less of a man!* (Man E)

Table 2. Sociodemographic characteristics and health status of the research participants. Sobral, Ceará, 2016-2017.

Variables	Male group (n=21)	
	n	%
Age range		
Aged 30 or under	6	28.5
Aged 31 to 59	10	47.7
Aged 60 or over	5	23.8
Education		
0 - 4	3	14.3
5 - 9	15	71.4
10 or over	3	14.3
Condition		
With a partner	9	42.8
Without a partner	12	57.2
Morbidities (number)		
0	7	33.4
1 o 2	9	42.8
3 or more	5	23.8
Overweight[a]		
No	8	38.1
Yes	13	61.9
Residence Period (years)		
0 to 4	2	9.5
5 to 9	4	19.1
10 or over	15	71.4

Source: Own elaboration.
[a]Overweight: BMI ≥ 25.0 kg/m2.

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> *We also need to take care of our health. We are human beings and we also have our weaknesses.* (Man A)

> *It is interesting to come to the health center without being sick. Men must also take care of themselves*. (Man F)

One of the most relevant aspects of this research study is related to the various causes described by male participants as the elements that hinder men's engagement with self-care habits. The narratives refer to matters such as lack of time, lack of information regarding the services rendered by health centers, and even the embarrassment of talking about their concerns, as well as other factors such as the fact that health centers are primarily composed of women, that this services do not have a broad comprehension of men's health, operating hours of primary care services, and also mockery on the part of co-workers:

> *We say that we don't have time to come to the group meetings, but as soon as we feel something, we'll have to find the time to visit a doctor.* (Man E)

> *I didn't know that the health center offered these types of activities to have discussions and give us advice. In my opinion, the talk we have here is really fruitful and there are other groups.* (Man B)

> *Whenever I needed to see a doctor I would go straight to the hospital, but after talking to the doctor here, I noticed that many things can be solved in this center, and it's even much closer to my house.* (Man N)

> *During the first meeting, I was asked if I knew what the prostate was, I said yes, but I didn't even know what it was, I felt I didn't have enough information. At first, everybody laughed embarrassingly when talking about the subject, but in the end, all of us learned about something that is important to us men.* (Man F)

> *As in the health center the majority of professionals are women, I don't know, it seems that they are more accustomed to taking care of women and children.* (Man M)

> *Medical staff think that men are just a prostate. There are other things to be aware of, we have diseases, therapies, and everything, but men are only seen at the health center in November.* (Man B)

> *Operating hours of the health center are not helpful either, I find out what's happening only by coming here to the group, that's because I can only come here at night.* (Man H)

> *My co-workers make fun of me when I mention that I went to the doctor's. I don't listen to them; I'm just taking care of myself.* (Man C)

DISCUSSION

Among the analyzed narratives of the male participants in the initiative, many aspects should be highlighted. Some of them have to do with the identification of the stereotype of a "strong" man, which has its roots particularly in the "communication from father to son" and, at the same time, the acknowledgment of the need to overcome this stereotype. Among the potential elements that prevent men from overcoming their lack of visibility in health services, male participants mentioned relevant factors, such as certain male characteristics (for example, that sometimes men feel embarrassed in many situations) and, especially, aspects related to such health services, which include: operating hours of health services, the minority of men working at the primary care staff, and the lack of a broader comprehension regarding men's health on the part of these services. Furthermore, men's lack of information on the scope of primary care services should be noted, which to some

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extent highlights, on the one hand, the need for a wider dissemination on the part of these services and, on the other hand, the pressure that other people may exert on men who seek high-quality self-care services.

The results illustrate a prospect of new possibilities in relation to the perception of men taking part in the health system, the meaning that they attribute to masculinity, and the changes introduced to their self-care processes. The approach focused on men may re-signify both their perception of masculinity and their roles regarding male gender, as well as the importance of self-care by using the experience of having participated in the health education group.

These roles are established according to the needs and values prevailing in a society.[5,13] The conventional idea of the strong and indestructible man strengthens two aspects of the hegemonic masculinity model. If, on the one hand, strength and health reaffirm men's virility, it is, on the other hand, the ability to maintain and keep those virtues that assure male moral strength.[14]

Therefore, although their cultural identity is not associated with health care, after getting rid of their role as unbreakable individuals, men could notice how their strong and virile appearance was gradually eclipsed.[15] Given these circumstances, men's involvement in health services encourages the reflection on masculinity and the formation of more democratic and equal relations in the health field.[16,17] As one of the participants stated, this new interpretation helps to establish a more harmonious relationship between being a fragile and destructible man and the ideal of what is to be a "true man." This new perception was possible due to the attribution of new meanings to the concept of masculinity as seen in the participants' narratives.

Furthermore, it is important to remember that the participants live in an area of the country defined by stigma, violence, and sexist influence.[18,19] In the formation of masculine identities, this influence is strongly connected with the ideal of masculinity and of the "breeding male as a symbol of fertility."[18] However, experiencing the aspects that incorporate self-care, not as a spectator, but as a direct participant, help these men have a new interpretation of the meanings attributed to self-care and masculinity.[20]

The masculinity model may be different from the model imposed: lonely, conservative, and superficial men throughout their lives.[21] Men could be more sensitive and should not feel obliged by the fact of physically being a man to search for virility.[18,21] The process of re-signifying masculinity as shown in this research study was followed by an action of introspection, changing the relationship between men and their own health. Traditionally, the hegemonic masculinity model has led men to sublimate issues concerning self-care and to be more prone to risk factors for premature mortality caused by avoidable ailments, which causes men to become individuals afraid of getting sick.[22]

According to Gomes,[23] these fears should not be simply considered to be "ignorance" but reactions to the fact that the perception of hegemonic masculinity is breaking down and needs to be discussed in order to be deconstructed. Rectal examination, for instance, may be seen by men as a violation of their masculinity, since they consider that certain parts of their bodies are untouchable. The feelings of embarrassment and pain while being penetrated and the erection as a physiological response violate and hurt the hegemonic masculinity model. In this sense, the rectal examination does not only involve the prostate but also masculinity itself.[24]

In this respect, the process of re-signifying the participants' masculinity is followed by the breakdown of the myth regarding masculine invulnerability. In Brazil, this myth is supported by the disregard for men's health care within the area of the Unified Health System (SUS) [*Sistema Único de Saúde*], particularly in primary care settings.[25] It should be highlighted that the National Policy for Comprehensive Men's Healthcare created new possibilities to engage men with public healthcare services, although it still has an inactive approach towards male subjectivity, which does not even take into consideration relevant issues such as mental health and sexuality.[4,17]

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Thus, the collected data contribute to a better understanding of the way that self-concept influences self-health care, given that the concept of the hegemonic masculine model, in which certain typical attributes of these social agents encouraged a perception of invulnerability over men's body and which results in behaviors that predispose men to diseases and death, has been deconstructed and, therefore, an idea of a new man has been formed.

This research study has certain limiting factors. As little research has been conducted on this subject, many problems arise when addressing it, given that men still have no knowledge of their public healthcare rights and policies, and have little information with respect to mental and physical health protection. Traditionally, men who are involved as users in healthcare practices are strongly related to the taboo and stigma of weakness, and not to the possibility of choosing health care.

However, despite being involved in much more complicated problems, such as social vulnerability situations, these men broke cultural paradigms by taking part in the health and education group and were able to modify perspectives of their behavior, these circumstances may even result in a cultural change that deviates from the idea of the unbreakable man immune to all diseases in order to form a better human being.

In the "culture circle" in which the professionals working at the Basic Health Unit participated, the methods and the results of the initiative obtained from the participants' narratives were shown. The institutional, intersectoral, and multi-professional interaction was a fruitful experience and provided a vast gathering of interrelated services and information available to the population in each new stage of the initiative. The combination with other health fields such as the dental specialty center, municipal laboratories, and the outpatient care for leprosy treatment is based on the principle of healthcare decentralization, under which it is essential to complement these services to enrich men's health care in its entirety.

It was decided to continue with men's group meetings, at night, and on a monthly basis. It should be noted that this decision was considered a valuable strategy to strengthen the relationship between men and healthcare services given that daytime operating hours constitute an institutional barrier to the health care of this population. Therefore, this action helped to explore masculinity, created a sense of belonging with respect to Basic Health Units, and encouraged and improved the development of men's healthcare services and practices of health protection and promotion.

Among the several limiting factors of this research study, we can find that it was not possible to accompany the individuals in their search for health care in the primary care services after the initiative. This information may contribute to the understanding of the frequency of men's engagement with spaces of health promotion and their search for health care. We could mention, as a key point, the understanding on the part of healthcare users and professionals that men's healthcare services require these professionals to be qualified, to question the reality of men in the health-disease process and, along with healthcare managers, to envision and implement engagement strategies for men, including flexible service hours and the implementation of specific programs.

According to Gomes and Nascimiento,[10] with respect to men's health care and, primarily, for the actions aimed at this population to be successful, it is essential to understand that there are many ways to be a man, without limiting this quality to only one hegemonic model. These different forms of masculinity are influenced by several factors, such as race, social class, age group and should be taken into consideration by healthcare professionals and services when developing actions aimed at this population.

Although common aspects were identified when analyzing the participants' discourses concerning their definition of masculinity, the experience helped us to reflect on the importance of developing strategic

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actions oriented towards promoting men's engagement with health services, such as their prominence and self-care, particularly in the context of primary care, which is a significant space for ailment prevention and health promotion. Holding group meetings, though on a monthly basis, is seen as a crucial step towards men's engagement with health services.

It is necessary to educate the population group under consideration regarding the use of primary care services as a gateway to the Unified Health System. In this respect, re-signifying actions oriented towards men's health and changing the perspectives of professionals who provide care to this population may create a sense of belonging in men in spaces of health promotion, protection, and recovery.

Given the current crisis of masculinity and of the concomitant identity conflict, the results show a possibility of re-signifying masculine identity by means of the reconstruction of the ideal of "being a man." This process requires that men be seen as individuals who work on their vulnerabilities, leaving the concept of indestructible beings behind. Thus, this research study highlights men's participation in the health-disease process itself in terms of such identity reconstruction. Men's low level of participation in healthcare services entails the risk of strengthening the hierarchical stereotype that sees men in a vulnerable position as weak and unworthy of the qualities of strength and virility.

While the participants' definitions were not consciously formed, they may give healthcare professionals guidance on the way they design future healthcare actions oriented towards men. Therefore, it is necessary to conduct more research studies into men's health, putting great emphasis on the several discourses present in healthcare settings.

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