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RESEARCH ARTICLE

Challenges Faced by Nurses in the Provision of Health Care to Men in Primary Care, Brazil

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Abstract:

Introduction:

The provision of primary care to men by nurses has been relevant, but there are challenges to be overcome.

Objective:

To analyze the challenges faced by Brazilian nurses in the provision of primary care to men.

Methods:

This was a qualitative descriptive study carried out by including 40 nurses working in the Family Health Strategy of a Basic Health Unit in Northeastern Brazil. Individual in-depth interviews were carried out and analyzed using the Discourse of the Collective Subject (CSD) method, supported by the Praxis Intervention Theory for Nursing in Collective Health – Tipesec.

Results:

The challenges faced by nurses in the provision of care to men originate in the academy and are transposed into professional practice, manifesting as limitations in the work process, lack of a specific health agenda, difficulties in raising male adherence, and professional demotivation.

Conclusion:

These challenges significantly affect the development and promotion of men's health, resulting in the maintenance of the indicators of male morbidity and mortality in Brazil.

Keywords: Men's Health, Nursing, Health Care, Primary Health Care, Tumors, The Brazilian Unified Health System (SUS).

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1. INTRODUCTION

Knowing and understanding the still incompatible relationship between men and health poses a challenge that should be overcome to ensure the provision of a comprehensive, humane and equitable care that embraces the particularities, needs, and demands of men, and that is able to lead them to regularly seek health care services without worries or stigmas [1 - 4].

In 2016, epidemiological morbidity and mortality indices

showed a higher number of deaths among Brazilian men compared to women, representing 57.2% of the total deaths in almost all age groups. This problem is even worse when analyzing the 20 to 24-year-old age group, in which 80.8% of deaths were of male individuals [5, 6].

Regarding the vulnerabilities related to men's health, we can highlight the greater number of deaths associated with external causes and the greater frequency of circulatory diseases, followed by tumors, diseases of the digestive system, and, finally, respiratory diseases [5, 7].

In contrast, these high male morbidity and mortality rates lead to the recognition of the relational conception of gender as

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a way to understand and analyze the health-disease process afflicting the male universe [8, 9]. Given this scenario, men have a higher predisposition to contract diseases compared to women due to their increased exposure to sociocultural and behavioral risks, rooted in gender stereotypes, which also reinforce their neglect of health care and prevention practices [10 - 12].

To transform this reality and improve the health conditions of the Brazilian male population, the Ministry of Health produced and launched, on August 27, 2009, the National Policy for the Provision of Comprehensive Care to Men (PNAISH), based on the precepts of the Brazilian Unified Health System (SUS) and on the prioritization of actions related to men's health in primary care services, focusing on the Family Health Strategy (FHS), which is the most prevalent entrance door to other health services. This policy aims to reduce male mortality and morbidity by promoting coping strategies to avoid risk factors and sociocultural determinants related to this population [7, 13, 14].

With the proposal of PNAISH and anchored in new strategies focused on men's health, nursing professionals become an indispensable part in the promotion of actions aimed at meeting the health needs of men, especially in primary care, where nursing interventions follow a dynamic methodology, with a dialectical and participatory perspective [15]. In the context of men's health, the provision of nursing care strengthens these professionals' commitment to attentive listening, holistic care, and humanized perception of the vulnerabilities of the male population [7, 15, 16].

However, despite the potential of nurses for promoting and implementing preventive care practices and developing external strategies that ensure the access of men to health services, governmental, sociocultural, institutional, and management barriers jeopardize the quality of the care provided, hindering the viability of health policies and the performance of comprehensive care actions by these professionals [17, 18].

This study is based on the need to understand the obstacles encountered by nursing professionals in the provision of primary care to men and the challenges of implementing PNAISH, seeing as there is an obvious gap in the scientific literature about these obstacles, demonstrating the relevance of discussing this theme to raise male adherence.

The research was guided by the following question: What are the challenges faced by Brazilian nurses in the provision of primary care to men? Therefore, this study is expected to contribute to the promotion of men's health, subsidizing nursing practices and interventions, and improving the quality of the care provided by primary health services to the male population.

2. METHODS

This was a qualitative, descriptive study, carried out with 40 nurses working in seven Basic Health Units and 26 Family Health Units in Bahia, Brazil, under the main research project entitled *Men's health care in a scenario in Northeastern Brazil*, approved by the Research Ethics Committee under opinion number 1.208.304, and its subproject, *Nursing in men's health care: challenges of implementing actions in the Family Health*

Strategy, also approved by the Committee under opinion number 996.821, both funded by the authors.

Most participants were female, women, heterosexual, married, self-reported as brown/mixed race, and aged between 25 to 48 years old. They had been working in the health units for more than one year as assistant nurses and had 2 to 16 years of nursing experience, most with specialization in the area of public and/or family health, followed by urgency and emergency care and employment bond.

The study included nurses who worked in providing direct care to patients. Those who were still under training, on vacation, and nursing interns (referred to in the city as nursing graduates) were all excluded. Of the total sample, four professionals refused to participate in the study: two declared not having knowledge about and/or experience with the theme, one due to lack of time to answer the questions, and the other professional did not disclose the reason for the refusal.

Data was collected from the health units in the territory, in partnership with the city's Health Department and its Nursing Division. Individual in-depth interviews were carried out, guided by a structured instrument composed of closed-ended questions addressing the participants' professional, social, and economic characteristics, and open-ended questions about the study's central problem. They were recorded with a device owned by the authors and subsequently transcribed and presented to the participants to obtain their consent, in accordance with the guidelines proposed by COREQ, on which the qualitative study was based.

For this purpose, pilot and calibration tests were previously applied to a team of 15 researchers, including nursing students and professors from the area, based on the guidelines of SQUIRE 2.0, to ensure the reports' compliance to the quality standards.

The interviews occurred in a private environment within the health units' facilities, at different times in which nurses met patients, upon prior scheduling, and at the convenience of the deponents. The collection process began by previously visiting the units to present the research to the nurses, invite them to participate, and ask those who accepted to sign the informed consent form.

Throughout the development of the research, the ethical recommendations for studies involving human beings were preserved, considering the guidelines of Resolution 466 of the National Health Council. For this purpose, the participants' right to autonomy was maintained, as well as the confidentiality of the information and the anonymity of the deponents, in accordance with the Discourse of the Collective Subject's (CSD) methodological presentation, identified as *CSD for nurses who work in the FHS*.

The data collected were organized and systematized using the NVIVO12 Software for qualitative analyses, following the Discourse of the Collective Subject method, which is based on the representative recognition of the structuring constructs of Social Representations in the individual and collective dimensions, so they can be subsequently grouped into general semantic categories by associating the similar opinions expressed in the various statements. In this way, CSD allows synthesizing discourses based on methodological figures called

Key Expressions, Core Ideas and Anchorages, which are capable of representing collective concepts expressed by individuals [19 - 21]. The findings were supported by the Praxis Intervention Theory for Nursing in Collective Health – Tipesec, which aims to understand the contradictions of reality in the context of Nursing in Collective Health from a theoretical and practical perspective, in accordance with the foundations of historical dialectic materialism [22 - 24].

3. RESULTS

The collective discourse of nurses working in the Family Health Strategy of Basic Health Units revealed that the challenges in the provision of care to men are related to multifaceted factors, which originate in the academy and are then transposed into professional practice, manifesting as problems and limitations in the work process, lack of a specific health agenda, difficulties in raising male adherence, and professional demotivation.

The findings reflect the nursing practices aimed at meeting the health demands of men, which are impacted in different ways, compromising the advancement of the nursing care provided to the male population in this context.

There is interest in providing nursing care to men, but the presence of structural, governmental and organization barriers, as well as those created by hegemonic masculinity, makes the job of nurses even more challenging.

The data reveal that the dimension of men’s health is affected by the weaknesses in the academic and professional training of nurses. This scenario is transposed to their daily practices, as many lack the skills and competencies needed to promote health care actions directed to the male population.

3.1. CSD: Weaknesses in Academic/Professional Training

The presence of weaknesses in the academic and professional training of nurses poses a challenge to the promotion of men’s health. These weaknesses are mostly related to the limited access to content, being transposed to their professional experience, where it manifests as the lack of the knowledge needed to provide care to the male population.

In this group of the nurses’ collective discourse, the findings highlight the elements weakening the training of nurses in the dimension of men’s health. The anchors, which represent the reasons why these weaknesses come to be, are influenced by key expressions and central ideas. The strongest elements affecting this context may be identified in the reports (Table 1).

It may be noted that the weaknesses that exist in the training of nurses compromise the provision of nursing care to men. However, nurses deal with problems that, according to the collective discourse, are driven by existing limitations related to the work process in the context of Primary Health Care.

3.2. CSD: Limitations in the Work Process

The discourse points to the existence of limitations in the work process of nurses, with an emphasis on the provision of primary care to men. It highlights aspects such as the accumulation of administrative, care-related and structural demands, which affect their work routine, particularly in the development of health education and promotion actions (Table 2).

Table 1. Collective discourse of nurses working in the Family Health Strategy about the weaknesses in their academic/professional training in the dimension of men’s health. Salvador, Bahia, Brazil, 2020.

Key Expressions: [...] <i>limited [...]</i> <i>incipient [...]</i> <i>lack of content [...]</i>	<i>I had no training in this area during college. I heard of men’s health only after college. It was so limited, incipient, almost invisible because there was a lack of content addressed exclusively to the dimension of men’s health. Only as a nurse, I came to know of it, which is the reason why I had so much difficulty finding out the diseases that most affect them and bringing them to the unit. The men’s health policy is currently being disseminated, and I realized that only since 2013 they have started promoting more actions focused on the male population’s daily activities and on blue November (CSD) of nurses working in the Basic Health Unit – FHS and BHU).</i>
Core Ideas: [...] <i>I heard of men’s health only after college [...]</i>	
Anchor: [...] <i>I had no training in this area during college [...]</i>	

Table 2. Collective discourse of nurses working in the Family Health Strategy about the limitations related to the work process in the context of men’s health. Salvador, Bahia, Brazil, 2020.

Key Expressions: [...] <i>many demands every day [...]</i> <i>the absence of vehicles poses a challenge [...]</i> <i>investigations, visits, unit supervisions, accountability to the health department [...]</i>	<i>A positive strategy would be going to the workplace of men to organize awareness campaigns and health promotion actions, but there are some barriers created by the system itself, such as the difficulty in leaving the unit due to the excess management demands. There are so many demands we have to deal with every day, investigations, visits, unit supervisions, accountability to the health department, in addition to the provision of care itself. I am not making excuses, because I can accomplish it all if I plan it first, but there are many attributions. The absence of vehicles poses a challenge, as it prevents me from getting to the men in the community. For a health action to happen, it needs to be well planned in advance. Additionally, the structural problems in the unit are also a problem. (CSD, nurses working in the FHS).</i>
Core Ideas: [...] <i>many attributions [...]</i>	
Anchor: [...] <i>excess management demands [...]</i>	

Table 3. A collective discourse of nurses working in the Family Health Strategy about the absence of a health care agenda that is specific to men. Salvador, Bahia, Brazil, 2020.

<p>Key Expressions: [...] are unable to find what they need [...] we have yet to incorporate anything of the sort [...] low adherence [...]</p>	<p><i>In this sense, the policy is great on paper, but in practice, it would limit the performance of certain functions regarding men’s health, restricting actions to the treatment of hypertension and diabetes. The prohibition of transcription is also another problem, preventing male adherence because men come to the unit and are unable to find what they need. Though we need a program that is specific to men to analyze issues related to the health of this population, with specific consultations, we have yet to incorporate anything of the sort. We have no programs focused on men’s health. Unfortunately, I cannot make time to provide care to the male population because of their low adherence. They come to the unit asking for exams, electrocardiograms, medications, consultations, which are not always available. It is really hard to get examined by a nurse. At the end, I end up having little to no contact with men.</i> (CSD, nurses working in the FHS).</p>
<p>Core Ideas: [...] We have no programs focused on men’s health [...]</p>	
<p>Anchors: [...] Unfortunately, I cannot make time to provide care to the male population, because of their low adherence [...]</p>	

The work of nurses is permeated by specificities, which can be limited by other factors, as observed in the previous collective discourse. However, the lack of inclusion of the health demands of men as a priority in the provision of nursing care to this population can compromise this scenario, as revealed in the analytical category below.

3.3. CSD: Absence of a Health Care Agenda Specific to Men

The challenges faced by nurses in the provision of care to men revealed in their collective discourse are related to the absence of a specific health care agenda, with actions being focused only on the program for prevention and control of Systemic Arterial Hypertension and Diabetes Mellitus. Furthermore, the absence of services specifically aimed at meeting the health demands of men results in this population’s invisibility in nursing consultations.

Given the above, the pre-conceived idea of nurses that the development of a health care agenda specific to men will be an ineffective strategy is based on their perception of low male adherence to health services (Table 3).

The findings reveal that the performance of nurses in the provision of primary care to the male population is affected not only by professional and institutional barriers but also has to do with the way these nurses perceive men and promote their adherence to health services. The nurses’ discourse points to the existing attitudinal barriers preventing men from being made aware of the importance of self-care and of seeking

health services in a preventive manner.

3.4. CSD: Difficulties/Limitations in Raising Male Adherence

The collective discourse revealed that the difficulties and/or limitations in raising male adherence faced by nurses are mainly related to the influence of sexism and to the social roles played by men, such as providing for their family, leading to the perception of health units as not intended for them. Additionally, the incipient, non-participative, and non-spontaneous nature of this adherence is associated with the increase in the male population’s mortality from preventable causes (Table 4).

The barriers faced by nurses in the provision of care to men were revealed to be the cause of the relational obstacles expressed by the professionals, preventing the scenario of men’s health in the context of community health care to change, as can be seen in the category below.

3.5. CSD: Lack of Motivation to Reach Out to the Male Population

The lack of motivation expressed in the nurses’ discourse regarding the provision of care to the male population is permeated with stereotyped constructions of gender, crystallizing the idea of a hegemonic model of masculinity, which supports the assumption that men do not care for their own health. Furthermore, this lack of motivation pervades the low adherence of men to the services and to the actions offered by the team, under the nurse’s coordination (Table 5).

Table 4. Collective discourse of nurses working in the Family Health Strategy about the difficulties and/or limitations in raising male awareness. Salvador, Bahia, Brazil, 2020.

<p>Key Expressions: [...] digital rectal exam [...] they are wage earners [...] they still will not come [...] male adherence is not spontaneous [...]</p>	<p><i>Actually, it is hard to deal with and have access to the male population due to sexism and authoritarianism influencing even health care, as happens with the digital rectal exam that many avoid, feeling uncomfortable and using this as an excuse for their absence in the services, alongside the fact that they are wage earners, which interferes with the dissemination of information to them. Consequently, I see many men losing their lives because of preventable causes. Sometimes there are symptoms, but they only come to the unit when the health problem is already in an advanced stage, like Sexually Transmitted Infections. They think health units are not intended for men, and despite all of this, I have been reaching out to these men, but they still will not come. We do whatever is possible in partnership with Community Health Workers, I ask them to go to the residences, but men are totally absent, they do not participate. In family planning, for instance, male adherence is not spontaneous, which makes it difficult to get in contact with men</i> (CSD, nurses working in the FHS).</p>
<p>Core Ideas: [...] They think health units are not intended for men [...]</p>	
<p>Anchors: [...] sexism and authoritarianism influencing even health care [...]</p>	

Table 5. Collective discourse of nurses working in the Family Health Strategy about feeling unmotivated to reach out to the male population. Salvador, Bahia, Brazil, 2020.

Key Expressions: [...] they are ashamed to come, they do not adhere to preventive practices [...]	<i>They do not come at all, it is almost impossible, they are ashamed to come, they do not adhere to preventive practices, not even routine exams. They do not take care of themselves, nor do they worry about their quality of life. I ask the team to tell them that, during the activity, they will receive snacks, but still, they do not show up. Adherence is higher only during blue November, when we perform the digital rectal exam, then they do come. We try to carry out some actions in the unit, but only two or three show up, and our initiative ends up being useless. The adherence is so low that we feel unmotivated. In my opinion, the policy has not moved forward nor been successful because of the men themselves, who do not seek the health services (CSD, nurses working in the FHS).</i>
Core Ideas: [...] do not seek the health services [...]	
Anchors: [...] They do not take care of themselves [...]	

4. DISCUSSION

The analysis of the interviews with the participants of this study reveals several challenges in the provision of care to the male patients of the Basic Health Units (BHU) and Family Health Units (FHU) comprising the Brazilian primary care network, with emphasis on the weaknesses found in the training of nurses, the heavy workload of these professionals, the absence of guidelines that are specific to men's health, and the lack of motivation expressed by the team regarding the provision of care to this population, given the historical remnants associated with the idea of being a man in Brazilian society, which to this day limit the demand for health services.

Similar results have been described in the literature [25]. Studies conducted with primary care nurses in other Brazilian cities, such as João Pessoa, Uberaba and São Paulo, have revealed the same concerns of health professionals working with men's health, as well as the same difficulties and obstacles in providing care to this population [25 - 27].

The scenario of lack of professional training in this regard has been demonstrated in several studies [25, 26, 28]. This fact is pointed out as one of the reasons for the low adherence of men to the actions of the health system, also reinforcing the need for training nursing professionals, so they are able to meet the health needs of this population, considered vulnerable [26, 28, 29].

However, to this end, there are challenges that need to be overcome, which partly originate in the academy, where there is a lack of content pertaining to men's health, affecting the professional practice of nurses. Moreover, greater investment in continuing education is necessary to minimize or resolve the gaps in the academic training of nursing professionals, emphasizing the importance of providing care to this vulnerable segment and, thus, enhancing their visibility in primary care [26].

Furthermore, it is essential to consider the symbolic dimension of nursing as a social and historical practice, focusing on the feminization of the profession and especially on how the gender issues influence the care provided by these professionals [30 - 32]. Therefore, the work of nurses is imprinted with gender constructions, which are transposed to the perception of the subjects and their demands. In addition, the role of primary care nurses in collective health, associated with historicity and dynamism, is guided by historical and philosophical bases which, from the point of view of historical

materialism, are involved in continuous social transformations [33].

According to the Brazilian Ministries of Health and Education, the gap between the academic universe and the reality of health services has been described throughout the world as one of the causes for the crisis in the health sector, mainly regarding the high rates of male morbidity and mortality from preventable chronic diseases [34]. Notably, in the context of the implementation of actions aimed at the promotion of men's health in primary care, nurses have to deal with a historical and social territory that is full of provisional, unstable and imperfect qualities, in addition to precariousness, which is associated with other factors, such as economic development and the transformations in the modes of production and in the exchange and division of societal classes it entails, as presented in the Tipesc [33].

The obstacles encountered by nurses in the implementation of PNAISH are directly related to the fact that it was created and disseminated to promote men's health and prevent the diseases affecting this population through actions developed in primary care services [7]. One of its guidelines is basing these actions on an inclusive proposal that leads male patients to consider health services as spaces intended for men and, in turn, health services to recognize men as subjects who need to be cared for, implementing strategies aimed at the inclusion of the male population to fully meet its health needs [7].

Thus, there is a gap between the knowledge of nurses and the health education and promotion actions intended for the male patients of Basic Health Units (BHU), as well as between them and the knowledge of managers about this policy and its action plan, contributing, in this way, to the absence of both these actions and of an agenda focused on the male population.

The deficiencies in the training and work of nursing professionals related to the provision of care to men were highlighted, revealing asymmetrical nuances, such as the differences in the professionals' attitude towards male and female patients, which reflect the gaps between the theoretical discourse and the professional practice of nurses regarding the gender perspective [35]. To support the actions developed in primary care, the Tipesc indicates society, man, the health-disease process, collective health, care, nursing, work, need, vulnerability, and education as fundamental concepts that should be considered [36].

The role of higher education institutions in the academic

training of health professionals is also important, representing a challenge to be overcome. Curricular changes need to be adopted by applying a pedagogical model that allows students to not only learn the theoretical contents but also have real-life experiences [37, 38].

Nevertheless, there is an urgent need for introducing the critical dimensions of sex, gender, and reproduction as interdisciplinary and comprehensive categories, considering the social paradigms associated with the symbolic production and reproduction of social identity and emphasizing the social role of nursing in the development of the uses and meanings attributed to health care [30].

The proposed policy of inclusion of men as subjects of care requires reviewing and reworking training models, since of the health needs of the male population pervades the explanation of the gender category as an element of organization of social practices, including the provision of care. These needs include men's health, which, is thus, a relevant type of content that should be considered just like the others. Given this, professors must be prepared to work alongside students in simulations of professional practice, considering the new pedagogical context, content, and procedures [39, 40].

The participants of this study point to heavy workload as a factor influencing the performance of actions in collective and individual health, particularly those focused on the health needs of men. The analysis of the primary care nurses' work process revealed it to be pervaded by bureaucratic-administrative activities that could jeopardize the care provided by these professionals [41 - 43]. In order to manage the work process in collective health, the Tipesec suggests considering the structure in its totality, with praxis and interdependence as fundamental dimensions [33].

The current organization of the work process generates an excessive amount of administrative demands, on which nurses spend much of their time, restricting the possibilities of their involvement in health prevention and promotion actions, such as those directed to the male population [44].

The heavy workload of Brazilian nurses has been addressed by several studies, such as the one by Lauter [45]. According to the author, the professionals interviewed revealed that the accumulation of functions, including those of administrative nature, leads them to have no time to participate in other activities.

Other studies have pointed to the excessive workload of nursing professionals in different health care sectors, which is a worrying factor, especially in the context of men's health, which requires new strategies for this population's insertion in the sphere of health care services [46, 47]. Nonetheless, the work process of primary care nurses should be further explored, considering the unique characteristics of this sector to review and change conventional health care practices, a transformation that could be triggered by the promotion of men's health.

Despite the creation of PNAISH in 2008, health professionals still have to face several challenges before it can be effectively implemented and operationalized. It is possible that nursing is the category that has most invested in the

understanding of the policy's implementation process, especially in the context of primary health care [7, 48, 49].

There is still a long way to go before this policy's goals are fully achieved, as demonstrated by the analysis of the discourse of the participants of this study, as well as others performed in other regions of the country [25, 26, 50, 51]. In this sense, health care services need to be reorganized, assuming an ethical stance of co-responsibility for the social production of men's health by straightening the bonds with this population and promoting actions and services aimed at its health needs. The incorporation of the theoretical precepts of the Tipesec will allow applying theoretical-methodological instruments that may be able to adapt the work process of nursing professionals to the changes in the organizational process of contemporary society, and, consequently, in public policies [33].

This effort is necessary to overcome the justifications given by men for their low adherence to health services and involves complex changes to structural issues of historical, social and cultural character, as well as the organization of the work process of health professionals [27, 50]. Continuing education in health may be an indispensable tool to encourage the questioning and resignification of the work process, making it possible to not only reflect on, but also transform professional practice, technically and critically redirecting the provision of care to men, especially considering the active inclusion of patients in the planning of actions.

Thus, actions and services directed to the promotion of the quality of life and health of the male population are crucial in the context of the changes required so that men assume the leading role in the development of happiness projects [27, 52].

Therefore, overcoming these barriers requires new attitudes on the part of managers, health professionals, and the male population itself, so that subjects who were once invisible but have unique health needs can be successfully inserted in the health care context, establishing complex relationships with themselves and with the services to, above all, ensure their right to health care.

Health professionals recognize the existence of the difficulties in effectively inserting the male population in the health care context, which is, in part, due to the perpetuation of the hegemonic model of masculinity, which hinders the demand for health services by distancing men from the responsibility for their own health [7, 53 - 55].

In Brazil, men have assumed this distancing behavior based on the model they are socially expected to conform to, according to which the signs of weakness, fear, insecurity or anxiety, leading them to seek health services, would put their masculinity at risk, being associated with representations of femininity. This model is based on the cultural endorsement of the social values attributed to men, favoring their involvement in behaviors that expose them to risks and that potentially endanger their health [56 - 58].

The access to and use of health services by the male population are socially mediated by the relations of power, success, and strength permeating the model of masculinity followed by many societies being transposed into complex symbolic and political obstacles to their insertion in the health

care context [59, 60].

Men have historically failed to adhere to preventive practices, especially due to the cultural conditioning of their social roles, such as the head of the household, wage earner, and source of brawn, which distance them from the services. Their perception of themselves is shaped by their background, education and social relations, being associated with strength and invulnerability. As self-care is not a common cultural practice of men, creating strategies to promote the health of the male population is still seen as a great challenge [48, 55]. Men believe they should seek health services only in urgent situations, such as for the treatment of chronic diseases or pain and discomfort threatening their position as wage earners and providers. This reality is depicted in various qualitative and quantitative studies [26, 27, 48, 50].

In a study with 29 men, only one reported seeking health services for preventive purposes [48]. In another study, most (54.1%) of the drivers evaluated reported seeking health services only in emergencies, reinforcing the need to change the male population's historical perception of health care. In addition, society conceives men as invulnerable, not allowing them to demonstrate their weaknesses [50]. They cannot cry, feel emotions, and/or show fear or anxiety. Therefore, seeking health services to prevent risks is seen as an act of weakness that threatens the beliefs of this androcentric society [9, 27, 61].

One way to better guide actions and overcome challenges is performing the five steps of the Tipesc, which can help achieve better results. These include: 1. Understanding the objective reality of the phenomenon and its situations; 2. Interpreting this objective reality based on dialectical contradictions and the occurrence of phenomena; 3. Proposing an intervention plan to overcome the phenomenon in context of vulnerability and transformation; 4. Changing the objective reality by triggering critical, reflective, and pedagogical processes to acquire skills in a scenario of transformation, and finally, 5. Reinterpreting the objective reality based on the assessment of a 'product' of collective changes and improvements, which will be used to guide nursing practices in collective health [33].

This all points to the absence of men in the context of primary care services, which they seek only after the onset of morbidities, often chronic, increasing the risk of mortality from potentially preventable health conditions [9, 50, 55].

The epidemiological data on morbidity and mortality in Brazil indicate the male gender as more vulnerable to severe and chronic health conditions, dying sooner than women, which reinforces the need to implement health education and promotion of actions focused on this population, as well as promote its adherence to preventive health services [13].

Professional demotivation is the result of a chain of events and challenges in the provision of care to this vulnerable population segment, triggered by insufficient training. It is worsened by the heavy workload of nurses, which leads them to often fail to implement health education and promotion actions and other strategies aimed at increasing male adherence to health services [62 - 65].

The reorganization of the perception of men's health and of the health service itself, as well as continuing education focused on this population segment and better distribution of tasks within the service, can help improve the work environment, stimulating the development of new actions and strategies that allow nurses to face the challenges in the provision of care to the male population [27, 44], the comprehensiveness of which can be ensured with a better synergy between the policy, management practices and nursing professionals [13, 27].

The successful implementation of PNAISH and its actions is of extreme importance to minimize the deficits in the provision of care to men, being in accordance with SUS's principles of universality, comprehensiveness, and equity of care. Thus, the proper understanding of the policy is crucial to ensure that the professionals' actions are effective, always from a perspective of promotion of men's health [7].

CONCLUSION

This study shows the barriers found by nurses in the promotion of men's health, highlighting the weaknesses of professional training and performance and of the organizations' work process, as well as the symbolic and cultural implications of the masculinity model and of the perception of health care services and nursing professionals.

Given this scenario, it is essential to question the political and historical constitution of care practices, particularly in the context of nursing, culturally associated with femininity and less valued in hierarchical relations of power within the health care context.

It is necessary to deepen the understanding of the gender perspective as a method of the reorganization of health services, so that the demands of subjects, which vary according to the unique characteristics of each man and his way of experiencing masculinity, can be met.

Men's health represents a political challenge and, in the context of primary care, an opportunity to restructure the work of nursing professionals, who stand before a vast field to be explored, which allows them to assume leadership positions based primarily on the understanding of gender as a constitutive element of social relations.

ETHICS APPROVAL AND CONSENT TO PARTICIPATE

Men's health care in a scenario in Northeastern Brazil was approved by the Research Ethics Committee under opinion number 1.208.304, and its subproject, Nursing in men's health care: challenges of implementing actions in the Family Health Strategy, also approved by the Committee under opinion number 996.821.

HUMAN AND ANIMAL RIGHTS

The fundamental ethical and scientific requirements for research involving human beings were met, according to Resolution 466/12 of the Brazilian National Health Council.

CONSENT FOR PUBLICATION

Informed consent was obtained from all participants.

AVAILABILITY OF DATA AND MATERIALS

Not applicable.

FUNDING

None.

CONFLICT OF INTEREST

The authors declare no conflict of interest, financial or otherwise.

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Not applicable.

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