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ORIGINAL ARTICLE

UNDERSTANDING THE HEALTH NEEDS OF MEN IN HOME CARE: A STRATEGY FOR COUNTER-HEGEMONY[1]

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ABSTRACT

Objective: to understand the health needs of men cared for at home. **Methods:** study with a qualitative, analytical and interpretive approach, based on the theoretical-epistemological framework on Needs. Data collection took place between January and February 2019. The survey included 34 caregivers and 24 men assisted by the Home Care Service in João Pessoa, Paraíba. Data were obtained from open interviews and unsystematic observation and submitted to Critical Discourse Analysis. **Results:** the discourses reveal that the health needs of men assisted by home care refer to a hegemonic and invulnerable biological model, built by moral leaders, dominant ideologies and particular cultures. But, due to the condition of limitation, the participants started to identify health needs considered counter-hegemonic, such as gregariousness; to be welcomed; to have a bond; religiosity; access to health services and technologies; inputs; leisure; digital technology; socialization and accessibility. **Final considerations:** we conclude that the singularities of men in home care must be recognized for a more comprehensive and equitable health care.

Keywords: Men's Health. Home Nursing. Nursing. Comprehension.

INTRODUCTION

Need is considered as a conscious desire, an aspiration, an intention directed at all times towards a certain object and that stimulates action, which can be a product or a way of living life. Accordingly, every system of needs is specific to a particular social formation and civilized society[1].

The relationship between men and health needs is the object of attention in the context of services and also in studies that, over the last two decades, have sought to understand the links between the exercise of masculinity and the care practices[2-5]. Masculinity is a symbolic space that structures the identity of human beings, shaping behaviors and emotions that now have the prerogative of models to be followed, including their health status, denying the existence of pain or suffering, vulnerability, in order to enhance the idea of virility and strength[2].

The cultural gender issue is defined as one of the major responsible for keeping men away from health services, contributing to the high rates of illness in the male population[6]. In some cases, cultural models of masculinity can be the main responsible for the fact that men are more vulnerable than women to some diseases and lifestyles that undermine health[2].

In addition to the restrictive and binary view of sex, the understanding of masculinity from the perspective of gender understands individuals in a performative way, that is, from a sociocultural construction[4]. Thus, the hegemonic masculinity assumed as an ideal is permeated by an ideal of invulnerability, where men, when they become ill, endure the disease or just request, as a last option, curative assistance, with preventive guidelines being unnecessary[3].

In this sense, social processes related to

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gender, including, in particular, masculinity, produce differences in the pattern of morbidity and mortality between men and women, as well as in health-protective behaviors[4]. In Brazil, for the male population, the main causes of mortality and morbidity are related to injuries, poisoning, consequences of external causes, as well as circulatory, respiratory and digestive system diseases[7].

Given this context, where injuries and diseases affecting the male population constitute public health problems, in 2009, the Brazilian Ministry of Health (MS, as per its Portuguese acronym) published Ordinance nº 1.944/GM, which establishes the principles and guidelines of the National Policy for Comprehensive Attention to Men's Health (PNAISH, as per its Portuguese acronym)[8]. This public policy seeks to protect the health of the male population by promoting health actions that significantly contribute to the understanding of men's reality in various sociocultural and political-economic contexts[9].

In this context, Home Care (HC) plays an important role within the Health Care Network (HCN) with the provision of services that replace or complement the hospital and outpatient levels. These services aim at the continuity of care and promote a broad knowledge of the user's life, such as routine, culture and family ties, favoring preventive, educational and rehabilitation actions for comprehensive care that guarantees male particularities in relation to health[10].

Based on this understanding, the question is: how can the health needs of men at home relate to patterns of masculinity? It is assumed that men are permeated by social conceptions as dominant and unshakable and that they are treated, in health care, by a hospital-centric biomedical vision, focused on the disease, its limitations and incapacities. Nonetheless, in the context of care produced in HC, it is hoped that practices can capture the needs of these individuals beyond the biological model.

After a broad integrative review of national and international literature[11], as well as participation in a study group, with expanded discussions on the construction of the male *Ethos*, we recognized that there is a large gap in the perception of the historical, social, political and economic singularity of men. Accordingly, it is necessary to understand how the health needs of these men can relate to the standards of masculinity in the construction of their *Ethos*. The objective of this study is to understand the health needs of men who are cared for at home.

METHODS

This is a study with a qualitative, analytical and interpretative approach, based on the theoretical-epistemological framework of Heller's Needs[1], which enables us to understand how masculinity interfereswith the process of production and satisfaction of life needs and, consequently, of health needs of men immersed in a society regarded as capitalist[1].

Data collection took place between January and February 2019. The research setting was the municipality of João Pessoa, capital of Paraíba, Brazil. Data were obtained from interviews with 34 caregivers and 24 men assisted by the Home Care Service (HCS) in the aforementioned municipality. This service aims to improve the health and quality of life of men who are discharged from hospital to home, regardless of the diagnosis, but who require continuity by means of home care. In this research, we adopted non-probabilistic sampling, through accessibility or convenience, assuming all eligible individuals from the population universe, in order to contemplate the singularity and respond to the objectives of this study. We included men aged between 18 and 59 years, registered in HCS, at the time of collection, with preserved verbal ability and without cognitive deficit, as verified by the researcher's assessment. This delimitation of the age group is justified by the PNAISH principles and by the certainty that men under 18 and over 59 years have resources such as the Elderly Health Policy and the Child and Adolescent Statute.

For caregivers, the inclusion criteria were to be formally or informally responsible for the care offered to the man registered in HCS and, as established in HC, to be 18 years old or older. The exclusion criterion was the presence of cognitive deficit. The nursing professionals or caregivers with registration by the Brazilian Classification of Occupations hired by the family were considered as formal providers,

while the spouses and family members who assumed the care procedures with the men in HC were considered as informal providers.

The instrument adopted for the production of empirical material was, firstly, the open interview, with audio recording, guided by a script, which contained a guiding question about the health needs of men at home and the care provided by their caregivers. The men and caregivers were personally approached to carry out the interviews, which had a duration ranging from 7 minutes and 33 seconds to 85 minutes and 51 seconds. After the interview was recorded, if the participant requested it, the audio was played so that he/she could hear. The interviews took place in various environments in the homes, such as the living room, bedroom, and even the kitchen, places that, for the participants, stood out as areas of trust and empathy. In the second moment, the unsystematic and participative observation of men and their caregivers at home allowed the complementation of empirical data and acquisition of information, especially regarding interpersonal relationships and care actions between men and their caregivers, within the home environment, which could not always be perceived in the participants' speeches.The observation took a total of 54 hours and complied with the following sequence: context (environment/location); people who make up the environment; behavior/attitude; actions/reactions; and specific situations of care aimed at meeting the needs of men in HC.

After transcribing the interviews, the content was submitted to Critical Discourse Analysis (CDA), having Fairclough as a conceptual basis[12], which considers discourses as different interpretations of social life, instruments of action and modes of representation, in a dialectic relationship with the social structure. Thus, the discourses were analyzed in a three-dimensional way, identifying the text and the discursive practice as dimensions inserted in the social practice. CDA made it possible to understand the structures of discourse in terms of social organization, recognizing the present hegemonic ideologies, meanings and orientations.

The research complied with the guidelines of Resolution 466/2012 of the National Health Council and was approved by the Research Ethics Committee, under CAAE 61343716.2.0000.5149. All interviews were preceded by the signing of the Free and Informed Consent Form (FICF). In the presentation of results, in order toguarantee confidentiality and anonymity, we identified research participants by means of nicknames.

RESULTS

Respondents reveal the perception of a hegemonic and invulnerable masculinity, built by moral leaders, dominant ideologies and particular cultures. The speeches portray this understanding with the use of the *lexical item need* related to the elementary conditions of biological health. In addition, they reveal how the imaginary of hegemonic masculinity influences men's understanding of their health needs, exposing them to irreparable risks and damage:

> [...] need, not need, but I like to go out. I go out from time to time anywhere, it can be the beach, shopping, cinema, restaurant. (**Lucas, HC user**)

> [...] need is pretty good, right, for me, normal for now. It's normal [...] there's nothing [...] He took the probe, thanks to God [...] (**Matheus, HC user**)

In this study, most of the men were admitted to HCSbecause of consequences of injuries from external causes, especially related to violence by firearms and motorcycle accidents. This condition that imposed on them health care at home placed them in a differentiation that culminated in subordinate ideological patterns of masculinity, intermingled with dominant ones.

In this context, the participants, when faced with situations that placed them in conditions different from those common to existing social groups, recognized the health needs hitherto unknown in their imagination. Among these *needs*, we can mention the very *knowledge*, considered essential for men to leave an illusory picture of *alienation* and recognize other needs.

The discourse of the caregiver Susana, mother of a male HC user – 23 years old, with hydrocephalus since birth – demonstrates the need for knowledge as a way to change her child's life:

> [...] I always talk to him, I'm always enlightening. Knowledge for him, for him to know. He studied,

studied until the fifth grade. (**Susana, caregiver mother**)

The *gregarious need* illustrates the importance of affection for health. It can be included in the *need to be welcomed and linked*, either by the professional or by the family member. The discourses below illustrate the importance of meeting this health need:

> [...] everything we have here at home. It's the presence of my mother, my brother, my sister, my father, my whole family, all of this helps me [...] (**Lucas, HC user**)

> [...] His special needs are the love and affection we have for him, understand [...] This is a typical love affair, understand [...] (**Jorge, caregiver, spiritist**)

In his speech, Lucas makes it clear that the presence and bond with his family members in the interpersonal relationships established within his microspace is all he needs. During observation, it was possible to experience these relationships between the mother and him, during cuddling, and between him andhis brother, with the provided care.

The *need to be welcomed and linked with the caregiver*, in order to carry out or help the activities of daily living of men in HC, limited by quadriplegia, also appears as a health need. In the discourses of Josefa and Antônio, we identified the *need for a bond between professionals and users*. In Josefa's discourse, *intertextuality* establishes this bonding relationship through the nurse's speech. In turn, in Antônio's discourse, the *textual cohesion by the conjunction by cause* explains the logic of the bond as a cause for the continuity of life, in addition to the *affirmative evaluation* attributing meaning to the link through the adverb and the exclamation mark *too important*!

> [...] there was a nurse here, they transferred her to another place. Then when she came to tell him she was going out, he had a fever for eight days. He almost passes away. I think it's emotional. [...] (**Josefa, caregiver**)

> [...] I'm still encouraged to have strength, energy, because of the support I'm getting from the team and my relatives [...] Yes, you have to put these things in the thesis, which is too important! Too important! The support of the family and the team in the continuation of our lives. (**Antônio, HC user**)

The dominant religious ideologies are present in excerpts from the discourses of Jorge and Antônio, who express *religiosity* as a *need of a social nature*. In Antônio's discourse, in the textual dimension, the *affirmation with deontic modality* is highlighted, when expressing the obligatory use of the verb *to want* in the middle of the discourse. Moreover, we observed the *cohesion* for the effect of emphasis between the sentences, when using the conjunction *because*with the purpose of justifying the cause of some thoughts and actions of the study participant:

> [...] every night I put him to sleep, the three of us pray together. Every night, he likes to hear about God [...] (**Jorge, caregiver**)

> [...] I don't see support when no one answers for me, the life mysteries. Do you know why? Because we were created, what is the use of people. Is it for this business of reproducing and everything else. That's not it. I want an answer to this emptiness of life, you know [...] I wanna know about this, this existence. Nobody answers me [...] I'm not convinced, but it's not because I'm rebellious. It's because there's no explanation. The truth is missing, you know [...] (**Antônio, HC user**)

In the excerpts of the participants' speeches, we identified that *access to health services* is correlated to the known *needs* for *guaranteed access to all technologies that improve and prolong life and also the needs for good living conditions*. In the discourses, mention is made to the affirmations of deontic modality expressing obligation and need through the verbs *topower, to order, to want* and*to need*:

> [...] I don't know how to have access, for example, to a stem cell treatment, I've already looked it up on the internet. But I've already talked to one/ I've sent a message to some people on the internet, but they didn't reply [...] (**Lucas, HC user**)

> [...] some needs that I need, that I need that I don't achieve, it would be a car for me to move around, to go to some places (**Felipe, 27 years old, paraplegic, single**)

Men report the *difficulty in achieving certain essential inputs* to meet their basic health *needs*,

such as hygiene under eliminations, medicines, material for bandages, among others. They make it clear that the distribution of these inputs was the responsibility of the State as a guarantee of the right, but that, at the moment, they are the ones who are buying, even with low *purchasing power*:

> [...] in this case, some materials that could help, but they don't offer, right, for fail of the government [...] (**Leonardo, single**)

> [...] it's been a year and four months since I've had a diaper. Therefore, I buy diapers, I buy medicine that the doctor applies, I buy ointment that the doctor applies. Therefore, everything comes out of my pocket [...] (**Leandro, brown, evangelical**)

In Maria's discourse, we observed the meaning attributed to access to health services, the *need for access to all technologies that improve or prolong life*, being attributed a discursive content of difficulty to this technology, due to the *purchasing power* of the participant of the study, removing from these men the property of productive worker and home provider, associated with the ideology of hegemonic masculinity:

> [...] gosh! Today, there are so many things that are good for J's health that cannot be done, for example, the exams[...]. A small surgery to do the bedsore [...] These things that are lacking, they have to be done urgently, and there is no way [...] (**Maria, 63 years old, caregiver grandmother**)

The discourses of men in HC and their caregivers still relate *leisure to social well-being*, which consists not only of maintaining life, but of a pleasant and happy life. In Bruno's discourse, we can see the construction of social relationships between different actors to meet health needs linked to *leisure*. In Cristiane's discourse, we identified discursive characteristics that are peculiar to the hegemonic pattern of masculinity, the one that allows men sovereignty in their outings, enjoying alcohol as an instrument that brings pleasure and, therefore, mentioned in the discourse as *leisure*:

> [...] I'm going to walk around. Now and then, I go for a walk on the beach [...] I go with my friends by car [...] (**Bruno, HC user**)

> [...] the only leisure he sees is this one, going to the bar, because the guys only take him here to drink. Then, the only fun he has is this [...] (**Cristiane, caregiver**)

In the speeches of participants José and Lucas, we can note that *digital technology is as an artifact to meet the need for leisure* in discursive productions. Digital technology provides social actors with an experience in universes far from their reality:

> [...] I just watch TV, play games on the tablet too [...] (**José, HC user**)

> [...] what I request is the internet, TV, movies, things like that [...] (**Lucas, HC user**)

For the participants of this research, *socialization* is also seen as a need, and the discourses demonstrate the difficulty in strengthening interpersonal relationships among social actors who are outside the microsocial space of men in HC. The *need for inclusion andaccessibility* is shaped in Leandro's discourse through the affirmations of deontic modality, expressing needs:

> [...] what needs to be improved, I think it's on the accessibility issue. How I talked about quality of life. We, wheelchair users, we often dispute space with a car because of the sidewalks [...] (**Leandro, HC user**).

DISCUSSION

The results indicate how the health needs of men assisted by HC persisted in a hegemonic biological model. In today's society, there is still a dominant ideology, enshrined in common sense, of male invulnerability, which makes men unable to demonstrate their feelings so that they do not represent signs of weakness.

Nonetheless, ideology is more effective when its operation is less visible[13], that is, when someone becomes aware of a certain aspect of common sense, the inequality of power is assured by itself, causing that aspect of common sense to lose the strength to sustain itself. This is how the study participants positioned themselves in the face of common sense ideologies regarding their masculinity, expressing counter-hegemonic needs.

This perspective on needs enables the interposition between micro and macro-social processes, respecting the reciprocal and complex

interaction between structure and individuals. However, health needs are socially and historically defined, but human beings have the ability to change themselves and their surroundings, in order to improve their lives. It is in this allusion that the participants of this study imprint a counter-hegemonic look by recognizing health needs that go beyond those taken as natural (existential) and elementary for good living conditions.

Knowledge, identified as a need in the participants' discourse, is a tool for hegemonic paradigm shifts in society. It develops in the course of social relationships and can be used as an artifact of domination or liberation. In the daily life in which the human being is constituted, when there is the insertion of some knowledge in an automatic way in people's lives, it can be said that this new way of acting constitutes the individual's identity[14].

The counter-hegemonic need for the gregarious aspect, described by men in HC and their caregivers, demonstrates a face of needs that refer to the very achievement of the human condition, the lack of affection, shelter, tenderness and protection; this need goes beyond the recovery of health, it is the very condition for human survival. In this sense, home care provides the comfort of home and the bond with the family, meeting this need in the historical-philosophical-anthropological aspect, provided by light and light-hard technologies [15].

The need to be welcomed and to have a link with professionals/health teams or family members permeates the gregarious aspect, reaching a dimension that expresses the need to have a caregiver (formal or informal) and strengthen affective ties with family members and professionals, in order to carry out what can be understood by health. We emphasize the understanding of the need as a conscious desire, an aspiration, a directed intention that stimulates action[1].

In addition to the technical needs related to the disease, we identified the importance of the bond in the care practice. Among other elements, the bond facilitates understanding and answers to people's doubts and anxieties[16]. The performance of the HC team is based on affection, respect and the formation of bonds that contribute to guaranteeing continuity of care, using the guidelines and training of users and caregivers. These elements make up the perspective of bonding in the sense of meeting health needs[15,17].

Most of the men who participated in the survey also recognized the need for religiosity; however, only after the health problems that conditioned them on their limitations and on home care. The caregiver, when recognizing the patient's vulnerability (HC user), tries to give a metaphysical meaning to the suffering, that is, he/she seeks, through faith in God, the strength to support himself/herself and his/her patient[18]. Religiosity has always been present in human life and is an important aspect in the care of sick people[19]; it encompasses a system of beliefs and doctrines that is shared by a social group and has its own behavioral, social and moral attributes. In times of illness, people look to religion for meaning and relief from suffering [19].

When analyzing the discourses of men and their caregivers regarding access to health services, they make clear the need to guarantee access to all health care technologies that improve and prolong life. During the disease process, the expenses for materials, diets and medicines are very costly, a burden on the family budget, leading to an intense search for resources offered by the health system free of charge [18]. The men in this study are allocated to the proletariat. Thus, their needs have a reductionist nature, i.e., the vital type for their survival[1].

We believe that the men, from whom the speeches came, experienced changes in ideological paradigms regarding their masculinity, when mentioning leisure as a need in the discourses. Because, when it comes to hegemonic masculinity, work is the only tool to prosper, excluding from this interaction everything that opposes it, as in the case of leisure.

The fulfillment of social needs, associated with the desire to be well with oneself, is the subjective dimension that men in HC relate to the achievement of their health. The discourses of men and their caregivers relate leisure to social well-being, which consists not only in maintaining life, but a pleasant and happy life. Happiness and quality of life are directly related to health[20]. In addition, biological needs raise

other needs of a social nature, which are superior and motivated by social living conditions and may include the needs to relate to other people and leisure[16].

Access to digital technology is also included in the discourses as a need related to leisure. The world today is full of information and communication technologies, where all humans, anywhere and at all times, are connected to the network and interacting with people and the world in the digital space. This condition characterizes this study finding as a need[1], as it is conditioned to an increase in material production through the consumption of products and technologies. Nevertheless, the information society allows for positive social change possibilities, but also ambiguous and undefined. Among these changes, there are the challenges to allow all people to have access to information published on the world wide web, regardless of their perceptual, cognitive or motor limitations[21].

In order to allow men with physical limitations to enjoy leisure and digital media in an equitable way, as meeting a need, the 'social macro-structure' (State) would need to guarantee the construction and application of inclusion and accessibility policies, aiming at avoiding the exclusion of some social actors. If this need were met, it would certainly be considered as a radical need [1].

Finally, to have accessibility, to be included and to socialize are pointed out as radical needs to be met for men in HC. Radical needs are properly human and correlate to autonomy, self-achievement, self-determination, freedom, moral activity and reflection [1]. Accessibility is conceptualized as an association with the philosophy of universal design, where an architecture oriented towards human diversity is conceived, seeking to respect the specific needs of each human being and favoring the accomplishment of various daily activities, with autonomy, independence, safety and comfort[22].

This study recognizes a possible limitation regarding the influence of the participants' personal, sociocultural, historical and political contexts on the research results, in addition to the presence of the participating researcher in the data collection.

FINAL CONSIDERATIONS

We analyzed the discourses of social actors, men and caregivers, about the relationship with the objects of their health needs, identified as counter-hegemonic to the common sense of the ideologically invulnerable man, such as knowledge, gregariousness, bonding in the care practice, religiosity and access to all health care technologies, inputs, leisure and accessibility.Based on the empirical findings, we conclude that the social construction of a hegemonic masculinity can generate obstacles to the recognition of the health needs of men in HC. Accordingly, the singularities of HC users must be recognized to guide a more comprehensive and equitable health care.

The study contributes to the development of Nursing, which has care as a guiding practice of the profession, by producing differentiated care for the men in home care, in view of the recognition of the health needs of these users, guiding caregivers from care proposals that are mediated by the historical, cultural, social, demographic and economic profile. Moreover, it contributes to the theoretical construction and practical implementation of PNAISH and HC guidelines.

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COMPREENSÃO DAS NECESSIDADES DE SAÚDE DO HOMEM EM ASSISTÊNCIA DOMICILIAR: ESTRATÉGIA PARA A CONTRA-HEGEMONIA

RESUMO

Objetivo: compreender as necessidades de saúde dos homenscuidados no domicílio. **Métodos:**estudo de abordagem qualitativa,analítica e interpretativa, fundamentada no referencial teórico-epistemológico sobre Necessidades. A coleta de dados foi realizada entre os meses de janeiro e fevereiro de 2019. Participaram da pesquisa 34 cuidadores e 24 homens assistidos pelo Serviço de Atenção Domiciliar de João Pessoa, Paraíba. Os dados foram obtidos de entrevistas abertas e observação assistemática e submetidos à Análise de Discurso Crítica. **Resultados:** os discursos revelam que

as necessidades de saúde dos homens assistidos pela atenção domiciliar remetem a um modelo biologista hegemônico, invulnerável, construído por lideranças morais, ideologias dominantes e culturas particulares. Mas, devido à condição de limitação, os participantes passam a identificar necessidades de saúde consideradas contra-hegemônicas, tais como gregária; ser acolhido; ter vínculo; religiosidade; acesso aos serviços e tecnologias de saúde; insumos; lazer; tecnologia digital; socialização e acessibilidade. **Considerações finais:** conclui-se que as singularidades dos homens em atenção domiciliar precisam ser reconhecidas para uma assistência à saúde mais integral e equânime.

Palavras-chave: Saúde do Homem. Assistência Domiciliar. Enfermagem. Compreensão.

COMPRENSIÓN DE LAS NECESIDADES DE SALUD DEL HOMBRE EN ASISTENCIA DOMICILIARIA: ESTRATEGIA PARA LA CONTRAHEGEMONÍA

RESUMEN

Objetivo: comprender las necesidades de salud de los hombres cuidados en el domicilio. **Método**: estudio de abordaje cualitativo, analítico e interpretativo, fundamentado en el referencial teórico-epistemológico sobre Necesidades. La recolección de datos se realizó entre los meses de enero y febrero de 2019. Participaron de la investigación 34 cuidadores y 24 hombres asistidos por el Servicio de Atención Domiciliaria de João Pessoa, Paraíba-Brasil. Los datos fueron obtenidos de entrevistas abiertas y observación asistemática y sometidos al Análisis de Discurso Crítico. **Resultados**: los discursos revelan que las necesidades de salud de los hombres asistidos por la atención domiciliaria remiten a un modelo biologismo hegemónico, invulnerable, construido por liderazgos morales, ideologías dominantes y culturas particulares. Pero, debido a la condición de limitación, los participantes pasan a identificar necesidades de salud consideradas contrahegemónicas, tales como gregaria; ser acogido; tener vínculo; religiosidad; acceso a los servicios y tecnologías de salud; insumos; ocio; tecnología digital; socialización y accesibilidad. **Consideraciones finales**: se concluye que las singularidades de los hombres en atención domiciliaria necesitan ser reconocidas para una asistencia a la salud más integral y ecuánime.

Palabras clave: Salud del Hombre. Asistencia Domiciliaria. Enfermería. Comprensión.

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