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Health needs of men in home care: visibility of different masculinities

Necessidades de saúde dos homens em atenção domiciliar: visibilidade das diferentes masculinidades

Necesidades de salud de los hombres en atención domiciliaria: visibilidad de las diferentes masculinidades

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ABSTRACT

Objective: to analyze the health needs of men in home care considering different masculinities. **Method:** this is a qualitative study based on the Health Needs framework. The study was conducted in João Pessoa, Paraíba, with a population sample of men receiving home care, aged between 18 and 59 years, and their caregivers. A total of 58 interviews were conducted, and the data were analyzed using Fairclough's Critical Discourse Analysis. **Results:** the need for mobility was highlighted as essential for men who consider themselves free. In this context, many men experience a threat to their masculinity due to limitations caused by health conditions. The need for wound care places them in a position of limitation and segregation. Additionally, it was identified that these imposed conditions have an impact on their sexuality. **Final considerations:** men's health needs are conditioned by the hegemonic model, linked to natural needs.

Descriptors: Nursing; Men's Health; Health Services Needs and Demand; House Calls; Masculinity.

RESUMO

Objetivo: analisar as necessidades de saúde dos homens em cuidado domiciliar mediante as diferentes masculinidades **Método:** trata-se de estudo qualitativo, fundamentado no referencial das Necessidades de Saúde. O estudo foi desenvolvido em João Pessoa, na Paraíba, com amostra populacional delimitada por homens em cuidado domiciliar, com faixa etária entre 18 e 59 anos; e por cuidadores. Realizou-se 58 entrevistas e os dados submetidos à Análise de Discurso Crítica proposta por Fairclough. **Resultados:** ressalta-se a necessidade de locomoção como algo indispensável para o homem que se considera livre. Neste sentido, muitos homens, têm a masculinidade ameaçada pelas limitações ocasionadas pelas condições de saúde. A necessidade de curativos os coloca em condições de limitação e segregação. Além disso, identificou-se que as condições impostas a esses homens geram impactos para sexualidade. **Considerações finais:** as necessidades de saúde masculina estão condicionadas ao modelo hegemônico, vinculado às necessidades naturais.

Descritores: Enfermagem; Saúde do Homem; Necessidades e Demandas de Serviços de Saúde; Atendimento Domiciliar; Masculinidade.

RESUMEN

Objetivo: analizar las necesidades de salud de los hombres en atención domiciliaria por medio de las diferentes masculinidades. **Método:** se trata de un estudio cualitativo, basado en el marco de las Necesidades de Salud. El estudio fue desarrollado en João Pessoa, Paraíba, con una muestra poblacional delimitada por hombres en atención domiciliaria, de edad avanzada entre 18 y 59 años; y por los cuidadores. Se realizaron 58 entrevistas y los datos fueron sometidos al Análisis Crítico del Discurso propuesto por Fairclough. **Resultados:** se destaca que la necesidad de locomoción es algo indispensable para el hombre que se considera libre. Por ende, muchos hombres ven amenazada su masculinidad por las limitaciones que les generan las condiciones de salud. Necesitar atención los pone en una situación de limitación y segregación. Además, se identificó que las condiciones impuestas a estos hombres afectan su sexualidad. **Consideraciones finales:** las necesidades de salud masculina están condicionadas por el modelo hegemónico, vinculado a las necesidades naturales.

Descriptores: Enfermería; Salud del Hombre; Necesidades y Demandas de Servicios de Salud; Visita Domiciliaria; Masculinidad.

INTRODUCTION

The discussion on gender issues in the health and disease process has contributed to health professionals' reflection on the challenges encountered in providing care to the male population. This population, due to lifestyle habits, is often more exposed to risk situations that impact their health, such as violence, traffic and work accidents, alcohol and drug consumption, as well as a lack of attention to health. These factors contribute to the increase in male morbidity and mortality across almost all age groups[1].

From a gender perspective, the high levels of male morbidity and mortality are also related to cultural constraints represented by the ideology of invulnerability, developed throughout human history. This ideology hinders men from adopting preventive health practices, as seeking healthcare services may be associated with weakness, raising doubts about socially imposed masculinity[2].

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In Brazil, the life expectancy of the male population is lower compared to that of women. While women live an average of 79.3 years, men have a maximum life expectancy of 72.2 years, with higher mortality rates among men in nearly all age groups[3].

In this context, in an effort to address the health needs of the male population, the Brazilian Ministry of Health (MH) established the National Policy for Comprehensive Men's Health Care (PNAISH) in 2008. This policy aims to protect men's health through health actions based on the reality of male habits in their various cultural, political, and economic contexts[4].

However, despite the MH's efforts, morbidity and mortality rates remain high among Brazilian men, indicating the need for specific health policies[5]. It is important to note that men's resistance to healthcare can lead to the worsening of illnesses, consequently increasing harm, the need for specialized treatments, and healthcare costs[6]. In this regard, reflecting on how to meet men's health needs and reduce healthcare costs, Home Care (HC) emerges as a powerful strategy within the Health Care Network for men[7].

A study on the profile of patients served by HC services identified that the most frequent comorbidities among HC patients were Systemic Arterial Hypertension, Diabetes Mellitus, and Neoplasms. These comorbidities are more common among men, highlighting the importance of this care modality for this population. However, there is still a need to promote a culture of adherence to men's health care, as the same study found that the majority of HC service users were women[8]. Therefore, it is crucial to understand the health needs of men receiving home care to highlight their demands and provide indicators to enhance men's health policies and improve the quality of home care offered.

Currently, four types of masculinities are described: hegemonic masculinity—associated with the legitimacy of patriarchy, which values male dominance over women; subordinated masculinity—referring to inequality among men themselves; complicit masculinity—related to men who do not conform to the hegemonic model; and marginalized masculinity—stemming from subordination due to race, social class, and minority ethnic groups[9]. Based on this understanding, it becomes important to investigate the health needs associated with the singularities surrounding these masculinities.

In this context, the present study aimed to analyze the health needs of men in home care considering different masculinities.

METHOD

This is a qualitative, analytical, and interpretative study based on the theoretical-epistemological framework of Health Needs by Matsumoto[10], which enables understanding the meaning men attribute to their experiences in home care. Regarding masculinities, this study considers that they are produced in different social contexts, including relationships among men, those of domination, marginalization, and complicity, with a certain hegemonic form of masculinity potentially encompassing other masculinities around it[9].

Data collection took place between January and February 2019. The research setting was the city of João Pessoa, capital of Paraíba, Brazil. Data were obtained through interviews with 24 men assisted by the municipality's Home Care Service (SAD) and 34 caregivers, either formal or informal, responsible for the care provided to men registered in the SAD. A non-probabilistic, convenience sampling technique was used, including all eligible subjects from the population universe to capture the uniqueness and meet the study's objectives. Men aged 18 to 59 years, registered in the SAD at the time of data collection, with preserved verbal capacity and no cognitive deficit (as assessed by the researcher), were included. This age range was justified by the principles of PNAISH and the understanding that men below 18 and above 59 are covered by policies such as the Statute of the Child and Adolescent and the Elderly Statute.

For caregivers, the inclusion criteria were being the formal or informal caregiver of a man registered in the SAD and, as established in home care, being aged 18 or older. The exclusion criterion was the presence of cognitive deficits. Formal caregivers were defined as nursing professionals or caregivers registered under the Brazilian Classification of Occupations and hired by the family, while informal caregivers included spouses and family members who assumed care responsibilities for men in home care.

The first phase of data collection involved open interviews guided by the following questions: "*What are your health needs, and how are they being addressed here at home?", for the men*, and "*What care is provided to the man at home to meet his health needs?"*, for the caregivers.

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Men and caregivers were approached personally for the interviews, which lasted between seven and 85 minutes. The interviews took place in various areas of the home, such as the living room, bedroom, and even the kitchen—spaces that participants identified as areas of trust and empathy.

The participants' responses were recorded using a digital recorder and fully transcribed, following conventions adapted from the standard suggested by Marcuschi[11], as well as transcription models and guidelines described in the adopted framework[12,13]. A database of texts derived from the participants' audio recordings was created at the end of the transcription process.

The empirical data from the interviews were subjected to Critical Discourse Analysis (CDA), following the Social Theory of Discourse[12], due to its alignment with the theoretical and methodological purposes of this study and its potential for reflecting on the conditions under which the discourses were constructed and assimilated.

Regarding ethical aspects, the study adhered to the guidelines and regulatory standards established by Resolution No. 466/2012 of the National Health Council, which governs research involving human subjects. All interviews were preceded by the signing of the Informed Consent Form (ICF). To ensure participant anonymity, they were represented by alphanumeric codes, using the letter M for men and C for caregivers.

RESULTS

The discourses reveal the **emphasis on the need for good living conditions** and survival for men in home care. These needs are recognized through the use of terms that prominently mention natural and social needs such as food, bathing, and clothing—conditions considered essential for life.

> *For eating [...] I need assistance [...] For moving around, they both always help me [...] my sister is the one who gives me a bath. (M11)*
> *For bathing, I always received help from my wife and my mother. In the beginning, eating was very difficult because I couldn't eat much, mainly because I wasn't urinating. I wasn't defecating either. (M13)*
> *Helping him get dressed because he can't bend down, right, serving his lunch and bringing it to him, you know. When he goes to take a bath, being close to him, right, so he doesn't slip, staying near him. (C25)*

The discursive formations are characterized by the expression of health needs that are essential for a good quality of life. In this context, the need for mobility and movement is highlighted as indispensable for men who consider themselves free, enabling them to come and go, work, and perform their daily activities.

The interviewees, as social actors who assume a differentiated role in society, mention physiotherapy and physical exercises as significant and imperative conditions to ensure the fulfillment of a need that will largely provide a better quality of life. In this regard, in caregiver C24's discourse, the importance of physiotherapy is also identified as a health need for men in home care. A textual property of cohesion through conjunction is observed, enhancing the connection between clauses and qualifying them with a causal characteristic through the connective “because”:

> *I need a lot of things, right, like walking [..] I stay here all the time. I only go out for physiotherapy and to see the doctor [...] what I need most is food and physiotherapy, right. (M8)*
> *That's all, and regarding physiotherapy, right. Because now he's only getting it two days a week, and I think that's way too little for him, you know. Because I think if he stops, things will get worse. Why? Because when he's at home, he's at home Saturday, Sunday, and Monday he doesn't have physio, right. He only gets it on Tuesday. [...] his feet get really stiff, a lot, and I move them, you know, pull them this way. Pull them that way, like she does, I try to do the same, I don't know, but I try, and his knee too, which gets really tense, you know, that's it. (C24)*

Mobility is referred to in the discourses as a **natural (existential) need**, in a process of differentiation, uniquely expressed in M1's discourse through the discursive strategy of metaphorical symbolization, where mobility is portrayed as a dream.

> *At this age, I need exercise, right, every day, daily baths, medication, and look, I have, look, I have the need to walk, the desire to walk, but I can't because oh: Parkinson's disease hit me hard and is locking up my whole body. I'm using a catheter, [...] urinary, and it's locking up [...] so the need is that I need to walk. Walking would be a dream because I love to travel. (M1)*

Care for skin integrity emerges in the discourses as another essential need for quality of life, correlating with those previously mentioned. Men in home care, due to the morbidities and comorbidities they face, are exposed to the presence of lesions that require special care, such as dressings.

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In the discourses, it is observed that the need to address skin lesions assigns characteristics to men that contrast with those ideologically accepted by hegemonic masculinity. For the study participants, the need for dressings places them in a position of limitation and segregation, excluding them from social environments and weakening their health.

Interdiscursivity is noted in the excerpts from the interviewees, with specific technical terms from the healthcare field, represented by words such as bedsores, infection, bacteria, dressing, healing, and ulcers, integrated into the discursive corpus of the men and caregivers interviewed.

> *Physiotherapy is really needed. I believe it would greatly improve my situation. I have bedsores, which are wounds, right, ulcers, so it's hard for me to go out because of that. My position is the same for everything, for eating, sleeping, bathing, for everything. (M10)*

> *I think I need surgery. I have two bedsores on my side, and to improve my health, it would be, I don't know, surgery or something to heal these two bedsores, which are two wounds this big. That's where my health gets even worse because if it weren't for these bedsores, I'd be in pretty good health. You have to be careful in the bathroom to avoid infection, bacteria, you know. (M14)*

> *Food, dressing care, always being careful, he raises his leg, and I always guide him in every way to ensure better healing, how do you say, healing, I'm the one who does it. Every day, since he left the hospital. Now I only skip the day when the SAD comes. Then I let them check, right, how it's going. At the beginning, I used to do it twice a day. Once in the morning and once in the late afternoon, because he needed it. (C27)*

Another discourse present in the pursuit of a good quality of life by the study subjects refers to the need for "medication" for men in home care. The terms highlight this need as an imminent part of the daily routine experienced by men receiving home care. This discourse is also found in the statements of caregivers, who in many cases are responsible for administering and managing the medications.

> *It's changing his clothes, giving him medication, and providing food, because he eats every three hours. (C4)*

> *Food, clothes, medication, I handle all of that, right. For bathing, I put a plastic chair in the bathroom. He goes in the wheelchair. Then, in the bathroom, he sits on the chair, takes a bath, and I help move him back to bed. On the bed, I dry him completely, do the dressing. The most important thing we hope for, right, is for him to walk again, right, to walk again and for the bedsores to heal. (C9)*

Sexuality, understood as synonymous with sex, is highlighted in the discourses as an important health need for men in home care. For H2 and C8, sex is linked to a health need and the man's ability to have an erection, thereby associating his masculinity with the presence or absence of virility. When this does not occur, it leads to a sense of loss and asexuality, as exemplified by expressions like “I'm in trouble” and “the lower part is dead”.

> *Today, no sexuality at all [...] but no, my mind is crazy. I'm always on the internet looking at these women, damn. I'm screwed, the desire is huge (laughs), mentally, but no physical reaction. (M2)*

> *And as for life, B. just doesn't have the [...] sexual life, right? He doesn't have that, never dated, although of course, he has those girls he likes, who sometimes come over, and we joke with him, and he says she's pretty and all. But to say that he had an active dating life, he didn't. Also because he has no erection, the lower part is dead. (C8)*

In caregiver C11's discourse, there is a mention of sexuality as sex, and sex, in turn, as the ability to have an erection. The mother assumes the role of caregiver for her son, who has hydrocephalus and is confined to bed with limited movement above the waist. She projects her own ideology regarding sex onto her son. It is well known, through gender culture, that there is a difference between men and women when it comes to the topic of sex and sexuality. The man's need is viewed through the eyes of his female caregiver, suggesting a gap in the understanding and addressing of this health need for the participant.

> *He doesn't have sexuality, not that he doesn't experience erections. In the beginning, he felt it more, many times when I was giving him a bath, he would sometimes be erect like that. Today, not anymore, and honestly, I think it's better this way. I prefer that he stays like this, you know? Because, like, he doesn't feel what we don't feel. Let him be, right? Because if it were for his own good, I would say, go ahead. Sometimes I even tell him, find a girlfriend, but knowing that if he finds a girlfriend and starts kissing and all that, it will stimulate him, and maybe that would make things worse, right? [...] So, I prefer that he stays quiet [...] (C11)*

The participants' hegemonic masculinity is weakened, as one of the main qualities of this masculinity for men relates to sex, sexual practices, and their virility as a 'man' who engages in sex. It is important to note that C8 and C11, despite being women and recognizing this need in their sons, in some way prefer that it not be fulfilled.

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However, regardless of these mothers not wanting their sons to engage in sex, the desire expressed by this need is felt by them.

Caregiver C23, also a woman influenced by historically and culturally ingrained convictions about male gender, which are reproduced in her practices, recognizes in her son the health need represented by sex and sexuality. She acknowledged this need when her son, as one of his first words, mumbled a request to go date, and experienced erections whenever any woman entered his room.

> *He understood that he stays/and now that he's talking, he's asking, asking to go after the girls, asking to go date [...] I tell him he's not ready yet, I tell him you're not ready to get out of that bed yet. (C23)*

DISCUSSION

Health needs are situated between nature and culture; thus, they are not only about preserving life but also about realizing a process in which the individual progressively humanizes, acting as a link between the specific and the general[14]. Health needs cannot be explained solely by the individual in isolation, without the influence of their social and concrete relationships, nor by society in a generic, undifferentiated manner[15].

The discourses highlight the need for mobility and movement as indispensable for men who consider themselves free. For them, freedom was synonymous with working, going out, celebrating; now, it is about exercising, doing physiotherapy, preventing muscle atrophy, and dreaming. Common belief holds that illness strips people of their freedom and autonomy, limits their achievements, and, especially in the presence of pain, reinforces the perception of human fragility. However, it is emphasized that in the process of fragility, when the care recipient is supported by a caregiver who expresses affection, respect, and closeness, this contributes to an internal sense of freedom for the person being cared for[16].

Caregivers play a fundamental role in the lives of these men whose health is compromised. It is considered that the health needs of these men can be identified both directly and indirectly by professionals and informal caregivers during care or through daily observations. However, the literature emphasizes the importance of the individuals themselves expressing their health needs, as this will guide care based on a broader understanding of the men's desires and expectations regarding their treatment[17].

When describing their wounds, the subjects indicate the urgency of skin care as another health need. Wounds are a significant public health issue because they increase morbidity, reduce quality of life, and raise care costs[18].

To meet this need, health teams, caregivers, and family members must remain vigilant to maintain skin integrity. Evidence on wound prevention indicates that caregivers of patients with wounds are engaged and interested in wound care, which becomes a potential avenue for professional interventions to address this need[19].

Additionally, references to medication as an essential need for maintaining life are common among men receiving home care. Expressions such as “take the medicine,” “bring the medicine,” and “give the medicine” are part of the daily routine for both users and caregivers[20].

Medication becomes a health need that will determine good living conditions. Thus, it is the responsibility of users and their caregivers to manage the administration of these medications. In this regard, the literature reveals difficulties faced by these actors in using medications, including administering them at the correct time, administration errors, and the use of contraindicated medications due to self-medication and a lack of knowledge about potential interactions and side effects[21].

To ensure access to treatment and meet this need, the implementation of policies, caregiver and healthcare professional engagement, and effective health education actions are necessary. Among the health needs identified in the participants' discourses, those related to sex and sexuality were also noted.

In 2000, the World Health Organization identified sexual health as a fundamental right for all individuals[22]. From the discourses, it is understood that sexual concerns manifest to varying degrees for the men in the study. Sexual health is highlighted as a health need that significantly contributes to quality of life. These findings urge caregivers to address this topic with users and contribute to the recovery of male sexual health.

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However, a study conducted with healthcare professionals found many barriers to discussing sexuality between caregivers and their patients. These barriers indicate deficits in knowledge and experience on the topic, as well as discomfort among professionals in questioning and addressing sexual issues[23].

It is emphasized that as long as concerns about sexual health remain unspoken, due to neglect or taboo, it will be impossible to implement strategies to address the difficulties faced by users. It is up to healthcare professionals to find ways to communicate and effectively address this health need[24].

Thus, masculinities constitute a symbolic space that structures human identity, shaping behaviors and emotions that become models to be followed, including in health, by denying the existence of pain or suffering, vulnerability, in order to reinforce the idea of virility and strength[9].

Another important aspect relates to the power position imposed by the caregiver over the user's sexual health. The results of this research show that the caregiver's discourse assumes a contradiction by recognizing this need, but by holding a "certain" power over the man who depends on their care, the caregiver can act as a controller of this need.

It is also considered that this caregiver is often a woman related to the man[16]. This relationship may contribute to controlling the described needs due to taboos and discomfort in discussing this topic.

Thus, the data from this study show that the social construction of masculinities creates barriers to understanding and addressing the health needs of men receiving home care. It is crucial to recognize and emphasize their particularities to improve the comprehensiveness and equity of healthcare. The difficulty in recognizing men's health needs, both by caregivers and patients, compromises the application of the principles of the Unified Health System. Awareness of these limitations is essential to transform this reality.

In the theory of health needs, it is necessary to reflect, theorize, and build possible alternatives for a praxis capable of restructuring daily life, resulting from a new way of living. The change in the daily life of a man receiving home care leads to reflection on his new health needs, and consequently, from the points raised in this discussion, it is understood that improvements and strategies must be considered to ensure effective care for the health needs of these men in home care.

The literature indicates that health services have organized their processes in a way that only partially meets health needs[20,25], highlighting the difficulties users face in achieving good living conditions.

Study limitations

A limitation is the inability to delve deeper into the process of addressing the health needs experienced by the men in the study, thus requiring further research to understand this relationship.

FINAL CONSIDERATIONS

The discursive findings described show that men's health needs remain conditioned by the ideologically hegemonic biological model, linked to natural (existential) needs as well as those ensuring good living conditions for survival. Counter-hegemonic masculinity, revealed through compromised health, remains aligned with hegemonic masculinity, which is strongly characterized by the discourse of sexuality and virility.

The fulfillment of health needs is ensured by the guidelines that govern the Unified Health System (SUS), and it is the responsibility of the local health system to provide the resources for health and social development. Understanding the needs of men in home care facilitates the planning and comprehensive execution of actions.

REFERENCES

1. Ferreira JA, Marques RC, Silva KL, Duarte ED, Schreck RSC. Understanding the health needs of men in home care: a strategy for counter-hegemony. Ciênc. Cuid. Saúde. 2021 [cited 2023 Jun 05]; 20:e58613. DOI: http://dx.doi.org/10.4025/ciencuidsaude.v20i0.58613.
2. Abreu TCA, Oliveira GS, Feitosa ANA, Silva ML, Medeiros RLSFM. Integral health care for men's health: military police adherence. Rev. Enferm. UFPE on line. 2018 [cited 2020 Apr 30]; 12(10):2635-42. DOI: https://doi.org/10.5205/1981-8963-v12i10a237503p2635-2642-2018.

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Artigo de Pesquisa
Artículo de Investigación

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3. Instituto Brasileiro de Geografia e Estatística (Br). Censo demográfico brasileiro de 2022. Rio de Janeiro: IBGE; 2022.
4. Ministério da Saúde (Br). Política Nacional de Atenção Integral à Saúde do Homem (Princípios e Diretrizes). Brasília: Ministério da Saúde; 2008 [cited 2023 Jun 05]. Available from: http://bvsms.saude.gov.br/bvs/publicacoes/politica_nacional_atencao_saude_homem.pdf.
5. Oliveira JCAX, Correa ACP, Silva LA, Mozer IT, Medeiros RMK. Epidemiological profile of male mortality: contributions to nursing. Cogitare Enferm. 2017 [cited 2023 Jun 05]; (22)2:e49724. DOI: http://dx.doi.org/10.5380/ce.v22i2.49742.
6. Firmino M, Moura GG. A saúde do homem e sua percepção sobre o sistema público de saúde: a UBSF e o atendimento ao público masculino no bairro Morada Nova, Uberlândia/MG. Hygeia. 2020 [cited 2023 Jun 05]; 16:105-20. DOI: https://doi.org/10.14393/Hygeia16053468.
7. Procópio LCR, Seixas CT, Avellar RS, Silva KL, Santos MLM. Home Care within the Unified Health System: challenges and potentialities. Saúde Debate. 2019 [cited 2020 Apr 30]; 43(121):592-604. DOI: https://doi.org/10.1590/0103-1104201912123.
8. Silva DVA, Carmo JR, Cruz MEA, Rodrigues CAO, Santana ET, Araújo DD. Caracterização clínica e epidemiológica de pacientes atendidos por um programa público de atenção domiciliar. Enferm. Foco. 2019 [cited 2020 Apr 30]; 10(3):112-8. DOI: https://doi.org/10.21675/2357-707X.2019.v10.n3.1905.
9. Connell RW, Messerschmidt JW. Masculinidade hegemônica: repensando o conceito. Rev. Estud. Fem. 2013 [cited 2023 Jun 05]; 21(1):241-82. DOI: https://doi.org/10.1590/S0104-026X2013000100014.
10. Matsumoto NF. A operacionalização do PAS de uma Unidade Básica de Saúde no município de São Paulo, analisada sob o ponto de vista das necessidades de saúde [dissertation]. São Paulo: Universidade de São Paulo; 1999.
11. Marcuschi LA. Análise da conversação. São Paulo: Ática; 1986.
12. Fairclough N. Discurso e mudança social. Brasília: Universidade de Brasília; 2001.
13. Magalhães I. Eu e tu: a constituição do sujeito no discurso médico. Brasília: Thesaurus; 2000.
14. Hino P, Bertolozzi MR, Takahashi RF, Egry EY. Health needs according to the perception of people with pulmonary tuberculosis. Rev. Esc. Enferm. USP. 2012 [cited 2023 Jun 05]; 46(6):1438-45. DOI: https://doi.org/10.1590/S0080-62342012000600022.
15. Cecilio LCO, Matsumoto NF. uma taxonomia operacional de necessidades de saúde. In: Pinheiro R, Ferla AF, Mattos RA, editors. Gestão em Redes: tecendo os fios da integralidade em saúde. Rio de Janeiro: IMS/UERJ; 2006.
16. Silva YC, Silva KL. Constitution of the caregiver subject at home care: psycho-affective, cognitive and moral dimensions. Esc. Anna Nery Rev. Enferm. 2020 [cited 2023 Jun 05]; 24(4):e20190335. DOI: https://doi.org/10.1590/2177-9465-EAN-2019-0335.
17. Aikman K, Oliffe JL, Kelly MT, McCuaig F. Sexual health in men with traumatic spinal cord injuries: a review and recommendations for primary health-care providers. Am. J. Mens. Health. 2018 Nov [cited 2020 Apr 30]; 12(6):2044-54. DOI: https://doi.org/10.1177/1557988318790883.
18. Lindhardt CL, Beck SH, Ryg J. Nursing care for older patients with pressure ulcers: A qualitative study. Nurs. Open. 2020 [cited 2023 Jun 05]; 7(4):1020-5. DOI: https://doi.org/10.1002%2Fnop2.474.
19. Guimarães TK, Sousa RR, Coelho DG, Galdino Junior H. Behavior characterization of informal caregivers of wounded patients in the hospital environment. Rev. Eletrônica Enferm. 2017 [cited 2020 Jul 08]; 19:a02. DOI: http://dx.doi.org/10.5216/ree.v19.39588.
20. Silva KL, Silva YC, Lage EG, Paiva PA, Dias OV. Why is it better at home? Service users' and caregivers' perception of home care Cogitare Enferm. 2017 [cited 2020 Apr 30]; 22(4):e49660. DOI: http://dx.doi.org/10.5380/ce.v22i4.49660.
21. Tramontina MY, Ferreira MB, Castro MS, Heineck I. Comorbidities, potentially dangerous and low therapeutic index medications: factors linked to emergency visits. Ciênc. Saúde Colet. 2018 [cited 2020 Jul 28]; 23(5):1471-82. DOI: https://doi.org/10.1590/1413-81232018235.07512016.
22. World Health Organization. Sexual and reproductive health: Defining sexual health [Internet]. Genebra: WHO; 2018 [cited 2023 Jun 05]. Available from: http://www.who.int/reproductivehealth/topics/sexual_health/sh_definitions/en/.
23. Pieters R, Kedde H, Bender J. Traininig rehabilitation teams in sexual health care: a description and evaluation of a multidisciplinary intervention. Disabil. Rehabil. 2018 [cited 2020 Apr 30]; 40(6):732-9. DOI: https://doi.org/10.1080/09638288.2016.1271026.
24. Rothberg D, Ferreira VL, Muniz AJ, Mendonça AVM. Qualidade da comunicação promotora da saúde: como avaliar? Proposta de instrumento de avaliação de campanhas de prevenção de Infecções Sexualmente Transmissíveis (ISTs). Interface (Botucatu). 2022; 26:e220004. DOI: https://doi.org/10.1590/interface.220004.
25. Farão EMD, Penna CMM. The health needs of users and their interaction with primary care. REME Rev. Min. Enferm. 2020 [cited 2020 Apr 30]; 24:e-1299. DOI: http://dx.doi.org/10.5935/1415-2762.20200029.

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