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Access of first contact in the primary health care: an evaluation by the male population

Acesso de primeiro contato na atenção primária: uma avaliação pela população masculina

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ABSTRACT: ***Introduction:*** Primary care is considered a gateway to other levels of care, however, men seek mainly specialized or emergency services, especially when they already have some affection**.** ***Objective:*** the objective was to verify how male users evaluate first contact access in primary care. ***Methodology:*** Cross-sectional study, conducted in Campina Grande/PB, from October 2016 to February 2017, with 384 men. A sociodemographic form and the Primary Care Assessment Tool (PCATool) were used. ***Results:*** There was an association between service use and age ($p = 0.001$), income ($p = 0.036$), creed ($p = 0.018$) and knowledge of the National Men's Health Policy ($p = 0.007$); The components of first contact access (utilization and accessibility) obtained a score of 5.79 and 2.7 respectively, being this attribute considered by users as poorly oriented to primary care. Ensuring accessibility and reception in primary care is critical. The service must be organized to have the ability to receive and respond positively to the health demands of the population, to have resoluteness and ability to link the service with the user. ***Conclusion:*** Users do not perceive primary care as a gateway to the health system, and efforts should be made to ensure first contact access.

Keywords: Health services accessibility. Primary health care. Health services evaluation. Health evaluation. Health policy.

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RESUMO: ***Introdução:*** A atenção primária é considerada como porta de entrada para os demais níveis de atenção ao cuidado, no entanto os homens buscam principalmente os serviços especializados ou de urgência sobretudo quando já se encontram com alguma afecção. ***Objetivo:*** Verificar como os usuários do sexo masculino avaliam o acesso de primeiro contato na atenção primária. ***Metodologia:*** Estudo transversal realizado em Campina Grande (PB), no período de outubro de 2016 a fevereiro de 2017, com 384 homens. Foram utilizados um formulário sociodemográfico e o Primary Care Assessment Tool (PCATool). Efetuaram-se os testes χ^2, Fisher e razão de verossimilhança. ***Resultados:*** Verificou-se associação entre a utilização do serviço e a idade (p = 0,001), a renda (p = 0,036), o credo (p = 0,018) e o conhecimento da Política Nacional de Assistência Integral à Saúde do Homem (p = 0,007). Os componentes do acesso de primeiro contato (utilização e acessibilidade) obtiveram os escores 5,79 e 2,7, respectivamente, sendo esse atributo considerado pelos usuários como pouco orientado para atenção primária. A garantia da acessibilidade e do acolhimento na atenção primária é fundamental. O serviço deve se organizar para ter as capacidades de acolher e apresentar uma resposta positiva às demandas de saúde da população, além de ter resolutividade e disposição de vinculação do serviço com o usuário. ***Conclusão:*** Os usuários não percebem a atenção primária como porta de entrada do sistema de saúde, sendo necessários esforços para garantir o acesso de primeiro contato.

Palavras-chave: Acesso aos serviços de saúde. Atenção primária à saúde. Avaliação de serviços de saúde. Avaliação em saúde. Política de saúde.

INTRODUCTION

In 2008, the high morbidity and mortality rates among the male population led the Ministry of Health, following other health policies, to formulate the National Men's Health Policy (*Política Nacional de Assistência Integral à Saúde do Homem* – PNAISH) to bring men closer to the health service, focusing on primary care[1-4].

To ensure the active participation of individuals, PNAISH combines efforts with the National Primary Health Care Policy (*Política Nacional de Atenção Básica* – PNAB), whose guideline proposes encouraging people's participation, autonomy, and the capacity to build care, seeking to mitigate inequalities and prevent social exclusion. In this scenario, the National Policy of Health Promotion also has among its guidelines social participation as an essential instrument to achieve health promotion and individual empowerment results[5,6].

Despite the rights and guarantees provided by the policies mentioned above, the small demand for primary care services by male users is evident, demonstrating the need of reinforcing to this population the idea that primary care is the first level of the health system and can satisfy their needs, in order to prioritize health promotion and disease prevention actions, as well as assistance with their problems[7,8].

This awareness is necessary for men to see primary care as an opportunity of using the services offered in the first assistance level. Such understanding, associated with the capacity of the service in satisfying this demand, can result in a lower concentration of

health conditions and diseases and increased utilization of services available in primary health care (PHC)[9].

In Brazil, PHC operationalization follows the Starfield model[8], which classifies the essential PHC attributes – first-contact care, longitudinality, comprehensiveness, and coordination of care –, in addition to three derivative attributes – family-centeredness, community orientation, and cultural competence. Thus, first-contact care is regarded as the ability of the subject to access the health service and using it as a source of care whenever they have a new problem or episode[8,10,11].

Starfield[8] divides first-contact care in accessibility and utilization. Accessibility is understood as a structural care element because the service must be accessible when the individual needs it, be it regarding its working hours, location, or the possibility of treatment through planned or scheduled appointments[8,12].

Utilization is considered a combination of the subject's direct contact and the service provided, which, together with the means available to the user for accessing the service and their perceived health, will facilitate solving their problems, verifying the effectiveness of the actions performed and, consequently, their satisfaction with care[13,14].

However, a better understanding of men's health is necessary, particularly concerning the access to and utilization of health services so as to analyze and plan actions that meet the demands of this population[15]. Therefore, conducting a study to provide support to PNAISH, and consequently, help improve care for these users is necessary[16].

To this end, adopting tools capable of evaluating actions in the context of men's health is essential. This assessment acts as an instrument to obtain a value judgment, be it about an intervention or its components, as well as assist in decision making[17]. The assessment focuses on reducing decision-related uncertainties, creating a new perspective about possible consequences and effects of policy implementation[18,19].

Hence, this study is justified, as it aims to contribute to knowledge production targeted at the male population, especially concerning primary care, given that this issue still needs further investigation. In this context, we sought to determine how male users evaluate first-contact primary care.

METHODS

This is a quantitative analytical cross-sectional study performed in the city of Campina Grande, Paraíba, Brazil, from October 2016 to February 2017. The study sample consisted of men registered in Basic Health Units (*Unidades Básicas de Saúde* – UBS).

The adult male population of Campina Grande comprises 101,459 men aged 20 to 59 years[20]. In order to estimate a representative sample, we used the formula expressed by Equation 1[21]:

$$n = \frac{Z^2 \, NP \, (1\text{-}P)}{e^2 \, (N\text{-}1) + Z^2 P \, (1\text{-}P)} \quad (1)$$

In which:
n = sample value;
Z = confidence interval (1.96);
N = population;
P = prevalence;
e = tolerable error (0.05).

This study adopted a prevalence of 0.5. After the calculation, we obtained n = 384. The municipality has 80 UBS, distributed into eight health districts. We chose to conduct the research in the urban area, excluding all other administrative districts and rural areas that constitute the municipality, resulting in 62 units in six districts.

A simple random draw was carried out to operationalize the research process, with probability proportional to the number of UBS in each health district, totaling 12 units. Inclusion criteria were: participants aged 20 to 59 years – target age group of PNAISH – and registered in the UBS for at least six months.

The strategy used to approach the subjects for data collection was a household visit, with the presence of the community health agent (*agente comunitário de saúde* – ACS) responsible for the microarea of the corresponding Family Health Strategy (*Estratégia Saúde da Família* – ESF). To that end, we surveyed houses registered in the household and territorial record of e-SUS, as well as a draw of households. If no men aged 20 to 59 years lived in the household, the next record was selected.

Data were collected with an instrument aimed at investigating demographic and socioeconomic variables, in addition to questions from the Primary Care Assessment Tool (PCATool) and about their knowledge of PNAISH.

Validated for Brazil, PCATool is considered the closest instrument to the ESF proposal, being, therefore, suitable for this evaluation[22,23]. The tool allows measuring the presence and extent of PHC essential and derivative attributes. The adult version of PCATool has 87 items divided into 10 components related to PHC attributes:

- degree of affiliation with the health service;
- first-contact care — utilization;
- first-contact care — accessibility;
- longitudinality;
- coordination — integrated care;
- coordination — information system;
- comprehensiveness — services available;
- comprehensiveness — services provided;
- family-centeredness;
- community orientation.

Each attribute can be evaluated separately. This study assessed first-contact care (utilization and accessibility)[10].

PCATool is an instrument with a Likert scale, with responses ranging from 1 to 4:

- 4: Definitely yes.
- 3: Probably yes.
- 2: Probably not.
- 1: Certainly not.

We added the option 9, which corresponds to I do not know/do not remember.

The answers to the items allowed us to calculate a score for each PHC attribute and their components, as well as the essential and general score. Scores for each attribute and component were obtained by the arithmetic average of responses related to the respective item, as follows (Equation 2):

$$\{\text{score} = \text{sum of attribute items}/\text{number of attribute items}\} \quad (2)$$

In order to achieve the objective of this study, we transformed the scores of components of the first-contact care attribute, as well as the utilization component (Equation 3) and the accessibility component (Equation 4), as follows:

$$\{\text{score} = B1+B2+B3/3\} \quad (3)$$
$$\{\text{score} = C1+C2+...C12/12\} \quad (4)$$

Next, we transformed the score into a 0–10 scale using Equation 5:

$$\{(\text{score obtained} - 1) \times 10/3)\} \quad (5)$$

Score was considered high or primary care-oriented when the result was greater than or equal to 6.6 and low or poorly oriented to primary care when the result was lower than 6.6[10,24].

Data were entered into Excel 2016 and exported to the Statistical Package for Social Sciences (SPSS), version 20., for analysis. As with most studies that adopt the PCATool, the findings were expressed as mean and standard deviation[25], including the 95% confidence interval (95%CI), minimum and maximum scores, and median.

Results related to demographic profile were expressed as absolute and relative frequencies of the items, mean, median, minimum and maximum scores, standard deviation, and 95%CI. The independent variables used to test the association were: age, creed, ethnicity, marital status, schooling, number of people living with the subject, household and per capita income, in addition to knowledge about PNAISH. The utilization and accessibility components were assessed as dependent variables.

We verified the association using the χ^2 test. When more than 20% of the expected frequencies were lower than 5, we performed Fisher's exact test or the likelihood ratio test. Data are presented in tables.

The study complied with the ethical precepts listed in Resolution no. 466/12 of the National Health Council (NHC) and is registered in the Research Ethics Committee of Universidade Estadual da Paraíba (UEPB).

We declare that we respected ethical aspects when conducting this research since it involved human beings. The Research Ethics Committee previously approved this research, under the Certificate of Presentation for Ethical Consideration (*Certificado de Apresentação para Apreciação Ética* – CAAE): 56386516.3.0000.5187.

RESULTS

Table 1 presents the sociodemographic profile of participants. When questioned about PNAISH, 70.3% (n = 270) of interviewees reported not knowing the policy, while 29.7% (n=114) declared knowing it.

Table 2 shows the item scores of the utilization component. Item B1 — When you need a return visit, do you go to UBS before going to another health service? — had a mean score of 6.78, followed by item B3 — Is UBS your only means of referral to a specialized service? —, with 5.48, while item B2 — When you have a new health problem, is UBS the first service you seek? — presented the lowest score: 5.12.

In the accessibility component (Table 3), all items had scores below recommended levels. The worst scores were identified in items C1 — UBS opens on Saturdays or Sundays; C2 — UBS opens some evenings until 8 p.m.; C6 — UBS provides support on weekends if the patient is sick; and C7 — UBS provides care even at night if the patient is sick; all with mean scores below 1.

Table 4 presents the association of the utilization and accessibility components and the first-contact care attribute with sociodemographic and PNAISH knowledge variables. Thus, we can infer 53.4% (n = 205) of users evaluated the utilization component as greater than or equal to 6.6; however, the mean score was 5.79, making it not primary care-oriented. The accessibility component was assessed by 99.7% (n = 383) of users as not primary care-oriented, with a mean score of 2.7. We found an association between the utilization component and age (p = 0.02), income (p = 0.036), creed (p = 0.018), and PNAISH knowledge (p = 0.007).

DISCUSSION

Access to primary care is an essential tool for reducing morbidity and mortality rates, particularly when it promotes the subject's first proper contact with the service[8]. Moreover, a health system based on primary care must have a series of structural and process elements aimed at promoting and ensuring adequate coverage for the population and universal access to services, as well as equality growth[26].

Table 1. Sociodemographic profile of male users of primary care in Campina Grande, Paraíba, Brazil, 2017.

Variables	N	%	X ± SD (95%CI)	Min–Max (median)
Age				
> 40 years	194	50.5	40 ± 11.9	20–59
≤ 40 years	190	49.5	(38.81 – 41.21)	(41)
Creed				
Has a religious creed	317	82.6		
Does not have a religious creed	67	17.4		
Ethnicity				
Non-white	280	72.9		
White	104	27.1		
Marital status				
Domestic partnership	246	64.1		
No domestic partnership	138	35.9		
Years of schooling				
> 8 years	197	51.3	8.49 ± 3.62	0–18
≤ 8 years	187	48.7	(8.13 – 8.86)	(9)
Residents in the household				
≤ 4 residents	293	76.3	3.24 ± 1.93 (3.05 – 3.44)	0–12 (3)
> 4 residents	85	22.1		
Does not know/did not declare	6	1.6		
Income				
≤ 2 minimum wages	258	67.2	1,715.14 ± 998.76 (1,612.20 – 1,818.09)	0–7,040 (1760)
2–3 minimum wages	66	17.2		
> 3 minimum wages	43	11.2		
Does not know/did not declare	17	4.4		
Per capita income				
≤ 0.5 minimum wage	225	58.6	493.44 ± 397.16 (452.51 – 534.38)	0–3,520 (440)
> 0.5 minimum wage	139	36.2		
Does not know/did not declare	20	5.2		

X: mean; SD: standard deviation; 95%CI: 95% confidence interval.

The findings of this study show men's negative evaluation of first-contact care, as the components of this attribute obtained scores below recommended levels, demonstrating that male subjects considered the service poorly oriented to primary care in these aspects.

When assessing the utilization component according to frequency, the study revealed that approximately half of the men evaluated the item positively, with a higher percentage among those older than 40 years, evidencing an association between age and service utilization. This finding corroborates those of investigations that indicate a higher demand for health services among men, especially in the public system, with 57% prevalence, as well as increased demand for services with age[27,28].

Studies suggest both income and creed are associated with the utilization component among men and creed could positively influence health conditions and the adoption of healthy behaviors by the subject[27,29].

The utilization item best evaluated by men addressed whether the service is the first they seek for a return visit, revealing men usually access the service for consultations, corroborating a study developed in Southern Brazil, which reached a prevalence of medical visits in health services of 45.6% with no difference between genders. Among the services analyzed, the most used for medical visits was UBS (49.5%)[30]; however, this use was mainly for established diseases or morbidities, as preventive visits still present low demand among men[28,29,31].

When assessing whether UBS is the first service the user seeks in case of a new health issue, episode, or condition, the mean score was low, showing men do not see primary care as the first health care option. The literature demonstrates that men judge the service unable

Table 2. Scores calculated by the mean responses to the respective items of the utilization component. Campina Grande, Paraíba, Brazil, 2017.

Items	Score 0–10				X ± SD (95%CI)	Min–Max (median)
	Low score (< 6.6)		High score (≥ 6.6)			
Utilization	N	%	N	%		
B1: When you need a return visit (routine visit, check-up), do you go to UBS before going to another health service?	99	25.8	285	74.2	6.78 ± 4.01 (6.38 – 7.18)	0–10 (10)
B2: When you have a new health problem, is UBS the first service you seek?	179	46.6	205	53.4	5.12 ± 4.39 (4.68 – 5.56)	0–10 (6.7)
B3: Is UBS your only means of referral to a specialized service?	163	42.4	221	57.6	5.48 ± 4.05 (5.07 – 5.88)	0–10 (6.7)

X: mean; SD: standard deviation; 95%CI: 95% confidence interval; UBS (*unidade básica de saúde*): basic health unit.

to meet their demands, especially in a timely manner, complaining of the wait to receive medical care. Also, men believe seeking a health service is an expression of weakness and feel ashamed in doing so[2,32,33]. The fact that men do not consider the service effective can discourage access and utilization.

As to whether UBS is the only means of referral to a specialist, the mean score was below recommended levels. Study conducted in Paraíba based on data from the National Program for Improving Access and Quality of Primary Care (*Programa Nacional de Melhoria*

Table 3. Scores calculated by the mean responses to the respective items of the accessibility component. Campina Grande, Paraíba, Brazil, 2017.

Items	Score 0–10				X ± SD (95%CI)	Min–Max (median)
	Low score (< 6.6)		High score (≥ 6.6)			
Accessibility	N	%	N	%		
C1: UBS opens on Saturdays or Sundays.	384	100	-	-	0.74 ± 1.38 (0.60 – 0.88)	0–3.3 (0)
C2: UBS opens some evenings until 8 p.m.	384	100	-	-	0.67 ± 1.33 (0.54 – 0.81)	0–3.3 (0)
C3: UBS provides care on the same day when it is open, and the subject is sick	154	40.1	230	59.9	5.41 ± 3.78 (5.03 – 5.79)	0–10 (0)
C4: UBS provides fast phone support when it is open.	343	89.3	41	10.7	1.79 ± 2.48 (1.54 – 2.04)	0–10 (0)
C5: UBS provides phone support, even when it is closed.	360	93.7	24	6.3	1.23 ± 2.16 (1.01 – 1.45)	0–10 (0)
C6: UBS provides support on weekends if the subject is sick.	384	100	-	-	0.26 ± 0.90 (0.17 – 0.35)	0–3.3 (0)
C7: UBS provides care even at night if the subject is sick	384	100	-	-	0.41 ± 1.09 (0.30 – 0.52)	0–3.3 (0)
C8: Scheduling a return visit in UBS is easy.	170	44.3	214	55.7	5.34 ± 4.00 (4.94 – 5.75)	0–10 (6.7)
C9: The wait for medical or nurse consultation is longer than 30 minutes.	306	79.7	78	20.3	2.59 ± 3.45 (2.24 – 2.93)	0–10 (0)
C10: Scheduling an appointment takes a long time or requires talking with many people.	186	48.4	198	51.6	5.19 ± 4.13 (4.78 – 5.59)	0–10 (6.7)
C11: Difficulty in receiving medical care when necessary.	198	51.6	186	48.4	5.01 ± 4.13 (4.60 – 5.43)	0–10 (3.3)
C12: The subject has to miss work or school to go to UBS.	257	66.9	127	33.1	3.65 ± 4.30 (3.21 – 4.08)	0–10 (0)

X: mean; SD: standard deviation; 95%CI: 95% confidence interval; UBS (*unidade básica de saúde*): basic health unit.

Table 4. Association of the utilization and accessibility components and the first-contact care attribute with sociodemographic variables, as well as those related to the knowledge about the National Policy for Integral Attention to Men's Health (*Política Nacional de Assistência Integral à Saúde do Homem* – PNAISH). Campina Grande, Paraíba, Brazil, 2017.

Variables	Utilization					Accessibility				
	Score 0–10					Score 0–0				
	Low score (< 6.6)		High score (≥ 6.6)		p	Low score (< 6.6)		High score (≥ 6.6)		p
Age	N	%	N	%		N	%	N	%	
≤ 40 years	104	54.7	86	45.3	0.001	190	100	0	0	0.505
> 40 years	75	38.7	119	61.3		193	99.5	1	0.5	
Total	179	46.6	205	53.4		383	99.7	1	0.3	
Creed										
Has a religious creed	139	43.8	178	56.2	0.018	316	99.7	1	0.3	0.826*
Does not have a religious creed	40	59.7	27	40.3		67	100	0	0	
Total	179	46.6	205	53.4		383	99.7	0	0.3	
Ethnicity										
White	54	51.9	50	48.1	0.204	104	100	0	0	0.729*
Non-white	125	44.6	155	55.4		279	99.6	1	0.4	
Total	179	46.6	205	53.4		383	99.7	0	0.3	
Marital status										
Domestic partnership	120	48.8	126	51.2	0.259	246	100	0	0	0.359*
No domestic partnership	59	42.8	79	57.2		137	99.3	1	0.7	
Total	179	46.6	205	53.4		383	99.7	0	0.3	
Years of schooling										
≤ 8 years	82	43.9	105	56.1	0.290	187	100	0	0	0.513*
> 8 years	97	49.2	100	50.8		196	99.5	1	0.5	
Total	179	46.6	205	53.4		383	99.7	0	0.3	
Residents in the household										
≤ 4 residents	143	48.8	150	51.2	0.152	292	99.7	1	0.3	0.775*
> 4 residents	34	40	51	60		85	100	0	0	
Total	177	46.8	201	53.2		377	99.7	1	0.3	
Income										
≤ 2 minimum wages	114	44.2	144	55.8	0.036	258	100	0	0	0.179¥
2–3 minimum wages	40	60.6	26	39.4		65	98.5	1	1.5	
> 3 minimum wages	17	39.5	26	60.5		43	100	0	0	
Total	171	46.6	196	53.4		366	99.7	1	0.3	
Per capita income*										
≤ 0.5 minimum wage	103	45.8	122	54.2	0.751	225	100	0	0	0.382*
> 0.5 minimum wage	66	47.5	73	52.5		138	99.3	1	0.7	
Total	169	46.6	195	53.4		377	99.7	1	0.3	
PNAISH knowledge										
Yes	41	36	73	64	0.007	114	100	0	0	0.703*
No	138	51.1	132	48.9		269	99.6	1	0.4	
Total	179	46.6	205	53.4		383	99.7	0	0.3	
X ± SD (95%CI)	5.79 ± 3.55 (5.44 – 6.15)					2.7 ± 1.47 (2.55 – 2.85)				
Min–Max (median)	0 – 10 (6.7)					0 – 6.7 (2.5)				

X: mean; SD: standard deviation; 95%CI: 95% confidence interval; *Fisher's exact test; ¥: likelihood ratio.

do Acesso e da Qualidade da Atenção Básica – PMAQ) identified users leave the health unit with an appointment in 10.2% of family health teams, while 47.2% of appointments are scheduled by UBS and only latter the date is informed to the user, leading to prolonged wait and, consequently, user dissatisfaction[34].

We found no study in the literature indicating an association between PNAISH knowledge and utilization; however, the PNAB guideline states the importance of user participation in increasing their autonomy and the capacity of building care for individuals and communities. Therefore, encouraging users to access the service to which they are registered becomes important. That way, they can be informed about policies and participate in discussions for their implementation and quality improvement[5].

With respect to the accessibility component, most subjects evaluated this component as poorly oriented to primary care with a low mean score. Study conducted in Recife[35] also detected dissatisfaction among UBS users in this respect, reporting that impairment in this component compromises one of the main UBS goals – be the entry point into an effective and universal health system.

A non-accessible service creates a barrier, preventing it from being used by potential users. Accessibility is directly connected to what the population expects from the service, representing the main issue to be overcome by the user[12,13]. However, according to PNAB, primary care should be the preferred contact by users, the main entry point into the health care system. It should be guided by principles, such as accessibility, and have mechanisms to ensure their full application[5].

When evaluating accessibility items, the elements UBS opens on weekends and UBS opens some evenings until 8 p.m. had scores below recommended levels. In this regard, study conducted in Paraíba suggests the need for restructuring UBS working hours, especially the night shift, given that this population has rigid schedules due to their participation in the labor market[33].

Schedule-related issues were evidenced when users were questioned about the need to miss work or school to be able to visit the health service, in addition to the difficulty in scheduling an appointment when necessary. Moreover, men's aversion to the service can be explained by the difficulty of the service in solving problems when required, the waiting period longer than 30 minutes to consult a professional, the hardship of scheduling appointments, and the lack of medical care, as well as the ineffectiveness of the service in satisfying health demands from this population, the struggle to have access to tests and exams, and the prolonged care, motivating evasion[33].

In addition, a concerning fact is the obstacles faced by users when it comes to getting phone advice in case of doubts about their health, communication when the UBS is closed, and support by UBS professionals when the user gets ill on weekends or evenings. This concern is related to reports from the literature that indicate the connection between users and primary care staff as an important tool to promote the construction of new relations, allowing a closer interaction of the user with UBS and favoring the adherence to health services as the user starts believing in them[33].

Considering what has been described in the literature, our findings reinforce the idea of a differentiated service for this population, either by having special working hours at night, at least on some days of the week, or by opening on weekends, with the purpose of eliminating barriers to primary care access among men. To this end, implementing pilot units could be a strategy to assess if the night service is effective.

Ensuring accessibility and user embracement in primary care is crucial. Therefore, the service must prepare to receive the population, respond positively to their health demands, be effective and capable of connecting service and users, as well as solve their problems. These aspects are essential to establish primary care as the contact and entry point into other health levels[5].

A limitation of this investigation was evaluating only one PHC attribute, and we emphasize the need for studies to verify the remaining attributes and provide a better understanding of men's evaluation of the service. Despite the limitation mentioned, the many barriers related to men's health became evident, with access being one of the most important to overcome. Therefore, we suggest further studies to expand knowledge that could promote men's access to primary care, especially to monitor the social determinants of health.

CONCLUSION

The study showed male users evaluate first-contact care negatively and consider the service as poorly oriented to primary care. Despite the efforts made by the public sector, including the formulation of PNAISH, men still do not see primary care as the entry point into health services. Thus, efforts are necessary to ensure the first contact-care in particular, making this population realize the importance of primary care and use the services provided. One of PNAISH priorities is to strengthen ESF, allowing men's full access to health with one of the actions targeted at access and embracement of this demand. Although the policy is recent – less than ten years –, we underline the negative evaluation of primary care by the men in this study, which suggests PNAISH still has not reached full effectiveness in these components.

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