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CHILEAN MEN’S HEALTH: PERCEPTIONS AND RELATIONSHIPS WITH THE PUBLIC HEALTH CARE SYSTEM

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A thesis submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy on Community Health, The University of Auckland, 2013
Abstract

Globally research shows that men have worse health than women; on average men present lower expectancy of life at birth and show more health risk behaviours. A range of investigators have established the importance of gender and masculinity in men’s health. Gender construction is a dynamic process; and health care systems represent a particularly important institutional influence in the construction of gender and health. Currently in Chile there are few studies about the health beliefs of men, and encounters between men and health services usually begin only when men are sick. Hence, a better understanding of men’s relationships with their health and the health system is important, leading to the research question: What is the relationship of Chilean men with their health and with the public health care system? Using a constructivist paradigm, an ethnographic study was conducted in a socioeconomically vulnerable community in Santiago de Chile. Fieldwork lasted seven months, involving participant observations, interviews and focus groups with two groups: a group of men belonging to a soccer club and a group of health workers belonging to a primary health centre. Chilean men participants understood their health as the ability to remain active and work, and to fulfill the culturally assigned role of provider to the family. All behaviours associated with health and illness are related to the relief of physical symptoms that prevent them remaining active; in this construct there is no room for the expression of emotional problems, neither for disease prevention or health promotion behaviours, since they do not relate to the relief of physical problems. Consequently, men access the formal health system only for the relief of physical symptoms, delaying seeking advice for as long as possible. Men’s reluctance to access the Chilean primary health care system is compounded by perceived barriers, including the absence of health programs tailored to them. For their part, health workers consider men to be "irresponsible" with their health, perceiving a lack of interest from men to maintain their health and, consequently, they do not generate programs or interventions targeted to this group. These findings highlight the complexity of masculinity as a social determinant of health, providing information that can inform the design of health strategies specific to the needs of Chilean men, and to better focus health policies and service delivery.
Dedication

To Gala & Aroa
Acknowledgements

First of all, I would like to show my appreciation for the participation and support that I received from the groups involved in this study: to the group of men belonging to the soccer club and the group of health workers belonging to the primary health centre, as well as to the men and women who participated as members of the Community Advisory Committee who supported and advised me throughout the research process.

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I dedicate this academic effort to my family – and especially to my daughters Gala and Aroa who have changed my world since their arrival last year-. Without the support of my family none of this research would have been possible, I am very thankful for all their patience and unconditional love.
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Glossary

**Accidente** [Accident]. The word *accidente* was used by men participating in this study to refer to an unexpected event that affected their health.

**Aguantar** [To endure]. The word *aguantar* is a verb used in Spanish to refer to the ability to resist adversity; it comes from the Italian word *agguantare*, related to resist, withstand the pain (Corominas, 1976)

**Alcalde** [Mayor]. The word *alcalde* is used in Chile to refer to the principal authority of a local government or Municipality.

**Centro de Salud Primaria** [Primary Health Centre], a *centro de salud primaria* represents the primary health care level in the Chilean public health system, people usually refer to such centres as *centro de salud* [healthcare centre] or *centro de salud primaria* [primary health centre]; both concepts relate to the same service and are used interchangeably in the development of this thesis. There some specific concepts used by health workers at primary health centres:

**Horas de Morbilidad** [Morbidity hours]. The concept *horas de morbilidad* is used at primary health centres to refer to hours associated with the consulting of a general physician. “Morbidity hours” are planned, either for patients who need an appointment for any specific health problem during the same day at the healthcare centre, or, a preventive examination.

**Horas de control** [Monitoring hours]. The concept *horas de control* is used at primary health centres to refer to hours for monitoring patients belonging to the different health programs offered at the healthcare centre, such as health programs for chronic conditions.

**Patologías AUGE, Acceso Universal a Garantías Explicitas en salud** [AUGE diseases, Universal Access to Explicit Health Guarantees]. *Patologías AUGE* is a concept used to refer to a list of prioritized diseases. This list of diseases stems from a
health reform carried out in Chile in the year 2000 (Burrows, 2008; Chilean Ministry of Health, 2007) and which aims to guarantee that any Chilean, who has one of the pathologies prioritised by the health authority, will have certainty of access to health interventions. The selection of these AUGE diseases is related to the highest prevalence of pathologies in the country.

**Comuna [Commune].** The word *comuna* is used in Chile to refer to a district or a specific geographical area inside a city, where a local government or Municipality is in charge.

**Macho [Male].** The word *macho* is commonly used in Latin America to refer to a man characterized by qualities considered manly, especially when manifested in an assertive, self-conscious, or dominating way (Oxford University, 2011).

**Medico Privado [Private Doctors].** The concept *medico privado* has been used by the men participating in this study to refer to “doctors” that are usually physicians who come from overseas countries but who lack the legal authorization to work in Chile (for instance Cubans, Paraguayans or Colombians); such doctors give health care attention in their homes and their charges are very inexpensive; nonetheless, they are not part of any formal health system.

**Municipalidad [Municipality].** The word *Municipalidad* is used in Chile to refer to a local government that is in charge of the political administration in a *comuna*.

**Sacrificio [Sacrifice].** The word *sacrificio* is used in Latin America as a term associated with a great effort that someone makes for the benefit of others, it is an act of selflessness inspired by the vehemence of an ideal or affection (Iglesias, 1995). The concept comes from the Christian Church tradition; Christ's offering of himself in the Crucifixion for the salvation of others, that He offered His life in exchange for others’ wellbeing (Oxford University, 2011).

**Trabajar [To work].** The word *trabajar* is a verb used in Spanish to refer to the ability of work. It comes from the Latin word *tripaliare*, which means suffering or torture (Corominas, 1976).
Chapter 1. Introduction

The study of men's health is a field of research that seeks to determine how both gender and masculinity influence men’s health. Although traditionally studies of gender and health have been focused mainly on women's health, recently, men's health has emerged as a focus of international interest (Baker, 2001). In 2004, at the Men's Health Forum in UK, it was established that a male health issue arises from any physiological, psychological, social, cultural or environmental factor that has an impact on men’s health (Men’s Health Forum, 2004). Considering the importance that this topic had begun to acquire, in 2005 the European Men’s Health Forum invited researchers and health professionals to adhere to the Vienna Declaration on the Health of Men and Boys; this Declaration had arisen in the context of the Forum held that year in Vienna (The European Men's Health Forum, 2005). The document invites the recognition of men’s health as a distinct and important issue in order: to develop a better understanding of men’s attitudes to health; to invest in ‘male sensitive’ approaches to providing healthcare; to initiate work on health for boys and young men in school and community settings; and to develop coordinated health and social policies that promote men’s health.

1.1. Positioning the Research

Epidemiological trends in different countries show that, on average, men’s lives are shorter than women’s, and that men have greater health risk factors. According to the World Health Organization, for the year 2009, the life expectancy at birth was lower for men in comparison with women in every region of the world and for all income groups. In addition, globally the probability of dying between the ages of 15 and 60 years, per 1000 population, was 212 for men and 139 for women, throughout the world, a tendency that is also present in every region and income group (World Health Organization [WHO], 2012). While some authors state that the biological differences between men and women influence their vulnerability to some health conditions (Austad, 2006), other authors claim that the differences in the incidence of disease and mortality among those groups is related to socio-cultural variables that go beyond the differences seen through their respective biological bodies (White & Richardson, 2011).

According to the literature, health behaviours adopted by men are characterized by the presence of increased health risk behaviours and delays in seeking help from formal health
systems (Courtenay, 2000b, 2003; Mahalik, Burns, & Syzdek, 2007). The origins of those behaviours relate to the role of gender assigned to males, that is, “…the social expectations of what men and boys should and should not do and how this directly affects attitudes and behaviour related to a range of health issues” (Barker, Ricardo, & Nascimento, 2007, p. 3). The gender role culturally assigned to men interacts with the relevance – or irrelevance – given to men’s health by health systems and health policies (Courtenay, 2003). According to Payne (2009), it is difficult to calculate the exact proportion of the gender gap that can be attributed to gender inequality in the planning and delivery of health services.

**Gender Role: Machos at Risk**

According to several authors (Cameron & Bernardes, 1998; Courtenay, 2000a, 2000b; Mahalik et al., 2007; Oliffe & Bottorff, 2006; Sobralske, 2006) the gender role, and especially the way in which a man’s identity is developed in interaction with his culture, is an important factor in understanding the health differences between men and women. Men are more likely to ignore disease symptoms, and social constructions of masculinity are influential in the practice and experience of ill health (Sixsmith & Boneham, 2002). Masculinity is associated with the traditional male lifestyle (Galdas, Cheater, & Marshall, 2005), and numerous studies have shown the relationship between male beliefs and health behaviours (Mahalik et al., 2007; Sixsmith & Boneham, 2002; Sobralske, 2006).

The perception of invulnerability and invincibility described by some authors (Courtenay, 2000a; Galdas et al., 2005) is related to the fact that men choose to adopt more high risk behaviours such as drinking or smoking, try to normalize their pain and delay seeking help. The macho maxim of “strength in silence” (Banks, 2001) influences a man’s reluctance to look for help when he feels unwell. Men tend to delay seeking help until a health crisis or a particular incident has occurred (Cameron & Bernardes, 1998). Probably, for the same reason, men are more likely to use emergency services (Galdas et al., 2005); and, typically, they do not use preventive health care (Mahalik et al., 2007).

The issue of mental health is even more problematic for men, because the possibility of having a mental disorder, such as depression, represents a disruption between masculinity and identity (Galdas et al., 2005; Sixsmith & Boneham, 2002). The pressure by peer groups can be especially strong in this area, because mental problem are associated with feminine characteristics (Sixsmith & Boneham, 2002; Sobralske, 2006).

According to Courtenay (2000b), the health care system represents a particularly important institutional influence in the construction of gender and health. Hence, it is central
to men’s health to understand the structure of the health system, and the way in which the system could influence the existing gender differences in health.

**Men and Health Policies: The Chilean Case**

The health situation in Chile currently presents several challenges to researchers. Epidemiological trends show a constant rise in chronic conditions, and it is necessary for the health care system to deliver attention to different communities with particular needs. In this context, the design of strategies that focus on health promotion and disease prevention are essential, since it is through such strategies that the wellbeing and quality of life of the population could be improved and their lives consequently extended.

Since the promulgation of the Alma Ata Declaration, one of the priorities in health has been to guarantee the population access to appropriate health care, one of the main strategies being the strengthening of the primary health care system: this system usually represents the first contact between the users and the formal health system (World Health Organization [WHO], 1978). In 2008, the WHO once more emphasized the importance of primary health care, establishing that the responsibility of health workers at this level is to focus on the particular needs of each user/patient, and to work with communities on the design of health strategies, whilst taking their social context into consideration (World Health Organization [WHO], 2008b). The introduction of the social determinants to health model, as variables that influence people's perceptions and behaviour in health, is relevant in this discussion. This model offers a perspective to health workers to analyse the specific health needs for each social group (World Health Organization [WHO], 2008a).

Considering the health challenges in Chile, and the health guidelines and priorities established by the WHO, it could be assumed that Chilean health workers belonging to the primary care level will work together with the population and that health workers would know what the specific health needs are for each population group. That is the anticipated way of working in the Chilean public health system, a way that indeed operates in many population groups. Health workers know what the needs of the children, the women and the ageing population are, and they have developed effective health strategies for these groups. In fact, primary health centres are usually divided into areas or departments such as child health, women's health and chronic illness (Arteaga, Astorga, & Pinto, 2002; Arteaga, Thollaug, Nogueira, & Darras, 2002). However, members of this same group of primary health workers usually declare that they do not know the men of the community or their needs. The main argument is that because men do not regularly attend primary health centres, the health
system does not offer health programmes which focus on the needs of their group (Chilean Ministry of Health, 2011b).

Recently, in order to develop strategies that meet the needs of this group, the Chilean Ministry of Health expressed interest in being made aware of what the health situation of Chilean men is. The first attempt at better understanding men’s health involved using the available epidemiological data to analyze the health profile of men (Chilean Ministry of Health, 2011b). The document gathered information regarding mortality, morbidity, and major health risk factors. With regard to mortality, the main causes of death in the male population were: diseases related to the circulatory system (25.6 %), tumours (24.5 %), external causes, including accidents and suicide (12.8 %), and diseases related to the respiratory system (9.3 %). Additionally, it was established that, in all age groups, the mortality of males was greater than the mortality of females. In relation to morbidity, the largest numbers of health consultations by men to the formal health system were for: injuries and poisonings, diseases related to the digestive system, diseases related to the respiratory system, diseases related to the circulatory system, and diseases related to the genitourinary system. Finally, regarding health risk factors, the Chilean Ministry of Health has been aware that some behaviours located men in a position of risk, among them were: tobacco consumption, alcohol consumption, being obese or overweight, and sedentary lifestyles. All these behaviours have impacted on the health of men, who, consequently, have high rates of chronic conditions such as diabetes and arterial hypertension. In summary, the Ministry of Health in Chile has developed an epidemiological profile of the male population; however the available epidemiological data on men’s health is, of itself, insufficient to allow for a full understanding of the needs, perceptions, motivations and behaviours of this group, including the cultural components that influence their beliefs.

Another element to consider in the analysis of men’s health, is the recent Chilean Healthcare Reform (AUGE) announced by the Chilean Government in the year 2000. This reform focuses on guaranteed access for all people who are suffering from specified pathologies. Currently, this new system of health guarantees that any Chilean who suffers from one of the pathologies prioritized by the health authority will have timely access to certain health interventions. Despite this strategy allowing for the reduction of some of the difficulties of access, new issues have emerged (Burrows, 2008; Roman & Muñoz, 2008). If a person has a pathology that differs from those covered by the system, that person has no clear health solution available to them. This situation has many implications, because, from the point of view of the system, it does not focus on people; it focuses on pathologies. This type
of structure does not capture the diversity of people’s needs, and it is also a system that offers attention to sicknesses, not to people (Roman & Muñoz, 2008).

In summary, the Chilean health system presents three situations that especially affect men. First, at primary health care centres, there are no special places or health programmes for men. Second, men present health risk factors that situate them in a position of vulnerability in health, and there are no health strategies tailored to men’s requirements. Finally, the current health reform focuses on disease, not on the particular needs of different groups.

1.2. Positioning Myself: Why Men’s Health?

During the four years prior to my doctoral studies, I had the opportunity to work in a research setting with disadvantaged Chilean communities. I worked with families, groups of men, groups of women, and with health workers. In this setting, I could appreciate the importance of developing research according to the particular problems and needs of the people.

The research that my colleagues and I developed focused on HIV prevention in communities with limited economic resources. The intervention included a workshop that was divided into four, two hour, modules, each reviewing ideas relating to HIV and AIDS. We started working with women's groups, who always attended the workshop. Once the women were enrolled in the workshop they never failed to attend; their main motivation was to have the tools to talk to their children about sexuality and HIV prevention. Additionally, after each two-hour session, women received financial compensation of CH$ 2000 (NZ$5, US$ 4) for their participation; for this group, the payment represented a financial reward that was significant. When my colleagues and I wanted to work with men, the experience was completely different; although we adapted to their schedule and needs, they only attended the sessions once or twice, and then never again. They did not want to think about HIV, or their health. Neither the fact that we adapted workshop times to suit their schedules, nor that we offered them money for their participation, was sufficient to secure their attendance. It was always easier to work with women because we understood their motivation as being an interest in the care of their families and their children. With men it was different; my colleagues and I never really understood how we could motivate them to participate.

That was a key experience, because I then started to realize the importance of gender differences among groups in a health setting, and the importance of understanding how to
deal with those differences as a health professional. In the specific case of the group of
Chilean men, during my informal contact with them, I observed that such men are interested
in being strong and healthy, but do not want to be put in a situation of feeling vulnerable to a
disease such as HIV. Indeed, the perception that they could be part of a higher risk group was
something that made them feel uncomfortable. In addition, the men in question were of the
belief that worrying about health was a female concern.

In this context, I concluded that such men are especially vulnerable, because they do not
develop a relationship, either, with health professionals, or, with the healthcare system.
Health workers are generally unaware of the health needs of this group of the population. We
know about their risk factors, based on the epidemiological descriptions made by the Chilean
Ministry of Health, but in spite of knowing what their health risks are, or the areas in which it
is necessary to develop health promotion and disease prevention, the way to approach and
motivate men remains as yet unknown to those involved in the health system.

1.3. Purpose and Research Question

Factors relating to gender role and masculinity are associated with the barriers to the
Chilean health care system, and also put men in a vulnerable position within that system. In
Chile, no information is currently available in regard to men’s beliefs in relation to health,
and how these influence their individual relationships with the health care system. Indeed,
contact with members of this group usually only occurs when they are sick. For that reason, I
believe it is important to improve our understanding of men’s relationships with their health
and with the health system, including how men perceive their own health, what their health
behaviours are, and what their relationship with public health system is. This information
could be fundamental to the design of health strategies directed at the specific needs of this
group, thus improving, not only health care policies, but also, the service that the system
offers.

In this context, the research question that emerges is:

What is the relationship of Chilean men with their health and with the public health
care system?
1.3.1. How I approached the research question: Rationale

The philosophical framework of this study reflects a constructivist paradigm (Creswell, 2007a; Patton, 2002), which validates the co-existence of multiple social meanings and experiences regarding a single phenomenon, validating and elevating the subjective account of the subject in relation to a particular stimulus. Through this approach it is possible to validate the perspectives of different social actors in relation to the phenomenon of men’s health.

Ethnography was selected as an appropriate strategy to conduct the research, since the central aim in this type of methodology is to provide holistic insight into people’s points of view and their actions (Savage, 2000), whilst giving importance to the routine or daily lives of people (Fetterman, 1989). This is precisely the type of information that allows an understanding of how men relate to their own health in their daily lives. According to the opinions of some authors (Oliffe & Bottorff, 2006; Sobralske, 2006), the study of men’s health is an issue that is especially influenced by cultural beliefs; for example, the meaning of pain, illness, or health is associated with virility and manliness. Therefore, an ethnographic approach allows a study of this specific group and also, the development of contextual cultural explanations in regard to men’s health.

In ethnography, data collection is centred on fieldwork, where the most important element is ‘being there’, sharing with people in the community (Fetterman, 1989). Thus it was that I was on site within the community for approximately seven months whilst maintaining contact with people in two locations within the community: a soccer club where the men usually congregate; and a primary healthcare centre near this soccer club. The procedures I employed included the gathering of the beliefs and perceptions of the men concerning their health. This information was complemented with the experiences and perspectives of health workers about the ways in which men establish their relationships with the healthcare system.

This study was conducted in both New Zealand and Chile. The theoretical design of the study, data analysis and thesis writing were conducted in New Zealand, while participant recruitment and data collection was conducted in a community in Santiago de Chile. Fieldwork was carried out in Spanish, which is the main language in Chile, and the thesis writing was in English. Throughout the study, I had the support of my supervisors at the University of Auckland, my Advisor at the Pontificia Universidad Catolica de Chile, and the
support of a Chilean Community Advisory Committee who advised me during the fieldwork and in the analysis of the preliminary findings.

1.4. Theoretical Approach

Considering all the elements involved in the analysis of the men’s health phenomenon, it is possible to establish that this is a *hybrid* thesis. This is a research in the field of Community Health; however, in order to approach the research question, it collects its contributions from various disciplines (Figure 1).

![Figure 1: Theoretical Approach](image)

Taking as framework the Social Determinants of Health model (World Health Organization, 2007; 2008), I give emphasis to the gender theory, health policies and health systems, and health anthropology. From the **theory of male gender**, the contributions of Connell (1995) and Bourdieu (2000) who introduced the concepts of *hegemonic masculinity* and *masculine domination*, respectively, are considered; this is in addition to the contributions of Courtenay (2000a, 2000b, 2003) who analysed the phenomenon of men’s health from the constructivist paradigm. In relation to **health policies**, an analysis is included of the guidelines established by the World Health Organization (World Health Organization [WHO], 1978, 2008b) concerning the functioning of health services. Also included, is an
analysis of Chilean health policy; this is reviewed in detail in relation to the health of Chilean men. Reflecting the sub-discipline of health anthropology, some elements of the relationship between two different cultural groups (men and health workers) are considered, and an ethnographic approach as the methodology that emerges from the anthropological discipline is used; this is a methodology which can be used in other disciplines, setting, as it does, the objective pursued and the research questions that guide the researcher’s procedures (Wolcott, 1994). For the purposes of this research, my own background, both as a health professional, and as a doctoral student in the field of community health, has undoubtedly influenced the focus of the research question and the choice of methodology.

1.5. Thesis Structure

This report has been divided into four parts. Considering that the research question focuses on men´s health perceptions and behaviours and the relationship that they establish with the public health system in Chile, the first part of the thesis sets the background for the research. Corresponding to the context and the literature review, Chapters 2 and 3 focus on three aspects. First, a description of the Chilean Health System, explaining in detail how this system works is given; this includes an explanation of what the men’s alternatives are in accessing the health system, and the presence – or absence – of health programmes for men. Secondly, the relationship established by health workers with the users of the public health system is analyzed, taking into account the fact that both groups are likely to have their own health beliefs, perceptions and needs. Finally, the focus is on gender theory, including a discussion concerning the way in which male gender is related to health perceptions and behaviours and an analysis of the theories of Courtenay (2000a), Connell (1995; Connell & Messerschmidt, 2005) and Bourdieu (1990, 2000).

In the second part, in regard to the research design (Chapter 4), the philosophical framework is discussed in consideration of the constructivist paradigm and an explanation is given as to the way in which an ethnographic methodology has been employed; these elements form the basis of this study. Additionally, a description is given of the research procedures used, these include; a description of the participants, the recruitment strategies and methods used during fieldwork, details of data analysis strategies, and the ethical implications of this research.

In the third part, which corresponds to the findings section, the ethnography is exposed in a written account. This section has been divided into four chapters: in the first
chapter (Chapter 5), an overview of the community is provided, including a description of some of the social practices of the participants and their ways of organizing various activities. In the second chapter (Chapter 6), there is a detailed discussion relating to the men’s perceptions, beliefs, and behaviours in relation to their own health. In the third chapter of that section (Chapter 7), the beliefs and perceptions held by health workers regarding the group of men in the community are described. Finally (Chapter 8), the relationship between the group of men and the primary health centre is further explored; this highlights the barriers to encounters that exist between them.

In the last part of this thesis, the findings are discussed and the conclusions are presented (Chapters 9 and 10). The main findings are summarized and interpreted in the light of the literature and the final thoughts, contributions and limitations of the study are highlighted. Appended to this report are: the information sheet and consent forms, the demographic information form completed by the participants, the interviews and focus group guides used during the fieldwork, and a copy of the approval letters from the Ethics Committees that had been consulted prior to the implementation of this research. The appendices are presented in English and Spanish, since the fieldwork was undertaken in the latter language.
Chapter 2. Locating Men in the Chilean Health Care System

2.1. Introduction

Chile has some of the best health outcomes in Latin America (Pan American Health Organization, 2009), since its economic and political stability during recent years has helped to create an appropriate stage for the development of the country in a variety of areas, such as in education and health. That stability is one of the reasons why, in 2010, Chile became the first country in South America to join the Organization for Economic Co-Operation and Development [OECD] (2010). Despite these achievements, the situation in regard to the health of the Chilean people still presents some important challenges. During the decade from 2001 to 2010, the Chilean Ministry of Health established a set of goals relating to the population's health needs, these included: to improve health, to confront the problems associated with the extension of life, to decrease inequity in health, and to improve the quality of service in relation to the population’s expectations (Chilean Ministry of Health, 2002, 2006). The evaluation of the fulfilment of those goals was not successful, basically because the improvement in risk factors was linked to the acquisition of chronic disease and to the reduced preventive aspects of health contained in the plan (Chilean Ministry of Health, 2011a). Currently, the National Survey of Health shows a worrying picture; chronic non-communicable conditions already represent a major problem for the country, and these conditions are associated with habits that have developed during childhood or adolescence, such as; obesity, a sedentary lifestyle, smoking, and alcohol consumption (Chilean Ministry of Health, 2010).

In this context of achievements and challenges, the situation pertaining to some population groups and their needs deserves specific focus. In this particular research, the focus of interest has been on Chilean men and their position in the public health system, especially in the context of the primary healthcare service that has the function of both gatekeeper and agent of referral for the entire public system. Hence, the purpose of this chapter is to give a context for the understanding of the position of men in the Chilean Health Care System (CHCS). The chapter begins with a general overview of the Chilean health situation in the context of the Americas. Then, the CHCS is analysed from a historical point of view, with a focus on the current situation. Finally, the discussion concludes with a commentary on the position of men at the current stage in the development of the Chilean health services.
2.2. Chile in the Context of the Health Situation in the Americas

Across the various regions and countries of the Americas, the epidemiological situation shows extreme variation. While some countries still present high levels of morbidity and mortality in relation to communicable diseases, at the same time, the incidence of chronic conditions is affecting the populations of the continent. According to Giovanella (2007), 46.7% of the population in South and Central America does not have permanent access to basic services related to health care, and in some cases there are problems of access to potable water. On the other hand, other countries such as Chile and Costa Rica have a good level of access to health care services and the incidence of communicable disease is controlled (Pan American Health Organization, 2009). In this context, the epidemiological polarization in Latin America described by some authors (Acuña, 2008; Sojo, 2008) could be understood by the presence of different health problems in different countries and, simultaneously, the presence of epidemiological differences between the people within a country.

Latin America is a region with high levels of social inequity (Giovanella, 2007), with economic differences impacting particularly on health and education. In Chile for instance, in late 1998, while 20% of the wealthiest households captured 57.3% of income, 20% of the poorest households received only 3.7% (Pan American Health Organization 2002); this inequality was maintained for 2006 (Chilean Ministry of Planning, 2006), and for the year 2010, the Gini coefficient was 0.53 (Gattini & Alvarez, 2011). Another problem facing Latin America is that its health care systems, through reliance on taxes as a source of funding, are strongly associated with the employment situation, and a large proportion of the population has only informal employment. Therefore, those people who do not pay taxes are excluded from the health system (Acuña, 2007, 2008; Levcovich, 2007). In this context, the only alternative for this group is to go to emergency rooms when they have a health problem or an accident, because emergency services are usually available to people who are not part of the health system. Thus, one of the challenges is to include this group in health policies, in order to improve their health and to deliver elements of disease prevention and health promotion.

Regarding the specific health problems that are affecting the Americas, the incidence of chronic health conditions is constantly increasing, and this contributes substantially to mortality and to the burden of disease within the region. Chronic conditions, that formerly primarily affected only the older members of the population in high-income countries, are now affecting younger populations and poor people in the lower-income countries of Latin
Chapter 2 – Context of the Study: Locating Men in the Chilean Health Care System

America and the Caribbean (Pan American Health Organization, 2009). The main problem is that for many countries, such as Peru or Bolivia, the incidence of chronic conditions is increasing, but the significant incidence of communicable diseases remains an important contributor to premature mortality. The mortality rates from communicable diseases are 61.2 per 100,000 inhabitants for Latin America as a whole, while Chile presents only 33.5, compared with Bolivia and Peru, with 109.8 and 135.9 respectively. In regard to life expectancy, the differences between neighbouring countries such as Chile and Bolivia are 78.7 and 66 years of age, respectively; this is a consequence of the disparity of access to health care between these two countries (Pan American Health Organization, 2009).

In the presence of all these elements, the current concern for the Americas, and in particular for Latin America, is to decrease health inequity, this includes: the improvement of access to health care; and the design of health systems based on solidarity, considering those who, either, do not have a regular income, or who have no income at all (Pan American Health Organization, 2009). Currently, Chile has become a model for other Latin American countries, since its health outcomes demonstrate the overcoming of health problems that are still present in other countries. However, the performance of the CHCS still presents challenges; including the inadequate offer of health interventions and health strategies for some population groups, such as, men.

2.3. The Chilean Health Care System

As highlighted in the above discussion, Chile is a country with one of the best health indicators in the region. Hence, the Chilean Health Care System [CHCS] is the focus of numerous studies, and represents a model for other countries to emulate (Acuña, 2007). However, the Chilean health situation still presents important challenges. In the following section, an historical vision of the CHCS is presented in order to provide a context for the research and to analyse the current situation.

2.3.1. Historical Vision

During recent decades, the CHCS has experimented with multiple changes and reforms; this has modified health access for the Chilean population. Until 1979, the State, represented by the Ministry of Health, was responsible for the administration and supervision of the financing and quality of service for all Health Care Centres in the country (Annick, 2002; Chilean Ministry of Health, 2007, n.d.). All Chileans were covered by the public health
system, and only those people who wanted better services consulted private health professionals; however, this type of interaction was not supervised by the Ministry of Health. The SERMENA (National Medical Service for Employees) was the organization in charge of managing the financial resources from employees’ tax, and employees could choose a health care centre according to their requirements (Annick, 2002).

Towards the end of the 1970s, the military Government, led by Pinochet, undertook a structural reform with the aim of reducing the role of public institutions and to increase the role of markets, increasing the private sector participation in the economy of the country (Burrows, 2008). In 1979, the functions of the Ministry of Health decreased and SERMENA disappeared. In their place, other public organizations (listed below) were implemented (Chilean Ministry of Health, n.d.; Pollack, 2002). The role of the Ministry of Health in this new structure was: (1) to design strategies and interventions in health, and (2) to supervise, evaluate and control the health policies. The agencies established under this structure included:

- **FONASA** (National Health Funds), in charge of coordinating the financial resources collected from the employees’ tax, equivalent to 7% of the salary, according to the Budget and Resources Law [*Ley de Presupuestos y Recursos*].
- **SNSS** (National System of Health Services), in charge of coordinating and supervising public health services.
- **ISP** (Institute of Public Health), in charge of supervising public laboratories and to approve drugs and medicines.
- **CENABAST** (Supply Centre), in charge of coordinating the purchase and delivery of all drugs, medicines and medical equipment for the SNSS.

In 1981, three years after the Declaration of Alma-Ata (International Conference on Primary Health Care, 1978), two new reforms were made to the CHCS. The first one was the transfer of the Primary Health Care administration from the SNSS to Local Governments, represented by Municipalities (Annick, 2002; Miranda, n.d.). The main goals of this transference were; to improve the power of decision-making at the local level in order to make health programs more responsive to the needs of local populations, to raise community participation in the health sector, and to generate, at a local level, collective co-operation between social programs, especially those pertaining to education and health (Annick, 2002). At the same time, Municipalities were required to follow the norms and programs articulated by the Ministry of Health.
The second Reform established individual freedom to choose between health insurance and health care services; through this, the health sector underwent a process of privatisation. As noted above, employees were required to pay a tax that corresponded to 7% of their salary, and after this Reform they had to decide whether this money went to the private or to the public system (Pollack, 2002). The private system was represented by ISAPREs (Health Provision Institutions); this was a private health insurance scheme that offered an alternative to those employees whose higher incomes enabled them to choose between ISAPRE or FONASA (the public system). In the private system, people receive health care according to their individual contributions, made through direct payment, or through freely agreed insurance schemes (Missoni & Solimano, 2010). Since this Reform, the Chilean health system, in relation to funding and delivery of services, is now divided into public and private sectors. The private system has begun to administer its economic resources and to build private clinics to deliver their health services. Those who remain in the public system are able to access health services through public primary health care centres and public hospitals.

In 1990, the CHCS experimented with new reforms. These reforms coincided with the end of the military government in Chile, and the beginning of the democratic governments, which sought to improve health access for the Chilean people and to supervise the private health sector. Its first achievement was the promulgation of Law 18,933, which established the ISAPREs Administrative Division [Superintendencia de ISAPREs] to supervise and control ISAPREs (Arteaga, Astorga, et al., 2002; Chilean Ministry of Health, n.d.; Pollack, 2002). In 1995, Law 19,381 was promulgated and, once more, that particular Law was oriented towards the supervision of the ISAPREs and to increase patient rights in the private health system (Chilean Ministry of Health, n.d.). The implementation of these two Laws was an important accomplishment, because members of the population began to have some protection of their rights in the private health system.

The most recent health reform was announced by the government in the year 2000. The System of Health Guarantees [AUGE] was the core of the Healthcare Reform (Burrows, 2008). The Healthcare Reform focused on access guarantees for all people who had a specific pathology, independently of whether they had private or public insurance. Currently, this new system of health guarantees that any Chilean who has one of the pathologies prioritised by the health authority, will have certainty of access to health interventions. The selection of these pathologies was related to the highest prevalence of diseases in the country and, according to the Government, a systematic review of the pathologies included in AUGE
would be made every three years, in consideration of epidemiological and economic studies (Chilean Ministry of Health, 2007). “The reform aimed to ensure universal access, opportunity of care and financial protection for the most prevalent health problems that represented 60 to 70% of the disease burden of the Chilean population” (Missoni & Solimano, 2010, p. 10). The first group of pathologies prioritised included 56 diseases (Table 1).
Table 1: First Group of Pathologies covered by The System of Health Guarantees [AUGE]

<table>
<thead>
<tr>
<th>Serious Accidents</th>
<th>Surgery Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Major burn accidents</td>
<td>34. Cleft lip and palate</td>
</tr>
<tr>
<td>2. Multi traumatism</td>
<td>35. Spin bifida</td>
</tr>
<tr>
<td>3. Ocular traumatism</td>
<td>36. Scoliosis, under the age of 25 years</td>
</tr>
<tr>
<td>4. Brain traumatism</td>
<td>37. Hernia lumbar</td>
</tr>
<tr>
<td><strong>Benefits to Old People</strong></td>
<td>38. Cholecystectomy, between 35 and 45 years of age</td>
</tr>
<tr>
<td>5. Hip Osteoarthritis, over 65 years of age</td>
<td></td>
</tr>
<tr>
<td>6. Pneumonia, over 65 years of age</td>
<td></td>
</tr>
<tr>
<td>7. Walking stick, over 65 years of age</td>
<td></td>
</tr>
<tr>
<td>8. Osteoarthritis, over 55 years of age</td>
<td></td>
</tr>
<tr>
<td>9. Hypoacusis, over 65 years of age</td>
<td></td>
</tr>
<tr>
<td>10. Oral Health, over 60 years of age</td>
<td></td>
</tr>
<tr>
<td>11. Ocular refraction, over 65 years of age</td>
<td></td>
</tr>
<tr>
<td>12. Prostate hyperplasia</td>
<td></td>
</tr>
<tr>
<td><strong>Chronic Conditions</strong></td>
<td></td>
</tr>
<tr>
<td>13. Chronic Renal failure</td>
<td></td>
</tr>
<tr>
<td>14. Diabetes mellitus I</td>
<td></td>
</tr>
<tr>
<td>15. Diabetes mellitus II</td>
<td></td>
</tr>
<tr>
<td>16. HIV/AIDS</td>
<td></td>
</tr>
<tr>
<td>17. Hypertension, over the age of 15 years</td>
<td></td>
</tr>
<tr>
<td>18. Rheumatoid arthritis</td>
<td></td>
</tr>
<tr>
<td>19. Haemophilia</td>
<td></td>
</tr>
<tr>
<td>20. Cystic Fibrosis</td>
<td></td>
</tr>
<tr>
<td>21. Epilepsy, under the age of 15 years</td>
<td></td>
</tr>
<tr>
<td><strong>Cardiovascular and Cerebrovascular Diseases</strong></td>
<td></td>
</tr>
<tr>
<td>22. Myocardial infarct</td>
<td></td>
</tr>
<tr>
<td>23. Arrhythmia, over 15 years old</td>
<td></td>
</tr>
<tr>
<td>24. Brain aneurism</td>
<td></td>
</tr>
<tr>
<td>25. Primary tumours in the Central Nervous System, over the age of 15 years</td>
<td></td>
</tr>
<tr>
<td>26. Stroke, over 15 years of age</td>
<td></td>
</tr>
<tr>
<td>27. Congenital heart defect</td>
<td></td>
</tr>
<tr>
<td><strong>Respiratory Diseases</strong></td>
<td></td>
</tr>
<tr>
<td>28. Chronic Obstructive Pulmonary Diseases</td>
<td></td>
</tr>
<tr>
<td>29. Asthma, under 15 years of age</td>
<td></td>
</tr>
<tr>
<td><strong>Ocular Problems</strong></td>
<td></td>
</tr>
<tr>
<td>30. Cataract, over the age of 15 years</td>
<td></td>
</tr>
<tr>
<td>31. Retina problems in Diabetics</td>
<td></td>
</tr>
<tr>
<td>32. Detachment of the retina</td>
<td></td>
</tr>
<tr>
<td>33. Strabismus, under the age of 9 years</td>
<td></td>
</tr>
</tbody>
</table>

**Cancer Treatment**
39. Infant Cancer
40. Cervical Cancer
41. Breast Cancer, over the age of 15 years
42. Testicular Cancer, over the age of 15 years
43. Adult Lymphoma
44. Pain relief and palliative cares in terminal cancer
45. Prostate cancer, over the age of 15 years
46. Gastric Cancer, over the age of 40 years
47. Leukaemia, over the age of 15 years

**Health of mothers and newborn babies**
48. Respiratory disorders in newborn babies
49. Respiratory Infection, under 5 years of age
50. Premature birth
51. Analgesia during the birth

**Mental Health**
52. Schizophrenia
53. Depression, over the age of 15 years
54. Drug abuse and dependence, under the age of 20 years

**Oral Health**
55. Emergency Oral problems
56. Integral Oral Health at 6 years of age.
Chapter 2 – Context of the Study: Locating Men in the Chilean Health Care System

The System of Health Guarantees was designed in conjunction with the Health Objectives for the Decade 2000-2010, which focused on extending the healthy life of Chileans, to decrease inequity, and to promote health care (Chilean Ministry of Health, 2002). The extension of life associated with a rise in degenerative diseases, socio-economic inequities in health, a widespread dissatisfaction with the care system, and the need for the improvement of the quality of service in the Health Care System, became a stage of challenges. In response to those challenges, the key goals of the Health Objectives for the Decade 2000-2010 were to improve health achievements relating to epidemiological reports, to confront the health conditions associated with the extension of life, to decrease inequity in health, and to improve the quality of service in relation to population expectations (Chilean Ministry of Health, 2002).

The actions designed in relation to the Health Objectives were to guarantee access to health care by any person suffering from any one of the 56 pathologies prioritised by the health authority, regardless of whether, or not, that person belonged to the private, or public, health system. This strategy was designed to allow for improvement in some of the problems of access to health care, as cover was to be provided for instances of chronic diseases that had a high level of prevalence in the country. However, the intermediate evaluation of these Health Objectives indicates that the efforts have not been successful, since the prevalence of chronic diseases continues to rise (Chilean Ministry of Health, 2006, 2007).

In the next section, an analysis of the current situation in the CHCS is presented; the section also includes a discussion in regard to recent health care reforms and the way in which they have affected the health status and access to care for Chileans.

2.3.2. The current status of the CHCS

The diverse health reforms executed in Chile over the last thirty years have modified both the access to, and the benefits of, the health system for Chileans. The total health expenditure in Chile accounted for 8.0% of GDP in 2010, less than the average of 9.5% for OECD countries; and while, in most countries, the public sector is the main source of health funding, in Chile, just 48.2% of health spending was funded by public sources in 2010 (Organization for Economic Co-Operation and Development [OECD], 2012).

The private health system, represented by ISAPREs, serves the members of the population with the highest salaries in the country. These patients receive healthcare in private clinics, the facilities of which are far better than those in the public system, since
private clinics and private health care centres are equipped with more advanced technology. Consequently, if people have sufficient income they prefer to use the private health care system; however, that is an option for only a small portion of the population (Table 2).

Table 2: Private and public health system population distribution (2006)

<table>
<thead>
<tr>
<th>Health Insurance</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>FONASA (Public System)</td>
<td>74.3%</td>
<td>79.2%</td>
</tr>
<tr>
<td>ISAPRE (Private System)</td>
<td>14.3%</td>
<td>12.7%</td>
</tr>
<tr>
<td>DIPRECA (Military/Policy)</td>
<td>2.8%</td>
<td>2.6%</td>
</tr>
<tr>
<td>Without Health Insurance</td>
<td>8.5%</td>
<td>5.5%</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

The private system establishes different levels of fees that are levied according to age, sex and medical records, using a risk rated insurance system (Burrows, 2008; Larrañaga, 1997). For instance, an obese, but otherwise healthy young man must pay higher fees than a man of normal weight of the same age, or, a woman of childbearing years pays more than a man of the same age. In this type of system, if a person has had private insurance and lost his/her job, probably this person has no option other than to move into the public system. The same would happen if a healthy, privately insured, person received the diagnosis of a catastrophic disease, such as cancer; in this instance, his/her increased insurance fees probably would be likely to become unaffordable. Therefore, in such situations, people generally prefer to change their insurance to the public system. Hence, the public health system provides care to people with the lowest incomes and highest health needs. Consequently, the CHCS is structurally segmented with low-income, high-risk populations being served mainly by the public sector and the high-income, low-risk populations generally being treated in the private sector (Missoni & Solimano, 2010).

DIPRECA (Table 2) represents the insurance for people who belong to the military and police services, including their families, who account for 2.8% of the population. People without health insurance (Table 2) are usually those with no regular job, for instance: university students, young professionals, seasonal workers, etc. This group has the option of paying their own insurance (private or public), but such people usually wait until they have a regular job, when they can claim a discount of 7% for taxes related to health contributions.
Those in the latter situation, and their dependents, currently present a problem for the health system, since the system does not have any contact with members of this group of uninsured, or their families, as they do not belong formally to the system; they are only able to have access to emergency rooms if they have a serious health problem.

The public health system, represented by FONASA, provides care for the highest percentage of the population (Table 2); it includes people who have a regular job, and those who do not have a job and who do not collect any income. This last group is categorised as indigent, since they do not have stable housing or any support from their families and are usually, homeless.

2.3.2.1. FONASA – The Publicly Funded System

FONASA has the mission of attending to the health needs of the population, and also maintaining the various health services distributed throughout the country; these can be divided into two types: public primary health centres and public hospitals. Both types of service are available to patients; however, the way to access the system is to enrol in a primary health care centre that works in coordination with the local government or Municipality (Arteaga, Astorga, et al., 2002; Pollack, 2002); each local government nominates a Health Committee, which meets periodically with the directors of the various healthcare centres (Urriola, 2007). People can only go directly to the public hospital in the case of an emergency health situation, or if they are referred by a primary health care centre.

Therefore, the public system in Chile works by prioritizing primary health, in accordance with guidelines of the World Health Organization (2008b); the guidelines have established that primary health centres, representing the first contact of the health sector that people in the community have, must be the main focus in any health system and that the general practitioner has the role of gatekeeper to the health system.

It is in the Primary Health Centres that people receive health care as outpatients. According to information provided by the Pan American Health Organization (2002), in Chile, there is be a primary care centre for every 28,500 people. Each healthcare centre has a team of professionals, including general physicians, nurses, psychologists, and social workers. These professionals provide the first level of care for patients and are also responsible for co-ordinating prevention programs in the community. Usually, Primary Health Care Centres are divided into areas or departments, such as those of; childcare, women's health, and chronic illness (Arteaga, Astorga, et al., 2002; Arteaga, Thollaug, et al.,
2002). There is no specialized medical care at this level; where users require consultation with a specialist (such as psychiatrist, orthopaedist, cardiologist) they are referred to secondary care at a hospital. The public hospitals and primary health centres lack personnel and equipment, thus generating long delays to their services (Missoni & Solimano, 2010). In this context, during recent years the focus of the Chilean Ministry of Health has strengthened the role of primary health centres across the country, and recently FONASA has developed the concept of SAPUs Servicios de Atención Primaria de Urgencia [Emergency Primary Healthcare Services], which are emergency care services operating in the primary health sector for the purpose of solving health emergencies at the primary level (Monasterio, 2007).

Despite the achievements of FONASA, some issues still affect its performance. First, the retention of health professionals is a problem; this is due to the fact that salaries are higher in the private sector; health personnel usually work in both sectors and eventually move to work entirely in the private health sector. Therefore, rotation of staff is frequent, and FONASA is constantly giving training to new people who must learn how the system works (Barria, 2008). Secondly, because of healthcare centre opening times and schedules, workers (the employed workforce) do not generally use the regular services provided at primary health centres; as a result, a major portion of the population use the emergency rooms only when they feel ill (Urriola, 2007). This situation has some implications; firstly, resources are not used efficiently, and secondly, and even more crucially, people tend to wait until they feel extremely unwell before seeking health care at an emergency room. Finally, at the primary level, FONASA has an unresolved duty; this is the adequate provision of programs related to health promotion and prevention (Barria, 2008; Urriola, 2007). This situation represents a concern for authorities, and is a consequence of the prioritization of diseases promoted by the recent Healthcare Reform, AUGE.

2.3.2.2. AUGE

AUGE focuses on guaranteeing access to health care for all people who have specified pathologies, regardless of whether they have private or public insurance. Currently, this new system of health guarantees that any Chilean, who has one of the pathologies prioritised by the health authority, will have access to the required health intervention.

AUGE endeavours to address the various problems that Chileans encountered during the period of time before the Reform was established. One problem for people in the private system was the amount of the cost associated with some pathologies; for instance, conditions
such as HIV caused insurance fees to increase; therefore, some people chose to exclude such pathologies from their health programs, and if they contracted a disease that was catastrophic, they had no health coverage at all. On the other hand, in the public system, the dominant problem was the queue for access to health intervention. For example, a person who suffered from cataracts could wait several years for surgery. Moreover, previously, AUGE patient rights were not clear, and the selection of interventions was undertaken by physicians without the necessary protocol to guide their actions. For instance, although, in some health services, a patient with cancer was able to receive treatment for pain relief and to have palliative care, in other places, physicians decided that this type of treatment was expensive and thus, did not offer it. Currently, those problems do not exist, because the private and public system must give attention to the pathologies prioritised, in consideration of the clinical guidelines made by the Ministry of Health, which establishes specific procedures and deadlines (Monasterio, 2008; Urriola, 2008).

According to Barria (2008), prior to the establishment of AUGE, the analysis of resources in the public system was made in relation to supply, which means that the number of cataract surgeries in one year depended on the number of ophthalmologists employed in the public service. Currently, the analysis is made in relation to demand; therefore, if one hundred Chileans need cataract surgery, and there are not enough professionals in the public system to provide the service, FONASA is required to purchase the services of health professionals in the private system in order to give attention to all patients (Monasterio, 2008).

The selection of the first group of pathologies was done in relation to the highest prevalence in the country. For instance, different types of cancer, respiratory disorders, cardiovascular diseases and diabetes were covered, as were some mental health problems such as depression and schizophrenia (Table 2). According to Urriola (2008), this first group of diseases represented the 70% of the incidence of disease in the country. The prioritized list is currently reviewed every three years, based on an analysis of existing epidemiology data (Barria, 2008; Monasterio, 2008; Urriola, 2008). Currently the list includes 69 diseases (Chilean Ministry of Health & FONASA, 2012), including the 13 new pathologies listed below (Table 3).
Table 3: Second Group of Pathologies covers by The System of Health Guarantees [AUGE]

<table>
<thead>
<tr>
<th>Pathologies</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Retinopathy of Prematurity</td>
</tr>
<tr>
<td>2. Bronchopulmonary dysplasia of Prematurity</td>
</tr>
<tr>
<td>3. Bilateral sensorineural hearing loss of Prematurity</td>
</tr>
<tr>
<td>4. Refractory epilepsy in people aged 15 years and over</td>
</tr>
<tr>
<td>5. Bronchial asthma in people aged 15 years and over</td>
</tr>
<tr>
<td>6. Parkinson’s disease</td>
</tr>
<tr>
<td>7. Juvenile Idiopathic Arthritis</td>
</tr>
<tr>
<td>8. Secondary Prevention Chronic Renal Failure</td>
</tr>
<tr>
<td>9. Hip dysplasia Luxante</td>
</tr>
<tr>
<td>11. Relapsing remitting multiple sclerosis</td>
</tr>
<tr>
<td>12. Hepatitis B</td>
</tr>
<tr>
<td>13. Hepatitis C</td>
</tr>
</tbody>
</table>

As a new strategy, AUGE has provided an answer to the diverse problems in the Chilean health system, especially in relation to the reduction of some of the difficulties of access; however, new issues have emerged (Burrows, 2008; Roman & Muñoz, 2008). The evaluation of the 2008 Reform, has revealed that the major problem is that people are not aware of the options within the system, and that only 8% of the population declare they know what to do if they need use the system (Monasterio, 2007). Therefore, it appears that people have not been adequately informed about their health alternatives and rights.

Even more problematic is the exclusion of those who present a pathology that has not been included in the 69 pathologies catered for in the system. For such patients there is no easy solution. For instance, if a person suffers from panic attacks, this is a problem because this mental disorder has not been included in the list. The same happens in instances of domestic violence or alcoholism, both of which have a high level of incidence in Chile. This situation has many implications, because, from the point of view of the system, it does not respond to people; it responds to pathologies. Prevention strategies are usually related to the same 69 pathologies, and once again, there are problems if a person has risk factors related to another disease, or if they are healthy, because in this case they do not have a particular space in the system. This type of structure does not analyze the diversity of peoples’ needs, and it is a system that offers attention to sickness, not to people (Roman & Muñoz, 2008). According to Solimano (2008), there is no true harmony between the logic of civil rights and the logic inserted into the disease prioritisation processes. A civil rights perspective does not tolerate either discrimination or exclusion, and prioritisation explicitly discriminates and excludes,
justified by insufficiency of resources. As a result, people who have diseases with low prevalence pose a problem without a clear solution, since these populations are left outside the health system.

2.4. Men as an Excluded Group

The health insurance options for men in Chile are presented in Figure 2. Basically, the alternatives for a man without a job are two: (1) he must pay for private health care when he needs it, or (2) he can pay a regular insurance premium (private or public, ISAPRE or FONASA, respectively) and, in this way, may access the benefits of the system. Only if this man without a job can demonstrate that he does not have any income or any possibility of work, then he will be categorised as indigent and can have access to the public system under this classification. A man with a job must decide whether he wants his taxes to go to the private, or to the public, health system. Regardless, if a man belongs to the public system or to FONASA under any conditions, when he has a health problem he must first access the system through the primary health centre or go to a hospital emergency department. The only group of men that do not participate in the previously-mentioned system of options, are those who belong to the military or police services, because they have their own system of health insurance.

![Figure 2: Health options for men in Chile](image-url)

"DIPRECA: Military and Police (2.8% of Chilean men)"
Chapter 2 – Context of the Study: Locating Men in the Chilean Health Care System

The organization of CHCS presents certain situations that directly affect Chilean men. The predominance of primary care level, despite its being in principle a sound strategy for working closely with the community, establishes the presence of health programs which usually are divided into areas or departments, such as those of; childcare, women's health or chronic illness (Arteaga, Astorga, et al., 2002; Arteaga, Thollaug, et al., 2002; Chilean Ministry of Health, 2011b). A specific area for receiving men with no specified illness does not exist (Chilean Ministry of Health, 2011b). Furthermore, community clinics are difficult for men to access because the hours are inconvenient for men who are working.

According to Gomez (2002), gender equity in health must consider the specific needs of each group. However, in Chile, during recent decades, the study of inequity in health related to gender has been focused on women, because, historically, they had been discriminated against by the system that established a different scale of fees and programs solely on the grounds of reproductive function (Gomez, 2002). For that reason, many strategies focused on decreasing the discrimination against women in the system, but it appears that the authorities have overlooked men’s health needs, and as a result some gender bias has emerged. For instance, women in FONASA could be either covered in their own right or included as dependants of their husbands if they were not formally employed, whereas men could not be included as dependants of their wives, a situation that could affect men who are not formally employed (Missoni & Solimano, 2010).

Regarding the Chilean epidemiological profile, for the year 2009, the rate of mortality in the general population was 5.4 per thousand inhabitants, a number that has remained relatively stable since 2005. The difference in these rates by sex reveals that more men die (5.9 per thousand) than do women (5.0 per thousand); this is a difference that has also remained constant since 2005 (Chilean Ministry of Planning, 2009). In terms of mortality by age group, it is possible to appreciate that at all ages, men’s mortality is greater than that of women. For instance, in 2009, the total number of deaths in males aged 20-44 years was 5,201 (1.6 per thousand men of that age), compared with women in the same age group, for whom the total number of deaths corresponded to 1,967 (0.6 per thousand women in that age group). The main causes of death for men in all ages corresponded to diseases related to the circulatory system (25.6 %), tumors (24.5 %), external causes, including accidents and suicide (12.8 %), and diseases relating to the respiratory system (9.3 %). These four groups constitute the 72.2 % of the causes of death in the male population (Chilean Ministry of Health, 2011b).
Concerning consultation patterns in the formal health system for both men and women, men between 20 and 59 years consult less than women in both the public and private systems when they have a health problem (Figure 3, created from data provided by the Chilean Ministry of Planning, 2009). Consequently, hospital discharges for the year 2008 corresponded to 38.7% of men and 61.3% of women. According to the Chilean Ministry of Health (2011b), the six main reasons for hospital discharge in men were: injuries, poisonings and other external causes (16.4 %); diseases relating to the digestive system (14.3 %); diseases relating to the respiratory system (13.1 %); diseases relating to the circulatory system (10 %); diseases relating to the genitourinary system (7.7 %); and tumors (6.6 %).

In 2007 the Ministry of Health undertook a study of the diseases and risk factors in Chileans, and the results showed that the main risk factors in the population related to lifestyles and the prevalence of chronic disease (Chilean Ministry of Health, 2007). The study pointed out that both socialization processes and alcohol consumption are major problems in the country, and especially affect men. Faced with this data, on numerous occasions men have been classified as alcoholics, as opposed to being persons with psycho-social
vulnerabilities (Aguayo & Sadler, 2010). Furthermore, hypertension, being overweight and salt consumption explains the lower life expectancy leading to premature mortality in Chilean men.

The personnel employed in the Chilean health system are aware of some of the problems that affect men. The epidemiological profile reported by the Chilean Ministry of Health (2011b) recognized that the mortality and morbidity rates men presents challenges that should be addressed. However, the public health system has not given priority to the design of health strategies that focus on men’s health needs. In summary, men present risk factors that affect their health, a situation that is exacerbated by their low attendance rate at the healthcare services provided by the formal health system. The previously mentioned factors confirm the fact that the health of Chilean men requires attention.

2.5. Summary

In this chapter, a brief global view of the health situation in the Americas was discussed in order to provide a context to the Chilean health situation. A historical view of the CHCS was then presented with the purpose of understanding the current health care context in the country, following which, the present health situation in Chile was analysed. Finally, the situation of men was discussed in order to understand their position in CHCS, in consideration of their options for accessing the health system.

A large proportion of the population of Chile belongs to the public health system; the system organizes its health strategies in accordance with the guidelines set out by the Chilean Ministry of Health which places great importance on the prioritization of diseases (AUGE). The primary health care system plays the role of first contact between the population and the public health system; this where a close relationship with health workers needs to be established in order for the design of strategies for health promotion and disease prevention to be undertaken. The structural barriers of access to the health system have put men in a vulnerable position in the Chilean health system. In this context, it is argued that this group is especially exposed, because, generally speaking, men do not develop a relationship with the health system, and the health system only encounters them when they are sick. Therefore, Chilean men do not regularly attend primary health centres; this is a situation that is described in detail in the Findings Section of this research and is analyzed in the ensuing discussion.
Chapter 2 – Context of the Study: Locating Men in the Chilean Health Care System

Barriers to access to the health system and the absence of specific programs focused on men's health needs, coupled with cultural factors, including the experience of gender role and masculinity that have an important influence on men’s health, create a context that influences the health perceptions and behaviour of Chilean men. In the following chapter, (Chapter 3: Cultural Influences on Health Perceptions: Men as a Special Cultural Group), certain theories regarding the health needs of different groups, including men, are reviewed in consideration of the relevance of the existence of the health systems that comprehend and analyze those needs. In that context, specific findings regarding the relationship that exists between masculinity and men's health are discussed.
Chapter 3. Cultural Influences on Health Perceptions: Men as a Specific Cultural Group

3.1. Introduction

The research question underpinning this study is: “What is the relationship of Chilean men with their health and with the public health care system?” There are two principal themes involved in this question: (1) the relationship that a particular Chilean group of men have established with the public health system, and (2) the way in which members of that group experience their own health: this is a topic that involves the gender role theory and its influence on health beliefs and behaviours. According to the literature, both topics influence men’s health actions. In the previous chapter (Chapter 2), the Chilean Health System, was discussed in depth; the alternatives that the health system offers to Chilean men were also discussed, thus providing a context for this research. In this chapter, in order to provide a framework for the analysis of the findings, two themes are discussed. First, I argue how some beliefs and social practices influence relationships inside health systems, taking into consideration the interaction between health workers and health care users/patients. In the second part, the theories of gender are exposed and, in particular, the theories that focus on masculinity. These themes are depicted in Figure 4.

![Diagram showing themes included in the Literature Review](image-url)
Chapter 3 – Cultural Influences on Health Perceptions: Men as an Special Cultural Group

One of the points of focus for this research into health systems is the encounter between two groups: the users/patients and the health workers. Although both these groups are generally drawn from a single society, in fact each represents a distinct social group and each has a different cultural background. For health workers, it is assumed that having an awareness and knowledge of, and respect for, those cultural differences will aid the success of encounters with health services users. In the first part of this chapter, the literature pertaining to the cultural differences present in such encounters is reviewed. This review is divided into three parts. First, some aspects of the cultural beliefs of health workers, who share beliefs and a professional language reflecting a particular cultural group, but nonetheless having their own values and points of view, are presented. Secondly, a set of literature is reviewed; this work illustrates the cultural beliefs of the patients/lay people. Finally, I present an analysis of the main elements to be considered in the encounter between health workers and patients/users.

In the second part of this chapter, an overview of gender and masculinity is presented. This includes the findings of international studies in regard to men’s health, including the discussion of three studies in Latin America conducted in Nicaragua, Mexico, and Puerto Rico, respectively. Then, I describe some theories of gender related to masculinities as a complex phenomenon, including studies of masculinities in Latin America. Considered here are the contributions of Courtenay (2000a, 2000b), who established a relational theory relating to men’s health from a social constructivist perspective; and the theories of Connell (Connell, 1995; Connell & Messerschmidt, 2005) and Bourdieau (2000) regarding Hegemonic Masculinity and Masculine Domination, respectively.
3.2. Relationship between Health workers and Patients/Users

Each cultural group and its sub-groups makes unique decisions regarding health and help-seeking behaviour for health problems and illness, reflecting a view that health and illness are phenomena that are socially constructed (Lincoln, 1992). From a constructivist paradigm, the way to approach the study of health and illness is to recognize their changing nature and in consideration of the multiple realities of each social group. The research approach includes consideration of the perspectives of health workers who, in this context, are also deemed to be part of a particular social group.

3.2.1. The Culture of Health workers: Biomedical Values

Biomedically based medicine has had a profound impact on health enabling the control and cure of many diseases and increasing life expectancy. However, adherence to treatment, lifestyle changes and communication with patients continues to pose challenges. These challenges have given rise to a small but important body of literature seeking to define the reasons why it is that health professional and patients may, at times, ‘talk past each other’. This particular literature views health professionals as being part of a cultural group not shared by lay people. From the beginning of their careers, health professionals become familiar with a particular way of analyzing the phenomenon of health and disease, acquiring codes and even a special language that makes them part of a social group with its own characteristics. “Physicians and other health providers may be viewed as constituting a cultural group. Health care practitioners have a style of discourse that differs in form and content from that of the general public” (Patcher, 1994, p. 690). In accordance with their creed, health workers are assumed to execute actions which they perceive as being the best for their patients. These beliefs are usually associated with scientific findings in relation to diseases and their causes. From there, they make interventions that are related to the treatments that they consider not only as being the most effective for the patient’s diagnosis, but also, in accordance with the biomedical paradigm.

From a biomedical perspective, the focus of attention is the diseases and pathologies that can affect the functioning of the body; therefore, the body is studied through its component parts. Thus, health is defined as the body operating efficiently as a “machine” (Helman, 2007b). Any situation that disrupts this effective process becomes a threat that is
studied, analyzed, and eventually conceptualized as a disease, defined as an entity with identifiable causes and effective treatments (Larson, 1999). Hence, the cure of the disease becomes the main objective, and health is understood according to numerical factors considered healthy: “health or normality are defined by reference to certain physical and biochemical parameters, such as weight, height, circumference, blood count, blood pressure, heart size or visual acuity” (Helman, 2007b, p. 122). This effort to find a cure for disease has had an enormous and positive impact on humanity, and many communicable diseases have been controlled and interventions in trauma surgery have been vastly improved. However, new problems that challenge the traditional view of biomedical paradigm have also arisen.

Through the control of infection and other diseases, and owing to the consequent extension of life, chronic conditions have emerged as a major concern in the area of health. These types of conditions by nature are incurable, becoming the first challenge to the traditional biomedical point of view. The need to deliver care rather than cure, has challenged health professionals to question their role as care deliverer, which requires a more permanent contact with the patient (Helman, 2007b).

Additionally, most chronic conditions require changes to the lifestyles of patients, therefore the health professional has two challenges: getting to know the lifestyles of patients, and to introduce changes to these lifestyles according to his/her health condition. One of the greatest risks of this situation is that medicine could result in a system of morality, in which some health workers condemn unhealthy lifestyles, and where the patient is blamed for failure to follow the “prescribed” behavioural changes (Helman, 2007b). Interacting with patients and making changes to their lifestyles is a challenge to health workers, who often know how to control the appearance and course of chronic conditions (for instance, changes in diet and the incorporation of physical exercise in daily life). However, because humans are social beings who do not work as machines, returning to the analogy used previously, it can be difficult to "reprogram" their behaviour.

Currently, adherence to treatments and communication between health professionals and patients are common issues in health delivery, and the biomedical paradigm does not provide a solution to these problems. The biomedical model as a paradigm has been highly productive in the advancement of medical science and health (Larson, 1999). However, what biomedicine has not done well is to consider diseases within the context of the lives of people (Baum, 2002). According to Kleinman (1973), medicine deals with two kinds of reality: the scientific and the ordinary. It is both a biophysical and a human science; and as a human
science, it should establish a relationship with people based on the knowledge of the other, respecting beliefs and traditions.

### 3.2.2. Lay People’s Perspectives

One of the most important aspects in understanding the differing perspectives between health workers and patients is the distinction between the concepts of disease and illness. Diseases correspond to objective diagnoses made by health care professionals; the diseases possess specific signs, symptoms and also require specific treatments. Illnesses are defined as a subjective experience, how an individual experiences a disease (Helman, 2007b; Kleinman, Eisenberg, & Good, 1978). In other words, physicians diagnose diseases, and patients suffer illnesses (Kleinman et al., 1978). Illness and disease do not stand in a one-to-one relationship. Illness may occur in the absence of disease. This means that the patients’ explanatory model regarding aetiology, presentation, diagnosis, or treatment may not fit into any biomedical disease category. At the same time, it may be possible that some diseases show no symptoms or signs that can be perceived by the patients, for example, hypertension, who may therefore not seek treatment or, if diagnosed, declare they are not sick (Kleinman, 1985; Kleinman et al., 1978; Patcher, 1994).

Furthermore, individuals from different cultures and social backgrounds may interpret physical or emotional discomfort in different ways (Gordon, 1994; Helman, 2007b). Hence, decisions about how to deal with some signs or symptoms also depend on the social context of the person. “How we communicate about our health problems, the manner in which we present our symptoms, when and to whom we go for care, how long we remain in care, and how we evaluate that care, are all affected by cultural beliefs” (Kleinman et al., 1978, p. 141). The process by which a person comes to define him/herself as ill is not a process that occurs in isolation from the social group. “Becoming ill is always a social process that involves other people in addition to the patient […] the process of becoming ill involves both the subjective experiences of physical or emotional changes and the confirmation of these changes by other people” (Helman, 2007b, p. 128). Usually it is family members and the closest members of the community who fulfil the role of caregivers.

In relation to this social process by which a person eventually defines himself as ill, Kleinman, Eisenberg and Good (1978) identified three structural domains, which each have a role both in the process of deciding to seek help, and in the decision-making process regarding what to do to address the health situation. First is the popular domain, represented
by family, social networks and community; where usually the decisions about where or when to seek care, how long to remain in care, and how to evaluate treatment occur, commonly in the context of family. Next is the professional domain, which corresponds to the group of health workers. Finally, there is the folk domain, which includes non-professional healers.

Each of these structural domains has particular characteristics, and “each domain possesses its own explanatory systems, social roles, interaction settings, and institutions” (Kleinman et al., 1978, p. 144). As mentioned above, usually the first domain encountered by people is the popular domain, because it is the nearest and is usually composed of the most trusted people. Once an individual has been recognized as being ill and that belief is also supported by his/her family and close community, then together they make the decision about what to do. Generally, the first attempt is to treat the symptoms and discomfort with home remedies, such as painkillers or a healthy diet and then, if the person is still feeling ill, they can go to a healthcare centre or to a non-professional healer. Individuals may use many sources of care during a single episode of illness (such as doctors or folk healers). However, most episodes of illness never enter either the professional or folk domain (Kleinman et al., 1978).

According to some authors, in different contexts people feel more comfortable with folk or natural healers than with health professionals (Anderson et al., 2003; Gordon, 1994; Helman, 2007b; Kleinman, 1992; Kleinman et al., 1978). This happens because healers treat illness rather than diseases, and thus the patient’s satisfaction with the outcome is higher. For this reason, it is important that health workers are familiar with illnesses as experienced and perceived by people, and try to address this aspect at the same time as addressing a disease. “Folk practitioners usually treat illness effectively, but do not systematically recognize disease […] only modern health professionals are potentially capable of treating both disease and illness” (Kleinman et al., 1978, p. 146).

### 3.2.2.1. Folk Illnesses

The concept of folk illnesses seeks to explain why some discomfort perceived by patients may not have any associated disease. However, these episodes affect patients and their families. If health workers do not know about this type of illness, they may not be of real support to the patient when he/her comes seeking help.

Folk illnesses are defined as “illnesses that are commonly recognized within a cultural group, and whose explanatory models often conflict with that of the biomedical paradigm”
The cultural group of the patient recognizes these illnesses, and they often have beliefs about the origin of an illness and the treatment required to relieve the discomfort. For instance, *Mal de ojo* [evil eye] is a common folk illness in Latin America, the origin of which is associated with a person with bad intentions who *ojea* (gives the evil eye) to another, who then begins to suffer symptoms such as headaches, tiredness or weakness (Gordon, 1994; Helman, 2007b). One way to avoid the evil eye is to wear red clothing or have a religious image nearby. If the evil eye affects a person, members of the community or healers deal with the illness; however, if the discomfort persists, people may go to healthcare centres.

In this context, it is important for health care providers to understand local folk illness and culturally mediated health beliefs and behaviours. This poses a major challenge for health workers, because such illnesses do not correspond with their biomedical parameters. In the U.S., for example, according to Gordon (1994), Anglo health workers tend to either ignore folk beliefs and practices or try to “educate” their patients by insulting the folk practitioners. Those providers, who refuse to accept the importance of traditional ideas about illness risk alienating patients, may affect future decisions-making regarding the seeking of health care.

In conclusion, for all people health and illness is an area in which they manifest their cultural background. “The experience of illness is a cultural or symbolic reality” (Kleinman, 1973, p. 209). Being sick is associated with a situation of vulnerability in which members of close social networks, family and community are drawn on, and where the health worker is just one of many actors.

### 3.2.3. Health workers and Patients: The Encounter

Just like any other encounter between two groups trying to discuss their ideas, the encounter between health workers and patients involves two worlds, two kinds of experiences, and two cultural backgrounds. Hence, in spite of the fact that health workers generally originate from the same society as their patients, through socialisation and acculturation into the medical and other health professions, “most clinical encounters can be analyzed as an interaction between two cultures, the culture of medicine and the culture of patients” (Patchar, 1994, p. 690). As mentioned earlier, major differences between the two groups concerning beliefs about health are associated with understanding and interpreting the health phenomenon. From a biomedical paradigm, the objective of an analysis would be to find the correct diagnosis, and from there, to define the appropriate treatment. For patients,
the most important objective is usually the relief of his/her symptoms, and the treatment of his/her illness. In Figure 5, I summarize some of the components present in the encounter between health workers and patients.

Figure 5: Encounter between health workers and patients

In any particular social context that can be represented either by a state or a country, there is a formal health system with particular policies. Within the health system are located health workers, who, due to their education, are usually influenced in their work by the biomedical paradigm. In the case of Chile, for example, as noted in the previous chapter (Chapter 2), there is an explicit prioritization of diseases; thus the system gives priority to the diagnosis and treatment of a number of pathologies (Chilean Ministry of Health, n.d.) This policy guides the actions of health workers in the encounter with patients, because health workers are aware that the health system resources are distributed according to the given prioritization, and that, generally speaking, the evaluation of their performance as workers is associated with the implementation of this public policy. Thus, the Chilean health system promotes the prioritized diseases as the focus of attention, both reflecting, and informed by, the biomedical paradigm.

Lay people, on the other hand, experience illness as a social process, and the recognition of their individual role as patient is supported by their social network. Such people usually have specific ideas about the cause of their discomfort and how this should be treated: seeking assistance from the health system is frequently a last resort after trying to
treat an illness with home remedies. However, the understanding that patients have may also be influenced by the health system and health professionals. In the Chilean case, for example, many patients may begin to believe that an important aspect of going to a health consultant is that they get a clear diagnosis that, hopefully, is on the list of prioritized diseases, because in this way they will be completely covered by the system.

The level of communication between health workers and patients is likely to be associated with the respect and honesty of both parties. If the health worker views each patient simply as a carrier of symptoms that require medical diagnosis, without consideration of that patient’s views and beliefs, including the way in which he/she explains and interprets their illness, the health worker may have difficulty in gaining the patient’s confidence. If a patient does not articulate their questions and concerns, and if they are not honest about their beliefs and the behaviours associated with their illness, health workers may not be able to satisfactorily address their problems. These misunderstandings and problems of communication between health workers and patients can occur even if they originate from similar social backgrounds. “Doctors and their patients, even if they come from the same social and cultural background, view ill health in very different ways” (Helman, 2007b, p. 121). Hence, in order for the consultation to be useful, negotiation is a central element. In this context, effective communication is maximized when both the patient and the health care provider share beliefs about the sickness or reach a shared agreement in relation to the condition and the treatment of it.

According to Helman (2007b), some of the strategies to consider in the encounter between health workers and patients include: understanding illness from the point of view of the patient; improving communication and creating an atmosphere of confidence where both can share their views; increasing reflexivity or self-awareness about one’s own background and possible bias; treating both illness and disease; respecting diversity; and assessing the role of context by understanding the social context of the patient and the political context in which the encounter occurs (public health policies). It is an essential challenge for those working in health systems to meet their users and to develop a relationship of trust with them. Cultural beliefs and the influence of social groups are of paramount importance, and if ignored or not considered, may become major barriers to effective engagement.

A social group that is of particular interest for this study is that of men. In the next section of this chapter, men’s beliefs and behaviours regarding their own health are reviewed; in addition, I discuss some of the theories pertaining to gender that are used as a framework for this research.
3.3. Men's Health: Gender and Masculinity Perspectives

Historically, gender studies related to health have been synonymous with women's health. Currently, however, men's health has become a focus of international interest (Barker et al., 2007; Doyal, 2001; Garfield, Isacco, & Rogers, 2008; Men's Health Consulting, n.d.; Smith & Robertson, 2008; The Coalition on Men and Boys, 2009). Consistently, health indicators such as life expectancy and the risk factors associated with chronic infections and diseases, show that men's health is in a worse state than women's health (Banks, 2001; Courtenay, 2000b). Recently, this situation has generated an interest among researchers and health professionals in various countries; this provides a background to the present study in regard to what is happening in the area of men's health in different locations in the world.

A common finding in research into men's health is the influence of gender, especially masculinity, on men’s health behaviour. For instance, the tendency to adopt risky behaviour, or to neglect one’s health, has been shown to be associated more with the male than the female gender. The study of masculinity and its relationship to men's health is important because men’s health related behaviour has implications for men themselves, and also for their partners and their children (Barker et al., 2007). Efforts to focus on the subject of men’s health requires the combined co-operation of researchers, practitioners and policy makers (Smith & Robertson, 2008).

3.3.1. Men's Health

In spite of the recent interest among researchers, men’s health has not provoked a great deal of interest among health workers and, generally, health interventions are designed without consideration of masculine gender. “The health sector has not often viewed men as a complex gendered subject” (Barker et al., 2007, p. 10). This lack of interest in the health of men has been permanent; Adams (1997) even refers to a “male sex invisibility” in the health sector. According to Adams, one of the reasons for this invisibility is the belief that it is unmanly to have health problems. This invisibility has also been referred to by some authors in Latin America, specifically in Argentina, by Oppezzi and Ramírez (2012) and in Colombia by Muñoz (2012) who have detected the absence of health programs tailored to the men in those countries.

Gender roles, and especially the way in which a man’s identity develops in interaction with his culture, are important factors in understanding the health differences between men and women (Cameron & Bernardes, 1998; Courtenay, 2000a, 2000b; Mahalik et al., 2007;
Oliffe & Bottorff, 2006; Sobralske, 2006). In a WHO published document, the authors state that the social expectations of men directly affect the attitudes and behaviours related to a range of health issues (Barker et al., 2007). Male gender norms include ideas that men should take risks, endure pain and be tough or stoic, in order to prove that they are real men (Barker et al., 2007). Fonseca (2006) refers to the fact, that, in Mexico, members of the population use the phrase “Ellos deben ser fuerte como un roble” [They (men) must be strong as an oak] in order to describe the men’s obligation to be strong; they must show their resistance and endurance even against their own forces if they want to be real machos. In this context, in order to be seen as a macho, men are more likely to ignore the symptoms of disease and to resist physical pain (Fonseca, 2006).

Social constructions of masculinity are influential in the practice and experience of ill health (Robertson, 2006; Sixsmith & Boneham, 2002). Masculinity is associated with traditional male lifestyle (Galdas et al., 2005), and numerous studies have shown the relationship between male beliefs and health behaviours (Mahalik et al., 2007; Sixsmith & Boneham, 2002; Sobralske, 2006). Even some studies in the UK have established that accidents and violence are phenomena that affect men’s health and that in consequence, men have lost years of potential life (Blane & Drever, 1998).

Mahalik, Burns and Syzdek (2007) conducted a study that examined the contributions of masculinity and men’s perceptions of the normativeness of men’s health behaviours in predicting men’s self-reported health behaviours. The study included the participation of 140 men aged 18-78, recruited in USA. The results revealed that men who endorse more traditional masculine norms would be more likely to report health risk behaviours and less likely to report health promoting behaviours (Mahalik et al., 2007). Additionally, the perception of other men’s health behaviours may be communicating social proof concerning the health behaviours potentially guiding their own health behaviours. Masculinity, then, is a social process constructed within a given culture in interaction with others.

Another finding, consistent in much research, is the importance attached by men to their employment function, which would be strongly associated with masculinity. Men’s identity is related to their capacity to work (Burin, 2009; Sixsmith & Boneham, 2002; Sobralske, 2006). Work is associated with being male, and in this context, illness, seen as an impediment to fulfil obligations at work, means not being able to be a man, while good health means being able to fulfil the role of a man. The perception of the body is associated by men with the importance attached to work. Men often speak about their bodies as if they were machines and think about illness in terms of the malfunction or failure of a particular body.
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part, using analogies such as that of going to a garage to get the car repaired (The Coalition on Men and Boys, 2009). Once the body is “repaired”, they can continue their normal duties. However, the decision “to repair the body” is often delayed.

The perception of invulnerability and invincibility described by some authors (Courtenay, 2000a; Galdas et al., 2005) is related to the fact that men try to minimize or normalize their pain. In this context de Keijzer (1997) uses the idea of "hombre como factor de riesgo" ["Masculinity as a risk factor"] to refer to some situations in which Mexican men are involved; these situations are the product of the gender roles culturally assigned to them that often relate to risk-taking behaviour, such as drinking alcohol or involvement in violent events, in which they put not only themselves at risk, but also their families. Men experience this “gender mandate” related to being invulnerable, which brings as a consequence the "vulnerability of the masculine gender", as defined by Barker and Greene (2011), who point out that men's health needs would be shaded by all these male behaviours associated with being the "strong sex" that prevent men from showing themselves as being fragile.

Consequently, the macho maxim of “strength in silence” (Banks, 2001) influences men’s decisions in seeking help when necessary. Men tend to delay seeking help until the occurrence of a health crisis or a particular incident (Addis & Mahalik, 2003; Cameron & Bernardes, 1998). Some reasons given by men for delaying going to the doctor for as long as possible are: “they did not want to waste the doctor’s time”, and “work or family responsibilities mean they had no time to deal with minor illnesses” (The Coalition on Men and Boys, 2009, p. 99). In this context, men are more likely to use emergency services (Galdas et al., 2005), and they typically do not use preventive health care (Mahalik et al., 2007). This situation is especially complex, because, in some cases, timing of seeking care can be a central factor for the success of the disease treatment.

As a complement of the “absence” of men in healthcare centres, health systems generally have not offered alternatives to motivate men to consult about their health. Even more, “men receive significantly less of doctor’s time in medical encounters than women and men are provided with fewer and briefer explanations” (The Coalition on Men and Boys, 2009, p. 86). Moreover, “…waiting rooms display all the propaganda of women’s and children’s health, but there are few if any examples for men” (Banks, 2001, p. 1059). Therefore, sometimes men do not feel welcome in healthcare centres.

The issue of mental health is even more problematic, because the possibility of a mental disorder, such as depression, represents a disruption between masculinity and identity
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(Galdas et al., 2005; Oliffe & Phillips, 2008; Sixsmith & Boneham, 2002). “Many men appear to have negative attitudes towards emotional expression” (The Coalition on Men and Boys, 2009, p. 99). A man who has a mental problem is a weak man: “mental illness was seen much more in terms of weakness than was a physical ill health, and for these men weakness was not an acceptable masculine status” (Sixsmith & Boneham, 2002, p. 55). The pressure from peer groups could be especially strong in this area, because mental problems are associated with feminine characteristics (Sixsmith & Boneham, 2002; Sobralske, 2006). In terms of the traditional notion of masculinity, the mental health needs of men are simply not an issue (Adams, 1997).

In the context described above, it is established that men’s health is a complex field. Currently, however, the understanding among health professionals of how men’s health connects to men’s socialization, and to risk taking and health seeking behaviours, is underdeveloped (The Coalition on Men and Boys, 2009). Banks (2001, p. 1060) claims: “Many myths surround men’s health, the greatest of which is that men do not care about their health. The fact is that men worry about health but feel unable to talk about their concerns or seek help until it is often too late” While most studies about men's health emphasise gender as a causal variable of the men's health behaviour, there are factors associated to the social context that could help the understanding of men's relationship with their health and with health systems. As I mentioned in the previous Chapter (Chapter 2), the Chilean health system does not offer health programs tailored to men. In this context, to emphasise gender as the only variable which influences men’s health behaviour is a mistake; Macdonald (2006) refers to the literature that does not give sufficient emphasis to the social context of men as reflecting a perspective of "blaming men". In the next section, I present three studies made in Latin America, which consider the social context for the understanding of men's health.

3.3.2. Hombre Latino and Health

Traditionally, studies in Latin America associated with masculinity have focused on specific topics such as substance abuse, domestic violence, or parenthood (Olavarría, 2009). However, the literature review conducted for this research has revealed three works conducted in Nicaragua, Mexico, and Puerto Rico, which provide important information regarding how Latin American men perceive their own health and adopt behaviours related to their own care. Considering the high relevance to the present study, and because no other
such studies of Latin American men’s health have been located, each of the three studies is reviewed in detail.

3.3.2.1. Nicaragua: An Ethnography of Rural Men

The aim of Ross’s study (2000) was to explore the cultural meaning of health and well-being among Nicaraguan men in relation to their general lifestyle and worldview. In this context, the research questions were: How do rural Nicaraguan men define health and well-being? What are the variables that influence health and well-being of rural Nicaraguan men? Finally; What are the self-care behaviours of rural Nicaraguan men related to health and well-being? The data collection included the use of field notes, participant observations, and semi structured interviews. Ross interviewed 20 Nicaraguan men between 19 and 61 years old, most of whom were married (70%).

The findings of the study were divided into five themes: (1) Health is believing that one will be cared for by God; (2) health is defined as being able to function and meet responsibilities for themselves, their family, and the community. Health and well-being are seen as a function, health, as not being ill; (3) health is comprised of five dimensions for Nicaraguan men: spiritual, physical, mental, family, and community; (4) economic, environmental, employment and worldview factors guide the health care practices of rural Nicaraguan men; and finally, (5) health is maintained through enduring the hardships of poverty.

Respondents recognized that the roles within the family are very important. Fathers work to provide for family, and mothers provide care for father and children. In this context, it is the duty of men to stay healthy for work. “Health is knowing your body and being able to recognize symptoms that prevented you from working” (Ross, 2000, p. 76). The methods used by Nicaraguan men to stay healthy, are to have faith in God, try to be peaceful and stay out of trouble, seek help from health services when very sick, eat well, and use natural medicines, such as herbal tea, to prevent diseases. None of the men surveyed indicated that they had regular health checkups for disease or for health promotion purposes. However, they did try to prevent illness using natural medicine. Natural remedies are an important component of health for Nicaraguan men, and many of them told the researcher that they believed in Curanderos (natural healers).

Another finding was the importance given by men to the process of the endurance related to hard work and sacrifice without complaint. A man must be able to endure pain.
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This belief has important implications. For instance, men stated that early symptoms of disease are ignored until performance is damaged; this can be very detrimental to health considering the importance of early diagnosis for the success of some treatments.

The main conclusions of Ross (2000) are that God is an important referent in the Nicaraguan culture. The men in the study really believed that God would provide them with strength to function or endure. Moreover, the concept of health is understood as being able to carry out responsibilities. Men see health care as a process of sick care. Those beliefs have multiple implications for health behaviour and health care, and according to Ross, health professionals should be aware of these cultural beliefs in order to design effective strategies to meet the needs of this group.

3.3.2.2. Mexican Men: Health Care Seeking

Sobralske (2006) presented an ethnographic study with the purpose “...to explore and understand health care seeking beliefs and behaviours of Mexican American men living in south central Washington” (Sobralske, 2006, p. 129). According to Sobralske, men have unique health beliefs, values and practices related to their gender. In the Mexican culture, a man must be healthy, and this means to be free of pain and able to work. “They [Mexican men] are culturally obligated to endure pain in the performance of their duties. The ability to endure pain stoically is valued, esteemed, and reflects inner strength, and men commonly tolerate pain until it becomes extreme” (Sobralske, 2006, p. 130).

The research questions raised by Sobralske were: How do Mexican American men define health and illness? What is the health care seeking process of Mexican American men? What kind of health care practitioners, including folk practitioners, do Mexican American men seek for health care and for what reason? And finally, do Mexican American men seek help from family and friends for their health problems?

An ethnographic methodology was used to answer these questions. The study was developed in a natural setting where people live and share their culture. As in Ross´ research (2000), data collection methods included: participant observation; participant interviews (initially eight participants were selected to interview and, after this first approach, 28 adult men and women were interviewed). In addition, the study included the revision of; ethnographic documents, cultural artefacts, and assessing acculturation, including census data, statistics that depict health trends, historical data, and geographic and topographic maps.
The findings of the study were divided into four categories: (1) The identity of manhood in Mexican American culture dictates health care seeking. Machismo is a natural part of life; hence, men are expected to exhibit behaviours in accordance with the macho role; (2) good health means being able to be a man. Men must be able to work; they must be strong and able to endure pain; (3) illness means not being able to be a man, illness means a man has nothing; and finally, (4) men seek health care when their manhood is threatened or impaired. Men go to the doctor as a last resort, and usually women (wives, mothers, sisters or daughters) influence men’s decision to seek health care. In addition, men mainly seek allopathic health care (healers) before going to health services.

SobralSke established that, in the case of Mexican Americans, the male gender definitely influences health care seeking and that men’s beliefs are a reflection of their culture and society. The author suggested that an important finding in this study was the influence of women in men’s health. This finding could influence the health professional’s actions since they could possibly work directly with women in promoting men’s health. The author emphasised the importance of continuing to research the relationship between gender and health in different cultures and places.

3.3.2.3. Puerto Rico: Masculinity Construction and Perception of Health

The purpose of the research by Felicié (2007), was to study the construction of masculinity and health perception in a group of Puerto Rican men. This descriptive exploratory study used a mixed design with two phases. The quantitative phase involved the issuing of self-administered questionnaires to 200 men. The qualitative phase consisted of carrying out in-depth interviews with nine men. The total sample was composed of men over 18 years of age, with an average of 37 years of age, all of whom were urban residents in Puerto Rico, and more than half of them had achieved a tertiary level of education.

The results suggest that men’s health beliefs are associated with masculinity. Men perceive themselves as very healthy, stating that they are very sick less frequently than women, and therefore they have less need to visit the doctor. The field of health is presented as a scenario in which men demonstrate their masculinity, a place where men are presented as strong, showing apathy towards self-care.

According to Felicié (2007), health beliefs associated with masculinity are a barrier to health promotion and disease prevention programs. Therefore, there is a need to develop
health interventions that are responsive to the beliefs and behaviours associated with the male gender.

Based on the findings of these three studies, it is possible to establish that the field of health becomes a stage in which Latino men demonstrate their masculinity. Common findings in the ethnographic studies, conducted both in Nicaragua and Mexico among rural and urban populations respectively, were that the phenomenon of the endurance of pain in order to fulfil the responsibilities of work, and also the importance of faith associated with health, either in God, or in the efficacy of folk medicines and/or traditional healers.

**3.3.3. Gender, Masculinity and Machismo**

Gender roles can be defined as social constructions that occur in a particular culture and relate to expectations about behaviours of men and women (Barker et al., 2007). All societies have cultural norms of gender, making up a scenario in which gender becomes a form of social order (Connell, 1995). In this context, conceptualizations about what it means to be female or male in any social group are fundamental to gender roles in those societies. Thus, gender roles would consist of a series of attributes and functions that go beyond the biological distinctions that are awarded to men and women during the socialization process. In this context, masculinity could be defined as a set of attributes, values and functions concerning men in a given culture.

**3.3.3.1. Masculinities in Latin America**

According to Olavarría (2009), an influential author on the subject of masculinities in Chile, gender studies in Latin America have had to analyze the phenomenon of masculinities as being associated with machismo and marianismo, two expressions of gender identity that interact with each other and that have prevailed from the time of Spanish colonization in the region. The phenomenon of machismo is understood as the obsession of men for domination and virility, associated with the idea that men are superior to women in biological, sexual, intellectual, and emotional aspects (Gissi, 1978). Men are expected to exhibit behaviours that are considered masculine or macho (Sobralske, 2006). Marianismo is understood as the female counterpart of machismo, highlighting values associated with motherhood and family care, and in a submissive role to men. The origin of the concept is associated with the Virgin
Mary, which, for many Latin Americans, is an important reference within the Catholic Church, as it represents the sacred image of a woman-mother who is willing to give everything for her family and her children (Montecino, 1996).

Each of these concepts, **machismo** and **marianismo**, has their roots in the era of Spanish colonization. The man, represented by the figure of the conqueror or defender of the territory, was to be aggressive and strong, in order to fight with his opponent. Women often remained alone at home, caring the family and children who grew up with the figure of an absent father, where boys were called to take the place of “El hombre de la casa” [man of the house] (Montecino, 1996; Olavarría, 2009). The concept of machismo in Latin America still has widespread use; it is reflected in the daily use of the concept among the people, and in the incorporation of **machista** phenomenon in research into masculinities (Olavarría, 2009).

Historically, there has been a view in Latin America that it is the man who leaves the house to fight or to work, and the wife stays at home caring for the children. Work then, is strongly associated with male identity. The body is also associated by men with masculinity, because the body is seen as a working tool (de Keijzer, 2003). The phrase "hasta donde el cuerpo aguante” [as far as my body can resist] is a common phrase which means that the strength of the body is exploited by men at work until they cannot work anymore. This is reinforced by the provider role that has, historically, been assigned to men. The construction of male identity is associated with work, and the body is experienced as an instrument that allows the implementation of gender role. According to de Keijzer (2003), self-care related to health is almost non-existent in the socialization of Latin American men.

Currently, the main emphasis of research in Latin America is on how masculinity is associated with sexuality, reproduction, parenthood, sexual diversity, work and domestic violence. According to Olavarría (2009) in current studies there is agreement among researchers that masculinity cannot be defined outside the context of the socioeconomic, cultural and historical contexts in which men are embedded. In today’s world, the consideration of historical context is of great importance; this is due to the fact that the re-distribution of tasks between men and women associated with the incorporation of women into the paid work force, requires the renegotiation of the social contract between genders. The review of the "traditional" masculine and feminine identities for men implies the review and re-formulation of what is supposedly in their “nature”: their ability to be protective, their ability to provide financially for the family, and their fatherhood (Olavarría, 2009).
3.3.4. Construction of Masculinity and its influence on Men’s Health

Courtenay (2000a, 2000b) emphasizes the contribution of the constructivist paradigm in the study of men and their health; this is a paradigm that highlights the role of culture in socialization processes. According to Courtenay (2002), studies of gender role have recognized five phenomena that characterize masculinity as a social construct, which reflects the constructivist paradigm:

(1) **Diversity of masculinities.** Masculinity is developed as a product of the social interactions in a given culture, and each culture assigns unique values to gender roles. Therefore, there are multiple masculinities, as many cultures exist. Moreover, within the same culture, there are differences between men in the way in which they each perceive masculinity, differences that would be associated with their social class, their work, or their ethnicity. Even when living together in a same social group, men express their masculinity in different ways.

(2) **Masculinities as social structures.** Masculinity is a pattern that can be observed in the behaviour of each individual, and it reflects a social order that guides interactions between people. Furthermore, this pattern can be observed in the management of institutions such as governments, corporations or health systems.

(3) **Masculinities as dynamic structures.** Masculinity is a changing and dynamic process. A man may behave differently in different situations and contexts. For instance, he may believe it is inappropriate to cry at work or in front of his friends, but it is appropriate to cry at home in the presence of his wife. In the same way, men’s belief about manhood can change over time.

(4) **Men’s agency.** Gender socialization is not something that just happens to individuals. Individuals are actors or active agents in the construction of those roles. Men are not passive victims of a socially prescribed “male role”; they can choose how to experience their masculinity.

(5) **Critical analyses of essentialist assumptions about gender.** Just because male and female reproductive organs differ, there are no essential differences between women and men. Gender socialization is a complex phenomenon that must be analyzed incorporating cultural differences and historical evolution.

In addition to the five phenomena described above, Courtenay (2000a, 2002) suggests that, in the process of gender construction, every society has certain **stereotypes** associated
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with the image of man and woman. These stereotypes can be defined as people's beliefs about some "typical" characteristics of being male and female. However, although men and society share certain ideas about what it means to be "male", they can act in different ways. For instance, men can agree that an important characteristic of being male is to be strong, but the way in which each man shows his strength differs for each individual man. From this point of view, each man uses different strategies to demonstrate his masculinity, and uses different scenarios of social interaction to reaffirm his manhood.

Analysis of the way in which a society constructs gender roles is important because it directly affects people’s health, for both men and for women. “Although many sociocultural factors are associated with health behaviour, gender is among the most important” (Courtenay, 2000b, p. 4). From his studies on men in the United States, Courtenay (2003) summarised key determinants of the health and well-being of men and boys; these can be grouped into four areas: behaviours, health-related beliefs, factors that influence health behaviours and beliefs, and health care.

Regarding men’s behaviour, they have less healthy lifestyles than women, in terms of their daily diet, stress management, and care of their own health. Added to this is the tendency towards risky behaviour, such as use of alcohol and other drugs, reckless driving, and engaging in violent episodes in which they can be both victims and aggressors.

Moreover, some of the values associated with masculinity appear to influence the health beliefs of men. For instance, the belief that men are the stronger sex leads them to believe that they cannot show weakness or ask for help when it is needed. When men are asked about their health, they tend to say that this is either, excellent, or very good, and they report fewer symptoms than women. In fact they only report symptoms and use the health system when they feel extremely unwell. Additionally, the perception of invulnerability is a strong belief in men who are not perceived to be in a state of risk in regard to their health; therefore, they do not regularly attend prevention or promotional health’s programs.

Among the factors that influence health behaviours and beliefs, Courtenay (2003) lists some socio-demographic indicators, and he mentions the influence of major social institutions, such as the mass media (television or cinema). Regarding the socio-demographic indicators, marital status, for instance, is important, since it has been found that single or widowed men have worse health indicators than married men; this is because the influence of wives in health care makes a difference. According to Courtenay, it is often women who convince men to seek care for their health problems, and it is women who generally accompany them to healthcare centres. Courtenay finally analyzes the influence of health
systems in the construction of masculinity, and in the way in which men face caring for their own health. The author refers to the lack of opportunity for working men to attend health services because of healthcare centre schedules, the tendency of some health professionals to link gender health with women's health, and the tendency of some health professionals to provide more information to women.

3.3.4.1. Hegemonic Masculinity

In recent years, internationally, studies on masculinity have been influenced by the work of Connell and colleagues (Connell, 1995; Connell & Messerschmidt, 2005), who have established the concept of Hegemonic Masculinity. Hegemonic masculinity is defined as an ideal form of masculinity at a time and place, a dominant social construction of gender that subordinates femininity, and even other lower forms of masculinity, thereby shaping social relations between men and women. In this model of power relations, the subordination of women is a way of legitimizing patriarchal power (Connell, 1995).

According to Connell (1995), hegemonic masculinity is not a stable construct with essential qualities. On the contrary, it is the masculinity that occupies the hegemonic position in a given model of gender relations, a position that is always contestable, allowing the existence of multiple masculinities within each culture and social group. The emergence of a hegemonic masculinity in a particular group would be conditional on the existence of four elements: hegemony, subordination, complicity and marginalization. The concept of hegemony refers to the cultural dynamic by which a group demands and holds a leadership position in social life, exalting one form of masculinity over others. The subordination is understood as the domination or oppression of certain groups in society, creating a hierarchy in which women would occupy an inferior position to men, and that also, within the group of men, there would exist internal hierarchies, positioning men "not male" in lower categories. Complicity is understood as an implicit agreement among men regarding the hegemonic project, because although the total number of men rigorously practicing the hegemonic pattern appears to be reduced, men in general get a dividend from patriarchy in terms of honour, prestige and right to rule. Finally, marginalization is defined as the relationship that exists between masculinities and dominant classes; for instance, in societies where there is a white dominance, black masculinities occupy an inferior place in the social hierarchy.

Recently, Connell and Messerschmidt (2005) reformulated the concept of hegemonic masculinity, incorporating new elements. According to these authors, two elements must be
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retained from the original formulation of the concept: (a) The combination of the plurality of masculinities and the hierarchy of masculinities; this means that certain masculinities are more socially centralised or more associated with authority and social power. (b) The hegemonic masculinity historic character, as a process of constant construction and reconstruction; this allows the dominant masculinity to change over time.

A reformulated element is the understanding of the gender hierarchy that was initially understood only in terms of a single pattern of power, which is the global dominance of men over women. Currently, Connell and Messerschmidt argue that there would be a reciprocal influence of masculinities on each other, allowing that the hegemonic masculine pattern may change by incorporating elements from non-hegemonic patterns (such as women or non-hegemonic masculinities). According to the authors, both incorporation and oppression can occur together; “...the understanding of hegemonic masculinity needs to incorporate a more holistic understanding of gender hierarchy, recognizing the agency of subordinated groups and the mutual conditioning of gender dynamics and other social dynamics” (Connell & Messerschmidt, 2005, p. 848).

Another element incorporated in the recent revision of the concept is the geography of masculinities. The incorporation of this element is in response to the multiplicity of realities that have occurred in different geographic locations; all of which are special and unique and which, at the same time, can influence each other by phenomena such as globalization. “Regional and local constructions of hegemonic masculinity are shaped by the articulation of gender systems with global processes” (Connell & Messerschmidt, 2005, p. 849). Therefore, hegemonic masculinities can be analysed at three levels: (a) local, constructed in the fields of the interaction of families and immediate communities; (b) regional, which represents the culture or the national values; and (c) global, constructed in transnational arenas.

Furthermore, authors employ the concept of social embodiment. Bodies are actively involved in social processes. The body is not only an object within social practice; it is also an agent in social practice. In a recent study conducted with men aged 18-21 living in London, De Visser, Smith, & McDonnell (2009) showed photographs of “famous men” to groups of men from different socioeconomic levels and, based on physical appearance, they determined whether the pictures represented "masculine" men. Participants were able to differentiate between muscular men who appeared in a "male" activity such as playing sport, and muscular men who participated in a "female" activity such as modelling. Based on that, they could establish a hierarchy relating to who it was that was shown to be more masculine.
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One of the findings was that regardless of socioeconomic level, all men agreed on which photos and which bodies seemed to be, either, more, or less, masculine.

Finally, through the discussion of the *dynamics of masculinities*, the authors analyzed the internal complexity of masculinities, recognizing that there may be internal contradictions in the practices, that is, contradictory desires or emotions. “Without treating the privileged as objects of pity, we should recognize that hegemonic masculinity does not necessarily translate into a satisfying experience of life” (Connell & Messerschmidt, 2005, p. 852)

In summary, hegemonic masculinity is a complex construct, which can be understood as a pattern or practice that defines social interactions based on gender roles, incorporating the body as an important element in social exchange. This concept supports the theory that there are a combination of the plurality of masculinities and a hierarchy of masculinities, incorporating a holistic understanding of gender hierarchy, in a system that allows the analysis of the diverse geographic realities.

3.3.5. Bourdieu’s Social Theory and “La Dominación Masculina”

The social theory developed by Bourdieu (1977, 1990) offers a theoretical lens through which to analyse people’s interactions among themselves, as well as their interactions with the various social institutions. The concepts of Habitus, Field and Capital are central to the understanding of his theory. Habitus refers to all the personal characteristics of each subject, which have been acquired unconsciously throughout his/her life. In this way, Habitus includes values, beliefs, and ways of thinking and feeling. In the words of Bourdieu, Habitus is described as “…systems of durable, transposable dispositions, structured structures predisposed to function as structuring structures, that is, as principles of the generation of practices and representations” (1977, p. 72). The field is the social space occupied by the different social agents, which can be represented by institutions, for example political institutions, or a space not delimited physically, such as religion. “Fields refer to a structures system of social positions occupied by either individuals or institutions engaged in the same activity” (Thorpe, 2010, p. 181). Subjects develop a habitus and interact in various social fields; “…fields shape the structure of the social setting in which habitus operates” (Coles, 2009, p. 35).

Each social field has implicit and explicit rules, and subjects interact in these fields through the exchange of Capital. Capital is understood in Bourdieu’s theory as a source of social exchange, a resource that is desired by the social subjects, allowing the interaction
and/or social advancement in different fields. Capital may be of different origins, for instance, the economic capital that refers to financial resources; the physical capital that refers to the attributes of the person’s own body; and the social capital, which refers to social networks, for example. The possession of a valued capital at a particular field gives power to the subjects. In this way, each subject is owner of a habitus that begins to form from early childhood in interaction with their social environment, which is composed of various social fields. The subject learns how to interrelate in those fields, and also learns how to generate the capital needed to interact and access the different benefits of the different fields.

Some authors understand gender and masculinity as a social field (Coles, 2009), postulating that masculinity has its own rules and desired capital that would allow the interaction of the subjects. However, for many other authors, masculinity and gender would be part of the habitus of each subject, rescuing the subjective experience of gender roles (Thorpe, 2010). In this study, I consider the gender and masculinities as part of the habitus of the individual, understanding that the experience of the gender is unique to each person and also has a major influence on the experience of each subject in the social interaction that occurs in any field (e.g. family, health and work, in the case of the present study).

Through an ethnographic study of the Kabyle society, a Mediterranean ethnic group, Bourdieu undertook an inquiry into the sexual order centred on male domination which, according to the author, would be present in all societies and in all institutions (Bourdieu, 2000). According to Bourdieu, the reality of the social order can be understood through what he called "the paradox of the doxa". The word doxa is a Greek word which means opinions or beliefs that are assumed by a group (Oxford Reference Dictionary, 2005). “The paradox of doxa” is a concept used by Bourdieu to explain the nature of the social order. The established order, with their relationships of dominance,, is unquestioned in our society and assumed as normal and natural, and masculine domination is a good example of such kind of domination/submission (Bourdieu, 2000). The division between the social status of men and women seems to be in the natural order of things. The domination turns into a lifestyle that is accepted and validated by the whole society. In this way, the social order that gives to the group of men the status of domination does not require justification; the biological difference between men and women appears as the natural justification for the difference between sexes, emerging in the concept of embodiment as the social construction of the bodies.

The body, with its movements and its appearance, is immediately affected by their social significance (Bourdieu, 2000). Therefore, the identity of gender is always a body identity. The experience of one’s own body is part of the social interaction; there would be an
order established according to the difference between the sexes. The body of men would be destined for public sphere, through the work and production, and the body of women would be destined for reproduction (Esteban, 2004). Within this order, a man may acquire physical capital by demonstrating his virility through force and capacity for work.

However, Bourdieu established that the apparent male privilege sometimes turns into a trap, since men are forced to increase their honour, to prove their masculinity and their virility in front of other men and the whole of society, which requires a constant effort. In this way, the virility necessarily has to be validated by others. These beliefs and behaviours begin to form part of the habitus of each subject; “the masculine domination is embodied and reproduced in the habitus of individuals” (Thorpe, 2010, p. 179). Those subjects must adjust their behaviours and beliefs to the ideal masculinity delimited by each culture or social group. Understanding masculinity and gender as part of the habitus that influences the social practice, not only of men but of all individuals, allows an understanding of the subjective and dynamic nature of the experience of masculinities. The ideal male varies from group to group and from field to field, requiring all individuals to discover the keys to approaching the “ideal masculinity” in different social groups.

In synthesis, according to the different studies on masculinity developed by Olavarria, Courtney, Connell, and Boudieu, the study of gender and masculinity requires the analysis of the culture of each subject, since gender roles are socially constructed and are unique for each group or community. In this way, a multiplicity of masculinities could exist together in a same culture, with a diversity of values and requirements for each type of masculinity in accordance with each social group. Therefore, masculinities are flexible and dynamic processes, and are changing over time, and according to Bourdieu (Bourdieu, 2000), the ideals of masculinities also are changing in relation to the different fields.

In the context of this research, the experience of masculinity and the experience of the body itself (embodiment) have a particular relevance, since the way men understand and experience their body could influence their health behaviour. In addition, the concept of ‘field’ as defined by Bourdieu, allows an understanding of health systems as a field that has its own rules, which has its own valued capital, and its members in social interaction with each other. Considering the social determinants of health model (World Health Organization, 2007; 2008) gender in this research is one of the variables taking into account to understand the Chilean men’s health behaviour; incorporating the review of other variables such as access to health systems and health systems organization.
3.4. Summary

In this chapter, I have reviewed two broad topics that provide a framework for this research: (1) the encounter between the group of health workers and users/patients, and (2) the theory of gender and masculinities, including an analysis of its influence on men´s health. In the first part, I presented an analysis of the way in which cultural beliefs associated with health have a major influence on people’s behaviour. Each social group, including health workers, have specific cultural beliefs, and an awareness of these beliefs is crucial to understanding. The encounter between health workers and patients is difficult for that reason, since people of two cultural backgrounds meet, and together they must reach agreements and make decisions. In the second part, I discussed the phenomenon of masculinity and gender roles; this incorporating the notion of masculine domination, hegemonic masculinity, the concepts of machismo and marianismo used in Latin America, and the constructivist paradigm as an important background for understanding the relationship between masculinity and men's health. The findings of international studies about health research in men, including three studies in Latino populations, Nicaragua, Mexico and Puerto Rico, discussed in detail, are particularly relevant to the present study being among the few such studies of men’s health in Latin American populations. However, while these studies seek to explain men’s health behaviours, perspectives of the culture of health workers in regard to men, are not explained.

The identification of barriers and conflicts originated in the encounter of two social groups requires that both groups be heard, that both groups give their version about their relationship with the other. This study seeks to understand the phenomenon of men’s health describing: men’s perceptions about their own health and their relationship with the public health system in Chile, and health workers’ opinions and perceptions of men’s health. Currently in Chile there are studies that focus on specific issues related to male health, such as, violence or alcoholism; this study seeks to cover the phenomenon of health in a broader way, seeking to understand the relationship that men establish with their own body, what their motivations for their health, are, and how they meet some of the barriers that currently keep them away from the health system.

The way to approach the research subject requires an analysis about the nature of the studied phenomena. The themes exposed in the literature reaffirm the subjective nature of the object of this study. The understanding of health as a socially constructed concept and the experience of gender and masculinities, necessarily involves the subjectivity of each subject
in building different realities from his/her own subjectivity. In the following chapter (Chapter 4: Research Design), the paradigm that is the basis of this study, the constructivist paradigm - which considers the importance of the subjectivity of any approach to the reality - is presented and discussed in detail; in addition, the methodology and methods that have been used to answer the research question are outlined.
Chapter 4. Research Design, Methodology and Procedures

4.1. Introduction

The three principal constructs involved in this research are masculinity, health, and health care systems. By their nature these constructs are social phenomena, because they are embedded in the culture of which they are a part. Health is a human construct; “change the construct and you can literally change the behaviours, and therefore the health of an individual” (Lincoln, 1992, p. 377). The social, behavioural, or community oriented aspects of human health deserve an inquiry model that takes into account the multiple meanings that individuals may attach to their own health. The epidemiological approach commonly used in health policy does not consider these cultural elements, and does not focus on the needs of particular groups of men in regard to their health issues. Therefore, the framework of theory, the procedures, and the analysis of the research must take into account the social complexity of the field, in consideration of the most appropriate approach in order to answer the research question.

This chapter is divided into three parts. In the first part, I present the philosophical framework and the paradigm that are the basis of this research, positioning myself in the research, and discussing how constructivism and ethnography offer an appropriate framework to answer the research question. Reflecting on this theoretical context, I present the aims for this research. In the second part, I discuss the research procedures; these include: a description of the participants, recruitment strategies, methods used for the data collection process, strategies used for data analysis, and a reflection on the need for the rigorous approach that has been essential for the authenticity of the research. The reflection includes a discussion on the relevance of having the support of colleagues and people from the community to ensure that research strategies are culturally sensitive and appropriate. In the last part of the chapter, I present an analysis of the ethical implications of this study.
4.2. Philosophical Framework: Constructivist Paradigm

The problem that this research aims to address arises from a personal concern, as outlined in Chapter 1, concerning the context of health care. As a health worker it was always difficult for me and other colleagues to understand why men appeared to keep away from healthcare centres, what their motivations and health related needs were, and why the relationship of health services with women was always easier and closer. Commonly, the information that health workers have about the population comes from national statistics: these provide an epidemiological profile of the population. It is from this profile that certain health strategies have been designed. In the instance of men as a group, as a health worker in Chile, I had been conscious of the areas on which I needed to focus; these included in particular the early detection of chronic conditions and the promotion of a healthy lifestyle. Nonetheless the following problems persisted; knowing how to start a dialogue with this group, how to get to know them, the way in which to ascertain what they wanted and thought and to understand how health workers relationship with men could be strengthened.

In developing a research design that seeks to respond to these concerns, a consideration of the philosophical framework has allowed me to look into these issues, understanding the social nature of the research question. When I decided to approach this problem from a qualitative research perspective, reflections necessarily emerged concerning the philosophical assumptions involved. A study that approaches men’s health as a social phenomenon must consider the multiple experiences of the members of a social group, their multiple perspectives, and the different ways in which members make sense of their own health. In this context there is no single experience or reality, no one truth; each group member has their own perspective, and the study of this social phenomenon requires the consideration of the multiple realities coexisting in this social group. The answer to the philosophical question emerges from the reflection of those multiple realities.

In the next table (Table 4), based on Table 2.1 in Creswell (2007b, p. 17), I present a summary of the five philosophical assumptions that are related to my choice of answering the research question from a qualitative approach. These assumptions have practical implications for the research design and research procedures.
Table 4: Philosophical Assumptions and Implications

<table>
<thead>
<tr>
<th>Philosophical Assumption</th>
<th>My Assumptions</th>
<th>Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ontological</strong></td>
<td>Reality is subjective and multiple, as seen by participants in this study, and interpreted by me in the data collection and analysis processes. The multiple perspectives produce as many “truths” as individuals involved in this study.</td>
<td>Quotes and themes are presented in the words of the participants, and I provide evidence of their different perspectives. At the same time, I discuss my own reflections and my interpretations of those perspectives.</td>
</tr>
<tr>
<td><strong>Epistemological</strong></td>
<td>It is possible to understand what is involved for people by spending extended periods of time in their setting, participating, talking to people, and observing what goes on.</td>
<td>I try to be as close as possible to the participants, spending time in the field, and using different methods to approach the reality of the social group.</td>
</tr>
<tr>
<td><strong>Axiological</strong></td>
<td>As a researcher I recognize that research is value-laden, that biases are present, and I discuss them.</td>
<td>I actively discuss some of my own values, including my own interpretation in conjunction with the interpretation of participants.</td>
</tr>
<tr>
<td><strong>Rhetorical</strong></td>
<td>Since this study represents my interpretation and my construction of reality, I use a personal voice. The writing needs to be personal.</td>
<td>I use the first-person pronoun, and I use the words used by the participant to explain the phenomena.</td>
</tr>
<tr>
<td><strong>Methodological</strong></td>
<td>I use inductive logic to study the topic within its context. Considering a flexible approach to stay close to the research problem, including different methods: participant observations, interviews, and one focus group.</td>
<td>I work with details before I describe general ideas, describing in detail the context of the study, and revising questions from experiences in the field.</td>
</tr>
</tbody>
</table>
The inquiry paradigm or worldview that guided this research has emerged in the context of the analysis of these philosophical assumptions. The constructivist paradigm informs the design of the research, a paradigm that represents my beliefs and which guides my actions and procedures.

4.2.1. Constructivist Paradigm

The way in which a health care system establishes priorities and procedures is a consequence of the definition of health in a specific culture; “human health is intricately tied to the dreams, hopes, attitudes, values, beliefs, and understanding of individuals; all of those characteristics form a part of what we call culture” (Lincoln, 1992, p. 388). Because of that, the study of these constructs must consider cultural aspects, and at the same time must be flexible in order to incorporate the possibility of multiple definitions of the concepts. In this context, constructivism provides an appropriate framework for the study of the relationship of Chilean men to their health and to the Chilean public health care system.

By definition, constructivism seeks to undertake research in a natural setting (Appleton & King, 2002). It aims to understand the variety of constructions that people possess, trying to achieve a consensus of meaning, but always being alert to new explanations with the benefit of experience and increased information. These constructions endeavour to help people explain and make sense of their experiences (Creswell, 2007b). According to this paradigm, people give meaning to reality, events or situations through a complex process of social interaction (Lincoln, 1992; Lincoln & Guba, 1985). Indeed, many means of knowing can exist together, and a variety of views may emerge during naturalistic inquiry (Appleton & King, 2002; Lincoln & Guba, 1985).

For the constructivist paradigm, the nature of reality is relativist, meaning that realities are socially constructed; “reality is actually realities, which exist in the form of multiple mental constructions that are socially and experimentally based” (Lincoln, 1992, p. 379). The realities are local, dependent for their form and content on the person who holds them (Lincoln & Guba, 1985). In a constructivist paradigm, the researcher is part of the reality that is being researched, and the methodology is interpretative and dialectic, involving a constant comparison of differing interpretations. The research focuses on people’s personal experiences, and these experiences are understood in their particular sociohistorical context.

According to Lincoln and Guba (1985) there are five principles of constructivism:
1. *Reality and its elements*. Reality is viewed as pluralistic, which means that within any research there will be different interpretations that can be made. People choose their reality individually and collectively, by interaction between an individual and a collective mind (Appleton & King, 2002). In this type of research each person’s experience and the context are considered valid, and incorporated into the emerging construction.

2. *Causality*. For constructivists, the concept of causality is ambiguous, simplistic and out of date, and it is impossible to establish the cause-effect progression in a complex social phenomenon, because all things influence each other. Furthermore, any construction that emerges from a qualitative inquiry may be seen as unique, for a particular set of circumstances may never occur again in exactly the same way.

3. *Unique contexts resulting in the absence of generalization*. Seeking generalizations is not meaningful when studying human behaviour. Therefore, findings are not static; constructions are created realities between participants and researcher, illuminating the understanding of similar situations.

4. *The relationship between the researcher and the phenomena under study*. As noted above, in the constructivist paradigm, study findings are the creation of the process of interaction between the researcher and participants. The researcher is a facilitator and co-participant in the inquiry process and the nature of the queries generates the way the phenomenon is constructed. Interaction continues with the dialectic process of data analysis, when the investigator seeks convergent and divergent points of view and explanations for any discrepancies.

5. *The impact of values on the inquiry process*. As I mentioned in Table 4, the values and preconceived ideas of the researcher always influence the inquiry design and process, and this situation is not seen as a disadvantage, because values are essential in knowledge creation.

These principles form the basis of this research, guiding the selection of research strategies and procedures, the interaction with participants, and the way in which the data has been analysed.

### 4.2.2. Positioning Myself: Triangulated Reflexive Inquiry

My self-construction as a field researcher in health is influenced by my cultural and academic background. I was born into and raised in a Chilean community with limited economic access; I lived all my childhood and youth in a neighbourhood close to where this
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research was conducted, attended public schools and public health services in Chile. I share a language, a common understanding and social background, with the participants. I am also a health professional, a clinical psychologist, a health researcher, and a graduate student. I am studying for my doctorate in an English-speaking country, in a different culture, with a supervisory team that has a different perspective and new points of view for analysing the research phenomena. My diverse roles and experiences allow me to switch my point of view from an *emic* or insider to an *etic* or external social scientific perspective (Fetterman, 1989).

My position is that of an insider from my social group membership: my language, my knowledge of the health organizations in Chile as a user of them, and my intimate knowledge of such a community; as a researcher, I am an outsider pursuing doctoral studies in New Zealand.

Triangulated Reflexive Inquiry

In qualitative research, usually a researcher is the main instrument for generating data, and in this study, I, as the principal investigator, was also the principal research instrument. One aspect of scientific rigour in a qualitative study is related to the researcher’s reflexivity during the process. Hence, the triangulated reflexive inquiry is of great importance before the data collection, since these reflections inform the selection of methods and data collection procedures (Patton, 2002; Srivastava & Hopwood, 2009).

*Self reflexivity*

After studying psychology, I worked in a public hospital, and there I had the opportunity to share experiences with health workers, who were constantly overburdened by their work and the demands of their patients. The staff working in the public health system had good intentions for improving, not only the way in which they worked, but also their relationship with the community. However, they had two problems: lack of time, and not knowing where to begin to make that change. In my experience at this stage, it was possible to appreciate the difference between men and women as patients; it was possible to see directly that men usually felt uncomfortable in the health system and specifically at primary health centres. During the four years prior to undertaking doctoral studies, I had the opportunity to work with disadvantaged Chilean men who belonged to the public health system, to interact with them in their communities, and to acquire some relevant knowledge about how to work with this group in a research setting. Through my experience, I came to
appreciate that the men were interested in receiving information relating to health, because they had health related questions and concerns. However, they were not eager to use the health care system, since they felt that this system did not offer a solution for their concerns. For instance, if they had domestic violence problems in their families, the system would assume that they were the aggressor, and in this case, they could receive support. Conversely, if they were the victim, the system did not offer an alternative.

My perceptions and experiences had an important role in this study, because my background and ideas influenced the way I approached the research design, the way I observed people, the way I interviewed people, and the way I formulated the questions. The findings of this study represent the histories of the participants, including my own.

Reflexivity about those studied

The participants of this study may be divided into two groups: Chilean men, and health workers, who are both part of the Chilean public health system. What did I know about these groups before data collection? As previously mentioned, I have had prior experience working with Chilean men, and I had already observed that whilst such men may usually be enthusiastic about participating in research projects, or other community activities, they will only participate if they feel comfortable with the conditions and are motivated to do so. In my experience, in HIV prevention groups, the men were enthusiastic at first, but then did not feel sufficiently motivated to continue participating. Another important aspect that I observed is that they behaved differently when they were in a group with other men; in the presence of other men they tried to be less sensitive, trying to be macho in front of their peers. Probably relating to the same situation, they appeared to feel comfortable talking to a woman in an interview situation; this is because usually, such men are used to establishing relationships of trust with their female friends, sisters, mothers and wives, and some men prefer to talk with women rather than men about their concerns (Sixsmith & Boneham, 2002). Furthermore, in my experience of working with health workers, I have observed they are always eager to participate in research projects if they understand the purpose and if they feel that the findings could be relevant for the population or in their own work. In regard to health workers engaging in research, the main concern is that their time is not wasted with “irrelevant” projects. I considered these aspects and experiences when seeking to establish a relationship with the participants, and I was open to any new situations that could emerge from this study.
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Reflexivity about the audience

The audience for this study and its findings can be divided into three groups: community and health workers, health policy makers, and other researchers. The language to present the findings in these different settings was adapted according to the audience. I presented the project’s findings in the specific community in which the study was developed, and at the same time, I presented a complete report to Chilean health policy makers. Finally, this study contemplates a dissemination phase focused on researchers and academics, and their feedback will generate further theoretical reflexivity.

The Triangulated Reflexive Inquiry, proposed by Patton (2002), as a way of thinking about the researcher’s own experience prior to the collection of data, offers the opportunity to understand and explain the antecedents of certain methodological decisions. The three aspects included in this reflection: my own experience, prior knowledge of the others (research participants), and the audience that I wanted to reach, illuminate the journey. The reflexivity process, which includes my own reflections, concerns and decisions, is also present in the following chapters.

4.2.3. Methodology: Ethnography

Ethnography was selected as an appropriate research strategy to conduct this study, because it is one of a range of methodologies reflecting constructivism principles. According to Patton (2002), ethnography makes it possible to answer the question: what is the culture of this group of people? The assumption is that any human group interacting together over a period of time will evolve a culture (Patton, 2002). Therefore, the ethnographer focuses on describing and interpreting the values, behaviours, beliefs and languages of a group which shares a culture (Creswell, 2007a). As I mentioned in Chapter 3, health workers and health users have their own cultures; therefore, an ethnographic approach allows a deep insight with which to analyse the phenomenon of men’s health from the interaction that occurs within different social groups: men and health workers.

The first step in this process is to determine if ethnography is the most appropriate design to answer a specific research question (Creswell, 2007a). This research question must reflect an issue or theme within a group requiring further study. The research problem guides the entire research endeavour (Fetterman, 1989), hence the importance of clarity in this first stage. The research design may begin once the literature pertaining to some of the issues and aspects relating to the group to be researched has been reviewed.
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By definition, ethnography is a qualitative approach which focuses its attention on the study of ethnos – a cultural group (Patton, 2002). Therefore, the central aim in ethnography is to provide an holistic insight into the perspectives and actions of a group of people (Savage, 2000), giving importance to their routine or daily life (Fetterman, 1989). This is exactly the type of information that allows an understanding of how men relate to their own health in their daily lives, and in interaction with their peer groups. The epistemological claim is that it is possible to understand what is involved for the people themselves by spending extended periods of time in the setting, participating, talking to people and observing what goes on (Parker, 2007).

According to diverse authors (Oliffe & Bottorff, 2006; Sobralske, 2006), men’s health is an issue especially influenced by cultural beliefs; for example, the meaning of pain, illness, or health, being associated with virility and manliness. Therefore, an ethnographic approach allows me to study this specific group, and to develop contextual cultural explanations concerning men’s health. In consequence ethnography, as a methodology, has been used as a tool for understanding a particular phenomenon in a group of men, their beliefs, perceptions and motivations in relation to their own health, and the relationship that they maintain with the public health system in Chile. Thus, ethnographic methods are employed in the area of community and public health, the field in which I, as a researcher, have focused my doctoral study. According to Wolcott (1994), ethnography, as a methodology that emerges from the anthropological discipline, can be used in other disciplines, setting the objective pursued and the research questions that guide the researcher's procedures. In this case, in consideration of my background as a health professional and as a doctoral student in the field of community health, my attention was clearly focused when undertaking the fieldwork.

4.2.3.1. Fieldwork

In ethnography, data collection is centred on fieldwork, which is the central tool of any ethnographic research design (Fetterman, 1989). In fieldwork, the most important element is being there and sharing the lives of people in the community for extended periods of time. Therefore, I was on site in the community in Chile for approximately seven months, from July 2010 to January 2011. The fieldwork was developed in two places: a soccer club in the community, a common place for men to congregate; and a primary health care centre close to this particular soccer club.
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My research procedures included, through fieldwork, the gathering of beliefs and perceptions of the men about their health. This information was complemented with the experiences and perspectives of health workers about the way in which men establish their relationships with the health care system (Figure 6).

**Figure 6: Research Stage**

4.2.4. Aims

In relation to the research question, the philosophical framework, the constructivist paradigm, and the ethnographic methodology, three aims were established for this research:

**Aim I:** To describe Chilean men’s perceptions of their health status and their health behaviours, and their relationship with the public health care system.

**Aim II:** To develop a model to explain the relationships between men and their perceived health status, health behaviours and access to health services.
Aim III: To inform the Chilean health system of the findings and implications of this study in relation to men’s health in Chile.

In consideration of the implications of this study, the inclusion of the final aim that goes beyond the research process and its outcomes has clarified my intent as a researcher to make the connection between health research and health practice, which is a central aspect in issues related to health development (Labonte & Robertson, 1996).

4.3. Research Procedures

4.3.1. Selection of the Study Site

Santiago is a city divided into Comunas - the Spanish word to denote a specific geographic area - (see Glossary), and each Comuna has a local government or Municipality. The Chilean Ministry of Health provides information in regard to some health indicators for each Comuna (Social Determinants in Health Department. Chilean Ministry of Health, 2010), therefore it is possible to ascertain which Comuna has the largest number of people belonging to the public health system, and what the major health problems in the community are.

For this study, I selected a Comuna in the south west area of Santiago. The selection of this geographical place was based on the knowledge that a majority of its residents belong to the public health system. Within that community, two groups were selected as participants: a soccer club and a primary health centre. Both groups inhabit a common geographical area in Santiago de Chile, and maintain a relationship each other. The selection of a soccer club was made in order to study men’s health perceptions and behaviours because this type of community centre is common in Chile and, according to the literature (Courtenay, 2000b), the area of sport is a major element in defining traditional masculinity. Additionally, the primary health centre is a place where this group of men are required to attend if they have a health issue, and for that reason it is a privileged place in which to study men’s health perspectives, motivations or needs.

4.3.2. Community Advisory Committee

During the course of the fieldwork, I kept in touch with another group of people; a Community Advisory Committee [CAC] that was composed of people outside the Comuna
that had been selected for the fieldwork. This CAC was formed at the beginning of the project for the purpose of advising me on research procedure. Collaborating with CAC facilitated broad community involvement and support, and ensured that all research strategies were culturally sensitive and appropriate (Reddy, Buchanan, Sifunda, James, & Naidoo, 2010). This committee also reviewed the preliminary findings and helped me to interpret meaning and implications.

The CAC was made up of:

– Four community leaders (one woman and three men). Usually Municipalities or local governments have information about community centres and leaders in the population; based on that information, these leaders were recruited from community centres that were other than the place (soccer club) where the participants (men) of this study had been recruited from, in order to protect the confidentiality of the identity of the participants.

– One primary health worker. This professional was recruited from a Primary Health Centre that was not the same one as that from which participants of this study were recruited.

– One academic adviser. This professional was recruited from a Chilean University – Pontificia Universidad Católica de Chile – and the criterion for inclusion in this CAC was that this professor has had experience of working with men in community settings. The role of the academic adviser was central for this research. We maintained supervision meetings throughout the entire process of data collection in Chile, the adviser assisted me with the preliminary data analysis, and she maintained contact with my New Zealand adviser. Additionally, as a bilingual professor, she assisted me with the translation of concepts from the Spanish to the English language.

During the course of the research, I had five meetings with the CAC (Table 5), and all the information obtained during these meetings was recorded in my field journal.
Table 5: Community Advisory Committee Meetings

<table>
<thead>
<tr>
<th>Meeting</th>
<th>Date</th>
<th>Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>July 21, 2010</td>
<td>Discuss the data collection instruments (interviews and focus groups), to assess whether the questions had been formulated in easily comprehensible language, and to include any suggestions about issues in relation to men's health that seemed be important to them. Additionally, we discussed certain issues regarding my entry into fieldwork.</td>
</tr>
<tr>
<td>2</td>
<td>August 30, 2010</td>
<td>Discuss the key themes arising from the first interviews with men, and assess the relevance of including other questions.</td>
</tr>
<tr>
<td>3</td>
<td>October 04, 2010</td>
<td>Focus group preparation, revision of the questions.</td>
</tr>
<tr>
<td>4</td>
<td>January 10, 2011</td>
<td>Discuss some preliminary findings prior to my return to New Zealand for the formal analysis. At that meeting we discussed some of the situations that had occurred during the fieldwork, and some of the issues emerging from the interviews and from the focus group.</td>
</tr>
<tr>
<td>5</td>
<td>September 5, 2011</td>
<td>After the thematic analysis conducted in New Zealand, we discussed the major findings. At that meeting I explained these findings, received feedback from CAC and, together, we discussed some of their implications.</td>
</tr>
</tbody>
</table>

4.3.3. Research Participants and Recruitment

In an ethnographic study participants are not persons or individuals: they are groups belonging to the same culture, and usually share a common geographical and social place. As the fieldwork comprised of two sites (a soccer club and a primary health centre), participants could be divided into two groups, a group of men belonging to the community, and a group of health workers.

a) Community Men. During the course of the fieldwork I kept in touch with a group of male members of a community association, specifically a sports club. All of the men who belonged to this soccer club took part in this study, since I, as an observer, was participating in a variety of club activities. A sub group of 23 men took part, either in an interview, or in a focus group. The inclusion criteria included; being a Chilean male aged over 18 years with access to health care through the public health care system, and having membership of a community association, specifically, the soccer club.
Chapter 4 – Research Design, Methodology and Procedures

Generally, a soccer club has 50-70 members who are over the age of 18 years. The members have periodic meetings, and the recruitment method for the study consisted of a presentation of the project to the whole group at one of the club meetings. On the occasion of that meeting the members were informed of the study and agreed to my participation in the club over the following months; male club members received an invitation to participate in an interview and/or a focus group, and were then given the options of directly contacting the principal investigator by telephone, by email, or during the meetings when I was working on participant observation in the club, in order to arrange a mutually convenient schedule and location., Men who participated in an interview or focus group received CH$ 2000 (NZ$ 5.00, US$ 4) to cover their transport expenditure.

b) Health workers. The fieldwork was also carried out in a primary health centre in which I conducted participant observations. Additionally, ten health workers from that primary health care centre participated in individual interviews. Inclusion criteria for participation in an interview were: working permanently at the primary health centre selected as the study site, and currently maintaining relationships with patients or users. In this way, this group was composed of health professionals and administrative staff. The Director of the primary health centre explained the research project to his health workers, and gave my contact details to potential participants.

The final number of interviews and focus groups was determined by the research question, and according to the appearance of new content; that is, once the themes started to become repetitive with no new information emerging, I stopped recruiting new participants (Patton, 2002; Pope, Ziebland, & Mays, 2000). This decision was taken in conjunction with the team of Chilean and New Zealand advisers, and with the support of CAC.

4.3.4. Methods

As indicated above, in an effort to include a variety of views and experiences from participants, the information came from different sources: participant observations, individual interviews, and focus group interviews. Triangulation of data from these sources, added to the information already available from preliminary studies, provided a rich understanding of the context of men’s health.
Participant Observation

Participant observation is the main method of data collection in ethnography. The researcher looks for an insider’s perspective in regard to social phenomena whilst establishing a close relationship with the community. Participant observation techniques are central to the study of a social group, since the researcher achieves a naturalistic perspective of the community. Therefore, research on social issues is carried out in a natural context. As mentioned earlier, I participated in the activities of a soccer club and a primary health centre for seven months. At the soccer club I took part in the daily activities of the group of men, sharing in their formal meetings, attending soccer games, and participating in certain group social activities; the presence of women in the soccer club is quite normal, wives or female friends of men are usually invited to social events, they bring food and participate in some activities. At the healthcare centre I focused on observing waiting rooms: the arrangement of furniture, posters, announcements, patients’ waiting times, and the patients themselves as they waited.

As several authors have mentioned, participant observation is a very flexible method (Lüder, 2004; Wolcott, 1994) which should be adapted to suit each community, according to the purpose of the research. My own perspective as observer was based on my role of researcher situated in the context of community health studies. According to Wolcott (1994), “...when observations are linked to a particular discipline or interest, one immediately gains a sense of direction and purpose...” (p. 160). Then, as a health professional observer, my interest was related to the opinions, perspectives, conflicts, and behaviour relating to Chilean men’s health.

Within this framework of health research focused on a specific group of people, I considered some of the elements described by Lüder (2004) regarding participant observations:

- **Making Contact.** Initial contact was made with the directors of both institutions who signed their approval to allow the participation of both institutions in the research (Appendix A). Observation, as a method, started at these meetings, since at the time both directors expressed their enthusiasm for participating, and gave me information about the community. With their authorization I began recording my observations at that time, taking notes about their comments and concerns regarding men’s health in the community. Both the director of the soccer club and the director of healthcare centre, acted as
gatekeepers and key informants in this research; this was crucial to the achievement of the acceptance and trust of both groups.

- **Entering the field.** My entry into the field was gradual. The first observations were aimed at describing places and interactions between participants, and progressively I began to interact with participants, asking about some situations and recording their views and comments. According to Reeves, Kuper and Hodge (2008), there are nine dimensions which are central in the description of any group: space, actors, activities, objects, acts, events, time, goals and feelings. Therefore, I focused attention on these dimensions which guided my attention, and then I described the group at different levels, in relation to the research question.

- **Establishing and maintaining a role in the field.** My role as participant observer in the soccer club was always in response to invitations from the group, including participation in formal meetings and social activities. I never attended the club at any other time on an unexpected visit, I always respected their space and I was present only when they felt comfortable with my presence. At the healthcare centre, since the observations took place mainly in waiting rooms, I selected a variety of differing schedules as periods of observation. My intention was to be there at different times, paying attention to any variation in the behaviour of users. For instance, I could observe whether the number of men in the waiting rooms was greater at certain times of the day than at others. According to Spradley (1980), as a participant observer the researcher moves among degrees of involvement. Considering those degrees, I took a passive role at the beginning of participant observations, describing the place and some of the interactions, and then moved from moderate to active participation, participating in the interactions of the field members.

- **Collecting and reporting data.** During deliberate participant observation, I recorded data using field notes, a field journal, and photography:

  1. **Field Notes.** Observations are not data unless they have been recorded in some way (Wolcott, 1994). The field notes that I wrote were divided into two types: notes on the fieldwork, and extended notes. The first type of record, notes on the fieldwork,
notes taken at community places, jotted-down notes - including words, phrases, or brief descriptions - written as a memory aid to the subsequent elaboration and expansion of the notes; these included a detailed description of certain situations that occurred in the field. During the seven months spent in the field, I was engaged in a total of 60 non-consecutive hours of participant observation; this resulted in written records in the form of expanded notes.

2. **Field Journal.** Throughout the data collection period I wrote a fieldwork journal in which I registered my experiences during participant observation, my perceptions after the interviews and focus groups, and my thoughts on my research as it progressed. As mentioned earlier, reflexivity is one of the key elements from the constructivist paradigm, and is essential in ethnography, since the construction of my perception of others arises from the reflection of my own experience. My record in the field journal was made in chronological order, and was separated into three sections: the fieldwork at the soccer club, the fieldwork at the primary health centre, and the information from meetings that I maintained with the Community Advisory Committee.

3. **Photography.** To supplement the field notes, I took some photographs to portray certain situations at the community. In words of Harper (2004), “...a text is never equivalent to the image, but the images by themselves do not communicate fully...” (p. 232). Therefore, I took some photographs, and, in addition wrote a description of the picture and the history that I wanted to represent with the image. I took a total of 14 pictures representing the various places within the community (Table 6).

<table>
<thead>
<tr>
<th>Place</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Soccer Club</td>
<td>4</td>
</tr>
<tr>
<td>Health Care Centre</td>
<td>7</td>
</tr>
<tr>
<td>Neighbourhood</td>
<td>3</td>
</tr>
</tbody>
</table>
Interviews

As an important complement to participant observation, ethnographic studies consider interviews with participants, which focus on the specific research topic. According to Fetterman (1989), “The interview is the ethnographer’s most important data gathering. Interviews explain and put in context what the ethnographer see and experiences...” (p. 47). Interviews allowed me a closer interaction with participants, considering specific aspects related to the phenomena of health and disease, and also allowed me to make sense of some observations in the field. The participant observations and interviews were conducted in parallel, and both methods interacted fluently: some of the elements emerged from participant observations to inform the questions for the interviews, while interviews allowed me to focus on certain topics during the observations.

I utilised semi-structured interviews, using open-ended questions with both the men and health workers (Appendices B and C). “An open-ended question allows participants to interpret it...” (Fetterman, 1989, p. 54), allowing a flexible interaction between the researcher and the participants. The questions were focused on the meaning of health and illness for men, and the relationship between men and the primary health care system. The answers relating to specific topics gave me a clearer view of the issues regarding health of the men in this community.

As a method that has the advantage of allowing more personal contact than that of other methods, and in order to deal with sensitive issues; the individual interviews with men allowed them to show themselves vulnerable and emotional, revealing feelings that I was unable to appreciate during participant observations or in the focus group.

Focus Group

One focus group was developed with men (Appendix C), with the aim of further exploration of the men's perceptions of health and their relationships with health services in the context of beliefs about masculinity and the situation of men in society. The social contexts for these perceptions and behaviours were also explored. Approximately 10 participants were invited, and five of them participated in the focus group.

In my previous experience in community work with groups of Chilean men, the information that was given to me in an individual interview could differ from the information that had been given to me during a focus group, mainly due to the presence of other men. For instance, working in HIV prevention, some men acknowledged their own risk in individual interviews, but not in presence of other men. For this reason, in this research project I
included a focus group, in order to observe whether the contents related to men’s health would change in the presence of other men. My intention, when planning the research, was to conduct one focus group, and after the review of its content, to possibly add a second or a third if it was necessary. However, the content given by the group of men at the first focus group, was very similar to that given in individual interviews, with the difference being that the narration of an emotional experience associated with health and disease was absent in the focus group. Therefore, in conjunction with my New Zealand and Chilean advisers, I decided to continue with individual interviews, since the main advantage was that during the interviews the men tended to talk more about their emotional experiences in relation to the process of becoming ill, they showed themselves as more vulnerable, and they clearly stated their needs; these were all aspects of the observations that did not occur during the focus group session.

The interviews and the focus groups were recorded digitally, and then transcribed verbatim. The written material from the transcribed interviews was a central element in the reporting of the findings (Table 7).

<table>
<thead>
<tr>
<th>Method</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men’s Interviews</td>
<td>20</td>
</tr>
<tr>
<td>Men’s Focus Groups (5 participants)</td>
<td>1</td>
</tr>
<tr>
<td>Health Workers’ Interviews</td>
<td>10</td>
</tr>
</tbody>
</table>

According to the procedures involved in this research project, the time the participants gave to the research depended on various strategies: the fieldwork took approximately seven months; therefore, the contact with people in the participant organizations was maintained during the whole process. Participation in interviews took approximately 50-90 minutes for each interview, and in the focus group was approximately 90 minutes.

4.3.5. Data Analysis

The analysis in an ethnographic study is an ongoing process that starts from the statement of the research problem, in which researchers analyze their experience and prior
knowledge of the group under study. In the words of Hammersley & Atkinson (1983), “...in ethnography the analysis of data is not a distinct stage of the research...” (p.174). The data collection strategies and the planning of my interaction with participants in the research process were designed based on the analysis of my own experience and knowledge of the research problem. As mentioned earlier, the fieldwork involved the use of different data collection methods; these included participant observations, interviews, and one focus group. This variety of methods is associated with the diversity of data obtained (Table 8):

Table 8: Variety of research data

<table>
<thead>
<tr>
<th>Method</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant Observation</td>
<td>Field Notes</td>
</tr>
<tr>
<td></td>
<td>Researcher Journal</td>
</tr>
<tr>
<td></td>
<td>Pictures (written history about the picture)</td>
</tr>
<tr>
<td>Interviews</td>
<td>Transcriptions</td>
</tr>
<tr>
<td>Focus Group</td>
<td>Transcriptions</td>
</tr>
</tbody>
</table>

All the data collected became written material. Field notes became extended notes, sorted by date; the field journal was also organized by registration date; and photographs were filed in chronological order with an account of each image. Interviews and focus group audio-recordings were transcribed *verbatim*. All of this material was electronically filed. Following the completion of the data collection and the organisation of all the written material, I began the formal analysis of the data for which I used a thematic analysis approach. According to Braun & Clarke (2006) “...the data needs to be transcribed into written form in order to conduct a thematic analysis…” (p. 87).

Ethnographic analysis progresses from lower to higher levels of abstraction, moving from the collection of raw data to the identification of common patterns and, eventually, to formulating major cultural themes (Sobralske, 2006). Therefore, the first phase of the analysis consisted of collecting, then describing and documenting, the raw data into a field journal. This phase also included recording interview data, observing what was happening in the research setting, identifying contextual meanings, and making preliminary interpretations.
I collected and analysed the data in Spanish with the support of CAC. Following this, the analysis was translated into English, with the support of my academic Chilean adviser, and with the aid of the International Student Support Group at the University of Auckland.

4.3.5.1. Thematic Analysis

Thematic analysis is a strategy for analysing qualitative data from an inductive approach. In the words of Braun and Clarke (2006), “thematic analysis is a method for identifying, analyzing and reposting patterns within data” (p.79). The main purpose of thematic analysis is to observe and describe the frequent, dominant or significant themes inherent in the raw data, establishing links among research objectives and findings in a transparent way (Thomas, 2003). The researcher has an active role in this type of analysis, identifying themes and reflecting on them. From the constructivist paradigm, in this research, my role as researcher was to identify socially produced patterns, and to describe the cultural themes relating to men’s health.

According to Thomas (2003), the use of thematic analysis requires the consideration of certain assumptions. First, data analysis is determined by both the research objectives (deductive) and the multiple reading and interpretations of the raw data (inductive). In this research, the analysis was guided by the research question and the aims; additionally, from an inductive approach, I was looking for emerging themes. Secondly, the primary mode of analysis is the development of categories from raw data that captures key themes. One of the first steps in the analysis was to read all the written material and to develop some categories and ideas concerning the data. Finally, the trustworthiness of the findings should be assessed, and one way to do this is to present and receive feedback from the participants in the research, or from users of the research findings. One of the strategies employed during the analysis was to present the findings to the CAC and to some of the participants in the study, checking to see whether the cultural themes represented the reality of the group. Following the consideration of this feedback some of the findings were complemented and re-analyzed.

In Figure 7, the process for this thematic analysis, based on, and elaborated from, Table 1 in Braun & Clarke (2006, p. 87), is explained:
The analysis process used is further elaborated on as follows:

1) **Analysis during the data collection.** A first step in the formal data analysis was undertaken on site, after the first four interviews with men and health workers. I checked the emergent themes in order to inform future interviews and to prepare for the focus group.

2) **Preparation of raw data files.** This involved the preparation of notes from participant observation, and transcriptions of interviews and the focus group. As mentioned earlier, field notes were ordered by date, and recorded interviews and focus groups were transcribed verbatim and converted into computerized transcripts. The recorded material was transcribed word for word and I replayed tapes at least twice to confirm the accuracy of the transcriptions; additionally, my academic Chilean adviser checked the first four transcriptions to verify the precision of the written material.

3) **Close reading of text.** As I worked on the transcription and on the preparation of field notes, I was very close to the data from the beginning. When all the material was ready for
the analysis I read it again, generating initial codes and reflections. I read all the transcripts, and a sub-sample was read by my Chilean adviser.

4) **Creation of categories.** After the first reading, I started the process of generating and testing categories, with the support of the QSR NVivo 9 data management software. Transcripts were also read “horizontally”, which involved grouping segments of text by category.

5) **Searching for themes.** Following my analysis and creation of categories, I examined them all in order to find patterns and cultural themes.

6) **Translation of codes and themes.** I translated all categories and themes from the Spanish, to the English, language: all the codes, new emergent themes, and sample verbatim quotes for each theme were translated into English to share with the New Zealand supervisory team and for incorporation into the thesis.

7) **Respondent Validation of Findings.** I checked the findings with CAC and some of the participants, to ensure the findings concurred with their own experience and perceptions in relation to people.

8) **Producing Report Findings.** I summarized and wrote a report on the themes emerging from the data. The final report was elaborated on in consideration of the research question and aims. Conclusions were developed by interpreting the meaning communicated by the research participants and by evaluating what was observed in the research setting.

Throughout the process of analysis I worked on the creation of memos from the data, and took notes concerning my own reflections. All of that writing material was subsequently shared and discussed with my advisory team and with the CAC.

### 4.3.6. Ensuring Rigour

According to several authors (Barbour, 2001; Johnson & Waterfield, 2004), in qualitative research it is especially important to be explicit about rigour when considering the credibility and dependability of the research (Guba & Lincoln, 1998). Credibility occurs
when multiple realities revealed by participants are represented as adequately as possible, and when those who live the experience recognise its description and interpretation. On the other hand, dependability is defined as the accounting for variability in the phenomena studied, or as changes in the research design employed because of the interactive process of inquiry.

To ensure the credibility and dependability of this study, five aspects of rigour were considered (Johnson & Waterfield, 2004):

- **Triangulation**: In qualitative research, triangulation requires the researcher to examine data collected from diverse sources or by different methods. In this study, I employed different sources (men and health workers) and methods (participant observation, interviews, and focus group).
- **Peer Review**: Two or more researchers review data and the analysis to evaluate whether the identified themes clearly emerge from data, and to help to validate the findings. In this study, to evaluate the findings and analysis, I had the support of an academic supervision committee, and a CAC reflected on the findings. Additionally, the Chilean academic adviser belonging to this CAC supported me in the translation process from the Spanish, to the English, language, confirming that translations of the information reported by participants reflected content.
- **Audit Trail**: This represents the clarity of the rationale for the theoretical, methodological, and analytic choices so that others can understand how and why decisions are made. I had been explicit in the reports about all decisions and choices, and I was supervised during the whole research process in order to be clear about each decision. Additionally, I maintained a research journal where I registered all my thoughts, ideas and experiences; that journal informs the reflexivity account during the analysis and writing process.
- **Reflexivity**: An explicit reflexive thread throughout the research seeks to recognise and value the researcher’s participation in shaping data and analysis. Reflexivity was an important aspect in this study; I was explicit about this in the report and in the meetings with the supervision committee and CAC.
- **Respondent Validation**: After completing the thematic analysis, I went to Santiago to discuss the findings with the CAC and some research participants. They gave me their feedback about these findings, and they confirmed that they felt that they could identify with the social dynamics exposed.
4.4. Ethical Implications

The purpose of documents such as the Belmont Report and the Nuremburg Code, and that of the Council for International Organizations of Medical Science is to protect the rights of those persons who choose to participate in research, as well as to guide the researcher and other investigators in the process of carrying out research with scientific integrity. In an effort to incorporate additional aspects not addressed in the previously mentioned documents and organizations, Emanuel, Wendler and Grady (2000) established seven requirements for the ethical realization of research: social or scientific value, scientific validity, fair subject selection, favourable risk benefit ratio, independent review, informed consent and respect for potential and enrolled participants. These seven ethical aspects do not contradict the standards established in the said documents and organizations, but rather attempt to form a more holistic approach to ethical analysis. It is for this reason that I analysed the ethical implications of this research using these standards.

The aspect of scientific or social value refers to the need for research to have the goal of leading to the improvement of health, well-being, or knowledge, in order to be ethical. This research was developed in response to real situations that currently affect Chilean men’s health; the reasons for its development concern factors relating to gender roles and masculinity that are associated with the barriers to the health care system, thus placing men in a vulnerable position. The findings of this study are a contribution to the better understanding of the way in which Chilean men perceive their own health and their relationship with the health system. This information can be used to design and implement future interventions directed towards this population.

Scientific validity of research ensures that findings obtained from the study are valid and reliable, and can be used once the research has completed. From a qualitative point of view, criteria of credibility and dependability are preferred to those of validity and reliability, which are commonly used in quantitative research (Johnson & Waterfield, 2004). As detailed above, to ensure credibility and dependability in this study five aspects of rigour were considered, these were: triangulation, peer review, audit trail, reflexivity, and respondent validation.

The aspects of fair subject selection and favourable risk-benefit ratio have also been considered in the study. The study population was selected because of the recognition of a lack of research regarding its vulnerability. The findings of the research have been shared with the Chilean authorities, and could be used for the better understanding of men’s health
(Aim III). This information will be available for the design and implementation of future interventions with the population that will respond to its specific needs.

Independent review is the next step in the ethical process, and refers to a review of the project by a group of experts in the area who are not related to the research itself. This project has been reviewed and approved by the Human Ethics Committee from The University of Auckland (Appendix D), and by the Ethics Committee of the Pontificia Universidad Católica de Chile (Appendix F), which represents the local requirements relating to ethical approval.

The aspect of informed consent is related to the autonomy of those participating in the research. To provide informed consent, a research project must not only inform the potential participants of the risks, benefits, alternatives, purpose and methods of the research being done, they must also ensure that the participants actually understand it. Once this understanding has been established a participant must be able to make a completely voluntary and un-coerced decision to participate. Every interview participant in this research was involved in a process relating to informed consent (Appendix G). This process included the sharing of information regarding the research with participants, and also time for the expression of questions and doubts. During this process, I informed participants that their participation and responses would be used for research purposes and would be confidential. Additionally, the voluntary aspect of participation was emphasised to ensure that participants understood that, should they choose to stop participating at any moment, they could do so without any repercussions.

The final aspect of respect for potential and enrolled participants included: the maintenance of confidentiality of information, respect for those who decide to withdraw from the study, the informing of participants in regard to new information related to the research, careful monitoring and following up of participants’ wellbeing, and a protocol for informing participants of the research findings. To ensure confidentiality, all signed informed consent forms were to be kept in locked cabinets to be stored for 10 years, being stored separately from the transcripts of interviews and the focus group. The personal information in regard to participants was removed from the transcriptions of the interviews and the focus group, and all electronic files that had been created for data analysis were stored on a password-protected personal computer drive. The voluntary aspect of participation was emphasised and the decision of an interview participant to withdraw from the study was respected at every point in the procedure.

In these ways, I established that this project complies with ethical standards. Beyond being in compliance with those documents and organizations traditionally utilized for ethical
standards, the project itself has been created and continues to be analysed and to act in accordance with an ethical paradigm.

4.5. Summary

In this chapter, the philosophical framework, the research paradigm, and the methodology that guided this study, has been outlined. I have positioned myself as researcher in relation to the study, and reflections on how constructivism and ethnography are, respectively, the appropriate paradigm and research strategy to answer the research question. The aims of this research have also been presented. In the second part of the chapter, the research procedures: participants’ recruitments, methods, and data analysis were detailed. Finally, I reflected on how rigour was assured in this project, and I argued the reasons as to why this research complies with ethical standards.

In the next section, the findings of this study are presented. These integrate all data and sources obtained during the data collection. In this way the findings are discussed according to the themes emerging and for the discussion of each theme, written material from participant observations notes, and from the transcriptions of interviews and the focus group, is incorporated.
FINDINGS SECTION

Introduction to Findings

As stated in the previous chapter, the ethnography in this research serves both as a methodology and a written account detailing the cultural practices of a particular social group. My main objective in this section is to present the findings that are the product of this ethnographic study, with the aim of providing a general framework for the particular social group, specifically describing the beliefs and practices that affect the health of Chilean men.

The analysis of participant observation, interviews and the focus group have allowed the identification of five themes, as set out in Table 9: Community, Health, Health Problems, Men's Health, and Healthcare Centre.

Table 9: Themes and Sub Themes Emerging from the Analysis

<table>
<thead>
<tr>
<th>Themes</th>
<th>Sub Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community</td>
<td>Social practices, the soccer club, instances of poverty in the community, instances of violence in the community.</td>
</tr>
<tr>
<td>Health</td>
<td>Health definitions, health behaviours, health experiences.</td>
</tr>
<tr>
<td>Health Problems</td>
<td>Instances of illness/Disease, implications of illness/disease and beliefs pertaining to the addressing of health problems.</td>
</tr>
<tr>
<td>Men´s Health</td>
<td>Specific beliefs relating to men´s health, men´s actions in relation to the health system, motivation of, and gender differences in, the health system.</td>
</tr>
<tr>
<td>Healthcare Centre</td>
<td>Men as patients, access to services, health strategies, problems, and suggestions to improve the healthcare centre performance.</td>
</tr>
</tbody>
</table>

Based on the information obtained and the themes that have emerged, this part of the thesis is presented in four chapters. In the first chapter (Chapter 5), an overview of the community being studied is given. This overview includes: a description of some of the social practices of the participants and their ways of organizing different activities; an
introduction to the group of men who belong to the soccer club, and a description of the
group of health workers who belong to the primary healthcare centre. In Chapter 6, I discuss
in detail what the men’s perceptions, beliefs, and behaviours are in relation to their own
health, reflects on the way in which these ideas can become obstacles in the relationship
between the men and the public healthcare system. Following this, in Chapter 7, I describe
the beliefs and perceptions held by health workers regarding the group of men in the
community; additionally I discuss the implementation – or non-implementation – of health
strategies and the interventions adopted in order to focus on the particular group of men.
Finally, in Chapter 8, the relationship between the men of the soccer club and the healthcare
centre are further explored; the chapter includes a discussion of the barriers that exist to
encounters between members of the soccer club and healthcare personnel; it also considers
the suggestions that the men have proposed in an attempt to strengthen this relationship.

In each chapter the various topics are discussed; the discussion is supplemented by
references from the literature, quotations from participants, and photographic illustrations.
Related quotations are used to corroborate and illustrate the findings; some of the quotations
have been obtained verbatim from interviews and focus groups; these will be cited in the text
as follows: (pseudonym of participant, date of the interview or focus group). In Tables 10 and
11, I introduce the interview and focus group participants.

Additionally, I use some quotations obtained from the participant observations, which
were registered in my field notebook during my participation in the various community
activities. Since these quotations were mostly obtained during the daily activities and social
interactions of the participants, I tried to register comments without the necessity of including
the names of those who said them. The quotations obtained from participant observations are
cited in the following way: (Soccer Club Member/Health Worker/Patient at the healthcare
centre, and date), indicating that the quotation belongs to a member of the specified
community and the date of participation-observation on which the quotation was obtained. It
is intended that the inclusion of photographs taken during participant observations further
illustrate some of the characteristics of the community.

Each chapter also includes reflections on the findings, consideration of the feedback
received by the CAC (Community Advisory Committee) and comments obtained from the
participants during a discussion on the summary of the findings (respondent validation of
findings). Additionally, I built my own reflections (reflexivity) about some issues, which I
registered during the data collection and during the analysis.
Table 10: Sociodemographic description of the group of men

<table>
<thead>
<tr>
<th>Sociodemographic Description</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>Youngest</td>
<td>26</td>
</tr>
<tr>
<td>Oldest</td>
<td>70</td>
</tr>
<tr>
<td>Average</td>
<td>48.13 (SD: 11.66)</td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>7</td>
</tr>
<tr>
<td>Married</td>
<td>12</td>
</tr>
<tr>
<td>Separated</td>
<td>3</td>
</tr>
<tr>
<td>Divorced</td>
<td>1</td>
</tr>
<tr>
<td>Sons/Daughters</td>
<td></td>
</tr>
<tr>
<td>Without Sons/Daughters</td>
<td>5</td>
</tr>
<tr>
<td>With Sons/Daughters</td>
<td>18</td>
</tr>
<tr>
<td>Level of Education</td>
<td></td>
</tr>
<tr>
<td>Elementary School Incomplete</td>
<td>2</td>
</tr>
<tr>
<td>Elementary School Complete</td>
<td>3</td>
</tr>
<tr>
<td>High School Incomplete</td>
<td>12</td>
</tr>
<tr>
<td>High School Complete</td>
<td>1</td>
</tr>
<tr>
<td>University Incomplete</td>
<td>4</td>
</tr>
<tr>
<td>University Complete</td>
<td>1</td>
</tr>
<tr>
<td>Employment Status</td>
<td></td>
</tr>
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<td>15</td>
</tr>
<tr>
<td>Self-Employed</td>
<td>5</td>
</tr>
<tr>
<td>Unemployed</td>
<td>1</td>
</tr>
<tr>
<td>Retired</td>
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</table>
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Table 11: Sociodemographic description of the group of health workers

<table>
<thead>
<tr>
<th>Sociodemographic Description</th>
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<tbody>
<tr>
<td><strong>Age</strong></td>
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<td>Youngest</td>
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<tr>
<td>Eldest</td>
<td>65</td>
</tr>
<tr>
<td>Average</td>
<td>37.6 (SD: 12.14)</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
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</tr>
<tr>
<td>Female</td>
<td>7</td>
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<tr>
<td><strong>Level of Education</strong></td>
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<tr>
<td>University Incomplete</td>
<td>2</td>
</tr>
<tr>
<td>University Complete</td>
<td>6</td>
</tr>
<tr>
<td><strong>Role at the Healthcare centre</strong></td>
<td></td>
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<tr>
<td>Administrative Staff</td>
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<tr>
<td>Professionals</td>
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</table>
Chapter 5. Getting to know the community

Who are these people? Where do they live? What are their houses like? What type of neighbourhood is this? What are their customs?

The main objective of this chapter is to describe some aspects of the community in which this study was conducted; this is in order to understand what happens there and to provide a context for presenting specific information relating to men’s health. I provide general information about the Comuna (the Spanish word to denote a specific geographic area of a city), and I introduce the study sites: these are, the Soccer Club and the Primary Health Centre. Additionally, I introduce some elements of conflict, reasoning, and tension regarding this community.

This chapter is divided into four parts. In the first part, regarding the Comuna, I present information about the administrative functioning of the local government in the area, and introduce some characteristics of the participants’ neighbourhood. In the second part, the routines of the Soccer Club members are explained; the section describes some of their activities and the conflicts that the men have in that setting. In the third part, I introduce the Primary Health Centre; this includes an explanation as to the way in which the centre operates, how people can access it, and some of the tensions that exist among the health workers. Finally, I offer some reflections relating to my first encounters with this community; the latter are offered since these reflections have enabled me to understand some of the phenomena relating to men’s health. The social practices outlined in this chapter, regarding the group of men and health workers are central to understanding the phenomenon of health in Chilean men.
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5.1.1. Comuna: Fieldwork Space

Santiago is the capital of Chile, and in 2002, the city had a population of 6,061,185 inhabitants, of whom 2,937,193 were male (Instituto Nacional de Estadísticas [INE], National Institute of Statistics/2002). Santiago is divided into 52 Comunas, and the geographical location of each Comuna often relates to patterns which have emerged in regard to the characteristics of its residents. For instance, in the North-East area of the capital, Comunas are associated with the highest income levels, while Comunas in the South-West area are associated with lower income and education levels.

In an attempt to reduce health inequities and in order to design and implement action for vulnerable neighbourhoods, the Chilean Ministry of Health has recognized the importance of identifying the most susceptible geographic areas, such as the Comunas with the higher levels of social and economic need (Social Determinants in Health Department. Chilean Ministry of Health, 2010). According to the Ministry of Health (2010), the concept of vulnerability is related to a situation which involves social groups that have poor quality of life as a consequence of reduced economic access. Therefore, some characteristics of a “Vulnerable Comuna” include a high proportion of poor families in certain areas of the city; these are areas whose inhabitants are affected by segregation, unemployment, high rates of teenage pregnancy, lack of opportunity, and a high level of insecurity (Social Determinants in Health Department. Chilean Ministry of Health, 2010).

This study took place in an identified “Vulnerable Comuna” in a south-western area of Santiago. In order to respect the confidentiality of community members, I refer to this place as “Comuna F”.

5.1.1.1. Comuna F: Municipalidad

As a devolved system of social service provision, each Comuna its own local government called the Municipalidad [Municipality]. The principal authority in the Municipality is the Mayor or Alcalde; he/she is in charge of the four main departments: Justice, Education, Health and DIDECO [Community Development] (Figure 8).
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**Figure 8: Organization Chart for a Municipality**

*Comuna F* has approximately 130,000 residents, including 63,000 males (according to the Website of *Comuna F*, 2011). According to the number of residents in a *Comuna* and the need for public services, such as those of education and health, a *Comuna* is divided into a number of areas or sectors. In this case, *Comuna F* is divided into 3 main areas, each one having a Primary Health Centre. The DIDECO, as the section in charge of community development, has the Department of Sport and Recreation within its divisions (Figure 8). This department is responsible for coordinating and regulating the work of the various Sports Clubs in the *Comuna*, including the Soccer Clubs, organizing and supervising soccer tournaments and various other soccer-related activities.

During the course of fieldwork, I was involved in the various activities of one Soccer Club and of one Primary Health Centre, in one specific area of *Comuna F*. Because both organizations are located in the same geographic area, it would be anticipated that the members of each would be expected to maintain a working relationship and to know each other. Therefore, if a man living in this particular neighbourhood who belongs to the area’s Soccer Club has a health problem, he would be obliged to go to the corresponding Primary Health Centre. Since he belongs to a specific geographical division he cannot seek care from another centre on grounds of preference alone. Similarly, the Primary Health Centre has an
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obligation to coordinate the community activities related to health in the geographical area where the Soccer Club is situated.

5.1.1.2. First approaches

My first approaches to the community occurred in December 2009, when I met separately with certain local authorities, specifically those working with the Office of Sports and Recreation, and the Director of the Primary Health Centre, with the aim of making contacts and to obtain authorization to conduct my research in these organizations. During these first contacts, local authorities were immediately supportive concerning the possibility of carrying out this research. In the words of the Director of the Primary Health Centre: "We know we do not have a close relationship with men from this Comuna, this is a group that is far away from our healthcare centre and we do not know why…" (Fernando, first meeting at the Primary Healthcare Centre, 10 December 2009). For his part, the Head of Sports at the Municipality felt that this research could be a first step to introducing a healthy lifestyle approach to the population through sport, particularly soccer; this, at the time of his comments, is a situation that was not currently occurring. One of the main concerns at those first meetings was that they thought it could be difficult for me, a young woman, to work in the community for two reasons: firstly, men are not usually available at "normal" times because of their work schedules; they would only be available to participate in activities during evenings or at weekends. Secondly, according to the Director of the Primary Health Centre: “The community can be a dangerous place in certain areas and at certain times, because of the high rate of crime, alcoholism, drug addiction and violence…” (Fernando, first meeting at the Primary Healthcare Centre, 10 December 2009). In fact, he was so concerned for his own safety that he actually stayed away from the community at night. As for myself, a personal insight arose from first meeting; I immediately thought about the challenges that could arise in trying to get to know a group, or to establish a relationship without actually having any contact with them, as was the case for the Director of the Primary Health Centre who never had contact with the group of men living in the Comuna F because they usually do not visit the healthcare centre, and the Director is absent during the time that the men are in the neighbourhood (evenings or weekends).

I was not worried for my personal safety because I had lived in Comuna F during my childhood, I grew up in this area and I had relatives who still lived near there, which is why I initially refused to believe that this could be "dangerous work"; although, I did understand that I would have to take some precautions. During my first meeting with the Community
Advisory Committee, I discussed this feeling of insecurity that I had sensed from the Municipality’s workers; I asked whether the risk was real and what precautions I should take. They shared two reflections with me. First, “It is always important to be careful; crime, alcoholism and drug addiction in these areas are not a myth” (First meeting, Community Advisory Committee, 21 July 2010). However, in their words:

We are tired that this excuse is always used by the authorities for not approaching our community and meeting our needs, there are many good, honest and hard working people, every day struggling to get ahead, and they will always tell you which are the real dangers, because they already know... (First meeting, Community Advisory Committee; 21 July, 2010).

Indeed, during the time of data collection I maintained a close relationship with families and members of the soccer club who advised me as to which streets I must avoid, and the appropriate time to leave each evening (many of the interviews were conducted at night after the men had returned home from their jobs). Also, on the soccer field, certain situations that needed to be avoided began manifest themselves. Even though I personally felt comfortable during my fieldwork, I understood the anxiety that a person might feel in a neighbourhood that authorities had called “vulnerable”, especially if that person has never previously lived in, or had contact with, such an environment.

In Comuna F many of the streets are narrow, with houses consisting of two or three rooms where usually resides an extended family (grandparents, sons/daughters with their spouses, grandchildren, uncles), with an average of 6-8 persons living in each house. For that reason, many people spend time outside the house in the street. During the day it is common to see children playing in the streets, housewives talking and there are always groups of young people standing on street corners (which could be associated with alcohol and drug consumption). One is never alone in those streets, everyone observes one another and can tell if you are not part of the neighbourhood; the residents are very suspicious of strangers. In fact, the only way they felt a little more relaxed with me was when I told them that I had grown up in a nearby neighbourhood. After that revelation, I was not a complete “stranger”, and, on more than one occasion, they actually said "You can understand, you know what it’s like to live here..."

While this is not among the poorest areas of Santiago, the income level in Comuna F is reasonably limited. Generally, the employment accessed by men is in administrative service, labouring on building/construction sites, or in menial jobs in large companies. The
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average monthly salary per household for this group of men is CH$ 400,000 (approximately NZ$1000, US$ 820), compared with to the median household income in 2006 in Chile of CH$ 590,000 (approximately NZ$ 1500, US$ 1230), (Chilean Ministry of Planning, 2006). Such wages must suffice for the whole family. This is one of the main reasons that the level of debt in this sector of the population is so high. For some, most of their wage goes in the paying off of credit; they have commented on more than one occasion that they feel really stressed about their financial situation. However, it is not unusual to enter a small house, in which live eight people with little space, to find a giant LCD TV. Some people recognize that there is a problem; living with debts which, eventually, overwhelm them:

In Chile there is a socio-economic problem, there is a problem because survival is expensive and interpersonal relationships are based on economics, then there are many fights, because if things are bad... that causes conflict, causes fights ... I think Chileans are sick...

Interviewer: And what would be the diagnosis of that disease?

The economic... the economy, the consumption, consuming beyond what you can, to show, if there is such a plasma TV you must have a plasma TV...

(Roberto; 29 September, 2010)

Men justify such a level of consumption that is beyond their income levels because of the “sacrifices” they make in their daily lives: “I sacrifice myself working like an animal from Monday to Saturday... Obviously, then I deserve to enjoy some things, to stay at my home comfortably watching TV, eating something delicious, to have a drink with friends...”

(Soccer Club Member, 5 August 2010).

The word *sacrifice* (see Glossary) is used in Chile as a term associated with a great effort that someone makes for the benefit of others. For example, women often say "I sacrifice myself for my children". In the Catholic tradition – Catholicism is the dominant religion of Chile - there is a belief that Jesus sacrificed Himself for the salvation of others, that He offered His life in exchange for the wellbeing of others; in this community the word ‘sacrifice’ is commonly used in a similar sense. However, it is important to note that although Chile is a country with a strong Catholic tradition that has a considerable impact on the country's culture, there is a group of people who do not declare themselves as “true” Catholics, and there are many who identify themselves as being Catholic, although they do not practice any behaviour associated with the religion. In the case of this particular group of men (the soccer club members), in the course of this research, although most of them
declared themselves as Catholics, they did not attend any church, nor go to Mass or Liturgy on Sundays; that is the day when they playing soccer or watch a soccer match on television. However, they did profess a belief in Jesus Christ and have been with imbued part of the cultural heritage of the Catholic religion, especially some of the ideas that give value to sacrifice for the benefit or wellbeing of others.

For this group of men, their own paid work is associated with this idea of sacrifice. The etymology for the word ‘trabajar’ (the Spanish word for work), comes from the Latin ‘tripaliare’, which means torture. The word ‘trabajar’ (to work) is therefore associated with suffering, effort, or torture (see Glossary). This notion of sacrifice is a key to the understanding of some of the dynamics in this cultural group. A person who sacrifices him/herself for others’ wellbeing deserves a reward or compensation, and usually that prize is associated with excess, such as overspending, overeating, or excessive alcohol consumption; the sacrifice is an acceptable justification for such behaviours. The sacrifice is also related to the verb “Aguantar” (a Spanish word that means to endure): you sacrifice yourself because you have to endure physical and emotional pain, to endure your own work and to endure your own life. Then, the enduring of pain is associated with the need for an escape, a way of escape, as a way to balance personal sacrifice (Figure 9).

Figure 9: Dynamic of “Sacrifice - Endure – Escape” in the Chilean context
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These men shared the idea that they continue to sacrifice themselves by working in unsatisfactory jobs for the good of their families and enduring the physical pain and fatigue associated with work; they thus believe that they consequently deserve the periodic escapes that are associated with the idea of obtaining pleasure. To compensate themselves for their sacrifice, they associate a moment of relief and relaxation with the consumption of food or alcohol, and, for this particular group, through social life at their soccer club. In the words of the Head of Sport from the Municipality:

Soccer is an absolute evader of your daily life. I mean, I think they (men) understand that, from Monday to Friday they are met with a routine, with work that is boring, something that is every day, something that I have to do without exceptions, even in the case that I don’t want to do it, and even if I don’t like my work... and finally, on Saturday and Sunday I have a prize that I want, which is to play soccer, which is being with friends at the soccer field... (Municipality Head of Sport; 08 September, 2010).

A member of the soccer club echoed these views:

I do (spend time at the soccer club) to distract myself a little, in order to discharge tension, and not thinking so much on problems and try to find ways to escape... soccer has allowed me to at least relax a little, forget my problems... (Jose; 07 September, 2010).

The notion of sacrifice is thus associated with enduring pain and the need to escape, and is a recurrent theme in the men’s explanations regarding some of their behaviours. For these men, escape is always related to the idea of pleasure, and there is a strong relationship between the concepts of sacrifice and pleasure. A man deserves pleasure through the over-consumption of material things, food, alcohol or drugs; but only if that man has sacrificed himself through working and enduring. If a man does not have a job, or is unfulfilled by his role as provider for the family, then he does not necessarily deserve any escape or pleasure.

Usually the behaviours related to escape are unhealthy; this may have some consequential health problems, both physical and emotional. The most common problem is the stress generated by the “over-debt” that some men acquire to buy various things or even food and alcohol. Then, if, as a consequence of their behaviour, they encounter any health issues, they come back to the idea that “a man must endure all physical or emotional pain”. Or, if they are in debt, they come back to the need for sacrifice; “a man should sacrifice himself to pay any debt or to provide for the family” (See Figure 9).
When I shared this model (Figure 9) with some of the study participants (in the process of respondent validation of findings) and the CAC, all of them agreed that the idea of “sacrifice-endure-escape” represents this group of Chilean men and their way of operating. In the words of one participant, “This is a real situation... we work all the time, then we deserve our escape” (Soccer Club Member, respondent validation of findings; 05 September 2011). According to the CAC, men in this group do not have another option, they have to work and “they need compensation, a prize, an escape”. Some members of the CAC mentioned that they believe that “escape” is a common strategy for men, because they need a “disconnection”. However, CAC members think that the main problems stem from the consequences of ‘escape’ Some men in the soccer club recognized that one of the big problems is the “over debt”, but they believe that they deserve to buy “some things” to improve their quality of life, even if they do not have the money to purchase them. In the words of one participant, “If I want to live in a good way I have to live with debts, even if I’m worried later because I don’t have enough money to pay those debts” (Soccer Club Member, respondent validation of findings; 05 September 2011).

The reactions of the health workers to this model were similar. They recognized that this model represents the reality of this group of men in the community and are aware of the risks associated with the “escape behaviours” adopted by them. However, despite the fact that health workers understood that the men’s lifestyles related to their beliefs could, in turn, endanger their health, the health workers claimed not to know how to intervene, or which health strategies could be effective.

In the following chapters these ideas will re-occur in the descriptions of the way in which men understand both their own health, and some of their own behaviours. In the meantime, the description of the community continues.

5.1.2. Soccer Club

My first encounter with this group of men, the members of the soccer club, was at one of their formal club meetings when the director gave me the opportunity to explain my project and to invite them to participate. They were very cautious at first and told me that many people go to the soccer club with “promises” of projects and interventions, but they never return. In this regard, they felt especially irritated by some of the political authorities who usually go to the soccer club during election time to make persuasive offers when seeking votes, and then never return to the club once the election is over. For this reason, the
issues of trust and expectation were the first matters to be worked through together. I allowed them to talk about their experiences and their frustrations, and then I explained again that my goal was not to offer anything, but that this was an exploratory study and that I would inform them of the findings. Initially, this explanation seemed to them to be sufficient; however, the issue pertaining to trust and distrust was something we talked about on several occasions during the fieldwork. After that first meeting, when all members agreed that I should be invited to take part in the club’s activities, I began to integrate into the daily activities of the community.

The family routines in the community are organised by the obligations of each member. Men work for most of the day (usually between 9 a.m. and 7 p.m.), children go to school, and the women stay at home taking care of the younger children and/or older people. Women do not usually work outside the home; however, in cases where they are divorced or separated from their partners, they need to work, and seek help for childcare from their neighbours or relatives. At 7 p.m. the street scene changes, with families returning home to eat or to rest, and the women preparing their children for the night. At 8 p.m. men replace the women and children as the greater presence on the streets; they congregate in groups on corners and walk towards the club. The soccer club is open daily from 8 p.m, closing time varies each day.

During the weekends, some men work on Saturday morning and the afternoon is the time they spend with their families. Sunday is dedicated to the soccer club, with children playing soccer in the morning, and adults playing in the afternoon. Soccer games are held on the five soccer fields of the Comuna F, which belongs to the Municipality. The whole family goes there; generally women bring food, children play, and men organise soccer games (Figure 10: Picture 1). Usually the group of men who belong to the club are together all day, giving advice to the children during the morning games, eating lunch together, and encouraging their team in the afternoon.
Admission to the soccer field as a spectator costs CH$ 500 (NZ$ 1.5, US$ 1) for men; this is money that the members spend on club activities. However, women and children are not required to pay. According to one participant in the study "Women do not pay because they are our guests, we assist them here... at home she is the one in charge and she assists me, but here I am in charge and I assist her..." (Soccer Club, 15 August 2010). Men thus consider women not having to pay as an aid or assistance to them.

The membership of the soccer club fluctuates between 50 and 70 men, who each pay CH$ 1500 (NZ$ 4, US$ 3) per month for the club membership; this money that is spent on the payment of electricity and water bills for the clubhouse in which the soccer club holds its activities. The building is owned by the Municipality, and provides the space in which to host the soccer club. In the Comuna F there are 20 soccer clubs in different areas and each one meets in buildings provided by the Municipality. In addition, as previously mentioned, there
are a total of five sports fields, and each soccer club can request their use for their practices or for playing soccer championship games.

The soccer club, at which the data for this research was collected, meets at a small building with a space at its centre, in which soccer club meetings are held. Inside the clubhouse, are chairs, tables, and a large TV on which to watch soccer matches, such as those involving the Chilean national soccer team. On one side of this room are two bathrooms, one for the men and another, smaller, one for women; there is also a small kitchen. On the other side of the meeting room are three small offices that are occupied by the club’s directors: the president, the treasurer, and the soccer game coordinator. For the purposes of this research most of the individual interviews with men were conducted in one of those offices, since they preferred to be in a private space, albeit, still inside the club.

Formal meetings of the soccer club are held on Tuesdays and Wednesdays at 8 pm, when usually members spend one hour discussing administrative issues (upcoming activities or tournament co-ordination); this is followed only by shared social activity, such as watching TV when an important soccer game is being screened or smoking, eating, or drinking beer together. I was invited to the formal meetings; after which members usually preferred to be interviewed. The presence of women in the club does not pose a problem; often the women bring some food and gossip with other women. However, while they are always invited, the men are very clear about the following: "This is our space, we can invite our wives or our partners, but we do not want women coming in to clean the club, this is our place and this is our order…” (Soccer Club Member, 05 August 2010). In fact, during one interview that I conducted in the Director’s office, I saw he had some papers lying around the floor and I almost fell over because of them. When I started to put the papers in order the interviewee said "Don’t worry, leave the papers on the floor, for us it is relaxing to have our own order here... so just leave the papers as they were…” (Soccer Club Member, 18 August 2010).

5.1.2.1. Playing Soccer?

As their space, is a “man’s space”, the male members of the soccer club are very clear and proud of it: "This is the only place where we can really make decisions, in our work places we have a boss, in the house the wife is the boss, but here we do what we want…" (Soccer Club Member, 15 August 2010). Soccer is the excuse to stay in this “man’s space”; however, the majority of members do not play soccer or any other sport. In fact, of the 23 men who were formally interviewed – either in individual interviews or as members of a focus group - only 9 of them were actually involved in playing soccer. The other members
attended meetings and participated in the social activities of the club. During meetings they discussed the techniques that the official team must practice together, and they watched soccer games on television. Although only a few men were actually involved in playing soccer, conversations tended to be always around the subject of soccer. In this context, soccer is much more than a physical activity. As I mentioned earlier, soccer is an escape, “…it’s fun, it’s leaving the house, it’s sharing with friends…” (Andres; 29 September, 2010). In the words of another man "…it’s my escape valve…” (Pablo; 22 September, 2010). In this context, soccer is not seen by most men as an activity associated with involvement in a healthy, active, lifestyle.

Soccer is like a social network, a place where they like to participate, regardless of whether it has, at the end of the day, a physical consequence... they say 'I am in the soccer club because I have fun with my friends, and because that's why I like it, but whether this has or has not an impact on my health, I do not care…' (Municipality Head of Sport; 08 September, 2010).

Soccer is much more than a sport or a game for this group of men; it is an excuse to forget their work and problems.

It's a passion, a strong magnet ... it’s a very strong magnet, imagine that sometimes I really have to work, but I'm sitting on my machine and I'm working, but my mind is on the soccer field, but my responsibility is to be working, and the responsibility is always strongest, I have to work, but if I could choose... I'm on the field... supporting my team (Pablo; 22 September, 2010).

Soccer, then, is a common ground on which friendships and connections are built, and sometimes it also represents a dream. This dream, associated with soccer, represents a “real possibility” for some of them to rise out of poverty; this is a future without financial worries through the means of professional soccer. Many of their soccer idols, who play in professional clubs, are men like themselves; who, although they have come from similar neighbourhoods and are without a high level of education, what they do know is “how to play good soccer”, they have been discovered by an agent from a professional soccer team and, thus, their lives have changed. This is a dream that many soccer club members have for themselves or for their children.
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I don’t play soccer now... when I was young I did not get to where I wanted to be and, and... and… I chose not to play anymore...

Interviewer: And where did you imagine that you could be?

Obviously, big soccer, I liked professional soccer and I wanted to be there... and make money with soccer, but I didn’t have luck, and I kept studying, I finished my high school, and I got married... (Juan; 11 August, 2010).

Other men described the same dream, but this time in relation to their sons.

I supported my son, I withdrew him from school when he was 15 years old because he was playing for Everton (professional Chilean soccer team), he was playing in the fourth division, then he played in third division in Colo Colo (professional Chilean soccer team)... well ... I thought that some day he could be a soccer star... (Pablo; 22 September, 2010).

I discovered that, when he was 4 years old, my son came out with ... with that ability, the ability to play soccer... He is 16 now, and he is my motivation every day... I feel something like... like a pride and happiness… (Carlos; 18 August, 2010).

In summary, a soccer club is not necessarily just a place where men play soccer or participate in physical activity; it is a place where they escape from their problems, where they share with other men, where they dream about the future, and where they feel comfortable. All these positive aspects could be expected to make an important contribution to their emotional health. However, club attendance is also associated with some activities and situations that could be a threat to their health, such as the over consumption of unhealthy food and alcohol, and the normalization of violence among men.

5.1.2.2. Soccer: The unhealthy side

Among the joint activities of this group of men is what they call "the third time". Usually a soccer game consists of two halves of 45 minutes each (divided by ‘half time’. When these two halves have finished, the game is over and then "third time" commences; this is basically the longer time. This is the time when men talk about the game, comment on the team’s moves, and so on. The “third time” occurs every weekend, and sometimes during the week when the Chilean national soccer team plays an important game. This "third time" is always accompanied by large amounts of food and a great deal of alcohol. It is a time to share
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with friends and even family; while the women are helping in the kitchen, the men prepare a barbecue. After a while, women and children go home while men continue to eat and to drink alcohol. They often spend many hours at this "third time".

Alcohol is the next step after completing the game. So, if you do not drink some glasses of wine or some beers, you're not macho enough... I mean, it... it is the complement of the game, after the game a group of men must drink together and eat together… (Municipality Head of Sport; 08 September, 2010).

Alcohol is always associated with any activity at the soccer club, and it is related to the need to escape from problems, “the alcohol consumption is complicated here in the club, you drink when you want to celebrate, or when you want to escape from your problems, or to get through the sadness... that's a little complicated...” (Alberto; 22 September, 2010). Although they do not have a first-aid kit in the club or at the field, they use the term “first-aid kit” to talk about the alcohol drinking. Thus, when they have any injury or wound, alcohol drinking is used to disinfect wounds; they literally put pisco (distilled alcohol) or tequila in the wound, and also drink it to dull the pain.

Men do not have a first-aid kit in the soccer field, and if they have a kit in the field they confuse the elements, they confuse the healing alcohol with the alcohol to drink, to have a first-aid kit for them is to have a bottle of wine or a bottle of liquor, called the first-aid kit to the drinking alcohol... (Laughter) (Jose; 07 September, 2010).

Probably due to the large amounts of alcohol and food that they consume a lot of the men from the soccer club were overweight, including three of them who had already been diagnosed as being morbidly obese. But the implicit rule is that machos must eat and drink together. While eating or drinking is not a formal obligation, in reality they have to become involved, because if they do not, they will be excluded from many activities and marginalised.

The other problem is the normalization of violence between men. In Chile it is very improper for a man to speak in favour of violence against women or children: violence against women or children is a situation that is punishable by law and is socially sanctioned. However, violence involving men is common; this type of violence is not rejected, and it is even desirable as a way of defending oneself and of being heard. During one interview, one of the men spoke of the violence as something that he cannot control:
Sometimes I realize I cannot stand the attitude of others and I want to fight... I'm angry, and that’s my problem at that time...

Interviewer: And what do you do in those moments of anger?

I try to count to 10 but sometimes I rile at 8...

Interviewer: Have you ever had a serious fight in your life?

Yeah, yeah, before, when I was young, I tried to fix everything with fights and beatings...

Interviewer: Why do you think that you did that?

I don´t know... maybe because I took refuge in fights... you take refuge from the problems and not knowing how to control others... and I was so good at fighting, I almost always won... (Hugo; 29 September, 2010)

In the soccer club the level of violence among men is high; men fight on the soccer field and fight if they feel any unfairness has occurred during the game in relation to another team. During one of the participant observations, I attended a meeting at the soccer club and in response to the question about the soccer game last weekend, one man replied that it had led to a fight on the field, but that it was a “beautiful fight” (Soccer Club Member, 07 September 2010). Then the Municipality Head of Sports told me that, during that fight, a man was stabbed, and that the previous week a referee had been given a death threat during a game. “They feel they have to take justice into their hands, because an unfair situation happened before in a previous game... and because of any problem or disagreement between clubs…” (Municipality Head of Sport; 08 September, 2010).

In fact, violence seems to be a major health problem in this group. When I asked the interview participants to: ‘Describe your last illness or the last situation when you had to consult a physician or attend a healthcare centre’, four of the 20 men interviewed stated that the last time they went to any healthcare service was after a fight. “The last time I had to rest in my bed was due to a fight, when another guy broke my head... that was the last time...” (Juan; 11 August, 2010). In the words of another man:

Interviewer: Do you remember the last time when you were sick? Or you felt bad?

No, I do not remember... but... I think that the last time was when I received a hit with a stone here (indicating his head)... I went to a birthday party for my
son who was 15, and I don’t know why a group was fighting, and I went... and suddenly I get a stone here (indicating his head) and I had to go to the emergency room because of that... they even had to give me some stitches, and they did a scan and everything... and then I had to rest some days... (Manuel; 24 September, 2010)

Alcohol and violence are not unrelated phenomena, and many of the fights develop when men are drinking. However, it is important to mention that this level of violence does not happen all the time, but when it does happen it is seen as acceptable by the protagonists.

5.1.2.3. Allowed and Not Allowed: Men (do not) Cry

As I mentioned earlier, the soccer club is a place to share with friends, and it is a space where men can discuss their problems. However, this group of men has some implicit agreements. Men do not discuss their emotions with other men, they cannot show sensitivity, and if a man talks about his emotional concerns he is treated as a "little girl". Apparently, in the presence of other men, they are comfortable with this situation. Consequently, during soccer club meetings or focus group sessions, which included five men, none of the men involved showed any personal emotion. However, during the individual interviews, seven of the 20 men interviewed cried for a variety of reasons that emerged in the interview; these included such matters as, the death of a parent, or the separation from a wife or partner. Furthermore, all the men showed personal emotion during the interviews. They told me that they have no space in which to share their concerns; and that they do not discuss things with anyone.

I'm so proud... that’s the problem... I'll give you an example, my dad died last year (he starts to cry)... -silence-

Interviewer: Do you want to stop the interview for a moment?

No, it does not matter (still crying) I forbade my brothers to cry and I do not cry... (continued crying) I think it's a foolish pride that I have ... (silence, continued crying) (Javier; 25 August, 2010).

Any display of personal emotion is associated with weakness, with being a little girl, and in this group there is an explicit rejection of looking like a girl. In this context, any suspicion of homosexuality is immediately rejected.
As discussed in the previous chapter describing research methods, all of the men at the soccer club were invited to participate in the interviews, and they were supplied with my contact telephone numbers. Then, as a general rule, when I went to the formal meetings held at the club they told me which of them wanted to be interviewed; 18 of the 20 interviews were conducted at the soccer club. However two men asked me to conduct their interview at another place; since both of whom worked near the club, the interviews were conducted at their workplace. Both men told me that they had been feeling distanced from the group at the club.

One of the interviewees was a man who, five years previously, had been abandoned by his wife, and he had been in charge of his four daughters ever since that time. His wife had left him for a lover; such a situation was a scandal and the news of it had been spread around the whole neighbourhood. Everyone knew what happened, and, in his words, "Nobody understands me or supports me because it is different being an abandoned man, everybody helps and supports an abandoned woman, but it is different when it is a man..." (Jorge; 01 October, 2010). He told me he had heard some rumours that were being spread around the neighbourhood; the rumours indicated that he was a homosexual and that it was because of this that his wife had left him. One group of men commented on this situation during one of my visits to the club "Jorge has gone away from the club just because it seems that now he likes other things... (Laughter)" (Soccer Club Member, 05 October 2010). In fact, the rumour about his homosexuality came because after his divorce he began to receive visits from other male friends in their home, and one of those friends, who was a frequent visitor, was suspected of being his "partner", according to the comments of men at the soccer club. In the words of the interviewee, "I've been very lonely during this process, only a couple of close friends have come to see me, the rest have gone away" (Jorge; 01 October, 2010).

The second case was that of a man who had always been bothered by other men because they had thought he is a “sissy”; he always felt bullied at the club because he did not have a female partner and was not married, thus other men believed that he is gay. However, during the interview he told me that he has two children and that he had a partner, although the relationship was not a stable one (Andres; 04 October, 2010).

Both situations were discussed in the club at the level of rumour, and none of those involved in the rumour-mongering spoke openly about it; however, there was a noticeable distance between these men and the rest of the group. A suspicion of homosexuality or “lack of manhood” is immediately sanctioned; for instance, when a team player is not playing very
well on the soccer field other men refer him as a *Lady*. If a man is not *macho* enough, then this man is not completely accepted by the group.

In summary, the soccer club is seen by these men as a necessary place, an escape from the routine of their working and family lives, and the only place where they - not their bosses or their wives - have the control. However, some situations are affecting soccer club members, such as the over-consumption of unhealthy food, alcohol consumption, violence, and the exercise of strong social judgement through which a few men are marginalized and are the target of rumour and salacious gossip.

To complete the picture of the neighbourhood, a description of the Primary Health Centre follows. Then, in the following chapter, the narrative returns to this group of men in order to describe some of their perceptions and behaviours in relation to health.

### 5.1.3. Primary Healthcare Centre

The healthcare centre is located 15 blocks from the soccer club. Users can access the facility on foot or by public transportation. The population with the right to access the healthcare centre corresponding to a delineated geographic area of the *Comuna F*, and the centre covers around 40,000 potential users. The healthcare centre is located in a building belonging to the Ministry of Health. There is a large hall in the centre of the building where the main waiting room is situated. On one side of the hall there is an information desk, and on the other side there is a food shop and toilets for healthcare centre users (Figure 11: Picture 2)
The building comprises four levels and is divided by a service area. On the fourth floor is the Director's office; there are also offices for statistics and epidemiology personnel. The consulting rooms for the health professionals are on the three lower floors.

The healthcare centre employs about 80 people; these include security guards, cleaning staff, administrative staff, and health professionals. Among the health professionals there are a total of 15-17 general practitioners; the other professionals include nurses, dentists, nutritionists, midwives, psychologists and social workers. As mentioned earlier, primary health centres in Chile are intended to be the first point of contact between patients and the health system; therefore, there are no medical specialists available at the primary level. If a patient requires specialized medical consultation, that patient is referred to the hospital.
5.1.3.1. How primary health centres operate

As mentioned previously (Chapter 2), primary health centres in Chile should work in coordination with the Municipality and local authorities of each Comuna, with the objective of meeting the specific needs of the local community. However, the Ministry of Health is responsible for coordinating and implementing health policies for the whole country. A primary health centre receives instructions from the Ministry of Health, and that centre should adapt those instructions to the needs of the community. However, according to the Director of the Healthcare Centre it does not work like this.

In one moment, we tried to have our own health programming...not coming from the higher level, I mean top-down.... to have our programming and to present it at ministerial level, and it didn’t work... Why? Because we, as a group, as a culture, preferred to receive instructions, like ‘look, you have to do this and this’, it was our fault... (Fernando: Healthcare Centre Director; 14 September, 2010).

Currently, staff are working according to the instructions received from the Ministry of Health, which highlights the importance of early detection of AUGE’s pathologies (see Glossary and Chapter 2), and the promotion of a Family Health Model at primary level. The Family Health Model aims to restructure the way in which primary healthcare centres work. Previously, healthcare centres were divided by area, for example, there was the women's department, the children’s department, and the department for the treatment of chronic diseases. According to the new model, primary health centres should be divided into health teams, and the population must be divided by geographical areas, identifying neighbourhoods within each Comuna. Each health team should be in charge of the families living in those neighbourhoods, and the health teams should maintain a closer relationship with the families in the Comuna. This information was conveyed to users, who were informed about this new model through a poster:

The healthcare centre wants to become a family healthcare centre. The health team requires knowledge about their families, their epidemiological characteristics, the family life cycle stages, and the risk and protective factors in families, promoting a family diagnosis to design interventions at the primary level (Poster at the waiting room, Healthcare Centre Participant Observation, 2 August 2010).

According to the Healthcare Centre’s Director no one, neither the health workers nor users, understands what this new model means.
They (health workers) do not understand much... eh... as director I have taken training ourselves as a strategy. The group who has the most training in family health is explaining the information to the rest, because otherwise this new model will harm us, the model is going to pass over us, or they (health workers) will not understand it and they will not contribute to a real change... (Fernando: Healthcare Centre’s Director; 14 September, 2010).

The vision that administrative staff has about this new model is completely different. They understand it, but it does not seem possible that this model can be implemented at the healthcare centre. In the words of one administrative worker:

I'm going to tell you the picture that we have as personnel. The directors of the centre want to build a fantasy castle that does not exist, because resources are not there. So we do not agree. We'll need more infrastructure, more resources... There is no budget for that. But even so, all the directors want to be a family healthcare centre. But we're not working as a family healthcare centre, and the directors want to work according to that model, those are the projects... but while we continue working as before... According to the same number of people... We continue working as before... (Carolina; Administrative staff; 02 November, 2010).

In summary, the primary health centre is working according to the Ministry of Health that gives priority to AUGE pathologies, and also they continue operating as a healthcare centre divided by programs targeting women, children, elderly, and the chronically ill.

It is important to mention that the differences of opinion between the director, departmental heads, and some of the health workers are marked. In fact, there is an implicit division of staff into two groups. One group includes the directors, some physicians, and some nurses, and it is they who make decisions. The second group includes: other health workers, administrative staff who live in the local area, and some other professionals such as social workers and psychologists. The problem is that the decision making process focuses only on the first group, which is not necessarily the group that is closest to the community; usually, the decision-making group lives in other Comunas and its members belong to a private health system for their own personal health needs. The second group does not interfere in the decisions, but it is they who are close to the community and are users of the public health system, including many who are users of the same healthcare centre in which they work. Thus the latter group has a much clearer idea about what the community needs; however they do not feel as though they are being listened to, and their opinions are not requested.
5.1.3.2. Services Offered and Access

Considering the health guidelines provided by the Ministry of Health, the healthcare centre offers various programs of care. There are four programs targeted to specific groups of the population: monitoring children and their mothers, pregnancy care, elderly care, and monitoring patients’ chronic conditions. Additionally, users can ask for general medical consultations with a GP or dental appointments with a dentist.

Anyone belonging to the public health system and living in the geographical area corresponding to the healthcare centre, may access healthcare services there. Enrolment in the healthcare centre is done by bringing proof of the patient identity and of his/her residential status. The service is free of charge for eligible users, and according to the programs to which they belong, they may be entitled receive free drugs and supplementary groceries; these are available for infants and the elderly.

The healthcare centre staff divide their time into “morbidity hours” (horas de morbilidad); these are the hours associated with consulting a general physician - and the hours for monitoring the patients belonging to the programs. “Morbidity hours” are planned for patients who need an appointment during the same day either for any specific health problem, or for a preventive examination. The hours for monitoring patients are distributed among users who require a health check, and appointments are allocated during certain periods of time. The allocation of the “morbidity hours” takes place at 8 a.m. each day. At that time, members of the administrative staff open the doors and distribute the appointments for the day. The number of “morbidity hours” is limited to the number of professionals available in the healthcare centre, that is, members of the administrative staff have a certain number of hours to allocate, and when all these hours are booked, and a patient is unable to make an appointment, he/she must return the next day in the hope of getting an appointment. For example, if a man has a severe headache and wants to consult a general physician, he must arrive early in morning at the healthcare centre in order to get an appointment. If he arrives after 9 a.m. and there are no more “morbidity hours” available, then he must return earlier still the next day to see if he can get an appointment. GPs’ appointments are delivered on the basis of first come, first served. For that reason, patients begin to arrive at the healthcare centre at 6 a.m., and even earlier, to get in the queue for appointments. However, there is no certainty that they will actually be able to access care. The hours are distributed throughout the day: if at 8 a.m. a patient gets a “morbidity hour” appointment, this patient could be attended to any time between 8.30 and 7.00 p.m. The appointment cannot be
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scheduled over the telephone or the internet; the only possibility is to request it in person at the healthcare centre.

In the case of patients belonging to the programs, they are able to request their monitoring hours at any time, usually scheduled at intervals of three to four months. For example, a patient with diabetes monitors his/her health condition by March 5th, and that day he or she requests their next monitoring appointment, for example, for June 5th. If the same patient needs to see a health professional for another health problem (e.g. abdominal pain, or a cold) he/she must ask for a “morbidity hour”.

The opening hours of the healthcare centre are between 8.30 a.m. and 7.00 p.m., but users cannot select the hours for their appointments, the hours are allocated at random by the administrative staff. Additionally, the healthcare centre is open on Saturdays between 9.00 a.m. and 1.00 p.m., with two doctors who are on duty for “morbidity hours”. The process of requesting a “morbidity hour” on Saturdays is the same as for weekdays. It is assumed that users need to understand the availability of appointments at the healthcare centre, and it is also assumed that they must understand the situation of excess demand and the consequent waiting times. Healthcare centre staff often use the phrase "the user has to know how to wait", and that was one of the comments the Director of the Healthcare Centre made in one of our first meetings; although, this time, the comment was aimed at me and my research. As I mentioned earlier, I started my fieldwork in July 2010, but I was only able initiate the interviews at the healthcare centre from September 2010 because, according to the Director, during the winter time (June to August) health professionals could not stop their work to give me an interview, and for that reason “you have to know how to wait” (Meeting with the Healthcare Centre Director, 20 July 2010). And I waited; I waited in the company of the patients in the waiting room whilst continuing to work on the observation of the participants.

5.1.4. First Reflections on the Community

There are three concepts that marked my first months in the community: the waiting, the trust/distrust, and the feeling of insecurity.

I had to learn how to act at the healthcare centre, starting with waiting; every time I had a meeting or an interview I had to wait an average of 40-60 minutes to be attended, a long wait considering that participants (the healthcare centre staff) had selected the most convenient time for them. I spent hours with the patients in the waiting rooms, in a situation that generated frustration, because there is nothing one could do, except wait. I understood how difficult it could be for patients to be in a waiting situation, with no control over their
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own time. They could not engage in any activity subsequent to receiving an appointment at the healthcare centre and on being seen, as they did not know at what time they would be seen, or even if they would be able to get an appointment for that day. The appointment’s system is most frustrating for its users. Through this process, a hierarchy is established because the ‘other’ (healthcare centre staff) have full control of the time, and there is nothing you can do, because they say ‘if you cannot wait you can leave’. But as a patient (and as a researcher) you cannot go, because you need an appointment; it is the only chance to access health care (or in my case to conduct an interview).

At the soccer club the issue was one of trust/distrust. It is usual for the soccer club to receive officials from the local authority as visitors during the electoral period; they go to the soccer club with promises and projects and then never return. During the first few weeks of the research members were unsure as to whether or not I would return the following week. There is a major feeling of distrust among the community towards people coming from outside of it; it was only when people understood that I was going to continue to visit the soccer club that they then opened up and began to trust me.

Regarding the feeling of insecurity associated with working in a vulnerable community, as was explained previously, having grown up in a similar neighbourhood, I generally felt safe during the course of the fieldwork. However, on one occasion I did feel unsafe, this was during a fight at the soccer grounds. A group among the spectators was smoking marijuana and drinking beer during the game, and when the game was over they started to fight. The men from the participant soccer club were very protective of me; they suggested that I leave and they accompanied me to my car: I left immediately. I discussed this situation with my New Zealand and Chilean advisers and consequently decided not to go alone again to the soccer field. Fortunately, I was able to discuss the situation with the Head of Sport from the Municipality and he suggested that I go to the soccer field in the company of some municipality workers, who were attending the soccer games to supervise players’ behaviour. It is very likely that, because of this decision, I no longer had access to certain situations, since groups behave differently in front of an authority. In fact I never saw another fight or any group smoking marijuana on the field again.

These three feelings or perceptions, which I had had from the beginning of my data collection continued throughout the fieldwork, and they have continued to be influential during the data analysis process in order to facilitate the understanding of some of the situations that occur at the community.
5.1.5. Summary

In this chapter I introduced some characteristics regarding Comuna F, the geographical area in which I conducted this research, and I introduced the two study sites: the Soccer Club and the Primary Health Centre. There are two issues in this chapter that are central to understanding the following chapters: the model “sacrifice-endure-escape” (Figure 9), which is essential to the understanding the dynamics relating to men’s health, and all the problems relating to gaining access to Primary Health Centre services; this is one of the main barriers reported by men for not seeking health care attention. Both elements are developed in detail in the following chapters.
Chapter 6. Men’s Health: Perceptions, Beliefs, and Behaviours

How do men perceive their own health? What do men believe in regard to illness? What do men do to stay healthy? What do men do when they are ill?

As discussed in the literature review (Chapter 3), some authors argue that health beliefs have a decisive influence on people’s health related behaviour. Based on this argument, it can be assumed that men’s beliefs about their own state of health and any illness they may have will have an impact on the decisions that they make to deal with any health condition that might affect them. The main objective of this chapter is to describe the soccer club members’ beliefs and perceptions concerning own their health, including their experience of illness, and the behaviours that they adopt in facing health problems and in their efforts to keep themselves healthy. The chapter is divided into three parts: men’s health perceptions and beliefs in regard to health and disease; men’s experience of disease; and men’s health behaviours.
6.1.1. Men’s Perceptions and Beliefs Regarding Health and Illness

I already talked to my son... the day I get sick and cannot continue working he has to put a bullet in me... I do not want to depend on anyone.

(Soccer Club Member, 05 August 2010)

Men in this community have described themselves as hard workers. They perceive their role as provider for the family as being very important and it is from this role that they build their own image as men. It is from their role as worker, and the high value placed on the capacity of their bodies to continue working and fulfilling their obligations, that these same men conceptualize their own health and shape their response to illness. Illness is a threat to their role as provider. The major fear in relation to illness is not being able to continue working, and the need to depend, either economically or physically, on others.

6.1.1.1. Function/Activity as an Indicator of Well-being

Health is defined by this group of men as the ability to work and to stay well enough to continue working. One of the men interviewed referred to staying healthy as: “To be one hundred percent... to do, to work on your daily activities...” (Juan; 11 August, 2010). In this context, labour becomes a primary reason for staying healthy, because health is what allows men to accomplish their obligation to work, and thereby to provide for their families. However, work is also seen as a necessary condition for maintaining health, which means that the work itself is seen as protective of health: “For me to be healthy is to have a job, a stable job…” (Victor; 24 September, 2010). Another participant echoed this view: “If you are good at work, you are good at all activities... and you can meet the goals that you have... you are well physically and mentally…” (Manuel; 24 September, 2010).

In this way men try to stay healthy in order to continue working, and at the same time, work, as an activity, is perceived as an element that protects health; consequently, illness is perceived as a condition that hinders the carrying out of daily activities.

I have a lot of activities during the week and weekend... so, if I'm not well enough, obviously I’m not going to be prepared to attend and participate in these things, and for me it’s important to be at my job and here (soccer club) all the time... (Manuel; 24 September, 2010).
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This conceptualization of health and illness relates the body to the possibility of maintaining an active state. A healthy body is a body that works, it is an energetic body. This is conveyed even in the men’s way of referring to the body in terms of its mechanical capacity. In the words of two soccer club members:

When I get sick... I say well, I'm sick... the machine is stopped, and fails to run... and if the machine is stopped you can’t walk, can’t continue... (Manuel; 24 September, 2010).

For me my body is like my car, when it works, fine, I can drive it very well, but suddenly it stops and I have to take it to the mechanic to fix it, then we can continue functioning well (Soccer Club Member, 18 August, 2010).

Taking care of one’s body is associated not with maintaining and promoting health, but with maintaining its function. When the body ceases to function and therefore impedes men in their ability to continue working, they realize that they are sick. Body care is related to the relief of annoying symptoms; the symptoms that interfere with the ability to continue operating in their daily activities. In this context, the concept of Aguante – to endure – emerges (see figure 9, Chapter 5; and the Glossary). Since the body is understood in terms of instrument of work, sometimes a man who is sick forces his own body to continue working despite illness; as a man he must “aguantar” – endure – his own pain:

Then you realize that you are machista... (a Spanish word used to refer to a person who lives according to strong machismo beliefs – see Glossary) because a real macho has to resist his pain, because usually the man is the provider for the family, so if you... especially when you work independently... if you get sick you lose money, I think that it is in the economic part that affects you immediately, affecting the family budget, affecting everything... (Alberto; 22 September, 2010).

In this context, for a man to report himself as sick, it is necessary that the symptoms or the discomfort must be sufficiently disabling in order to thus force him to stop working.

6.1.1.2. The Importance of Symptoms

Pain or discomfort as a symptom holds great importance. When suffering discomfort, generally a man’s first intention is to try to resist the pain, and only if the pain becomes unbearable, or is too disruptive, is it considered as a valid justification for the cessation of
work. However, a man must first resist the symptoms, reflecting the masculine role associated with the *aguante* (enduring).

This year I had appendicitis, but I went to work for two days with the pain and all... until one day the pain was very strong and my boss sent me to the hospital, I was in grave condition when I came to the hospital, and there I had surgery... but that has been the only time I missed my work due to illness, and I didn’t want to do it... (Soccer Club Member, 03 September, 2010).

Thus, a symptom has two important functions. First, the presence of a symptom gives notice of the presence of a possible illness, and this alerts a man of the need for medical care. Secondly, and the most important role of the symptom for this group of men, is that the presence of discomfort or pain is the only valid excuse for stopping work because of a medical situation. This is because if a man is dealing with severe pain, he is demonstrating himself as being *macho*: the presence of that pain allows him to remain male/*macho*, even if he is not fulfilling the role of provider.

I tell you honestly, I would have to have something (a disease) very serious, very serious in my life... for not working... for example, there was a time cleaning the gutters of my house before winter, I fell back and I spent a week as invalid, doing nothing, I could not move anything, I could not move! I could not walk, the pain was unbearable... was horrible and I was responsible for two jobs at the time, then the issue is to delegate to others what you have to do, but it's hard... (Pablo; 22 September, 2010).

Consequently, men who are perceived to “exaggerate” their symptoms are devalued; the group does not trust them. The man who complains or "exaggerates" his symptoms is regarded as less *macho*, “Women are the ones who complain about everything, for example my wife hurts a nail and goes to the doctor…” (Soccer Club Member, 03 September, 2010). In the words of another man:

One, as a man, minimizes things... you say ‘No, I'm not sick’, even if you are not feeling well... or if you are sick, then you think you are going to get better by yourself... and women no, if they have a pimple they go to the doctor... (Laughter) (Jorge; 01 October, 2010).

In this context, men who complain about symptoms that are generally regarded as being trivial are compared to women. In addition, distrust emerges toward men who are sick "very often":

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There are people, even men, who are hypochondriacs... every day they wake up with a new pain, and it isn’t normal that one day his arm hurts, the next day one leg hurts, the next day the head, the next day his back... I don’t know... and I think they are not really sick... (Alberto; 22 September, 2010).

In summary, a symptom must be serious “enough”, disturbing and credible, to be able to admit one is ill. Additionally, this symptom must be serious enough so that a man can maintain his manhood even when he is sick and his work is being affected by his indisposition. Distrust of a man who has a symptom that is apparently not “serious”, could be related to the view that this group of men share about mental disorders, where visible symptoms are less evident and thus, are not validated.

**Mental Health**

According to the way that health is conceptualized by this group of men, as being based primarily on the ability to work and participate in daily activities, mental health is difficult for them to understand. Mental health problems are not necessarily associated with the obvious symptoms that interfere with the functional capacity of the body; because of this absence of symptoms, the understanding of mental disease is complex. There is a tendency among this group to minimize any discomfort associated with a “simple” mental problem. However, at the same time, most of them view mental illnesses as very serious pathologies, even more serious than those of physical illness (Figure 12).
Mental conditions that are considered simple, including depression and some anxiety disorders, are regarded with suspicion because it is impossible to confirm the presence of any symptoms in the body or how “real the problem is”. Some men report distrust of other men who have a mental condition, especially if it is used as an excuse not to work; in this case the group tends to believe the person is taking advantage.

I think it’s harder to know when someone has some a mental problem... because if the problem is mental and if I do not know that person, I could not know if that person is manipulating me to take advantage... I have seen many cases... and then suddenly you realize that person just wants to take advantage... But that does not happen when the problem is physical, then you can tell immediately if it is true or not... (Pablo; 22 September, 2010).

I do not believe in depression and stuff... in fact I do not believe that because I had a co-worker who said he was depressed... but I have seen him a thousand times at different parties with friends having fun... I think they are fake people who take advantage and say they have a mental problem... but they don’t... (Francisco; 18 August, 2010).

For some men in this group a simple mental discomfort is normal, and they believe that only weak men unable to meet their daily challenges and that it is only women who have this type of problem. A “real” man has to know how to face his problems and how to overcome them. In the words of two soccer club members:

We, as men, cannot have those problems (mental problems)... I think everyone has problems and has to know how to solve them... I could not be failing in my job because I feel depressed or overwhelmed... Can you imagine that? No one would go to work... As men we have to take care of our things, our lives... (Soccer Club Member, 24 September, 2010).

I do not believe much in these things, such as depression... and men that I know, they do not believe either... maybe we minimize some mental problems because they are less abundant in men than in women... I don’t know... (Francisco; 18 August, 2010).

During interactions with the group of men in the club and during the course of the interviews, it became clear to me that, generally, they are suspicious of men who may be “lying” about their mental health symptoms, which are “difficult to prove”. The men involved tend to associate these mental conditions with the weakness that they perceive in some people; individuals who are regarded as not being capable of assuming responsibility for their own lives and the everyday problems that are part of life. In this context, depression
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is a condition that generates great mistrust, especially when the “depression” is used as an “excuse” for not working or for not fulfilling responsibilities. However, these impressions about mental health problems change in the presence of certain conditions that are considered “serious”, and are deemed as related to the idea of being “really crazy”. If a mental disorder is considered a severe pathology by this group of men, there is great fear associated with it.

I think it must be terrible to have a mental illness, I prefer to be fat, deformed, but not having a mental illness... really, I prefer anything, but not being mad...

Interviewer: Why do you think that?

I don’t know... because I imagine that a person with a mental illness has more problems coping in life... that maybe you want to do the right things and your subconscious would not allow you, you lose the control of your life... that's my opinion... maybe I'm wrong, I don’t know... (Rodrigo; 24 September, 2010).

In the words of another participant:

I prefer having a physical disease... with rest and medication, I don’t know... I have a friend who unfortunately has a bipolar disorder and I've seen how he is well today and the next day is bad, and he spends more days inside a psychiatric hospital than outside... it is difficult for him and for his family... (Victor; 24 September, 2010).

The fear generated by mental illness, reflects the fear associated with losing control of life, or the determination to do things, being dependent on others, being unable to work. It is probably because of those beliefs, that it is very difficult for these men to talk about their personal experiences in relation to mental health problems. For them there are only two possibilities in relation to a person who refers to having a mental problem: one, that he is pretending because he wants to take advantage and avoid responsibility; or two, he is really crazy and cannot be held responsible for his actions. From this perception, it is difficult for this group to openly express any mental discomfort they may have, since a man suffering from any problems associated with mental health is seen as weak, as a liar, or as completely crazy.

Vicente: I think it’s something about which you do not talk too much (mental health problems), a man always prefers not to talk about his problems... one prefers don’t comment mostly...

Hector: Nobody is going to be comfortable saying ‘you know what? I have this problem and I’m worried or I’m sad...’ Nobody! That does not happen...
Eduardo: Maybe, sometimes, you can talk with a close friend... but he must be a really good friend, your closest friend... but you always prefer to show yourself cool or relaxed about your problems, you are not seeking a friend and saying ‘...hey, I want to talk to you because I have this problem...’ because that friend is going to say ‘...you’re wrong, you're crazy...’ (Men’s Focus Group; 10 October, 2010).

According to some men in the group, the only situation where they could talk about these issues is when they are drinking alcohol together. In the words of one participant:

Suddenly, you can talk about some things, not everything... but a man is reserved about these themes... but, for example, when you are drinking alcohol with a friend, then he could start to talk, ‘You know, I have this problem with my wife’ or something like that... but when a man is clean and sober you don’t realize about those problems... as friend you don’t have any idea... (Jose; 07 September, 2010).

Despite a reluctance to talk with other men about any problems that might be associated with mental health or any emotional problem, during their individual interviews some men commented on emotional experiences that had been affecting them. As I mentioned in the previous chapter, seven of the 20 men interviewed individually cried during the interview, and most of them spoke of their painful emotions. One of the interviewees talked about his experience after the death of his mother:

The illness of my mother... that really affected me, I was very close to her... (He starts to cry)

Interviewer: Tell me, now that a year has passed since the death of your mother, how do you feel now?

I have been feeling better, but not completely... at night, when I sleep, suddenly I wake up, I'm anxious, I have trouble sleeping... at first I was afraid... yeah... you know... it is a slow process... (Rodrigo; 24 September, 2010).

Another participant talked about his experience after the death of his one-year-old son because of leukaemia:

Sometimes I have no desire to get up, or to go to work... little things that overwhelm me, sometimes I want to explode and send everyone to hell...
Interviewer: Is there anything you do to relieve those feelings?

I try to be strong, I don´t have more alternatives...

Interviewer: Do you talk to someone else about this?

No, never, I never talk about my problems, even with my wife, my problems are mine... I have to know how to solve them...When my son died I was alone in my house one year, I woke up and I sat on the couch, then from the couch to my bed... and I never went to the doctor... a year! I didn´t talk to anyone about it... (Victor; 24 September, 2010).

The need to be strong is greater than the need to talk about their problems; however these problems are still there. Often, at the end of such interviews, I offered the interviewees guidance for contacting a health professional to discuss their emotional problems, but nobody accepted it. The prospect of showing themselves as vulnerable in the presence of a “stranger”, and a health professional at that, generated immediate rejection, and so carrying on and trying to manage their emotional problems on their own was the preferred approach.

6.1.1.3. Implications Illness for Men: The Ghost of the Dependence

The main fear associated with having an illness, whether physical or mental, is that the illness could interfere with the ability to continue with a “normal” life, especially in the activities that relating to work. Dependence on another, either physically or economically because of a health condition, is a situation that creates great anguish that arises from the threat to maintaining the role of family provider. In the words of two interviewees:

At the end of the day, you don´t... when you aren´t one hundred percent healthy means... you depend on other all the time, depending on... economically, depending on everything... (Juan; 11 August, 2010).

I know... you're a human being within a community, you are not alone; you could ask help if you are sick. But you don’t want to be a trouble to others... that isn’t fair (Roberto; 29 September, 2010).

In this context, sometimes men prefer to hide symptoms from others. They tend to believe that if the symptom is ignored, then no-one notices and they are not a bother to anyone:
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I always get the same issue... I prefer to say no, you know... ‘I’m good, I’m fine’... and if they say ‘Hey! We knew you were sick’, I say ‘No, I’m fine’... I can have the pain, but I’m okay for others... it’s like the same theme as I said before... I have foolish pride... I do not want anyone to be worried about me (Javier; 25 August, 2010).

When the men become sick, when they need help, or when they have to stay at home because of a health problem, some of them reported that they felt out of place and that they do not feel comfortable at home:

What happens when I’m sick? I stay in my home... and what happens when I’m at home? I get bored! I have nothing to do, I don’t have a space to be there, I'm bored! So I just go out to work, I would have to be dying to stay at home doing nothing... (Soccer Club Member, 14 September, 2010).

Staying at home is not an option for some men; they prefer to stay at work, as another soccer club member explained during one of my participant observation:

Can I be completely honest with you?

Interviewer: Yes, tell me...

I think it's very good that you are worried about the men´s health... but, you know what the problem is? Doctors say "well if you want to live longer you have to do this, or you have to stop eating that", but who told them that I want to live so long?... I do not want to be like those old people who retire and have to be asking the family for money... or staying at home doing nothing... I prefer to work until I die, I don’t care when, could be tomorrow or in 20 years more... (Soccer Club Member, 25 August, 2010).

For men who are already ill, and because of that illness are unable to perform the same tasks as before, the frustration is always present. An interviewee reflected as follows on his situation following a cardiovascular incident:

For example I would like to move quicker, go further, or to do things that I cannot do... so many things I cannot do now that I am sick, and I cannot do!... and I have to ask for help, and sometimes I feel worse for having to ask for help than for my disease... (Andres; 04 October, 2010).

In the words of the Municipality Head of Sports, “I think that... when men are sick they feel horrible... they get angry, because they lose the ability to be the super macho” (08 September, 2010). An illness threatens the fulfilment of the culturally assigned provider role among these men. Therefore, the disease is an obstacle, a problem, and a challenge to the
constructed masculinity. Dependence on others is experienced as humiliation; to ask for help because of a health condition is something that they try to postpone as much as possible. This could be a key element in understanding how men structure their relationship with the health system and with health professionals, a phenomenon that is described in the following chapters.

6.1.2. Men's Illness Experience

The experiences of reported illness by this group, in their terms, are categorized as "accidents" (see glossary). An accident is understood as a health event that is outside the normal course of events and should never have happened. These “accidents” can be of different types, for instance a fight or a fall that caused an injury, or a medical “accident” such as stroke and heart attack. Describing these events as accidents allows men to understand these experiences as "isolated" situations, something that happened in the past, and does not necessarily have a connection with the current health condition. The significance of a disease as a temporary situation is central to understanding how men face some chronic conditions, or how they face the potential consequences arising from any health problem. Furthermore, a health problem or an illness perceived as an accident absolves men of personal responsibility related to that problem; from this understanding any change in their lifestyle is irrelevant.

In this section, I discuss three ideas that reflect the experience of illness in this group of men and how they give meaning to the event of illness: “common” health problems, chronic conditions, and the phenomenon of “I've never been sick”.

6.1.2.1. Common Health Problems

When I asked men about their experience with disease, many of them responded that they generally have “good health”, and rarely become ill. The most common health problems mentioned were colds and some stomach problems, but usually they did not give importance to these health situations because, despite the discomfort, they could continue working. Other situations are considered more serious, such as an injury caused by a fall, a street fight (as discussed in the previous chapter), or accidents at work. One participant talked about a work accident when he lost one of his eyes because he decided not to wear the protective glasses provided by his employer at that time:
For example, when I lost my eye... then that situation was hard for me, I had to have a protection, some glasses, and I didn’t... But now I'm fine. I have no problem with that, when somebody says for example "...hey you don’t have an eye…", I don’t care... I’m fine now... (Antonio; 03 September, 2010).

Although some accidents or injuries could have serious, permanent, consequences, some men tend to minimize their health problems, and they try not to talk about their own health. For example, when asked to talk about their experiences with disease or any problems that had affected their health, they tended to say "I have good health in general" or "I have no major health problems." For this reason, during the interview I asked men about their specific experiences with the most common health problems for Chilean men based on the data reported by the Chilean Ministry of Health (2007); these are very similar to the health problems reported recently in epidemiological accounts (Chilean Ministry of Health, 2010; Gattini & Alvarez, 2011). The health issues included; cardiovascular conditions, respiratory problems, issues relating to stress or anxiety, and problems relating to alcohol abuse.

Of the 20 men interviewed, seven of them reported some problems or discomfort during their life associated with cardiovascular disease. Four had received the diagnosis of hypertension associated with a stroke:

I have no such problems now (cardiovascular problems)... but when I had the stroke then my heart almost stopped, then the doctor told me that my heart had wanted to stop... but the doctor did a treatment and I'm fine now... (Hugo; 29 September, 2010).

One participant reported a heart attack:

I neglected myself... We, as teachers, we have a problem (he worked as teacher in a public school for 20 years)... our problem is the responsibility of being compliant... and sometimes we forget ourselves... and I forget myself... I thought that the cholesterol was a simple thing... and no... And I had a heart attack, but now the doctor says I'm fine, and I feel good... I was afraid before, but now I have no fear... no fear at all... (Miguel; 03 September, 2010).

Two participants reported some cardiovascular complications as a result of their weight. In the words of one of them:

Once I had to go to the doctor, last year, because I could not breathe and I was feeling some pain in my chest... and the doctor said I was overweight, I was weighing 128 kilos, and since then I’m trying to lose weight... (Rodrigo; 24 September, 2010).
Another interviewee claimed that he did not have cardiovascular problems, but then he remembered “some pain in the chest area”:

I don’t have that kind of problems (cardiovascular)... but, you know... I do not think it’s a problem, but several times I’ve had a strong pain in the chest, really strong you know... but then the pain is gone... that’s happened sometimes, but as I told you, I've never gone to the doctor for checkups... I don’t like it, so I really don’t know if I have a problem... (Marco; 25 August, 2010).

In relation to respiratory conditions, seven of the 20 interviewed reported having had some health problems. In their words, these problems related to "suffocation", “breathlessness” or "shortness of breath", and some men associated these symptoms with excess weight or tobacco consumption. “Once I had to go to the doctor because of this breathlessness, I had exceeded my weight... my body was very heavy” (Marco; 25 August, 2010). Nine of the 20 interviewed declared themselves as smokers, and two men even asked to smoke during the interview “to be more relaxed”:

I have to ask you please to let me smoke during the interview, I know I should not, but here at the club is the only quiet place where I can smoke and relax myself... at work it’s prohibited, and I cannot smoke in my house (Soccer Club Member, 05 August, 2010).

Tobacco consumption is common at the soccer club, and is often associated with alcohol consumption. “I smoke, but not so much. If I am smoking it is because I am drinking (alcohol), I have to smoke when I drink, it's like a habit that I have” (Marco; 25 August, 2010).

Considering all men interviewed individually, only two of them reported that they did not consume alcohol, and sometimes because of this “no-consumption behaviour” those men did not participate in some activities of the soccer club, or they participated just at the beginning of the activities. One of those two said he did not like drinking alcohol, while the other one was an alcoholic until age 38, and does not drink anymore,

I was very alcoholic... I drank a lot, every day... the last time I was drunk, I drank every day during three years! Every day! I drank five litres of wine per day minimum... with time I recovered, my family helped me, now I don’t drink a single drop of alcohol... (Hugo; 29 September, 2010).
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Although most men stated that currently they can control their alcohol consumption, eleven of the interviewed reported having had some problems related to alcohol consumption at least once in their lives.

For me it was like anxiety... anxiety of waiting until the Friday for going to drink alcohol... as a young man I spent a lot of money from my salary just drinking... Then you have a family and you can’t... now I drink but never as I did it before... (Juan; 11 August, 2010).

I'm not alcoholic, but my mom says I am... because there is no weekend that I am not drinking... but I think an alcoholic is drinking every day, Monday to Monday, or an alcoholic stops working because is drinking... I don’t, I drink just on weekends... (Marco; 25 August, 2010).

The consumption of alcohol is completely acceptable at the soccer club. As mentioned in the previous chapter, the "third time", the social activity that occurs after the soccer games, is always accompanied by alcohol. In this group of men there is an implicit agreement: “...they should drink together”. A man must know how to drink to celebrate, to face the difficult times, or to share with friends.

In relation to the consumption of illicit drugs, most men are against it. Drug use is not socially accepted by the group: “I don’t understand drug addicts... I don’t like it, and it is extremely expensive to be using drugs, I really don’t understand...” (Pablo; 22 September, 2010). Another participant echoed this opinion: “I think people who use drugs are mentally weak... when I've seen some young people in the neighbourhood consuming drugs I say to them that is wrong, they are wasting their money!” (Juan; 11 August, 2010). The Municipality Head of Sport also explained this rejection of drug use in the soccer club:

Sometimes on weekends you can find some groups smoking marijuana on the soccer field, but they are not part of soccer clubs, they are spectators of the soccer game... Then the club members say ‘You know what? It’s not our problem, they are not part of the game, they are just fans’. I think alcohol is much more accepted in the club... Drug addicts are not accepted at all... (Municipality Head of sport; 08 September, 2010).

In fact, I never saw anyone consuming drugs at the soccer club, and none of the men interviewed referred to using drugs. The social sanction of this group of men to drug addicts is very strong. For that reason I believe that if some club members were drug users, they would not comment on such a situation at the soccer club.
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Regarding the problems associated with stress and anxiety, 18 of the interviewed referred to having had some problems either currently, or in the past. These problems can be divided into two groups: problems related to any mental or physical disorder for which men have consulted a doctor and received a diagnosis, and problems that they consider "minor" or “normal” and for which they have not consulted a health professional. Among the first group of problems, the diagnoses received by men were diverse, including: nervous psoriasis, irritable bowel syndrome, and mental health related problems such as panic attacks or anxiety with an attempt at suicide.

It was psoriasis, I do not know what type, doctors never could tell me why I had that... but they told me I was nervous, they give me some creams, and suddenly I was fine... I do not know what happened to me... (Juan; 11 August, 2010).

I have the disease that is fashionable in Chile, the famous irritable bowel syndrome, and is caused by having many problems at work, concerns, you cannot be quiet... (Pablo; 22 September, 2010).

The irritable bowel syndrome indeed is very common in Chile (Klinger & Klinger, 2001), and many people who work associated the stress of their work to an intense stomach pain, self-diagnosed as irritable bowel syndrome. In some cases, these people consult a health professional, confirming a formal diagnosis of irritable bowel syndrome, but more commonly they do not go to the doctor and try to manage these stomach problems with home remedies.

In relation to mental health and anxiety problems, two participants talked about the diagnoses that they have received:

Product of a work overload, I was tired... that caused me stress or something... and I had a panic attack while I was driving... I was a taxi driver at that time... then I went to the neurologist and he told me I was having panic attacks... I was surprised, because I associated panic attacks when one has a fear or something like that... but no, it's something that affects your body, I had tachycardia, sweating, I was trembling... (Alberto; 22 September, 2010).

I'm not quite right, and the doctor told me... The problem started with the separation of my wife, I loved her so much... I just wanted to die... there was a time when... (silence) when I just wanted to cut myself... and I cut myself, and some neighbours had to take me to the emergency room. Then the doctor told me that I was bad... I had a lot of anger and sadness at the same time... now I'm a little better, but not completely... (Carlos; 18 August, 2010).
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Within the group of problems considered ‘normal’, most of them are related to situations of stress or anxiety that originated from some problems at work, in the family, or financial troubles.

You always have a problem that affects you... I was never diagnosed with anything, but when I analyzed some periods of my life, then I realize that maybe I've suffered from this sort of thing (stress or anxiety)... suddenly one is stressed at work, or sometimes you could have problems in your own home and that affects you... (Andres; 29 September, 2010).

Problems related to stress or anxiety because of a situation at work, or because of a family circumstance, are socially accepted by the group, but only if these problems are not used as an excuse to stop working. There is the implicit belief that a man can be stressed, but he must still work, and he must know how to deal with his problems; then his masculinity is preserved.

6.1.2.2. Chronic Conditions

Regarding the incidence of chronic conditions in this group of men, of the 20 interviewed five of them reported they had been diagnosed with a chronic health condition. Based on their own accounts, four of them had been diagnosed with hypertension, one of whom has elevated levels of cholesterol and has already suffered a first heart attack. Three of the men diagnosed with hypertension have already suffered either a cardiovascular incident or a stroke. In response to the doctor informing them that they should change their diet and incorporate physical exercise in their daily routine, only one of them is trying to walk a little more. Only two of these men reported maintaining regular checkups to monitor their health condition. The story that these men have constructed about their health condition is linked to the ‘accident’ or the ‘disease episode’ (heart attack, cardiovascular accident, or stroke). Experiencing a disease as an isolated event allows them to understand what happened, but once they have recovered from that “episode” they do not necessarily accept the chronicity of their health condition.

In February 2008 I was in my home with my family, trying to help because it was lunchtime, and suddenly my world was clouded... My niece called the ambulance and took me to the hospital... I think that has been the only time I've been sick, when I had the cardiovascular accident... luckily I'm fine now and I can work without problems... (Hugo; 29 September, 2010).
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Two years ago, I had a hypertensive crisis, a cardiovascular accident... I didn’t know... but one day I had a strong headache and I was dizzy... and I looked in the mirror and I had strabismus, and my sister told me that I looked weird... I went to the healthcare centre and explained my symptoms, and the doctor told me I had to take some tests to see if I had hypertension, and I did, and then he realized that I had hypertension... that was the problem, and I started taking medicine... but I'm fine now, good as new... (Jorge; 01 October, 2010).

The absence of symptoms or physical discomfort makes it difficult for these men to understand that they have a chronic condition; they usually say "I'm fine" or "that it’s over and everything is going well now". The situation that most concerned them is that their condition does not interfere with their work. One participant returned to his work just one week after suffering his stroke.

I had a problem in my brain, a stroke... The truth is that I didn’t feel any discomfort at the beginning, I didn’t notice anything. Some friends told me that my mouth was twisted and I had a very closed eye, then I could not move, it was so fast... So I went to the emergency room... Now I feel good. I saw so many sick people at the hospital worse than me, that makes me think I'm healthier than others... I recover quickly, even the doctor was amazed at how quickly I had recovered, because at first I could not talk, that was a Monday, and the next Monday I was already working... (Andres; 04 October, 2010).

A challenge in relation to chronic conditions is that men need to understand that their health condition has changed permanently. For this group of men it is difficult for them to recognize that there are health conditions that are permanent and do not present evident symptoms. It is probably for that reason some of them do not understand the importance of treatments, and they are not willing to change their eating habits or to attend check-ups.

6.1.2.3. "Never Sick"

Finally, there is a sub-group of men who claimed that they never have been sick. According to them, they have never had either a cold or any serious symptom that has made them think they were sick. “I've never been sick at all, not a single cold...” (Felipe; 01 October, 2010). In the words of another interviewed:

I’ve never had a disease... I’m telling you the truth... I have not been sick at all, I have good health... I have nothing to complain about... I have not seen a doctor during the last 20 years, maybe I went when I was a child, but as adult
I've never needed go to the doctor for a health problem... (Antonio; 03 September, 2010).

In some of these men there is an emphatic denial of the disease experience, including one interviewee who had already suffered a heart attack. He commented, “I never get sick, I've never been really sick, I'm the worst interviewee that you could find, because I've never been sick...” (Miguel; 03 September, 2010). Another participant who had suffered a cardiovascular incident also commented on his experience of "no disease":

The first thing the doctor told me was that I had hypertension, and I had no idea, I had never been sick, never in my life... I remember that the only time I've been sick was that time of the accident (cardiovascular), no more... I had never felt ill, if I had some discomfort, such as a stomach problem, I drank a hot water and that was all, I never had anything serious... (Andres; 04 October, 2010).

The implications for these men of declaring themselves as completely healthy, or to claim that they "have never been sick" are that this group has never felt the need to approach a healthcare centre. Any symptom or any discomfort is minimised, and this has a major impact on the relationship they establish (or not) with the healthcare centre and with health workers.

6.1.3. Men’s Health Behaviour

Men’s behaviour related to their health care or health risk can be divided into two types: everyday behaviour that is part of their lifestyle, and the behaviour adopted to deal with any symptom or illness.

6.1.3.1. Healthy and Non Healthy Behaviour: Men’s Lifestyles

I do not know what happens to me... I know my health is really important... but still I am not responsible to myself... (Juan; 11 August, 2010)

Among the behaviours that some men try to maintain in their daily life to stay healthy, and which are identified by them as “healthy behaviours”, are physical activity and certain precautions that they incorporate in their diet. As I mentioned before, not all men are
physically active, and only nine men in the group of 20 interviewed play soccer. However, for those who do play soccer, physical activity is assessed as central to their own health care:

> I play soccer every weekend, I’m in the goal... I am the goalkeeper... and I try to maintain an exercise routine.... also with some friends we are training children here in the *Comuna*, preparing them to play soccer... (Marco; 25 August, 2010).

For some of them, it is not just being active; it is also “sweating it out”:

> I maintain my health by doing physical exercises... when I feel physically or mentally exhausted, and I feel that I'm going to catch a cold for example, I run and I sweat, that’s my way to stay healthy, I exercise myself to stay well... (Alberto; 22 September, 2010).

In relation to care taken in relation to their own diet, most of men expressed their intention to eat “healthy food”; this, for the men, is associated with food cooked at home, and trying to avoid fat or fast food. “I try to eat well... I try to eat more natural, just in my home... not so much junk food. Sometimes I don’t eat lunch at work and I wait to get home for lunch and eat healthier food there...” (Alberto; 22 September, 2010). Perhaps more important than the type of food, the biggest eating problem is the amount of food the men eat. As mentioned, many of them avoid fast food, but when they eat home-cooked meals they do not necessarily evaluate the quantity:

> Usually you do not control yourself in your food consumption, some people do not control... men in general do not control their consumption... few men control themselves and say “No, I’m going to try to eat less”... I think that 90% of men do not do that, however in general women try to do that. Not all, but most women have a balance in that aspect, in their diet, they are worried because they want to look prettier, or they say “I'm too fat”... Women are more responsible with their diet, a man is not so careful in that aspect... (Alberto; 22 September, 2010).

The excess of food is related to the cultural beliefs associated with personal sacrifice (Chapter 5, Figure 9). Men sacrifice themselves by working all day and then, at home, they do not want to deprive themselves of anything. For example, for some men it could be a problem that their wives want to be on a diet to lose weight:

> There are times when I've worked all day, and I came to my home and my wife gives me a salad! Just a salad! At the end of the day I just want to get
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home and eat something decent, something satisfying... (Soccer Club Member, 07 September 2010).

When my wife comes up with her diet, because she thinks she is fat, I immediately took my precautions... and before I get home I go somewhere to eat something. Then I get home, there I eat what she wants to give me, and we do not fight that way... (Juan; 11 August, 2010).

In the context of discussing the behaviours that men considered unhealthy, they stated that the biggest problem is excess: excess of food, excess of alcohol, and excess of cigarettes.

Sometimes you do not control your consumption of alcohol for example, especially if you're in a party or celebrating with your friends... and then you do not control yourself... (Rodrigo; 24 September, 2010).

I am the most irresponsible person in this aspect, I don’t practise physical activity, I'm a smoker, I'm not restricting myself when I’m drinking or eating, and I eat a lot of fried food... (Victor; 24 September, 2010).

Some men try to balance these excesses with behaviours considered "healthier". For example, one respondent said that he cares for himself by drinking milk after drinking alcohol.

I drink milk... after the drunkenness I drink milk, for the hangover... I buy and leave at home one or two litres of milk... so if I drink alcohol on Friday, then on Saturday I drink a lot of milk... that's what I drink every time after the drunkenness... I care for myself in that way (Marco; 25 August, 2010).

In summary, the greatest threat to men's health according to them is the excess, the excess of food consumption, alcohol consumption, and in some cases, tobacco consumption. All of these behaviours were commented on by men in the interviews, and I was able to observe them directly in the soccer club during my interaction with the group. The major question is: Why do this group of men maintain these behaviours, considering that sometimes they understand that they could be damaging? Two men participating in the focus group commented:

Vicente: It could be a psychological thing... I don’t know... because I know what I have to eat, what is healthy food, I know! But it's like... I say ‘I’m going to care for myself, I’m going to care for my own diet’... and then I can’t...
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Pablo: For example you could know that the pork is high in fat and is bad for your health... you know that, but it is too tasty and I just eat it, and I don’t care. (Men’s Focus Group; 10 October, 2010).

Another participant commented in his interview:

You think in your head that you are fine; you think that is fine... but suddenly you realize that it's not fine and if you want to be healthy you have to be careful, and you don’t... I don’t know why... (Hugo; 29 September, 2010).

Many of the men in the group know which behaviours could harm their health, but for some reason they maintain their unhealthy stance. It seems that apart from in their work, the men are not willing to sacrifice themselves. The implicit belief is “I sacrifice myself at my work, but I'm not willing to sacrifice myself by restricting my food or alcohol consumption”.

6.1.3.2. Responses to Symptoms

Whatever happens... the function must continue...
(Alberto; 22 September, 2010)

The strategies adopted by this group of men in facing any symptom or disease can be summarized in four phases, set out in Figure 13.

![Figure 13: Responses to symptoms](image-url)
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The four phases are sequential. In the beginning men try to ignore their health problems, minimising them and doing nothing. Then, if the problem persists they tend to discuss it with someone, usually a female relative (mother, wife, sister). After that, they decide, either alone, or in the company of a female relative, to manage the symptom using self prescribed, natural, or traditional medicines. Finally, if the problem continues or the pain is too annoying, they decide to seek help at a healthcare centre, but this is the last resort, and the least common:

Well... the first thing I would do if I'm feeling very bad and I see that the pain is persistent, is to talk to my wife, then she would give me some medications, and then... if I still feeling bad... I would go to the doctor; I think that any man would do the same... (Rodrigo; 24 September, 2010).

Doing Nothing

In the presence of an illness or an annoying symptom, the first attempt is at ignoring or minimizing it. This can happen in two ways: doing nothing and waiting until the discomfort passes, or trying to "help" in some passive way, hoping that the symptom will disappear. “I never worry about that (disease), I never stay in bed, I do not rest... if I have a cold or fever, or whatever, I keep my normal life...” (Roberto; 29 September, 2010). In the words of another participant:

I don’t take even a pill when I have a headache... I don’t do anything if I feel bad...

Interviewer: But what do you do if you have a headache?

If the pain came by itself it is going away by itself, that's my principle... (Pablo; 22 September, 2010).

Two participants commented on how they try to accelerate the process of feeling better:

If I have a pain I try to be quiet. If I have a stomach pain I press my stomach and I try to fall asleep waiting for the pain go away (Javier; 25 August, 2010).

When I'm not feeling well I like to close my windows to keep out a single ray of sun, and I sleep all day, trying to help the process of getting better, because I have things to do, I have a job you know... (Pablo; 22 September, 2010).
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If the strategy of doing nothing or resting does not work and the pain or symptom persists, the next step is to discuss it with any female relative or a female friend.

Consultation with Women

Of the 20 men interviewed individually, 16 of them stated that, at home, the person responsible for the family’s health is their mother or their wife. Only four men in the group said that they should take charge of their own health because they are either single, divorced, and/or their mother has died, but even in those cases, they prefer to discuss their health with a female friend. The decision that a man makes to evaluate symptoms and take actions is discussed with his mother, wife or sister. The outcome of the discussion may be, either, to take a natural or traditional medicine that is available at home, or to go to any healthcare centre:

My wife is like a walking pharmacy... (laughs) so, she knows what to do when someone is sick at home... so if I'm feeling really bad I talk to her... (Pablo; 22 September, 2010).

The concept of “walking pharmacy” represents the idea that women are the ones who have the knowledge about the medicines that serve to manage illness at home. Those medicines could be “natural” or “traditional”, and the men would be inclined to ask the advice of “a woman at home” when they are sick:

If I’m feeling bad, my sister tells me what medicine I should use, and then she tells me ‘...if you do not feel well in two days we are going to go to the doctor...’ (Luis; 09 September, 2010).

Even the decision to seek help from a healthcare centre is done in conjunction with women:

When I am sick and when the pain is intolerable, my wife convinces me and she gets for me an appointment at the healthcare centre and she takes me there... (Rodrigo; 24 September, 2010).

Women are perceived as being responsible for health at home; they have the necessary knowledge regarding how to deal with a symptom or disease. During my participant observation, on more than one occasion I observed interactions between women (wives of the soccer club members) in which they exchanged health tips, for example "my
husband has a very strong cold”, and another woman answering "I have some herbs at that could help…” (Soccer club members’ wives, 09 September 2010).

**Self Medication/ Self Prescription**

A self prescription to relieve symptoms could include natural and traditional medicine. Some men prefer to try with natural medicine first, and then they can combine this with traditional medicine:

I always try to drink some herbal tea when I feel bad; I drink a mint tea with *matico* (natural medicine) for my stomach pain or for a headache... (Juan; 11 August, 2010).

Fifteen days ago I had a strong cold, I really felt bad, my back ached, my bones... so I went to the pharmacy to buy medicine and I was using herbs too… (Jorge; 01 October, 2010).

"Simple" medicines (e.g. aspirins, ibuprofen) are bought at the pharmacy without a prescription. Herbs are purchased from various businesses in the neighbourhood and from food markets, and sometimes the men reported that they had used medicines, such as antibiotics, that have been prescribed (but not used) for a prior illness. When the medicines used in the home did not work and the pain or disease continued, then they would decide to seek help from a healthcare centre.

**Seeking Health Care from the Formal Sector**

Some men in the group commented that their decision to seek help from a healthcare centre depended on two factors: severity of symptoms and/or duration of symptoms. If men had any pain or symptom that was very annoying and they were not able to move or to work because of the pain, then they immediately would consult a health professional. Also, if they had a symptom or pain that had been continuing for a long time (the time might vary from weeks to months) then they would seek help:

Eduardo: You go to the doctor when you get scared, when you lose control of what might happen, control of the situation... then I think you go to the doctor...

Alberto: In my case, I go to the doctor when the illness or symptom is longer than usual... for example once I had a intense stomach pain, vomiting everything, I spent three days... a week with that pain, and after three weeks with the same problem I went to the doctor... (Men’s Focus Group; 10 October, 2010).
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Another interviewee commented:

You know, what happens is that we, as men, we do not go to the doctor until you actually see that the matter is serious...

Interviewer: And when do you notice the matter is serious?

When you could not stand up by yourself, because you feel very bad, when you cannot work, because you aren’t well enough... (Pablo; 22 September, 2010).

Consultation with the formal health system is the last resort used by men, and this consultation will occur only when they perceive that they have lost control of the situation, and also that the management of the disease at home is not working. Any effort or any behaviour to make them feel better would continue only as long as the symptoms persist; this means that once the man feels "healthy" again he will not continue taking medication (traditional or natural) and would not continue attending the healthcare centre.

6.1.4. Community Advisory Committee Response to Provisional Findings

My aim in this chapter was to give an overview about the beliefs and behaviours of the group of men from this community in relation to their own health. These beliefs and behaviours, allow us to understand in part why this group is often distant from the public health system, since the postponement of health consultation seems to be linked to the gender role closely related to the role of family provider. The driving force behind the men’s attitudes seems to be that, because a man must work, it is necessary to postpone any health situation that might become an impediment to the continuation of his function as worker and provider. Consequently, health is understood as the absence of discomfort or pain in one’s body, a body that is seen as a working tool or machine; any symptoms or discomfort are minimized, and the seeking of an appointment in a formal health system is delayed as much as possible. This way of thinking becomes a barrier in the relationship that the men of this community could establish with the public health system. When I shared these provisional findings with some of the participants in the study and with the CAC (respondent validation of findings) they confirmed that these beliefs and behaviours accurately represent the group of men in the community. However, they also emphasized that it is very important to consider that there are other variables that act as barriers in the relationship between the
group of men and the health system, especially certain issues relating to ease of access to the health system and the length of waiting time. In the words of one member of the CAC,

"It is real that we as men have some beliefs that keep us away from healthcare centres. But my fear is that you or other people think that is just our fault, or that it’s just our responsibility for not attending the healthcare centre. Because the healthcare centre creates many barriers for us, especially related to access, and the problems related to access are an important reason because men don’t want to go to the healthcare centre" (CAC Member, Respondent Validation of Findings).

This fear related to the idea of blaming men for their absence in the health system represents a reality. In fact, as discussed in the next chapter, on many occasions the health workers blamed men for not going to healthcare centres, without considering the barriers that had been imposed by that same healthcare centre.

In my role as observer and researcher, I understand the apprehension of some men who do not want to be "blamed" for the poor relationship that they have with the health system, because the healthcare centre actually creates certain barriers that especially affect this group of men. However, my attention was drawn to the immediate reaction of some CAC members to "defend" the group of men, by putting some blame on the “other” (health system) in the failure of a relationship that they, too, are a part. The question is: who is responsible for the health of a community? A group? The individuals? The families? In the next chapter (Chapter 7), the discussion around this question continues and considers the opinion of health workers in relation to who the responsible for the population’s health.

6.1.5. Summary

This chapter has focused on three areas: men’s health perceptions and beliefs regarding health and disease, men’s illness experience, and men’s health behaviours. Men's beliefs about their own health are linked to their ability to stay active, working, and any experience of illness is understood from the inability of the body to perform its functions. In the presence of any symptom or illness, the first attempt for a man is to doing nothing and to wait for symptoms to disappear. If symptoms persist a man tries to manage the condition with home remedies with the help or advice from a wife, mother, or sister. Finally, as a last resort, in cases where symptoms become too disruptive or are prolonged, a man may finally decide
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to seek help in a healthcare centre. These findings are of great importance in the understanding of the health of Chilean men since it is from the role of gender that is culturally assigned to men, which includes: the role of provider for the family, the importance assigned to work, and the perception of one’s own body as a working tool, that it is possible to better understand the men’s health perceptions and behaviour. In the next chapter the way in which health workers perceive men’s health is described, with the intention of contrasting the positions of both groups and analyzing the spaces of agreement and disagreement among the group of men and the group of health workers.
Chapter 7. Health workers: Beliefs and Strategies pertaining to Men’s Health

How does the definition of ‘health’ assumed by health workers influence their health strategies? How do health workers perceive the group of men in the community? What do health workers think about the health of the group of men involved in this study?

This chapter includes a discussion of some of the ideas and beliefs held by health workers that might possibly influence the relationship between health workers and the group of men in the community. The health workers’ beliefs are a reflection of the health policies implemented in Chile, therefore to describe the perceptions of this group regarding men’s health will delineate future fields of action to improve health strategies focused on men. The chapter is divided into three parts: the first part, focuses on the concepts of health and disease as described by health workers; these are discussed along with some of the ideas held that could influence health workers in relation to the design of the health strategies. In the second part, details are revealed of the way in which health workers tend to observe the group of men as patients in the healthcare centre. Finally, I include my own reflections on the health workers beliefs and practices.
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7.1.1. Health Workers’ Beliefs

For what reason are you going to worry about men’s health if even they are not worried? (Administrative staff member, Information Desk at the Primary Health Centre; 01 September, 2010)

When I began my field work at the healthcare centre, in order to introduce myself, discuss the purpose of my research project, and obtain information in regard to ideas that the administrative staff might have concerning men’s health, the first step was to conduct participant observations in the waiting rooms. During one of my visits, I approached the information desk, the place where any patient is required go in order to ask any questions or to seek information. The first reaction to my enquiry was the question: “For what reason are you going to worry about men’s health if even they are not worried?” The two female staff members on information desk duty seriously enquired as to why I was worried about men’s health, and why I thought men’s health could be important. They told me that not many men sought care at the healthcare centre; for the most part, it was the elderly, or children accompanied by their mothers, who frequented the centre most often. Therefore, they could not understand why I wanted to focus my study on a sector of the population that is not generally represented at the healthcare centre.

According to my perception, the thinking of these women represents clearly the logic of the healthcare centre: Why design health strategies for a population group that does not frequent the healthcare centre? Why invest effort in a group that apparently does not care about their own health? The director of the healthcare centre reflected on those questions:

We organise our health service according with the expectations and the demand of the population. The problem is we do not know the men, and for that reason I’m very interested in your study... What are the expectations of men? What do they want? Because if they don’t want anything, we do nothing... So, it is interesting to know what they expect, because in that way we can offer that service (Fernando, director; 14 September, 2010).

As the director of the healthcare centre mentioned, the problem is that health workers do not know the men who belong to the community in which they (the health workers) are employed. As shown in Chapter 6, the group of men stay away from the healthcare centre.
The men avoid - or postpone as much as possible - seeking help from the formal healthcare system. However, even though this group is absent from the healthcare centre, health workers do hold certain opinions relating to the men in the community. The question is, how did the health workers form their opinions about the group of men in the community? The answer to this question could possibly come from a variety of different sources, either: opinions based on the limited contact that the healthcare centre staff members have with men at the healthcare centre; opinions based on the information provided by women in relation to their husbands, fathers, or any other male relative; or, opinions based on the personal experiences of the health workers themselves. In this last point there is an important distinction between those health workers living in the local community, usually the administrative staff, and the health professionals (who generally live outside the community) who do not feel safe in this neighbourhood (see Chapter 5) and who themselves access health services through the private health system.

Those health workers living in the local community are themselves users of the public health system, and include many who seek care in the same healthcare centre in which they are employed. These workers have an accurate opinion in relation to the reality experienced by men of the community; they know the needs and behaviours of the community, either by direct contact with their families, or, by proximity to neighbours and friends. On the other hand, health professionals living in other higher socio-economic communities, and who are users of the private health system, are often unaware of the reality of the community in which they work, since the only contact they have with local residents occurs during health interactions within the building housing the healthcare centre.

A clear example of the first situation arose during my interviews with health workers. I asked them to describe, using their own words, the relationship that the men from the community have with the primary health centre. In the words of an administrative staff member living in the community, the relationship established by men with the healthcare centre “…is a relationship marked by anguish or distress, because the access to the healthcare centre is very complicated and they realize that they don’t have a real health support for them or their families…” (Paula, administrative staff member; 26 October 2010). On the other hand, in the words of a professional living outside the community, the relationship between men and the healthcare centre was described as "distant" (Arturo, dentist; 26 October 2010), since men would not be interested in a relationship with the health system. Thus, the explanations given by both health workers reflect two quite different realities: the administrative staff member highlighted the access issues affecting the

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community, while the health professional understood the same situation as being a lack of interest from the group of men.

Based on these perceptions, health workers establish – or do not establish – a relationship with men of the community. As discussed in chapter 5, the situation is complex because it is usually the health professionals who make decisions about the health strategies and programmes to be implemented; generally, they do not give space to the views and comments of the administrative staff members who, in many cases, have the most accurate information in relation to the needs of the community.

In order to understand the variables influencing the relationship that the healthcare centre – including professionals and administrative staff – has with the community, it is necessary to explore three ideas or concepts constructed from the perspective of the health workers: 1) How do health workers understand the concept of ´being healthy´? 2) How are the healthcare centre’s health interventions and strategies initiated and designed? 3) How do health workers perceive the concept of ´self-care´?

7.1.1.1. How do health workers understand the concept of ´being healthy´?

Health workers at the Primary Health Centre understand the concept of health in different ways and in consideration of diverse elements. When I asked them: “How would you define ´staying healthy´?“ A few health workers began their answer by citing the official WHO definition of health:

I know the WHO definition by heart, but... you know, I think my understanding about the health concept is similar... It is the physical, social, eh... (Silence) psychological, social, the bio-psychosocial model! (Arturo, dentist; 26 October, 2010).

Others referred to their understanding of the healthcare centre`s perspective on health: “The concept of being healthy for the healthcare centre focuses primarily on physical and mental health…” (Paula, administrative staff; 26 October, 2010). When considering this concept of health, including mental wellbeing, some health workers mentioned the importance of emotional factors: “People know that there is a physical component and an emotional component within health…” (Fernando, Director; 14 September, 2010).

Additionally, two health workers mentioned the function/activity capacity as a health-related variable: “The person who is performing their duties, doing activities... having a stable job, to me that is to stay healthy... a stable person, engaging in physical activities”
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(Andrea, nutritionist; 19 October, 2010). “Well, for me, a person who is healthy is a person who can develop their daily activities…” (Rosa, nurse; 21 October, 2010).

However, among health workers, the most common definition for being healthy, which best represents the strategies used by the healthcare centre, is a definition relating to the biomedical tradition that understands health as the absence of disease. Even those health workers who mentioned other elements relating to the concept of health, then completed their answers by including the aspect of the absence of disease: “A healthy person is a person who is free of diseases…” (Andrea, nutritionist; 19 October, 2010). “A healthy person is someone who ideally does not have a disease…” (Rosa, nurse; 21 October, 2010). Another health worker echoed this view:

To be healthy it is important that all my values are normal; some chemical values are fine, within acceptable ranges. In other words, cholesterol, for example, all biochemical profiles, lipid profile, glucose... As a woman, the gynaecological aspects... All those values and aspects should to be normal... (Gloria, physician; 21 October, 2010).

Given this focus among the health workers on health as the absence of disease, the strategies of the healthcare centre and the Chilean Ministry of Health give special attention to the treatment of diseases, focusing on the treatment of “AUGE diseases” (see Glossary), and incorporating the early diagnosis of disease as one of the few prevention strategies. This understanding of health as a concept, defines the scope of health workers, who thus, necessarily, focus on the detection of disease.

As reported in the previous chapter, the definition of health given by the group of men refers rather to the absence of any symptoms or discomfort that might prevent them from continuing with their functions as worker or family provider. Men are not necessarily interested in the diagnosis of disease. More importantly, in the presence of an "asymptomatic" disease, such as hypertension, they would give no importance to the diagnosis and would continue on with their activities, without going to check their medical condition or making lifestyle changes.

Thus, while health workers place the emphasis on disease, the men are giving importance to the ability to continue functioning. This difference of views in relation to the same concept of 'being healthy', could be one barrier to an encounter and understanding between the two groups.
7.1.1.2. How does the Healthcare Centre design its health interventions and strategies? “Acting according to demands”

Health systems react according to the demand of the population. If there is more demand for an activity, then we are forced to open a new health service...

(Fernando, Director; 14 September, 2010)

In organizing the health strategies at the primary health centre, it is the health priorities established by the Chilean Ministry of Health that are of principal consideration for health sector employees. As I previously explained, the Chilean Ministry of Health has established the prioritization of diseases; called AUGE diseases (see Glossary). This prioritization of diseases is related to the epidemiological information of the population; the list includes the most prevalent diseases, those for which the health system receives a higher demand. In the same way, the Chilean Ministry of Health sends information to healthcare centres relating to the various health campaigns during the year, which are also designed according to the diseases that are most recurrent in the population; for example, the winter campaign focuses on the respiratory diseases that are prevalent during the winter time (Figure 14: Picture 3).
The design of health campaigns considers the entire Chilean population. Thus the same informative poster concerning a winter campaign is used, both in a healthcare centre in Santiago, or in the healthcare centres serving rural areas. However, the only place where information relating to health campaigns is disseminated, is in the healthcare centres; thus people who do not attend healthcare centres do not have access to such information:

We put all the information sent by the Ministry of Health on the walls of the healthcare centre, but who sees it? Who accessed the information? People who come to the health centre. People who do not come to the healthcare centre do not know which campaigns we have, or what the benefits they can access are (Fernando, director; 14 September, 2010).

There are always health campaigns, different health programmes, but sometimes people do not have the information and do not know where to go, and are supposed to be the people that need to be informed... but they do not know, or sometimes do not understand (Paula, administrative staff; 26 October, 2010).
As noted earlier, the on-going strategies at the healthcare centre are designed based on the priorities established by the Ministry of Health and the demands of the population. There are two programmes that are very strong at the healthcare centre: (1) attention to pregnant women and children up to six years of age, and (2) the programme for elderly people. Some health workers reflected on the limitations of both programmes:

We have some problems related to how we have planned health strategies over the time. Because, for example, the children's programme is up to six years old. The child is six and we have nothing else to offer. Until... (Silence) never, because there are not programmes for adolescent health... There are no goals associated with health strategies for adolescents... perhaps for women is different, because we focus on women from the start of the reproductive age, because the pregnancy prevention... and everything that is related to the reproductive area (Fernando, Director; 14 September, 2010).

We have some special strategies for older adults, sometimes we go to community with doctors, nurses, nutritionists, psychologists, we go to the community... we get a space there and we offer health services to the elderly people, so they do not have to come to the healthcare centre to seek health care, but we can only care for the elderly... if a woman or a child approach us because they want to ask something, we have to direct them to the healthcare centre, they have to come here (Andrea, nutritionist; 19 October, 2010).

The problem identified by some health workers is that some health programmes exclude patients who may be interested in receiving health care. Even some of the health workers recognized that health programmes are often focused on women, and that men are not included in the health strategies.

Everything is focused on women, because they (health professionals) are always talking about women should access to the papanicolaou, the mammography... but there are very little information to make a call to men, and I think they also should worry a little more about their health, their physical condition, they can be hypertensive, or diabetic... (Paula, administrative staff; 26 October, 2010).

In practice, at the healthcare centre, there is always information focused on attracting the attention of women; to control weight or to offer preventive testing (Figure 15: Picture 4). During seven months’ of fieldwork during which I kept in contact with the healthcare centre, I never saw a poster or any information that was targeted at attracting the attention of men.
This lack of messages focused on men, is analyzed by some health workers as being part of the lack of health prevention strategies. The healthcare centre is organised to respond, either to health needs, or, to health demands; this means that health strategies often focus on treatment, without including health prevention or promotion:

I think the problem is… there is no prevention, because I think it would be good to develop strategies to promote health, for example social workers promoting health at the community... including men... (Paula, administrative staff; 26 October, 2010).

In summary, the health system and the healthcare centre organise their strategies according to the demand of the population. A higher level of consultation by a specific group (women, children, or elderly) or a higher level of demand for a specific disease, such as a respiratory disease, are the key elements influencing the design of specific health interventions. Consequently, the health system responds only to those who present themselves at healthcare centres. The epidemiological or statistical information recorded by
the health system merely represents the status of the regular users of the system while ignoring the situation of those who do not regularly visit the healthcare centre. The information collected from patients at healthcare centres contributes to the epidemiological data that inform health priorities. Health services thus are strongly influenced by, and biased towards, some groups (the higher users) in the population, while ignoring others: the non-users. In this way, men are invisible and silent in the public health system. Again the questions emerge, such as: Why design health strategies for a group that is not represented at the healthcare centre? Or, the question mentioned by the staff members at the Information Desk: Why worry about the men’s health when even they are not worried?

7.1.1.3. How do health workers understand the concept of self-care? “Patient’s Responsibility: Self-Care”

The majority of health workers think that it is the user who has the responsibility for being in charge of their own health/disease for seeking help in a healthcare centre if they have any health problems. The concept of “Self-Care” emerges in this context; this is understood as the responsibility that a patient should have about their own health/disease. According to some health workers, they (the health workers) are not responsible for the health of the population. The patient should know how and when to seek help at a healthcare centre, and health workers should give prompt attention to the need if it is requested. In the words of the Director of the healthcare centre:

People should realize that the State, the Government, is not responsible for their health... the State may be responsible for providing the health system, and give you the possibility to access and take care of yourself, but it’s not responsible for your health... We, as a healthcare centre, should not look for anyone, we should have open health services and the user who needs help must come and ask for our services... the patient is responsible for their health... But today that does not happen, you smoke a lot, then you have a lung cancer, and who do you ask for help? To the State... and the State is expected to spend a lot of money, all the money necessary to help you... in a situation you knew very clearly about the consequence of smoking, and you knew what could happen... so the problem is that people are not responsible (Fernando, Director; 14 September, 2010).

In the words of another health worker:
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Some people have not understood the importance of self-care... to be responsible for my own health... being well, feeling good is your responsibility... drinking water, eating healthy... doing physical exercises, walking a little more. That is a responsible health (Andrea, nutritionist; 19 October, 2010).

Considering the concept of Self Care, according to some health workers, the big problem for men is that they are not responsible for their own health: “The problem is that... I think they (men) have not internalized the self-care” (Andrea, nutritionist; 19 October, 2010). The implicit belief of some health workers is that men are careless, irresponsible about their own health, and for that reason they have health problems. Another health worker reflected:

I believe it is necessary that they (men) take a little more time to worry about their health... thinking about their health and to say "I have to care myself, as a man, and worry about my health" because, at the end, who is going to receive the benefits? Yourself... That man is the first person called to care about their health. I believe every person has to care and worry about it... (Gloria, physician; 21 October, 2010).

The conceptualization of ‘health’ as the absence of disease, the organization of health strategies based on the demands of the population, and the belief that users of the health system are primarily responsible for their own health and for the accessing of care, has a variety of implications. On the one hand, the prioritization of diagnosis and treatment of diseases often leaves out the strategies for disease prevention and health promotion; thus becoming a system that gives answers, but does not anticipate problems. On the other hand, although the health system appears to be effective in giving answers to the members of the population who go to the clinic, the problem is that the system ignores the situation of those who do not present themselves at the healthcare centre. Finally, it considers that the user is responsible for seeking help for any health problem; however, the main risk is that some groups in the community will not attend the healthcare centre, even when they have a health problem. In this context, some health workers think that if men are not in the healthcare centre is because they do not need any health care or do not care about their health. In the following part of this chapter, some health workers’ specific beliefs concerning the group of men in the community are reviewed.
7.1.2. Men as Patients

Even though, for some health workers, the problems related to men’s health are associated with the idea that men do not care about their own health care, other participants recognize the difficulties that men could have in taking care of their health; such difficulties could be related to the men’s function of providing for the family and their responsibilities at work: “They (men) need to maintain a working position. Despite being sick they have to work and they cannot take the time to improve their health and continue. Men will always work, even if they are sick” (Maria, nurse; 21 October, 2010). In the words of the Director of the healthcare centre:

There are many people, many men, that need to work... and if they do not work one day they don’t receive money. Then, the problem is related to not being absent at work, because of the role of provider that they have in their family... then there is also a social aspect that limits the man for seeking help at the healthcare centre... The main problem is that salaries for men in this community are low, so men cannot lose even a day of their work in going to the healthcare centre... there is some degree of mandatory attendance at their work, sometimes there are sick men going to work for an economic reason (Fernando, Director; 14 September, 2010).

The importance of presence at work is evaluated by some health workers as a barrier that sometimes affects men, limiting their access to health care at the healthcare centre. However, some health workers also recognize that presence at work is something valued by men, not only because it is an economic issue. Some health workers recognize that to stay at home due to some health situation could generate discomfort amongst a group of men:

Men are psychologically affected when they are sick, and it is not just a matter of money… I think men want to be at work, not at home, is boring for them to be at home, because they get bored... I have seen many sick men who are angry because they cannot wait to return to work, they do not feel comfortable at home (Daniela, administrative staff; 28 October, 2010).

Therefore, health workers are often aware that men cannot suspend their duties at work in order to go to the healthcare centre, and they also understand that work can be identified as an important motivation for men to stay healthy. This perception about the importance of work as a motivation to stay healthy is similar to the information manifested by the group of men from the community:
The great motivator that men have to take care of their health could be the motor function, the possibility to continue working, doing things... If they have a health problem, if they have a stroke for example, and they have sequels... for example... they will not be able to move or to work, or they will not be able to play soccer... that would affect them (Rosa, nurse; 21 October, 2010).

What matters to men is keep working and continue to fulfil their function as men. As a male, as a macho, who must respond as a man... Even the sexual aspect... it's terrible for a diabetic, for example, when it decreases his libido... for them is terribly disturbing... Also many times the man is the provider of the house, then he should be able to continue working so he can provide for his home and for his children (Andrea, nutritionist; 19 October, 2010).

In this context, the maintenance of physical functioning could logically be seen to motivate men to care about themselves and the need to stay healthy:

If the man is feeling bad, if the man cannot continue working, he is going to worry, he is going to take care of his health... If the man is good, feeling good, no pain, no discomfort, the man is going to live his normal life, without worries about his health... that’s my opinion... (Arturo, dentist; 19 October, 2010).

7.1.2.1. Men and Disease

According to the health workers interviewed, the problems affecting men relate mainly to an unhealthy lifestyle and, in particular, to certain unhealthy eating habits, alcohol and drug consumption, and the delaying of health care access. This last issue, the delaying of access to health care, was seen as having important consequences for men in relation to their health outcomes and the severity of the diseases that they might present:

Many men in the population have digestive problems, but they think it is normal, they think that is a common stomach problem related to some food. For example, they eat beans or noodles at lunch, then they have a stomach pain and they think is because of that food, or because they eat too much... but many of these men will develop health problems over the time and eventually some of them even could have gastric cancer, which is one of the main diagnoses that occur more in men than in women here in Chile, but they would never go to the doctor because of a stomach pain (Rosa, nurse; 21 October, 2010).
I'm not sure why, because I don´t know the medical reasons, but in my workplace (administrative staff member in charge of organizing the medical records of patients) I have about seven thousand medical records and each one represents a person with cardiovascular disease; seven thousand persons with a diagnosis of diabetes, hypertension, and people who have high cholesterol... but men represent less than a half of these cases... and they live less than women, women come here suddenly at 87 years old, and they continue coming and demanding medical appointments, but men use less than a half of the drawers with these medical records (medical file capacity) linked to cardiovascular problems, which are the main cause of death here in Chile... (Paula, administrative staff; 26 October, 2010).

In regard to the consumption of alcohol or drugs, many health workers recognise that these are important problems in the community, and some of the health workers associated the use and abuse of alcohol or drugs with mental problems, such as depression: “I think some men use the alcohol or drugs to cope with emotional problems... depression for example, or changes in their emotions because their problems” (Maria, nurse; 21 October, 2010). For some health workers, men´s mental health may be an issue, often related to the social situation in which men are living, specifically the lack of economic resources:

I think that mental health could be another problem for men... because of their living conditions, especially in the public health sector where the working conditions of the population are not the most appropriate; often the salaries are not very good. In such circumstances, sometimes men have working times that are too long, to achieve a better salary. Then they are tired, sometimes frustrated, and they start using drugs or alcohol, then they could develop a depression... For that reason I think mental health is an important topic when we are talking about men´s health (Rosa, nurse; 21 October, 2010).

7.1.2.2. Mental Health

Health workers recognize that for men to have mental health problems could be part of a more complex issue. In the words of the Director of the healthcare centre:

Yes, you can get sick as a man... maybe that is accepted, but a man cannot have mental health problems, it is like ‘not allowed’... for example, as a man you cannot be sad because your partner left you… a man cannot have those problems, a man must be strong all the time, with his friends, with his family (Fernando, director; 14 September, 2010).
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In regard to mental health, the perspectives of men and health workers were in agreement. A man who has mental health problems is therefore seen as weak, and if he receives the diagnosis of having mental health problem, he could then experience problems at work. The Director of the healthcare centre also recognized that having a diagnosis of a mental illness could be problematic, and that some men may even lose their jobs:

In the mental health programme, we have few men, although they may have the same difficulties as the group of woman... because there are situations where it is better not to consult... or it is better not to have a diagnosis. For example, a mental health diagnosis sometimes is known at the place of work, by the boss, then... that can affect a man, because the boss could think that this problem could have an effect on his performance… (Fernando, Director; 14 September, 2010).

Other health workers, mostly women, think that the absence of men in mental health programmes at the healthcare centre is because men do not suffer from such problems:

I believe that is less common for men to have those problems (mental health problems)... there is just a little group of men that have depression... because for a man his functions are to work, to produce... they don’t have other concerns... Women are worried about the children. Sometimes they have a lot of problems with the children in the house, and because of that they are depressed. The woman is the one with the children, who cares all the time... such as when they are teenagers. But instead, the man does not care, and he suffers less stress, because when he gets home he watches TV... I work very closely with the psychologist here, and I have never see many men in the mental health programme (Andrea, nutritionist; 19 October, 2010).

According to other health workers, although men may have mental health problems, they, either, do not realize it, or, do not share their feelings with anybody else:

What I’ve observed is that men tend to be more self-enclosed... but they have emotional problems. In fact you can see men with depression... but it is harder to know the emotional state of that person, because men are self-enclosed. I believe that machismo (the Spanish word to refer strong beliefs associated with the role of men) still exists. That is what I’ve observed in my family's experience, I believe that for a man it could be very difficult to suffer an emotional state... they have a lot of problems trying to deal with it... and sometimes they seek refuge in other things like alcohol... (Maria, nurse; 21 October, 2010).

If they (men) don’t have someone who really realizes what is happening, they don’t do anything. They will withdraw into themselves and not tell anyone...
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because the psychological aspects may not affect them as much as some physical problems, so they continue living their lives, working… (Daniela, administrative staff; 21 October, 2010).

In any case, health workers all agree that it is rare for a man to approach the healthcare centre to seek treatment for any mental health problem, and when that does happen, the sufferer is embarrassed:

I´m working at the mental health programme, coordinating the appointments, and when men come to the mental health programme they feel diminished, they don’t like to talk loud, they feel observed by everyone, they talk just with the person who is in the window and hopefully no one else knows, no one else listens when they are asking for an appointment at the mental health programme... but when they come for a broken arm or something like that... then they do not care, that does not complicated them. The issue of mental health is really difficult for them, they feel embarrassed... (Paula, administrative staff member; 26 October, 2010).

This perception, relating to the difficulties associated with the recognition of a mental problem by the group of men, is similar to the information provided by the men at the soccer club, who manifest that to have a mental problem could be a threat to their individual masculinity, because a “real man” has to know how to deal with his problems. Therefore, a man with mental health problems is seen as weak or as being less macho.

7.1.2.3. Men’s Illness Behaviour

What men do when they are sick?
They do nothing… I do not really know what they do… (Laughter)
(Daniela, administrative staff member; 21 October, 2010).

When men have either, an illness, or a disease, that affects their physical or mental health, health workers perceive that the first response by men is to do nothing and wait until the symptoms disappear. Next, such men may try to manage the disease with medication at home, in company of their mothers or partners; and finally, if the problem persists, they may eventually seek help at the healthcare centre. This sequence is quite similar to the process reported by men when dealing with a health problem, as described in the previous chapter (Figure 13).
In the words of some health workers: “I think the first thing men do when they are sick is to shut up, and not to tell anyone what is happening” (Rosa, nurse; 21 October, 2010):

For example, if a man has a stomach pain... in those cases they try to eat lighter meal... they try to change their diet, and usually you, as a woman, if you realize that your partner or your son is sick, you try to cook healthier food (Daniela, administrative staff; 21 October, 2010).

Men are unconcerned about their health in general. They don’t worry about it, they don’t buy medicine, they don’t go to the pharmacy... they use what they find at their houses; they take something (a medicine) that someone else, usually their wives, took home... (Fernando, Director; 14 September, 2010).

Regarding the use of medicine without a prescription, some health workers perceive that men usually only use medicine on the recommendation of a female relative: “I think men don’t self-medicate... it is always a second person who gives them the medicines, their mother, their grandmother, their wife, or their sister” (Carolina, administrative staff; 02 November, 2010).

All the health workers interviewed agreed that seeking care at the healthcare centre is the last resort for men and that, most of the time, they delay formal consultation in regard to health for as long as possible: “From my experience, I think that men come here when they have something that prevents them continuing with their work and their family life...” (Maria, nurse; 21 October, 2010). In the words of another participant: “After about 3 or 4 days of feeling very sick... and sometimes after a marital fight because the wife is worried, then men go to the doctor...” (Carolina, administrative staff; 02 November, 2010).

Almost all the health workers commented that women have an important role in the management of men’s health and disease. Women are responsible for the family’s health, and they are also usually in charge of administering natural and traditional medicines, and in deciding when it is appropriate for a family member to seek care at a healthcare centre: “In general, men who came to the healthcare centre are those with a wife who is encouraging them to consult... Single men and younger men generally don’t consult because they also have less risk perception” (Rosa, nurse; 21 October, 2010). In the words of other health workers:

Sometimes wives become mothers to them, so if the wives are not saying: "Hey, you have to go to the healthcare centre"; "Hey, you are smoking a lot"... As woman, if you are not pushing them, they do not do anything... You
always have to say "Hey, go to the doctor…" or "Hey, please go and take a blood test, I’m going with you…” (Carolina, administrative staff; 02 November, 2010).

The dependence of men to women is strong when we are talking about health issues… the role changes… Usually he is in charge, the strongest… but not now. It’s the wife who takes care of health issues… I observe that in my patients with diabetic foot, when they come in with their partners, with their wife… then you can see how the roles change, she assumes the role of protection… She is the one who cares, who cares about the foot washing, who cares to bring the man to the healthcare centre; she cares about everything! (Maria, nurse; 21 October, 2010).

This dependence of men on women sometime is utilized by the health workers as an important element in maintaining contact with the group of men, giving information to women, understanding that they are responsible for the family´s health:

I think the health expert in a family is usually the woman, frequently the woman is who is in charge of health care at home… and we try to use that resource, for example when we want to have an impact on the child's health or the adolescents´ health, and even with the group of men… we know we have to give the message to the woman of the house, sometimes we give her the responsibility of the medications and we try that she understand the treatment (Fernando, director; 14 September, 2010).

Here, in this healthcare centre, we attend men who are 28 years old and they come with their mother to the doctor, and of course we try to explain to her some things about the treatment... (Andrea, nutritionist; 19 October, 2010).

The implicit belief of health workers is that women have the knowledge, the disposition, and the responsibility to take care of the family’s health. Consequently, men do not have the knowledge to be in charge of their health; this constitutes a major barrier to their self care competence. Thus, the "most appropriate" health strategy would be to educate men: “What is needed is education, education on health. We need to give them a good education... to promote... and disease prevention. That is what men need” (Arturo, dentist; 26 October, 2010). In the words of other health workers:

You have to educate the population... teach them to eat well... to worry a little more, worry about their dental health, their physical health… that is what is missing… (Gloria, physician; 21 October, 2010).

Education, that is what we need to give men... knowledge of some symptoms, knowledge of healthy eating, knowledge of healthy living conditions to avoid getting sick later, and what the recognition of symptoms, and have an early
consultation... encouraging that aspect of early consultation, which is a key issue with men (Rosa, nurse; 21 October, 2010).

From their role as "expert", some health workers perceive that the solution to improve men’s health is to provide education to the population, “using” women as the messengers of health messages.

7.1.2.4. The Implications of Disease for Men

According to the collective opinion of all health workers, it is hard for men to accept that they may have a health problem, and when they accept that they are suffering a disease, they begin to decay mentally, feeling weak: “In fact men are very affected when they are sick, the disease affects their ego (laughs)... I do not know why, they feel worthless, they feel diminished” (Carolina, administrative staff; 02 November, 2010). In the words of another health worker: “I think men are coming down faster than women when they have to face a disease, they are more emotionally-vulnerable than women... for men is difficult to accept a disease” (Andrea, nutritionist; 19 October, 2010). Some health workers say that any attempt to "be strong" disappears when a man accepts that he is sick, even exaggerating his complaints:

“When a man becomes ill he is the victim of the situation. They (men) are sick, and nobody can be sicker than they are. So... they can have the same disease of their wife, but they feel worse, they are always more serious... (laughs)” (Andrea, nutritionist; 19 October, 2010).

The worst scenario that can happen for a sick man is the necessity to suspend his function as the provider for the family. In the words of a health worker:

What I’ve seen for example, are men who suddenly have an accident or are having any health problem and cannot go to work, they say they feel horrible, and they are struggling with self-esteem problems... and they feel worse if the woman has to assume the role of provider, they begin to have problems in their marriages... because they are accustomed to have that role, to be the provider for the family (Rosa, nurse; 21 October, 2010).

Disease threatens a man’s self-esteem, he feels weak, vulnerable, and is also under an obligation to ask for help, either of his wife, or of a health worker. Perhaps that is one of the
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reasons why men delay, for as long as possible, the recognition of themselves as being unwell.

In summary, health workers perceive the group of men from the community as being a group who are absent from the healthcare centre who are often considered to be irresponsible in regard to with their own health care. This is why, in many instances, men are infantilized by health workers, assuming that it is the women at home who have the principal responsibility for the family’s health. In this way the health system assumes that men will not come to the healthcare centre. From such a lack of demand, the centre does not generate specific services or programmes for men, but rather, that it is the women who should bear the burden of caring for the health of their household.

When I discussed the summary of the findings with some health workers (respondent validation of findings), they recognized the absence of specific programmes for men. However, health workers also recognize that it is very difficult for them to generate such spaces, because that particular group of men is not a priority for the health system, due to the lack of demand from them. The health workers who were interviewed recognized the existence of a vicious circle: men do not demand health services, therefore the health system does not generate specific interventions for them; since they do not generate intervention, or specific spaces that are focused on men, the group in question do not come to the healthcare centre. Additionally, although health workers indicated that they ignore the health needs of this group, some of them even suspect that the men really do not have health needs.

7.1.3. Interpreting Health Workers' Perspectives

In this section, I review some of the concepts discussed by health workers in order to establish an understanding of the relationship that health workers establish with men in this community. The aim here is to emphasize two ideas: the conceptualization of health based on the absence of disease, and the importance of self care.

The conceptualization of health by health workers continues to focus on the absence of disease; from their perspective, the main function of the healthcare centre is to provide care and treatment for disease, thus leaving, as the second category any strategies for the prevention of ill-health; these are not considered to be a priority by the Ministry of Health that is focused on “AUGE diseases” (see Glossary). Additionally, health workers incorporate an element of self care, which refers to the user's responsibility to go to the healthcare centre
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when in need or care, while the actual role of health workers is to make health services available to those requesting assistance.

The idea of health as the absence of disease and the importance of self-care, offers male users two main challenges: 1) to be able to define themselves as ill including actively seeking care at a healthcare centre, and 2) the need to be able to care for their own health; this includes maintaining a healthy lifestyle. The problems emerge when health workers are unable to understand the concepts that are held by the community about what it is ‘to be healthy’, and the self-care associated with the definitions of ‘health’, as perceived by some community members; these may differ from those of health professionals. As I commented in the previous chapter, men of this community define themselves as being sick based on two criteria: the severity of symptoms (pain that prevents them to perform their functions) and/or the persistence of symptoms (pain that is maintained for long periods). For instance, a man declares himself as being ‘ill’ as a consequence of an intense stomach pain that is maintained over three weeks. Thus, the first challenge for men who consider themselves as being ill is to seek timely help at a healthcare centre, this is due to the fact that, for men, the first attempt at diagnosis is to wait until the symptoms disappear or to wait until the symptoms becomes persistent; thus, sometimes, the seeking of care at the healthcare centre simply does not occur, or does not happen within the time frame expected by health workers.

Considering the logic of self-care expressed by the group of health workers, which means that is the individual who should be responsible for his/her own health, it is possible to find other discrepancies arising from the different understanding that the men of the community and the health workers have about health as a concept. As mentioned in the previous chapter, for men in this community to be healthy is to be able to maintain their responsibilities at work, to be active; thus they take care of their functionality, by trying to relieve their symptoms and continue working. Thus, while self-care about their own health is present for this group of men, the problem is that their definition of health is not necessarily the same as that held by health workers. In the logic of this group of men "I care about what I consider important; not to show myself as vulnerable, not to show weakness, and to continue working". They have “self-cared” in regard to the aspects referred to. However, during the interviews my perception, as the researcher, was that health workers want patients to take care of the health care aspects that they, the healthcare centre staff, believe to be important, such as; the prevention of chronic conditions and maintenance of a healthy lifestyle. They consider those patients who do not adopt these self-care strategies to be irresponsible.
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In this context, health workers consider an effective health strategy for men is to educate them, using women as the messengers; this strategy often results in a list of instructions about what men should, and should not do, such as: they should not smoke, they should take care of their diet, they should take physical exercise, and so on. From the health workers’ position they want to tell the patient what to do. The treatment previously delivered to specific pathologies is now replaced by the education they provide to meet the new epidemiological trends that are focused on chronic conditions. In any event, they want to "give the solution" telling the patient what to do, and expecting the patient to want to go to the healthcare centre to receive that solution.

7.1.4. Summary

This chapter has been divided into three parts: the concepts of health and disease described by health workers, the way in which health workers observe the group of men as patients, and some elements of personal reflection about the ideas exposed. Many of the health workers do not know men of the community and are unaware of their health needs, referring to the group of men as irresponsible and as careless with their health. From this perspective the healthcare centre does not generate specific programmes for either disease prevention, or, health promotion that is aimed at men, since health workers themselves do not consider it necessary to design health strategies for a group that is absent from the healthcare centre.

To this point I have described the health perceptions and beliefs of the group of men, and the concepts and ideas that health workers have. Taking into account both points of view, in the next chapter, the way in which the two groups interrelate is discussed. Considering the primary health centre as the main scenario, the perceptions of both groups about the relationship with the other are described, what the barriers faced by them are, and what their suggestions are for improving health care and the access to it.
Chapter 8. Men and Public Health System: The Relationship

What happens at the primary health centre in relation to men and their health requirements? What are the barriers to the access of public health services as identified by men? What are some of the suggestions made by men in relation the improvement of the health services provided for them?

In this chapter, the procedures and practices at the primary health centre are discussed; the discussion includes the identification of barriers that may currently exist and possibly affect the relationship between the men of the community and health workers. The chapter is divided into three parts. The first part of the chapter details the existing procedures at the healthcare centre and emphasises the problems of access, in addition to some of the issues relating to the attention received by patients. The second part discusses; the alternatives used by men in order to avoid seeking health care at the primary health centre, the use of emergency rooms in the public sector, and the consultation of “private doctors”. The third part of the chapter presents some of the suggestions raised by men from the community for the improvement in the health services that are currently available to them at the primary health centre. Finally, I present my own reflections on the relationship established by men and health workers.
8.1.1. Primary Health Centre

As mentioned in Chapter 5, any resident of the Comuna, who does not belong to the private health system, can seek public health care at a designated primary healthcare centre. However, the main barriers to accessing primary healthcare, as identified by men from the community, are the difficulties associated with access and attention.

In Chapter 5, it was explained that the staff of the primary health centre divide their time into ‘morbidity’ hours, and hours to ‘monitor’ patients belonging to the programmes provided. On a daily basis, ‘Morbidity’ hours are planned for patients who, due to health issues, require an appointment during that day with either a GP or other health professional. These hours should be accessible to all those patients attending with common complaints, such as colds, fevers, or to those with other symptoms, and also to first time patients coming to the healthcare centre for similar common health conditions. The hours for ‘monitoring’ patients are designated for those users who have health conditions requiring continuous supervision, such as; those conditions that have been diagnosed as being chronic, pregnancy, or recovery from accidents.

The main proportion of the users attending the healthcare centre generally seek an appointment during morbidity hours; hoping to get an appointment with a health professional during the course of that particular day. The schedule is issued by members of the administrative staff from 7.30 a.m., and the appointments are distributed between 9 a.m. and 7 p.m., the working hours of the healthcare centre. If a patient does not receive an appointment because the entire schedule for the day has already been filled, that patient is expected to return to the healthcare centre on the following day to re-request an appointment. It is not possible to book an appointment for the next day, neither is it possible to request an appointment by telephone or through the internet. Many men say that it is this kind of access to the health system that influences the decision not to go to the healthcare centre; some of them think that is "humiliating" to have to get up at 5 a.m. to go to the healthcare centre when they are not even sure that they will be successful in accessing an appointment. Therefore, lack of easy access is the first barrier identified by the group of men, and many of them decide do not go to the healthcare centre just for the reason of access; these potential non-attenders constitute a large population sector that does not seek consultation at the primary healthcare centre and thus produces the first major escape of men from the health system (Figure 16).
The second barrier, and perhaps also the second escape of men from the healthcare centre, is the quality of attention provided by health workers. Many men say that attention from members of the administrative staff is poor, while others distrust health professionals. Both barriers – access and attention – are the main reasons reported by men to explain why so few of them are seek care at the primary health centre (Figure 16). In the words of some of the participants:

When do I go to the Healthcare centre? I think that I would go to the healthcare centre if I was alone and I had no economic resources to go elsewhere. In that situation I would go to the healthcare centre… Forgetting my pride as a person… because it is humiliating, it's really humiliating. (Juan; 11 August, 2010)

I think it's bad, it’s really bad, the health care is really bad… and why men don’t go there?... even if they have any health problems... Well, the man is very reluctant to go to the doctor, in general… But the problem is that you don’t want to go to any place when you are going to receive a maltreatment, because you know from your friends or from your family that in the healthcare centre you could receive a maltreatment... and I, as a man who
works, who sacrifice myself for my family, I'm not willing to receive a maltreatment… So, for that reason in the healthcare centre there are more women and children, not men, because we have not patient for that… (Luis; 09 September, 2010)

As previously mentioned, men either, avoid, or postpone as much as possible, seeking help from within the formal health system. For every man who decides to seek help from a formal health service provider, there are many others who, because of the problems of access and the length of time spent waiting for an appointment, never interact with a health worker in order to get an appointment at the primary health centre. From amongst that group that does decide to wait to get an appointment, there are sometimes those who decide not to continue with the appointments process; this is due to administrative issues relating to the lack of attention or to a negative interaction with the health workers at the centre. In the end, there are only a few men, amongst those who originally decided to go to the primary health centre, who finally gain an appointment and get to interact with a health professional (Figure 16). From their accounts, the majority give up before getting as far as consulting a health professional and receiving treatment.

8.1.1.1. Access

Interviewer: What do you have to do to get an appointment at the healthcare centre?

To get an appointment at the healthcare centre what I have to do is lower my dignity as person... (laughs)

(Miguel; 03 September, 2010)

The issue of access to the healthcare centre is quite controversial. All of the men mentioned that lack of convenient access is the major barrier they experience at the healthcare centre. However, some of the health workers told me that it was untrue that people should arrive at 6 a.m. to get an appointment. In fact, during the interviews, I observed contradictory information being given by the group of health professionals and the group of administrative staff in relation to this issue. According to some of the health professionals the problem of appointment access does not exist: “There are always appointments available during the day. Nobody is going to say to the patients ´no, we don’t have more appointments´. The person who comes to the healthcare centre has an appointment…” (Arturo, dentist; 26 October, 2010):
You can come in the morning and you can see a lot of people at the waiting room, but they are people who are already listed and they already have an appointment...

Interviewer: Have you heard that some people say that sometimes they have to wake up at 5 a.m. to come to the healthcare centre to get an appointment?

Yes, I heard that...

Interviewer: Do you think that happens?

At least here, in this healthcare centre, I think that is not real, that does not happen... every patient who comes here will receive an appointment on the same day. (Gloria, physician; 21 October, 2010)

The situation is quite different according to the administrative staff, who are responsible for coordinating appointments and for providing the healthcare centre schedule; many of them are themselves users of the primary health centre:

Interviewer: Could it happen that a person could come to the healthcare centre and not get an appointment?

That always happens, every day... there is always an over-demand. To give you an example we have a stock of 100 appointments and usually we have 150 people… we always have a lot of rejection, always... we have to explain them that they have to come back the next day… (Simon, administrative staff; 26 October, 2010).

Interviewer: At what time do people start coming to the healthcare centre?

At 6 or 7 a.m., the terrible situation is when people come at 9 a.m., because they could not come earlier, and there are no appointments… and that is the problem… mostly with people who are older... So usually people know that if they want to get an appointment they have to get up at 5 a.m. to come to the healthcare centre, and even in that situation they cannot be sure that they can get an appointment, it is frustrating for them and for us… (Paula, administrative staff; 26 October, 2010).

Given the discrepancy in information and perspectives, I decided to attend the healthcare centre at 6 a.m. on two different occasions to see what was happening with users. On both occasions the healthcare centre was full of people who had been waiting since before 6 a.m; there were at least 200 people whilst others were continuing to arrive. At 7.30 a.m. there were about 250 people waiting (Figure 17: Picture 5). One of the night guards opens the healthcare centre doors at 6 a.m. in order that people do not have to wait in the street. At 7.30
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a.m. people can obtain a service number; at 8 a.m. a group of administrative staff members start to call the first numbers in order to assign the appointments for that day. At approximately 9 a.m., one administrative staff member announces that there are no more appointments available for that day, and that those who had not received an appointment should come back on the following day to apply for a new service number. There is a huge amount of frustration among the would-be patients, for example; a woman who arrived 10 minutes after me (6.10 a.m.) failed to get an appointment. She told me that this was the third day that she had come to the healthcare centre; she had come because of a severe pain in her belly, and, despite this she had still been unable to get an appointment: other healthcare centre users suggested that she should go to the emergency room at the hospital. Another woman with a baby in her arms was desperate, although her baby had been sick all night long, she still did not get an appointment with a GP. Whilst I was at the centre, some of the users began to insult the administrative staff, but they, the administrative staff, were unable do anything to help. Once the health professionals began to arrive (doctors, nurses, nutritionists) the healthcare centre became quieter. Those users who had been unable to get an appointment had already started to leave, and in the waiting room the only those patients who had been assigned appointments remained.

Figure 17: Picture 5, Waiting Room at the Primary Health Centre, at 6.30 a.m. (02 November 2010)
The situation created a lot of anger and frustration in health care centre users. All of them awoke very early and even then some failed to get the appointment that they needed. Many men do not tolerate this type of situation:

The truth is… because of all the problems related to get an appointment we don’t go to the healthcare centre... you have to wake up at five o'clock to ask for a number, and you are not sure you are going to receive the appointment… is too much. Then, as family, we opted for not going to the healthcare centre, because it was humiliating to be waiting for an appointment, and get up at six o'clock, five o'clock... No! We don’t agree with that system (Juan; 11 August, 2010).

On both occasions that I arrived to the healthcare centre at 6 a.m. the situation was the same; there were many users who did not get the required appointment. On both days I had to wake up at 5 a.m. in order to arrive early at the healthcare centre, I travelled on a transport route that is very cold during winter months and on which the public transport is inadequate. In fact, not only do many users have to walk approximately 15 blocks to the centre health, this is because at this hour there is no suitable public transport available, in addition they are travelling under conditions in which many of them are sick or have annoying symptoms.

Waiting Times

The problems of difficulty of access to the healthcare centre and the uncertainty in regard to getting the necessary appointment are merely the first issues affecting users. The long waiting times faced by patients are another barrier identified by the group of men:

I feel anger! Frustration! Because all the time I have to wait! Anger because I always have thought that if I show cash and I put it over the table everything would be different… they would give me attention immediately… seriously! (Marco; 25 August, 2010)

Most of the users who are waiting for an appointment with a health professional have had to wait since early morning in order to try to get that appointment. For example, they may have arrived at the healthcare centre at 6 a.m. and at 8 a.m. have been given an appointment for the afternoon; they then have to return at 4 p.m. to receive the required attention. However, on their return at 4 p.m., for other reasons, such as delays, or not enough
health workers, they usually have to wait again. Thus, whenever a patient comes to the healthcare centre he/she has to wait:

I do not like going to the healthcare centre because the waiting times... as I told you I went there one time, and the doctor was very good, but the waiting time is too much, I do not like to wait... (Francisco; 18 August, 2010)

Another participant echoed this opinion:

I feel uncomfortable going to the healthcare centre…

Interviewer: Why do you feel uncomfortable?

What really bothers me is spending so much time waiting, I have to wait, wait, and wait! (Luis; 09 September, 2010)

As commented on Chapter 5, the discourse of health workers is that users “should know how to wait.” However, this is a wait without a limit; the patient must wait for all the time that is necessary in order to avoid losing an appointment, even if he/she has to wait 2 or 3 hours. Potential patients could protest to the administrative staff (also powerless to change the situation) they could become angry and frustrated, but still they must keep waiting. Some health workers are aware of the feelings of frustration generated by such long waiting times, however they refer to the fact that the patient must understand the over-demand that there is at the healthcare centre: “Men are always in a hurry, they always want a quick attention and that is impossible, there is an order, the first patient to come is the first patient that receive attention” (Gloria, physician; 21 October, 2010). In the words of another health worker:

In general for men it is much more difficult to wait... They are irritated easily, and generally claim to their wife or partner who accompanies them... "Do you see? I told you that I did not want to come here"; "I told you I would waste my time"; "Well! Are they going to attend me or not? "; “I told you, I do not like to come here, never ask me to come again!” (Carolina, administrative staff; 02 November, 2010)

The complaint of the people in the waiting room is "Why do they force me to waste my time?" "Why they don´t tell me to come later?" From my position I thought in exactly the same way. However, as a researcher and an observer, I interpreted this wait as a way of this
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group of health workers demonstrating their more powerful position in this hierarchy; they establish a relationship with patients from the wait.

Gender Differences regarding Waiting Times

Women are more realistic, we know we have to wait... we know that if we come to the healthcare centre we have to wait...

(Woman from the community, waiting room at the healthcare centre; 19 October, 2010)

Almost all men agree that for women it is easier to wait at the healthcare centre, some of them mentioned the fact that women do not work, so they do not feel under pressure from the waiting times. “Most women in this community do not work and for that reason they can go to the healthcare centre, they have time. For us, as men, is a problem, because we have to work…” (Hector, Focus Group; 10 October, 2010). Other participants referred to the concept that women are more passive and are accustomed to waiting:

The woman is different in that aspect... I don’t know why... maybe is because she has to wait all the time, she has to wait at the hospital when is delivering a baby... she is prepared to wait... the man is different, we don’t have time to waste… (Pablo; 22 September, 2010).

What happens is that women face different the waiting times at the healthcare centre, because they know how to be patient, they are calmer... of course, suddenly there are women who are overwhelmed and want everything to be fast, but in the case of men always you want a faster attention, for a man is important to make things go faster... (Jose; 07 September, 2010).

During my periods of time as participant observation I was able appreciate that the situation for women is generally less complicated while waiting at the healthcare centre; they come prepared to wait. They have food for themselves and children; they are knitting, reading or talking with other women. Men instead generally sit and wait without doing anything, and after a while they start to get angry, in fact some of them leave the healthcare centre without receiving attention (Figure 18: Picture 6).
Most women are calmer than men when faced with the same waiting period. One woman told me in the waiting room: "We, as women, wait nine months for our children, we know how to wait... if we have to wait an entire morning in the healthcare centre to get an appointment for our children that's nothing for us..." (Woman from the community, waiting room at the healthcare centre; 19 October, 2010). At the healthcare centre there are always pregnant women and women with children waiting for an appointment, they are quiet, seemingly untroubled. Some health workers recognize these gender differences in coping with the wait:

People don’t want to come to the healthcare centre, because of the queue and the waiting times. There are a lot of people, men, that don’t come... but for women is different, they told you "I do anything for my son", they say “I’m going to the end of the world for my son… or my daughter…” (Simon, administrative staff; 26 October, 2010)
Men generally have less time, and less patience, I'm talking about an average young man that generally has less patience, get bored, feel it's a waste of time, and many times they just leave… sometimes when they are with their wife, the wife convince them to stay and wait (Andrea, nutritionist; 19 October, 2010)

I think men are more impatient, they want everything faster, they do not like to be waiting, and is different for women, because you as a woman… you know you are going to use all the morning going to the doctor, and you are already prepared to spend that time at the healthcare centre, but men do not… (Rosa, nurse; 21 October, 2010)

The issues relating to access and the long waiting times are the first barriers to receiving attention at the healthcare centre identified by the group of men: the issues sometimes influence a man’s decision to stay away from the public health system. However, even when they have been capable of getting an appointment and waiting for attention, sometimes they report other barriers, inside the healthcare centre, which relate to the treatment that they have received from health workers, especially from the health professionals.

8.1.1.2. Health Attention: Health Professionals

About the quality of health services, I think that's good, not bad... I think the problem is... the problem is the attention, the kind of attention that they give to people…

(Vicente, Focus Group; 10 October, 2010)

Some men of the community referred to being mistreated by some health professionals, stating that the attention given to them by the professionals’ is too brief, with no time allowed for them to ask questions, and sometimes they are even reproached by health professionals. “Sometimes the treatment that you get is humiliating… I think that health workers think that they are the owner of the place (healthcare centre)... the only thing you ask as patient is that they treat people as people” (Juan; 11 August, 2010). Another participant echoed this view:
They (health workers) do not give attention in a good way... they are not always doing their job... For example, I have seen and heard cases of people that are a little fat, and the doctor says "hey, why are you so fat? ...don’t eat so much"... and you as patient feel horrible... instead of feeling better with the physician you feel horrible... I think they should give you a better attention (Luis; 09 September, 2010)

This view about health professionals is shared by some health workers that are part of the administrative staff, who are also users of the primary healthcare centre:

People do not come to the doctor because the attention, because the attention is poor and fast. As patient you come here with a problem, sometimes you are in anguish... for example, I see a man coming for an appointment... with a depression, he was very depressed and he was crying, and the professional don’t look at him, she was writing all the time at the medical record without looking at him! (Carolina, administrative staff; 02 November, 2010)

As a user I’ve experienced the same situation... I'm feeling sick, I'm concerned, I’m worried… my environment, my family is worried, and I ask an appointment with a doctor, I do all the official procedure, and the professional treats me in 5 minutes, giving me a paracetamol, an ibuprofen and that's it! (Paula, administrative staff; 26 October, 2010)

In addition to the maltreatments perceived by users, some men from the community referred to their distrust about the technical skills of health professionals.

Distrust

Some men from the community report that health professionals working in the healthcare centre “are not the best”, and for that reason they often make mistakes in diagnosis and treatment; “In public healthcare centre, many times the physicians are wrong in the diagnostic, because... they are not the best doctors. Do you understand me?” (Carlos; 18 August, 2010) In the words of another participant:

I went several times to a medical control in the healthcare centre, but a doctor told me one thing (a diagnosis), then the same doctor wasn’t available and another doctor told me something else... then, after a while, I got bored, because everyone told me something different, different diagnoses... (Hugo; 29 September, 2010)
According to some of the participants, only those health professionals who have failed to be employed by the private health system work in the public health system, where salaries for health workers are lower. In this way, the community has the perception that the worst physicians are in the primary healthcare centre, while the "good doctors" would be those working in the private health system:

I believe in my physician that gives me attention at the hospital, but not in the doctors from the primary healthcare centre... that doctors are... (makes a gesture of contempt). Sometimes I go to the healthcare centre just because is the only way to access the benefits from the AUGE diseases (see Glossary)... but you know, I have a concept about the doctors... the doctor who comes to the primary healthcare centre is a doctor number five on my quality scale, the worst doctors. Then, you have the doctors that work at the emergency rooms, those doctors are number four. Then you have the doctor from the public hospitals... there are two types of doctors there, number three or two. And finally you have the number one doctors, the private doctors, who work in private clinics at the private system, there are the number one for me... but we don't have access to them (Miguel; 03 September, 2010)

According to some of the men in the community, the remuneration that health professionals receive for services is used to determine the quality of the care they provide. In this way, doctors who work in the primary health centre would be likely to have the poorest technical ability, because they receive low wages;

I think that medicine is a business... obviously when you pay they offer you the best product... for example, you go to the supermarket and a kilo of tomatoes worth CH$ 700 because it is big and beautiful, and the other option is a kilo of tomatoes more wrinkled and uglier but worth CH$ 300. If you want to consume the best quality of tomatoes you have to pay CH$700, but if you don't have enough money you buy the other option, because you can only pay CH$ 300, but you know it is the poorest quality... For health is the same, if you go to the hospital and the doctor says “...you have a hernia and the cost for the surgery is one million Chilean pesos...”, if you pay that million you get a surgery the next day, but if you cannot pay and you are in the public system you could get the same surgery six months or one year later... then I think it is unfair, that way is unfair, because doctors are not what they said before, because they always talked about professional ethics, but now that's a lie, a lie! Because there is not ethics, is just a matter of money... (Jose; 07 September, 2010)

Added to the barriers identified by the group of men in relation to access to a healthcare centre and the long waiting times, are the issues relating to the quality of care
received and the distrust these men have of the health professionals who work in such centres. Together, these factors lead them to seek alternatives in order to avoid going to the primary healthcare centre.

8.1.2. Alternatives: Emergency Rooms & “Private Doctors”

When a man has a health problem that is considered "serious", he needs to seek help from a formal health system. As previously commented on, many men avoid going to a primary healthcare centre. The alternatives found by this group of men are to seek help from emergency departments at public hospitals, or to request an appointment with a “private doctor”, who usually works outside the formal health system.

Hospital emergency departments are a good alternative for this group of men, because they are part of the public health system. People who attend them do not have to pay for the health services, and they know they are going to receive attention to their health issues during that same day. Thus, even if they are required to wait for 10 hours for a treatment at an emergency department, they know they will leave the place with their "problem" solved:

I prefer to go to the emergency room, because there I´m sure I´m going to receive attention... but if I go to primary healthcare centre, I can go there at 6 a.m. and even then I´m not sure if they are going to give me an appointment (Francisco; 18 August, 2010).

However, there is a downside to using the emergency medical services; although people receive treatment for their health problems, they do not have access to any follow-up or monitoring of their health condition. Therefore, while immediate health problems may be addressed and symptoms relieved, such patients will return to the emergency department when a new health problem develops or if the present condition recurs. Any strategies for health promotion or for prevention of conditions or follow-up are impossible to apply in this context.

Regarding the seeking of help from a “private doctor” (see glossary), this is a very common practice for this group of men; “If I have the money I prefer to pay a private doctor rather that get up at 5 a.m. to go to the primary healthcare centre” (Pablo; 22 September, 2010). Usually this type of doctor with a private practice will provide a service from their own home to patients located in the same neighbourhood (Figure 19: Picture 7). They are neither part of the official healthcare system, nor of its private or public sectors.
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It is generally foreign doctors, who have not the legal authorization to work in Chile, who offer these services; they offer services to a particular audience for a low price.

If you go to primary healthcare centre you know you have to get up early and be patient... and that's why you opt for private doctors, because is so annoying go to the public health services... (Alberto; 22 September, 2010)

The problem with these “private doctors” is that they do not form part of any formal health system, and therefore they do not have access to the services that provide patient treatment cover from the Ministry of Health, or access to x-ray or medical laboratory services. Also they do not have access to the network of medical specialists and, for that reason, cannot refer the patient to another professional if this is necessary. Thus, the main function of this kind of private doctor is for the short-term relief of symptoms.

In this way, both the emergency departments of public hospitals and doctors in individual private practice offer alternatives that make sense to the particular group of men in
the community, because when they have a health problem, they expect someone else to solve the diagnosis of their symptoms or to alleviate their discomfort so that they can continue to work, regardless of any follow-up that may be necessary for their medical condition.

8.1.3. Suggestions for the Improvement of Primary Health Centre Services for Men

At the conclusion of the interviews and focus groups involving the men of the community, they were how they believed that the healthcare centre could be improved in a way that would encourage men to approach the public health system. Suggestions focused on three themes: (1) improving the system of access to the healthcare centre; (2) improving human resources, including increases in the salaries of health workers; and (3) the creation of programmes aimed specifically at men’s health:

(1) **Improving the access:** As mentioned previously, the major barrier identified by men at the healthcare centre was the access process. Therefore, for some of them, just improving health care access could change their perception of public health, and, as a result, they would be interested in attending the primary healthcare centre: “I would change the access, that’s all… everything would be different and easily if the access was faster” (Juan; 11 August, 2010). In the words of another participant: “They (health workers) have to create a better access process, expedite access! That’s what everyone wants at the community” (Pablo; 22 September, 2010).

(2) **Human resources.** The distrust perceived by men about the performance of health professionals arises because, according to the group of men in the community, health workers receive low wages, and for that reason, only “bad doctors” are perceived to be those who are employed in primary healthcare centres. Therefore, some men think that by increasing the salaries of health workers, the healthcare centre would improve immediately its quality:

I think that to improve the healthcare centre, health workers must be better paid, because if you pay them well, then they would give a better service… because the problem is that the good doctor does not want to work in primary health centre… because they receive poor salaries (Alberto; 22 September, 2010).

Additionally, some men believe, that by increasing the number of health workers, the access system would improve, and that waiting times would not be as long, since the healthcare centre would be less congested: “I think there are many things to improve, but maybe if they have more doctors and nurses at the healthcare centre, there would be an
immediately change, because you would never have to wait so long for health care” (Andres; 04 October, 2010).

(3) **Programmes focused on men’s health**: Some men in the community expressed interest in having health programmes aimed specifically at them, because in this way they would be invited to participate in such programmes at the healthcare centre: “I believe that as there are health campaigns for women, we need health campaigns and programmes for men… I think the healthcare centre have to implement more programmes for men, as they have been done with women” (Jorge; 01 October, 2010). Another aspect of the men’s beliefs is that they would like to have information about when it is necessary for them to go to the healthcare centre: “I think is important for us, as men, to know at what age you have to do a medical check, or something like a pattern that says that every so often you have to make these health exams… because we really don’t know” (Pablo; 22 September, 2010).

8.1.4. **How does access affect the relationship between men and the Public Health System?**

The issues related to access to the primary healthcare centre, are the main barrier that deters men from using the public health system. When I shared this information with health workers (respondent validation of findings), mentioning my experience of participant observations at 6 a.m. at the healthcare centre, describing the problems experienced in obtaining an appointment and the long waiting times for users who require appointments at the healthcare centre, many professionals mentioned ignored the situation. However, some said they did not know how to solve this problem, since, indeed, the healthcare centre is unable to change its access system due to the number of users requiring attention.

In my opinion, the main problem is that some health workers do not understand that, for some people in the community, it is actually an impossibility to become involved in this access process. It is very difficult for a worker to ask for authorization from his boss, to leave their duties for a whole day in order to attend the healthcare centre; in addition, for many workers, to lose a day's work is to lose a day's wages; this is a situation that directly affects the economy of the family.

During our discussion, some health workers acknowledged that for them it was a useful contribution to have been made aware of the barriers that confront the men when
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approaching the healthcare centre to seek medical advice (figure 16). However, the health workers interviewed conveyed no real desire to improve the system of access, noting that, due to the over-demand for services, users are obliged to understand the reason for the length of the waiting times. Setting aside the gender variables influencing men’s engagement with the healthcare centres, I think that there are better ways of organizing the access system, but the resistance to change on the part of some health workers is a real barrier that exists for men in approaching the primary health centre.

8.1.5. Summary

In this chapter there has been a discussion of the appointment procedures that occur inside the healthcare centre, emphasizing the problems related to access and also of some issues relating to the quality of attention received. The alternatives found by men in their avoidance of seeking health care at the primary health centre, have also been discussed the suggestions mentioned by men to improve health services in primary health centre have been presented. Finally, I have offered my own reflections on the relationship established between the men of the community and health workers, and how the access process to the healthcare centre affects that relationship.
Chapter 9. Discussion

9.1. Introduction

The findings described in Section II (Chapter 5, 6, 7, and 8) allow a first approach to provide a rich description of how men position themselves in relation to their bodies, their health and the public health system, and how health workers position men, to answer the research question that guides this study: What is the relationship of Chilean men with their health and with the public health care system? In this Chapter, the objective is to summarize the main findings and analyse them in relation to the literature available in regard to men's health, in order to address the aims of this study; aim I: to describe Chilean men's perceptions of their health status and their health behaviours, and their relationship with the public health care system, and aim II: to develop a model to explain the relationships between men and their perceived health status, health behaviours and access to health services. The chapter will be divided into three parts. In the first part, the most important findings are summarized and the models of emergent social phenomena are explained; an analysis of the models is provided in relation to the context of the situation in Chile pertaining to health and the framework exposed previously (Chapter 2 and 3). In the second part, a final reflection on the habitus and fields for this group of men is presented, using these elements to analyse the relationship between the two social groups involved in this study, that is; the group of Chilean men and the health workers from the primary health care centre. Finally, some personal reflections about my interaction with both social groups are presented.

9.2. Summary of Findings and Reflections


The group of Chilean men who have been the focus of this study present common features that allow us to recognize them as a social group. One of those common characteristics is the importance that they give to work as the activity that orders their lives. Work allows each of them to validate their role in the community: through work each corroborates their masculinity as provider for their family, and the relationship a man has with his own body is determined in relation to his individual physical capacity for work.
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Similar findings were described by Ross and Sobralske in Latin America (2000; 2006) who developed ethnographic studies with men in Nicaragua and Mexico, respectively. As mentioned in Chapter 3, work is associated with being male (Sixsmith & Boneham, 2002) and, for this group, a man who is unable to work for any reason, including that of an illness or health problem, occupies a low place in the hierarchy, considering the hegemonic masculinity model described by Connell and colleagues (Connell, 1995; Connell & Messerschmidt, 2005). Those men without work thus occupy a lower level in the order of masculinity; and do not have the same level of privilege as the group with a stable job. For the latter group of men, the notion of work is linked to the idea of sacrifice and endurance, and to the related notion of the expectation of a compensation for this sacrifice, understood as a necessary escape (Figure 20)

![Diagram](image)

Figure 20: “Sacrifice-Endure-Escape”

To endure the emotional and physical pain related to the obligation to work is a requirement of being a real *macho*. In this context, the role of physical pain is very important, and the fatigue and pain caused by work re-affirms the role of worker and provider. Physical endurance is central in social interactions within the group and creates the space for men’s own bodies to be accepted as a social resource. The body becomes a social element that allows the re-affirmation of the male role; a body that is capable of work that resists any obligation is a “*macho* body”. As de Keijzer says, the work must perform “as far as the body can resist” (2003). In this context, the notion of embodiment (Bourdieu, 2000; Connell & Messerschmidt, 2005) that gives an active role to the body in social processes, enables us to understand how the gender role is experienced through the individual body. According to
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Esteban (2004), the body is a place of intersection between the psychological experience and the social field of a person, where the social role is interpreted through the body. Any "exaggeration" of the physical pain or the interruption of work due to some pain, is seen as feminine; to be a "macho man" is to minimise pain and continue working.

Despite the fact that physical endurance is described by many authors as an important element for masculinity, the need for compensation in terms of an escape appears as a new aspect of what it means to be ‘macho’. As described previously (Chapter 5), this escape is generally associated with behaviours that are considered by health workers to be a threat to men’s health, such as, the over consumption of alcohol and food. An understanding of these behaviours in their social context allows us to comprehend why changing those “risk behaviours”, which is a frequent suggestion from the health workers, may be so difficult. For instance, to suggest a healthy diet to men with diabetes or hypertension could be a complex proposition, since the conduct of overeating or drinking in excess not only represents a personal choice, but also, a group’s behaviour, a group to which they want to belong and in which implied membership rules require such conduct.

“Risk behaviour” as a concept developed by health workers is not understood as a health risk by men; for them such behaviour is a reward for the sacrifice and endurance that they perceive in their daily work. Mechanic (1995) referred to the phenomenon of “the medicalization of social life”, understood as the inclination of some health workers to comprehend some behaviours solely from the biomedical perspective; thus reducing the comprehension of the problem to its social consequences As Helman (2007b), Kleinman (1985), and Kleinman, Eisenberg and Good (1978) established, health workers should understand the social context of their patients, as well as their cultural beliefs, in order to understand the social meaning of the behaviours that are present in the community.

9.2.2. Men’s Health: Perceptions, Beliefs and Behaviours

In regard to the health beliefs and behaviours for this group of Chilean men, the main findings are summarized in Figure 21.
Since, for this group of men, work is one of the most important elements for the experiencing of masculinity, health beliefs and behaviours are also related to the capacity for work. The men in the group defined health as being the ability of an individual to keep active and working, and illness as being related to the same concept, in that illness implies the inability to work. The implicit code of what it means to be a “real macho” indicates that to ask for help, or to show vulnerability ‘up front’, for any physical discomfort or illness is not allowed; such behaviour is associated with the female gender, while a man is able to resist/endure his own pain. According to Helman, pain has a social component and can be categorized as public or private pain. Public pain is communicated to the close social group, one’s own family and community; that pain is generally expressed in the seeking of help or advice. Private pain is held in silence; this type of behaviour is appreciated in societies in which stoicism is valued, “…in some cultures the ability to bear pain without displaying overt pain behaviour may be one of the signs of manhood” (Helman, 2007a, p. 186). For this group of men, the pain is minimized and hidden, and it is made public only when it generates severe discomfort and prevents the fulfilment of duties.
In this context, public physical pain serves two functions. First of all, it signifies the presence of physical symptoms; this gives notice of a possible illness and a warning about the need for care. Secondly, physical symptoms allow men to maintain their male role, which is always under threat outside the scope of work and endurance, the reasoning being: “I am not working because I am dealing with a very intense pain”. It is the resistance of that pain that allows a man to continue being a macho, even if he is, temporarily, not fulfilling his role as provider. The value given to a symptom is related to the cultural meaning of that symptom within the social group (Zola, 1966). Tiredness or fatigue, for instance, which could be a symptom of some diseases, in this group of men, is a bodily perception associated with work. None of them believe that the tiredness could be a sign of disease. Symptoms that "allow" a man to leave his duties are those that are very intense and “unbearable”, or at least those symptoms that men declare as being ‘very intense’. Consequently, experiences of illness referred to by this group of men are closely associated with the presence and intensity of physical symptoms that are usually associated with "accidents". As mentioned in the Findings Section, the word ‘accident’ is the literal translation of the word used by men in Spanish “accidente”, which they use to refer to an unexpected health event, usually unwanted.

An ‘accident’ is understood by men as representing a situation that is outside the normal course of events and as being beyond their control, as something that should not have happened. These ‘accidents’ can be of different types, and include a fight in which one was injured, or even a cardiovascular ‘accident’ or a heart attack. The story that such men make of their illness is frequently linked to the notion of ‘accident’, meaning that such events, viewed as ‘accidents’ allow men to understand them as being ‘isolated’ events, as something that happened in the past and which does not necessarily have a relationship to their current health status. This significance of seeing an illness as an acute condition is central to understanding how men face certain pathologies of a chronic nature, and the way in which they face the possibility of any long term consequences arising from any health condition.

Regarding illness behaviour in the presence of an illness, the men in this group identified four sequential steps: (1) doing nothing, ignoring or minimizing any symptoms and waiting until the discomfort passes; (2) consultation with a female relative, asking her advice about symptom relief; (3) self-management, including self-medication; and (4) seeking formal health care as last resort. Mechanic (1995) established that illness behaviour includes, among other things, how patients monitor internal states, define and interpret symptoms, take remedial actions, and utilize various sources of informal and formal care. In the case of the steps established by men in this group, the first step of "doing nothing", hoping that the
discomfort disappear, would not lead to a self-definition of being a “sick person”. However, at the point at which they decide to seek help from any woman in the family, men acknowledge their sickness role, which, according to Mechanic, could be used to justify release from their expected social roles and obligations. For this group, a disruptive symptom is the only valid excuse for suspending work and not fulfilling the role of provider. In this context, health workers have established that it is not usual for men to ask for help, but once they assume their sickness role they are very dependent on the care of another (a woman), and their autonomy and independence disappear. In that sense, men minimize their symptoms until they decide to accept them, and from that point in time the complaint may be "exaggerated".

When men decide to make public their pain and to seek help, they always ask a woman for advice and care, such a woman may be their mother, wife, sister, or even a female friend. The role of women in coping with men’s illnesses has been recognized by other authors (Courtenay, 2003; Sixsmith & Boneham, 2002). Bourdieu (2000) referred to the gender role assigned to women as being related to the care of others, mentioning that what society calls "female intuition" is just another requirement of the female gender role that forces women to observe and be attentive to the needs of others, and knowing what the ‘other’ needs in terms of care, to even anticipate a request. The health workers themselves recognize the relevance of this aspect of the female gender role, a recognition manifested in the fact that it is through women that they endeavour to transmit health messages to men. However, this strategy could be reinforcing gender roles that give the responsibility of health care solely to women, perpetuating the distance that currently exists between men and the formal health system.

In reference to the model (Figure 21), health and disease are related to men’s functionality, excluding elements such as mental health and strategies for disease prevention. Mental health is a complex phenomenon since there are no physical symptoms that prohibit men from continuing to work, resulting in the invisibility of mental health problems (Adams, 1997). Anxiety and violence appear as common problems among this group of men, however none of these issues appears in the “AUGE disease” prioritization. Some authors have suggested that such problems could be an expression of emotional problems such as depression; however, being depressed would constitute a failure to be masculine (Branney & White, 2008; Möller-Leimkühler, 2003). The men in this study highlighted the fact of not having a space in which to share their emotional problems, since one of the challenges of their gender role is to show themselves as invulnerable. In this context, vulnerability is a
capital of exchange which gives people the possibility of asking for, and receiving, support and help, and of showing what they need and what they feel. The cost of being unable to be seen as vulnerable represents the impossibility of asking for help, since such men perceive that it is socially unacceptable to do so. Men have been socialized in the role of provider, they give things (money) to their families, they do not ask. The inability to show themselves as vulnerable is perceived by men as having social implications for phenomena such as violence; the reasoning being: “I do not ask, I demand because it is my right”.

Violence among men is a serious problem referred to by the participants, a situation that is also reported in the IMAGES study, executed in three large cities of Chile, including Santiago (Aguayo, Correa, & Cristi, 2011). According to that study, 15 % of Chilean men admitted to having been beaten in the street during the last 3 months, and 13.8% had been threatened with knives or other weapons during the same period of time. In addition, the same study reported that about 70% of Chilean men say that if someone insulted them, they would defend their honour with strength (Aguayo et al., 2011). Violence among men in Chile is a common problem that directly affects the health of individuals; moreover, some men learn to solve any conflict by fighting, without receiving any of the sanctions associated with such behaviour. The central question would be whether we, as a society, are allowing and endorsing violence among men, in which the implicit message is: “you cannot hit your wife, but you can hit others men”. Discussion and dialogue are necessary in relation to these issues, since violence often becomes the only known strategy for men to use to solve disagreements.

In terms of disease prevention, since the male logic establishes that concern for one’s own body only occurs when a physical symptom is too annoying or alarming and prevents the continuation of working, it is not part of the male behavioural repertoire (Mahalik et al., 2007). This absence of preventive behaviours in this group of men, is reinforced by the health system, which fails to implement health strategies targeted at this group (Chilean Ministry of Health, 2011b).

**9.2.3. Primary Health Centre: Operating Mode**

Health System Reforms in Chile have focused on strengthening the local work of primary health centres, giving the administration of these healthcare centres to Municipalities or local governments (Annick, 2002). These reforms reflect WHO guidelines that give predominance to the work done at primary level (World Health Organization [WHO], 1978, 2008b). However, in this study, health workers indicated that local work focused on relieving
the specific health needs of the community by adapting national health strategies to local reality is not effective. Work in the primary health centre is organized according to the guidelines of the Ministry of Health, giving priority to the detection and treatment of AUGE diseases, in which the biomedical paradigm predominates, and the psychosocial paradigm is minimal (Figure 22).

Figure 22: Health workers: Beliefs and Strategies about Men’s Health

This biomedical paradigm gives emphasis to disease detection and includes within its main strategies the development of epidemiological profiles that give an account of the state of the health of the population. Every healthcare centre has a department of epidemiology, which regularly updates information about diagnoses. This information is sent to the Ministry of Health and it is from there that health strategies are planned. This strategy of prioritization has its own difficulties and challenges; for example, much of the information that is obtained comes from the population that attends the healthcare centre; thus, because men do not attend (as highlighted in the study) their needs are not represented in the epidemiological reports. Consequently, men are virtually invisible. This strategy continues to privilege the biomedical model of disease detection, leaving aside the socio-cultural analysis of social determinants in health (World Health Organization [WHO], 2008a).
Primary health centres act on the basis of demand, and there remain three clearly defined groups that are the focus of health promotion and disease prevention strategies: women, children, and the elderly (Chilean Ministry of Health, 2011b). Additionally, health workers reinforce the conduct of attendees, giving importance to their own logic about self-care in health. According to some of the health workers who participated in this study, self-care in health is closely related to responsibility. For them, patients are responsible for their own health and, within those responsibilities, would be go to the healthcare centre and ask an appointment if they had any illness or discomfort. According to the WHO (World Health Organization [WHO], 2009), self-care in health is a key strategy in primary care; however, the definition that WHO proposes involves the deliberate action of individuals, families, and communities to maintain good health, considering the social and cultural determinants of each group. Basically, when people feel there is something wrong or there is some symptom, they will attribute it to some cause and then try to get well by doing something to get rid of such symptoms. The ways in which they help themselves is called "lay self-care". In this context, the role of health workers is crucial for people in the implementation of self-care. According to WHO (2009), health workers have the responsibility to act as facilitators of the health processes, incorporating social variables in the analysis of each group in the community. If this were done by the primary health centre in this study, men would not be "neglected" or judged as "irresponsible" concerning their own health; a point to which some health workers participating in this study, referred. The problem is that strategies employed by men in relation to any health problem do not conform to the strategies expected by health workers; men do not seek help at the healthcare centre.

Arguing that a passive approach to communities and their health fails to help a considerable number of community members, represented by responding to demands but not proactively engaging with communities as in the primary healthcare model advocated by the World Health Organization (WHO, 2008b), one of the duties of health workers is to bring care closer to the people. Approaching groups at the community and their specific needs would make it possible to establish a clear difference between a primary health care model and primary medical care model. According to the Chilean health reform in 1981 (Annick, 2002), in which the main objective was to bring health to the communities, Chilean health workers should be approaching communities to meet their specific needs. However, according to the findings of this study such practices are not evident. The primary health centre participating in this research continues to work in a primary medical care model,
emphasising health priorities and disease treatment, but not seeking to establish what are the specific needs and priorities of the community.

Another issue regarding healthcare centres is that decisions about the mode of working are in the hands of health professionals, who are generally users of the private health system, who ignore the difficulties access experimented by members of the local community. Many of those health professionals believe that if a person from the community wishes to access the healthcare centre, that person will always have access. However, they do not know the reality that exists in the healthcare centre at 6 a.m. when people wait to get a number to achieve a health care appointment, and even then may fail to get that appointment.

Access Issues

For men in this community, waiting time is one of the major barriers to attending the healthcare centre that is related to access issues. As described in Chapter 8, many of the men do not attend healthcare centres just because of the long waiting times. The annoyance originating from the length of waiting time, in addition to the inconceivable notion of the possibility of being absent from the workplace in order to attend a healthcare centre, consequently results in a preference by the men to go to emergency medical centres (Figure 23), since they are open 24 hours a day, a tendency also reported by other researchers (Galdas et al., 2005). Additionally, the use of emergency centres could be closely related to the idea that men have about their health problems, which are classified as “accidents”, and usually when a person has an accident that person goes to an emergency room. In this way the use of emergency centres by men may have a more complex source than the convenience that they refer to in regard to their schedules. The need for going to an emergency centre gives the symptom a characteristic of being serious and urgent; if a man can sit in a health centre waiting for an appointment for a whole day it is likely that he cannot be seriously ill. In this way, attendance at an emergency medical centre gives severity to a perceived illness.
Figure 23: Alternatives to the Public Health System: Emergency Rooms and Private Doctors

The use of “private doctors”, who are usually situated in the same neighbourhood, is another alternative referred by men to avoid the use of primary health care centres. As mentioned in the Findings Section, these “doctors” are usually foreign physicians who do not have legal authorization to work in Chile (for instance, Cubans, Paraguayans or Colombians); such doctors give health care attention in their homes and their charges are very inexpensive; however, they are not part of any formal health system. They usually focus on treating the symptoms of patients, a very similar practice to that described by diverse authors in relation to traditional healers (Anderson et al., 2003; Gordon, 1994; Helman, 2007b; Kleinman, 1992; Kleinman et al., 1978), who have established that some patients decide to go to traditional healers since they alleviate their symptoms rather than diagnose any disease a patient may have. The “private doctors” working unofficially in Chile fulfill the same function: they alleviate symptoms.

Use of emergency rooms and “private doctors” limits men’s access to the health services and benefits of the Chilean Public Health System, since an emergency centre only attends to acute health problems and there is no continuity of service; and “private doctors” are outside the formal health system, hence the follow-up is impossible. Consequently, although all the men participating in this study are part of the Chilean Public Health System,
they choose not to use the health services provided, mainly due to the problems of access, according to them. Universal health care coverage has been defined as the appropriate access to the promotion of preventive, curative and palliative health care when people require it, and at an affordable cost (Carrin, James, & Evans, 2005). In other words, universal coverage signifies the real ability for a population to use health services. The achievement of universal coverage requires at least two levels of analysis: an economic analysis to determine the most effective way of distributing resources; and a social analysis that considers the real needs of people and how those needs should be met. If these two types of analyses were made, and reflected in the design of a health system, the result would be an inclusive health system, which would promote attention to people’s needs without any kind of discrimination; in other words, an equitable health access opportunity.

In countries such as Chile, health access problems are an issue of constant discussion and analysis for authorities. Important advances have been achieved, and the majority of Chileans have health care access (Chilean Ministry of Planning, 2006). This situation has positioned Chile as one of the countries with the best health indicators in the region of the Americas (Pan American Health Organization, 2009). However, the issues of access and administration, referred to by some people in the community, show that even for some of the groups that do have formal access to the Chilean health care system, they chose not to participate. The group of men included in this study is an example of this.

9.3. Final Reflections: Men´s spaces, as viewed through the lens of *habitus* and *fields*

As mentioned in Chapter 3, for this study, gender roles and masculinities have been considered as part of the *Habitus* of each man (Bourdieu, 2000; Thorpe, 2010). In this way, the *Habitus* of a *macho* requires a man to be strong, and hard-working, a man who sacrifices himself for the welfare of his family, enduring physical and emotional pain, a man who resists seeking assistance, preferring to solve personal problems without asking for help.

The fields in which the men participating in this study operate constantly correspond to family (home), work, and the soccer club (Figure 24). In the family field the role that has been assigned to men is that of provider, thus it is expected that a man will leave the house to go to work and will contribute financially to the family. In that physical space, which according to Bourdieu (2000), is a private space, women are usually in charge; they are the
ones who make decisions regarding the care of children, food and order, and men claim they do not feel comfortable when they are forced to stay in the house for long periods of time (due to a health problem for example). Bourdieu (1977) established that each field has internal hierarchies among those who possess the capital and those who wish to obtain it, conforming to a universe of exchanges. The capital can be divided into, at least, three types: economic capital, which is immediately and directly convertible into money; cultural capital, which includes among others: technical skills, specific knowledge, educational level and language, and social capital linked to a network or to the membership of a group (Bourdieu, 1986). According to this classification, men have different kinds of capital. At home they are the providers, they have economic capital, they provide for the family with economic resources, and this function is rewarded by the implicit authorization of the family to attend the soccer club and to "eat and drink" as a way of relieving their tensions and of rewarding their “sacrifice”.

In the field of work, men perceive that they meet the main male role. The role of worker is central to their masculinity, even in cases where they fulfil a subordinate role and a boss is in charge. Furthermore, in many instances, work is seen as a sacrifice that must be endured for the wellbeing of the family. The field of work allows men to obtain the economic capital necessary to fulfill their role as provider, but it also gives them the possibility of "maintaining their place in society" through compliance with the main task assigned to the masculine gender: to be worker. Despite the fact that the men participating in this study have had a limited level of education and their economic access situated them at a low socio-economic level, placing them at a level of subordination in the field of work, where the figure of the boss adopts the dominant masculinity, these men possibly are able to find strategies to negotiate masculinities and create sub-fields in their place of work (Coles, 2008).

The soccer club is a place identified by men as their means of escape, an escape from the problems that occur at home and at work, a place where they can relax, and the only place in which they feel that they are in charge and can make their own decisions. As such, the soccer club is a valuable social space where they congregate with other men. As Bourdieu (2000) established, it is in the public space (work and soccer club) where men feel comfortable and are able to experience the gender roles that have been culturally assigned to them. For this group of men, there is a close relationship between the public spaces (Figure 24); in the field of work, men meet their assigned social role of provider; in the field of the soccer club, they escape and are able to relieve themselves of the sacrifices associated with work. At the soccer club, men obtain the social capital required to validate their masculinity.
through the recognition of their male peers. It is in that place where men manage to have a
sense of belonging to a group, and even though behaviours relating to the consumption of
alcohol and food may be harmful to their physical health; abstinence is associated with being
marginalized by the group, as not conforming to ‘macho’. It can be argued that abstaining
from consumption patterns deemed harmful to physical health and associated with being
excluded from their social group could pose a risk to men’s mental health.

Figure 24: Fields making up the habitus of Chilean working men

The healthcare centre is a field that is outside the places that the men frequent. It is a
place that corresponds more to the feminine role of care; men do not feel comfortable or
welcome. At the healthcare centre men are seen as irresponsible in regard to their own health;
the logic of self-care established by this group of healthcare care workers is not part of the
habitus for men, since they are strong by nature (Courtenay, 2000a, 2003), and they do not
need “to care” for themselves all the time. The insistence by health workers of a focus on
disease and the vulnerability of the others does not fit with the experience of masculinity by
men.

As mentioned previously, the only place in which men do not have the capital to
interact is at the healthcare centre. The masculine gender role is played out beyond the
“healthcare centre field”. The vulnerability of the sick and the request for help becomes the
capital of exchange that users should demonstrate in order to access the healthcare centre,
considering that, in general, the waiting times for accessing the health service are prolonged. For men, this social capital (Bourdieu, 1977) that is required to interact with the services of the healthcare centre is in contradiction with all the mandates of the male gender role, in which men are unwilling to show themselves as being vulnerable, or to ask for help, or to wait for assistance. All this is added to the fact that the cultural capital (1986) possessed by health workers, given their educational level and the information that they possess, has placed them in positions of power; it is they who are in charge at the healthcare centre. If patients want access to health services they must be willing to wait for, and adapt to, the availability of the healthcare centre; this hierarchy is not tolerated by the group of men who participated in this study. Furthermore, health workers are not aware of the spaces or fields regularly occupied by the men; the physical spaces occupied by both social groups are distant, not in terms of geography, but in terms of social interaction, making it difficult for any interaction between the members of each group to result in a positive outcome.

This analysis about the spaces inhabited by Chilean men participating in this research, allows us to comprehend their everyday life, understanding the importance that they give to their work, their role as providers to their families, and their need to participate with their peer group at the soccer club. The social determinants of health model (Figure 25) (World Health Organization, 2007; 2008a) gives sense to these findings, allowing the construction of a global view of what is happening with the health of this group of men:

**Figure 25: Social Determinants of Health Model (WHO, 2008)**
Chapter 9 – Discussion

In relation to the socioeconomic and political context, through the AUGE reform Chilean public policies presently focus on the diagnosis and treatment of prioritised diseases and interventions, and health workers are familiar only with those populations attending health centres. Without also emphasising the specific needs of the wider population, this situation directly affects those communities of men who do not attend health centres and do not maintain a relationship with the health system. Regarding the socioeconomic position, which represents the mechanism of social stratification and the creation of social inequities, translating into specific determinants of individual health status (WHO, 2007), for this research the variables of gender, social class, education, occupation and income, are especially important to understand the reality of this group of men and their health behaviours. Just because they are men they are faced with the social expectation of being providers to their families and, given their educational level, they work in places that offer low salaries, which often are insufficient for all expenditures. These conditions put men in a situation of constant stress, directly influencing their health and disease behaviours. Finally, for this group, social capital is a key factor for the protection of their health, considering the cohesion that they found with their peers at the soccer club. In this way, each set of findings of this study can be read from the social determinants of health model, understanding that there is a constant interplay between the factors that make up this model, and allowing us to understand that gender is just one of the variables to understand health behaviours, but it is not of itself sufficient to comprehend the beliefs, perceptions and behaviour of a group of people regarding their own health.

9.4. Personal Reflections

From the collection and analysis of the findings, there emerges a question that I have discussed with other colleagues, and for which I still have no satisfactory answer: Should we, as health workers, adapt our strategies to groups of men whilst taking into account their gender role that is linked to strength and invulnerability as the *macho* imperatives? Or should we propose strategies that point to a cultural change of which the objective is that men should acknowledge their own health needs and vulnerability?

I am of the opinion that, perhaps, an alternative would be to set goals for the medium and long term. Whereas men require health strategies that respond to current needs, the design of strategies in health should consider all the variables linked to the male gender. At the same time taking into consideration the fact that health care systems are an important
social institution in the construction and stability of gender role beliefs (Courtenay, 2000b), perhaps a long term strategy would be to promote a social and cultural change, which would allow men to show their vulnerability with the support of an inclusive health system that is prepared for the implementation of health strategies with a focus on gender issues.

In any case, any medium or long term strategy requires the recognition of the fact that encounters between men and health workers present challenges. The relationship between two groups that have differing interests, motivations, and practices, is complex. This situation is accentuated by the fact that both groups perceive that the other has no interest in generating an encounter; the men in the current study perceive that the health system does not respond to their needs, neither does it design strategies which focus on their needs and situation. On the other hand, health workers perceive that the same men have no interest in taking care of their health. As a researcher, I can appreciate that it is difficult, to work with, or to establish a relationship with both groups. Men are hard to access in terms of their schedules and also because of their low level of trust with people who come from outside their own community; however, it is also difficult to gain access to health workers due to the high volume of work at the health care centre which means that the waiting times for access to their services are prolonged. Given these issues, and the negative perceptions each group holds of the other, the aim of establishing positive inter-group relations is complicated. In order for an encounter to occur, someone has to take the first step; health workers are probably the group that should undertake that responsibility; this could possibly be achieved through their promotion of suitable health strategies that have been adapted to suit the specific health needs of the diverse groups that make up the local community, including men.

In this context, examples of health policies tailored to men in countries like Australia or Ireland are a good guide to orient the future work in Chile and elsewhere in the world (Wilkins & Savoye, 2009). Both countries have national policies that are aimed at improving men’s health by incorporating the social determinants of health model (Macdonald, 2006). Australia has a strength based approach, making health services more "men friendly", incorporating an appropriate language to interact with this group, creating a respectful environment and designing services that focus on men’s need. Ireland has generated initiatives in education to the health services providers to be responsive to men’s health needs, and trying to promote a change of some paradigms in the society regarding gender roles, for instance they are changing the idea that seeking help is synonymous with weakness in men.
Chapter 10. Conclusion: Closing the health gaps for Chilean men

The purpose of this study has been to improve the understanding of Chilean men's relationships with their health and with the health system, including how men perceive their own health, what their health behaviours are, and also to illuminate their relationship with the public health system. The findings have revealed that, for the Chilean men participating in this study – men with low incomes that belong to the public health system –, health is equated with the ability to remain active in order to work, and to fulfil the role of provider to the family that has been socially and culturally assigned to them. Thus, all behaviours associated with health and illness are related to the relief of physical symptoms that prevent them from remaining active; neither is there any room for the expression of emotional problems or mental illness, or for activating disease prevention initiatives, or for the initiation of appropriate behaviour in regard to health, since none of these represents direct relief for a physical problem. The relationship such men establish with health systems is in accordance with this perspective; the formal health system is used only if necessary because a physical symptom becomes too annoying. However, these men postpone seeking care for as long as possible, since requiring assistance is considered to be "less masculine". In addition, the barriers, as perceived by the men, relating to access and receiving attention in the Chilean primary health care system, also make consultation problematic for this group; one of the biggest problems they face being the long period of waiting time that is required in order to get a health care appointment. In contrast, health workers consider that the men are "irresponsible" concerning their own health, and regard men´s non-access of health care as a lack of interest from men in maintaining their own health and, in consequence, the health worker are disinclined to generate programs or interventions targeted at the group of men.

An encounter between the group of men and the health workers should have a common purpose, that of the pursuit of health. However, there is a misunderstanding among those groups, originating from the differences about the meanings that each group gives to the concept of health. For men, health is deemed as keeping active, free of physical pain that prevents them from working and trying to minimize any "tolerable" symptoms in order to be able to continue working. For health workers, health is a more complex concept, involving the diagnosis and treatment of diseases by health professionals, and also health promotion and disease prevention guidance from health workers, which gives a central role to self-care;
this is understood by them as a patient’s responsibility to care for their own health. For health workers, someone who does not frequently come to the healthcare centre is regarded as irresponsible and carefree. Each group, the men and the health workers, thus have constructed the phenomenon of health from quite different positions; the men’s discourse on health does not coincide with the biomedical perspective of the health workers. It is therefore possible to anticipate the distancing that currently exists between men and health workers, as well as the difference in strategies that each group establishes to achieve what they perceive as being healthy.

This final chapter is divided into three parts. In the first part the focus is on the practical implications of these findings; it seeks to formulate a reflection on the following questions: What are the possible implications and applications of these findings? What is the audience that ought to receive this information? What are the needs that I, as a researcher, perceive in relation to the studied reality (research site)? In the second part, the focus is on the theoretical and methodological implications: What are the theoretical contributions of this study? How the quality of the information obtained is evaluated? What are the limitations of this study? What doors are now open for future research? Finally, I offer some concluding thoughts.

10.1. Practical Implications: So what?

Every time I have talked about these research findings with other colleagues or academics, the first questions that arose were: What are you going to do with this information now? Or, what kind of interventions could be designed from these findings? This research has been limited to describing the health perceptions, beliefs and behaviours of a single group; however, it is interesting to consider what to do now with this information. The immediate answer for me to this question lies in the dissemination of findings. Any change or modification in the behaviour of men in regard to their own health, as well as to the health delivery system, requires that stakeholders know the findings of this study. This reflection immediately leads me to the following question: What is the audience that ought to get this information?

As mentioned in Chapter 4, there are three groups that are considered as the audience for this study. Given the context in which this research, which relates to the realization of my doctoral studies, has been carried out, an academic audience is its main target. The communication of findings through scientific papers or exposure, at conferences or in
seminars, will enable the generation of a dialogue with other researchers, enriching the interpretation of the findings and opening doors to future research questions. In addition, the information obtained could be used in the training of future Chilean health professionals, in order for them to be aware of the importance of gender in the analysis of health needs and in the design of health strategies. A second group involved in the process of dissemination of findings is the decision makers and the policy makers situated within the Chilean health system. As established in the third aim (to inform the Chilean health sytem of the findings an implications of this study in relation to men’s health in Chile), for me, as researcher, it is important to make a concrete connection between health research and health practice. In this context, I have developed a summary of the findings in Spanish, which has been shared and discussed with a group of professionals from the Chilean Ministry of Health in a seminar organized by them to discuss men’s health (Chilean Ministry of Health, 2012). Finally, it has been important for me to give feedback on the findings to the community in which the study was conducted. In relation to this, two meetings have taken place with all the men from the soccer club and with a group of health workers, in order to provide them with a summary of the main findings; part of the information obtained in these meetings was recorded and reported on in the Findings Section.

Regarding the reflection about the perceived specific needs in relation to the site of the research, there are two aspects to consider: (1) First is the design for a working strategy in order to approach the men of the community. Working with this group is complex, both because of the demands in relation to the times at which they are available, as well the resistance they manifest in communicating their problems and their perceived vulnerability in doing so. (2) Health workers should comprise an in-depth analysis of the specific needs of each group in the community, incorporating an analysis of the social determinants of health, including gender. Having undertaken such an analysis, the next step is to adapt strategies to varying needs, which could even possibly involve moving out of the building where the healthcare centre is located in order to get closer to communities. For the implementation of this type of strategy, the support of the authorities on security issues is necessary, given in such a way that health workers do not feel afraid of leaving their workplaces and engaging in the community itself.
10.2. Theoretical and Methodological Implications

What are the theoretical contributions of this study? How has the quality of the information been evaluated? What are the limitations of this study? What doors are now open for future research?

The theoretical contributions of this study focus on two areas: gender roles and health policies. Regarding gender role theory, based on the findings of this study, it is possible to understand how the experience of masculinity and the gender role assigned to Chilean men, which relates directly to their function of family provider, influences the processes of health and disease. Work becomes the structuring axis of the men’s lives; the body is seen as a tool that allows them to stay active. The seeking of pleasure, as an escape behaviour that is often related to “health risk behaviours” – considering the categorization of those behaviours made by health workers – is a response to the sacrifice associated with the role of being the worker and the bread winner. From the perspective of men, health and disease are understood from their individual physical capacity to continue working; health assistance is avoided since the healthcare centre is viewed as a women’s place, in which the men do not feel comfortable. From the experience of masculinity, it is possible to understand and make sense of the health beliefs and behaviours of this group of men.

In relation to health policy, it is important to critique the way in which the analysis of population needs is developed; what the variables are, that are involved in the development of health strategies. In this framework of analysis, it is important to ask why men have been left out of the system; what the responsibilities of the health system are. In regard to the exclusion of some groups; what the real problems of access affecting men are. Closely related to those issues is the analysis of the type of data built up by health workers; focused mainly on epidemiological surveys that give an account of the epidemiological profile of the population. In this context, this study makes a contribution, since the use of the constructivist paradigm reveals the importance of subjectivity and personal experience as important information to be taken into account in the analysis of the community health profile. A theoretical understanding explains the absence of men from the formal health system and offers insight into novel approaches for working with men in the health setting.

Health, as a social construct, requires the design of research strategies that consider social and community oriented aspects, in a model that takes into account the multiple
meanings that individuals may attach to their own health and health care. There is no doubt about the importance of epidemiological studies; these allow a global view of the population’s disease pattern and also allow the establishment of priorities and the administering of the limited budget provided by the Ministry of Health, designing health strategies to be the AUGE prioritization list. However, it must be remembered that this big picture does not necessarily represent the local reality of individual people and communities. If traditional epidemiological studies were to be complemented by qualitative methods, which focus on particular social and cultural aspects, then our picture of the population would be clearer and more complete. The next step is for decision makers to consider evidence from different types of methods and studies. In regard to training, future health professionals must be capable of adapting to a variety of situations, respecting protocols and guidelines in a flexible way in order to meet people’s needs; for example they should be capable of providing alternatives and guidelines to people who have health problems that are not included in the AUGE list, in consideration of specific bio-psychosocial needs. The implication of such strategies would be to better understand community requirements, based on scientific evidence, with health professionals being equipped to, and capable of, coping with those needs.

Concerning the usefulness of the findings, despite the fact that, by nature of the methodology used, the findings are not generalizable outside the community where the study took place, it is, however, possible to talk about transferability (Patton, 2002), since these findings can illuminate the understanding of other similar groups of men. As mentioned in previous chapters, it is impossible to talk about one kind of masculinity, there are multiple masculinities. It is not the same being a hardworking man in the south area of Santiago belonging to the public system, as being a farmer man living in a rural area, or a banker living in a wealthy area and who belongs to the private system; each group has its own beliefs and perceptions in relation to health. Even though this study was never intended to represent fully the beliefs and behaviours reported by other groups, its findings can give signals regarding some aspects to take into account in the consideration of men’s health.

Regarding the limitations of this study, these can be divided in two areas: the limitations concerning my role as researcher, and the limitations of the study itself. One possible limitation relating to my role as researcher is that this has been my first experience in ethnographic research, and at the commencement of the fieldwork, the development of participant observations was a challenge. It was difficult for me to decide what to observe and
how to register the information; the support of my supervisors in Chile and New Zealand was central to this process, since the constant discussion of methodologies and procedures allowed me to develop effective registration techniques.

Another possible limitation is my own gender. Since the beginning of this study, one of the most recurrent questions of my colleagues was whether the fact of being a woman would affect the development of this research. Despite the fact that I understood those apprehensions, in my opinion one of the most important aspect in any investigation is to develop a close and respectful relationship with participants. In this context, Helman (2007) uses the concept of cultural competence to refer to the sensitivity that a health worker or a researcher must develop to work with anyone at the community, considering that the possibility of facing someone "different" is high, whether by gender, social class, ethnicity, or immigration status; and health workers should be able to adapt their strategies to different realities. Taking into account these challenges, it is important to generate methodological strategies to verify if the procedures carried out during the research and interpretation of the findings really represent the reality of the community. Considering this situation, the role fulfilled by the Community Advisory Committee was central during the entire process, especially during the analysis and interpretation, balancing the influence of my own gender role in the reading of the information. In addition, the respondent validation process allowed me to confirm that the findings represented the beliefs and behaviours of the participants. The inclusion of these strategies has allowed me to reduce the potential bias of my own gender perspective in trying to interpret and represent the experience of this group of men in a genuine and respectful manner.

In relation to the research design, some limitations in terms of the findings could be related to the fact that this study considered the inclusion of just one Comuna of Santiago de Chile, one Municipality, a single primary health centre and only one soccer club; therefore, it is impossible to know whether the findings represent the health perceptions and behaviours of other Chilean men in similar circumstances. However, as I mentioned previously, this study does not seek to be representative of the population of Chilean men, nor is it intended to generalize the results for other groups; its purpose is to illuminate the understanding about some important topics in regard to health of men health in Chile. Another limitation could be the non-consideration of men belonging to the private health system; however, given that approximately 70% of Chilean men are in the public health system, I was in a privileged position to approach this last group. Finally, a possible limitation could have been not
formally considering the opinion of women in this study, given the central role that men assigned to them in all issues relating to health; despite the fact that women were not formally interviewed, some of their opinions were recorded in participant observations, in the realization that their opinions are very important in relation to male health, and could be transformed into a focus of interest for further research.

In terms of the development of future research, many doors have been opened by the findings. Given the importance assigned by this group of men to their work, the workplace could be an appropriate scenario to investigate possible health strategies that are consistent with the role of worker. Any health strategy focused on men should consider the design and evaluation of actions that include a gender role perspective, for example incorporating actions that do not start from the position of vulnerability in health, but rather about how to strengthen some elements of one’s own body, which is seen as the main resource for carrying out tasks related to the male role; additionally, if health workers were to go to a men’s workplace, it is possible that the natural hierarchy that occurs at the primary health centre would be broken, the health workers would not be “in charge” in such a place (that is different from the building where the healthcare centre is located), and perhaps in this way men might be more receptive to health strategies. In terms of specific variables, analysis of the ways in which to work from the perspective of gender role, in the area of men's mental health, seems to be an urgent and necessary action, including working in the area of intra-gender violence that currently affects the community. In relation to possible future research into health systems, it could be important to investigate the ways in which to implement strategies that allow health workers to develop and alternative approaches for the analysis and interpretation of the specific needs of community groups in consideration of the gender role variable within the analysis of social determinants of health.

10.3. Concluding Reflections

Personal reflections on key questions that presented themselves in the course of this research and its analysis conclude the thesis.
How do we understand “health” as health professionals? How do we plan our health strategies?

Guidelines proposed by the WHO (World Health Organization [WHO], 2008a, 2008b) clearly focus on the specific health needs for each group in the population; requiring at least two actions: (1) the design of strategies to approach and to know the population, and (2) the adjustment to specific health needs detected in that population. Currently, the Chilean health system prioritizes treatment based on epidemiological profiles. However, there are no strategies that inquire into the subjective positions of each population group and the specific realities of each one. It is understandable that the allocation of resources requires the establishment of priorities, and in that context, it is my opinion that we, as health workers, have a responsibility to be inclusive in our daily work, trying to meet the differences in the population and adapting health strategies accordingly. In the case of men’s health, for instance, each occasion on which a man decides to go to a primary health centre is a unique opportunity for an approach to this group, and the perspective of gender is essential in this context. As health professionals, we must develop competency in the ways in which to contact and interact with people, in our roles as facilitators of health processes; it is necessary to be open minded in our approach to others and to try to remove – or be aware of – any type of prejudice. Such an approach may offer a path through which universal health coverage would become more real, generating more inclusive systems, in which every citizen could have his/her health care assured, and in which, inclusion – rather than – standardization would be the guideline.

What are the limits to my goals and what are the other (patient) needs?

What happens when patients deliberately decide not to adhere to treatments? What happens when a man with a diagnosis of diabetes decides not to modify his diet because that diet is what allows him to remain in, and be accepted by, his social group? What is my role as a health worker in such cases? As Helman (2007b) suggests, a risk is that health practice can become a code of morality and the health worker want becomes situated in a role of evaluating "good" and "bad" behaviours. Following the completion of this study, a clear realization has been that it is impossible to enumerate measures for health promotion and disease prevention without knowing the motivations and health needs of the various groups who are involved. The visibility of the needs of others is vital for any practice inside the health system.
Chapter 10 – Conclusion: Closing the health gaps for Chilean men

How could I use my own subjectivity in my relationship with the other/patient?

During the development of this study, the constructivist paradigm employed has allowed, not only the illumination of the needs of others, but also, of my own subjectivity. It has allowed me to ask how I understood the phenomenon of health, based on my previous and current vision of the community as the beneficiary of health services, questioning me and also the Chilean health system at different levels. The use of my own subjectivity to analyse findings and try to understand the needs of others, is a practice that I now consider as being paramount in the work of any health worker. For instance, during the fieldwork for the research, I was able to experience, alongside patients, the access barriers to the formal primary health care system, and to report on those barriers from my own subjectivity; this experience forced me to have the conviction – and any arguments required – to explain these problems to health authorities. Furthermore, the possibility of discussing with New Zealand colleagues, my personal experience on the research site with academics and researchers outside Chile, has been vital to the generation of new perspectives in relation to the Chilean health system and to the health of Chilean men.

How has this research contributed to my training as a health professional?

The experience of analysing a health problem from the constructivist paradigm and responding to the research question using qualitative methodologies has undoubtedly been a contribution to my career both as a researcher and as a health worker. Since gaining this new perspective (at least new to me), I think that any health strategy that I designed from my desktop, without being a groups’ motivation to maintain (or not maintain) their health, would be destined to failure. Additionally, the immersion in the phenomenon of gender role, as a social determinant of health, has provided me with a new tool for analysis. To understand that gender, as a determinant in health, goes beyond the analysis of women's health is crucial, not only for me as researcher, but also for anyone who wants to work with groups of men, understanding that their perceptions, beliefs and motivations will necessarily be related to their health behaviours.
List of References


List of References


Barker, G., & Greene, M. (2011). ¿Qué tienen que ver los hombres con esto?: Reflexiones sobre la inclusión de los hombres y las masculinidades en las políticas públicas para promover la equidad de género. In F. Aguayo & M. Sadler (Eds.), *Masculinidades y políticas públicas, involucrando a hombres en la equidad de genero* [What men have to do with it: Public policies to promote gender equality]. Santiago, Chile: Universidad de Chile - Facultad de Ciencias Sociales Departamento de Antropología.
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Felicié, J. (2007). *La construcción de la masculinidad y la percepción de la salud en una muestra de hombres puertoriqueños heterosexuales* [The construction of masculinity and the perception of health in a group of heterosexual men in Puerto Rico]. Universidad de Puerto Rico, Río Piedras.


List of References


List of References


Levcovich, M. (2007). *Segmentación y Articulación en el Sistema de Salud Argentino [Segmentation and articulation in the Argentinean health system]*. Presented at the meeting of the ¿Que ha pasado con las Reformas en salud en América Latina? [What has happened with the health reforms in Latin America?], Santiago, Chile. Retrieved

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List of References


Organization for Economic Co-Operation and Development [OECD]. (2010). *Chile signs up as first OECD member in South America*. Retrieved from http://www.oecd.org/document/26/0,3343,en_33873108_39418658_44365210_1_1_1_1,00.html


Parker, M. (2007). Ethnography/ethics *Social Science & Medicine, 65*, 2248-2259. doi:10.1016/j.socscimed.2007.08.003
List of References


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Appendix A: Information Sheet and Consent Form Participating Organizations
FORMULARIO DE INFORMACION A PARTICIPANTES
Director Centro de Salud Primario

Título
HOMBRES CHILENOS Y SALUD: PERCEPCIONES Y RELACIÓN CON EL
SISTEMA DE SALUD PÚBLICO
Investigadora: Margarita Bernales Silva

Introducción
Mi nombre es Margarita Bernales, soy académica de la Escuela de Enfermería de la Pontificia Universidad Católica de Chile; y actualmente me encuentro estudiando un programa de doctorado en la Escuela de Salud de la Población, en la Universidad de Auckland. Mis estudios en la Universidad de Auckland son financiados por una beca del gobierno chileno.
Este proyecto de investigación representa mi tesis para obtener el grado de Doctor en Filosofía en Salud Comunitaria. Por esa razón, durante todo el proceso de investigación seré supervisada por un comité académico, perteneciente a la Universidad de Auckland.

Descripción del Proyecto e Invitación
Actualmente, la situación de salud en Chile presenta diversos desafíos. Las tendencias epidemiológicas muestran un constante aumento de las condiciones crónicas y el sistema de salud debe estar preparado para entregar atención a diferentes comunidades con necesidades específicas. En Chile, actualmente no hay información acerca de las creencias de salud de los hombres, ni de sus necesidades en esta área. En este contexto, es central aumentar y mejorar nuestro entendimiento acerca de la relación que establecen los hombres con su propia salud y con el sistema de salud.
Los objetivos de este proyecto de investigación son:
- Describir las percepciones y conductas en salud de los hombres chilenos, y su relación con el sistema público de salud.
- Desarrollar un modelo explicativo de la relación entre el estado de salud percibida, las conductas en salud y el acceso a los servicios de salud, en hombres chilenos.
- Generar recomendaciones que permitan a los servicios de salud desarrollar estrategias que respondan a las necesidades específicas de los hombres.

Los resultados de este estudio serán un aporte para lograr un mejor entendimiento acerca de cómo los hombres chilenos perciben su propia salud y su relación con los servicios de salud. Esta información podrá ser usada para diseñar e implementar futuras intervenciones dirigidas hacia esta población.
En este contexto, me gustaría invitar a algunos trabajadores de este centro de salud a participar en una entrevista acerca de sus percepciones en relación a la salud de los hombres chilenos, sus conductas y como ellos se relacionan con el sistema de salud primario. En forma adicional, me gustaría solicitar su autorización para llevar a cabo algunas observaciones en este centro de salud, con el objetivo de profundizar en la relación que establecen los hombres de la comunidad con este centro.
Appendices

Procedimientos
Si usted está de acuerdo, mis actividades en este centro de salud serán: (1) presentar mi proyecto en forma individual a diferentes trabajadores de la salud e invitarlos a participar en una entrevista, que duraría aproximadamente 60 a 90 minutos, y (2) en paralelo documentar mis observaciones, específicamente en las salas de espera, con el objetivo de describir dicho contexto, para lo cual realizaré notas de campo y tomaré algunas fotografías digitales acerca de las ilustraciones en las paredes, posters, etc. El proceso completo tomará aproximadamente 6-7 meses, entre Julio 2010 y Febrero 2011.

La información recolectada será confidencial, esto significa que ninguna información identificará a este centro de salud primaria. Las observaciones estarán focalizadas en describir la relación entre los hombres y el centro de salud, sin embargo, las notas de campo no identificarán de ninguna forma este centro. Todas las fotografías serán examinadas, y cualquier persona o cualquier situación que pudiera identificar de alguna forma este centro de salud, serán electrónicamente alteradas; además, al finalizar la recolección de datos usted podrá ver las fotografías y chequear si alguna de ellas muestra algún detalle que pudiera identificar este centro.

Si usted acepta que yo realice este estudio en este centro de salud y que entreviste a sus trabajadores, necesito que me asegure que la participación de los trabajadores de la salud será voluntaria, y que su decisión de participar o no, NO afectará de ninguna forma la relación que ellos mantienen como empleados en este centro de salud.

Todos los datos entregados por los trabajadores de salud serán guardados y analizados eliminando cualquier información que pueda identificarlos. No informaré, ni a usted ni a otras personas, de las percepciones u opiniones específicas emitidas por los trabajadores de la salud.

Cualquier información entregada a usted o a otros acerca de estas entrevistas, serán solo resúmenes generales.

Este centro de salud no obtendrá ningún beneficio directo por participar. Sin embargo, la información obtenida será de gran utilidad para el diseño de estrategias que apunten a las necesidades en salud de los hombres, pudiendo mejorar de alguna forma las políticas y la entrega de servicios de salud.

Su participación y la participación de este centro de salud es voluntaria, usted es libre de decision si desea o no participar y esto no le afectará de ninguna forma.

Almacenamiento de datos/retención/destrucción/futuro uso
Toda la información recolectada será guardada por 6 años en una oficina de la Universidad de Auckland, sin ninguna información que pudiese identificar a los participantes de este estudio o a este centro de salud. Sólo la investigadora principal y su supervisora tendrán acceso a esta información.

Derecho a renunciar o retirarse del estudio
Usted tiene la libertad de permitir la participación de este centro de salud y sus miembros en este estudio.

Usted también puede retirarse en cualquier momento de este estudio, sin ninguna consecuencia negativa asociada, además podrá retirar cualquier información o dato recolectado en este centro de salud, de tal forma de que esta información no sea incorporada en los resultados de este estudio. El periodo en que podrá retirar dicha información en caso de que usted desee suspender la participación de este centro de salud, corresponderá al periodo de recolección de datos de este estudio, es decir, entre Julio 2010 y Febrero 2011.

Confidencialidad
Cualquier información que yo comparta o escriba acerca de este estudio será solo a través de resúmenes generales. La información no identificará lo emitido por los participantes de este estudio. Todas las fotografías serán examinadas, y cualquier persona o situación que pudiera identificar este centro de salud, será alterada electrónicamente.
Contactos
Si usted desea discutir cualquier detalle acerca de este proyecto o acerca de sus derechos como participante, usted puede contactar a:
Margarita Bernales (Investigadora Principal), margarita.bernales@gmail.com, Fono: 56-2 3547268
Nicola North (Supervisora Principal en Nueva Zelanda), n.north@auckland.ac.nz, Fono: 64-9 3737599 x 82931
Lilian Ferrer (Asesor Académico en Chile), iferrerl@uc.cl, Fono: 56-2 3545838
Cualquier pregunta acerca de las consideraciones éticas de esta investigación usted puede contactar a
The University of Auckland Human Participants Ethics Committee, The University of Auckland,
Office of the Vice Chancellor, Private Bag 92019, Auckland 1142. Telephone 09 373-7599 extn.
83711.
O en Chile, usted puede contactar a Claudia Uribe, Coordinadora del Comité de Ética de la Escuela de
Enfermería, Pontificia Universidad Católica de Chile, Vicuña Mackenna 4660, Macul, Santiago de
Chile. Telefono 56-2 354 5838.

Proyecto aprobado por UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS
ETHICS COMMITTEE el 17 de Marzo de 2010, por (3) años, Reference Number 2010/078
CONSENTIMIENTO INFORMADO
Director Centro de Salud Primario

Esta forma será guardada por un periodo de 6 años

Título
HOMBRES CHILENOS Y SALUD: PERCEPCIONES Y RELACIÓN CON EL SISTEMA DE SALUD PÚBLICO

Investigadora: Margarita Bernales Silva

He leído el formulario de información a participantes, he comprendido la naturaleza de esta investigación y por qué este Centro de Salud ha sido seleccionado para participar. He tenido la oportunidad de hacer preguntas y éstas han sido respondidas en forma satisfactoria.

- Estoy **de acuerdo/ en desacuerdo** en permitir la participación de este centro de salud y sus miembros en este estudio.
- Entiendo que la información recolectada será confidencial.
- Entiendo que la participación de este centro de salud contemplará la realización de:
  1) Entrevistas realizadas a algunos trabajadores de la salud acerca de sus percepciones en relación a la salud de los hombres chilenos.
  2) Observaciones realizadas en las salas de espera, en las que se utilizaran notas de campo y fotografías digitales acerca de las ilustraciones en las paredes, posters, etc.
- Entiendo que la participación de los trabajadores de la salud será voluntaria, y su decisión de participar o no en este estudio NO afectará de ninguna forma la relación que ellos mantienen como empleados en este centro de salud.
- Entiendo que no recibiré información acerca de las percepciones u opiniones específicas emitidas por los trabajadores de la salud.
- Entiendo que las observaciones no identificarán de ninguna forma a este centro de salud.
- Entiendo que tendrá derecho a revisar todas las fotografías realizadas, y que cualquier persona o situación que pudiera identificar este centro de salud, será alterada electrónicamente.
- Entiendo que soy libre de permitir la participación de este centro de salud y sus miembros en este estudio, y que podré retirarme en cualquier momento, pudiendo retirar cualquier información o dato recolectado, entre Julio 2010 y Febrero 2011.
- Entiendo que toda la información recolectada será guardada por 6 años, y que luego de este periodo será destruida.

Nombre Participante ___________________________ Firma ___________________________
Fecha __________________________

Proyecto aprobado por UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE el 17 de Marzo de 2010, por (3) años, Reference Number 2010/078
PARTICIPANT INFORMATION SHEET
Head Primary Health Care Centre

Project Title:
CHILEAN MEN’S HEALTH: PERCEPTIONS AND RELATIONSHIPS WITH THE
PUBLIC HEALTH CARE SYSTEM
Researcher: Margarita Bernales Silva

Researcher introduction
My name is Margarita Bernales. I am an academic at the Nursing School, Pontificia Universidad Catolica de Chile; and I am a PhD student at the School of Population Health, University of Auckland. My studies at the University of Auckland are financed by a scholarship from the Chilean Government.
I am conducting this research project as my thesis to obtain the degree of Doctor of Philosophy in Community Health. Hence, I will be supervised during the whole process by an advisory committee from the University of Auckland.

Project description and invitation
The health situation in Chile currently presents several challenges. The epidemiological trends show a constant rise in chronic conditions and the health care system must deliver attention to different communities with particular needs. In Chile there is no information about how men see their health and their health needs. Hence, it is important to improve our understanding of men's relationships with their health and with the health system.
Therefore, the aims of this project are:
- To describe Chilean men's perceptions of their health status and their health behaviors, and their relationship with the public health care system.
- To develop a model to explain the relationships between perceived health status, health behaviors and access to health services.
- To make recommendations for service development in order for the health system to be more responsive to men.
The results of this study will help to better understand how Chilean men perceive their own health and their relationship with the health system. This information can be used to design and implement future interventions directed towards this population.
I would like to invite some health workers of this primary health care centre to participate in an interview in relation to their perceptions about men’s health status and health behaviors, and the relationship between men and the public health care system. Also, I want to ask your authorization to carry out some observations in this primary health care centre aim to describe the relationship between men and the healthcare centre.

Project Procedures
If you are agree, my activities in the primary health care centre will be: (1) to invite different health workers (around 10 or 20) to participate in an interview, which will take 60-90 minutes, and in parallel (2) I will document observations in waiting rooms to provide a description of the context,
taking field notes and digital photography about the illustrations, posters, etc. The whole process will take approximately 6-7 months, between July 2010 and February 2011.

All collected information will be confidential. This means that information will not identify this primary health care centre. The observations will be focus on describe the relationship between men and the health care centre; however, field notes will not identify this primary health centre. All pictures will be examined, and any person or any situation that could identify this healthcare centre will be electronically altered. After all photographs have been digitally altered by me to obscure identities, they will then be examined by the head of the healthcare centre to ensure that no person or situation could be individually identified. Therefore, at the end of the data collection, you will have the opportunity to see all pictures and to check for yourself whether any of them show a detail that could be related with the identity of this centre. Changes as required will then be made.

If you agree to my conducting the study at this healthcare centre and interviewing your staff, I request assurances that the voluntary participation of your health workers in this study will not affect in any way the relationship they maintain, as employees, with the healthcare centre.

All data given by health workers will be stored and analyzed without any information that could identify them. I will not inform you of the perceptions or opinions given by a specific health worker. Any information I will tell you or others about interviews will have only general summaries.

Your participation and the participation of this primary health care centre are voluntary, you are free to decide that you do not want to participate, and this will not affect you in any way.

Data storage/retention/destruction/future use
All the information collected will be stored for six years in an office at University of Auckland, without any information that could identify the participants of this study or this health care centre. Only the principal investigator and her supervisor will be able to look at them.

Right to Withdraw from Participation
You are free to choose to allow the participation of this primary health care centre and its staff. You may also withdraw any time from the study without any adverse effect. Even more, you will be able to get any information or data collected at this healthcare centre. By these means, that information will not be incorporated with the research results.

The period in which you will be able to withdraw that information, in case you wish to suspend your participation, will be between July 2010 and February 2011.

Confidentiality
Any information I tell others or write will have only general summaries. The information will not identify what any individual person said. All pictures will be examined, and any person or any situation that could be identifying this health care centre will be electronically altered.

Contact Details and Approval Wording
If you want to discuss anything about this project or your rights as a participant, you can contact: Margarita Bernales (principal investigator), Telephone: 56-2 3545838 email margarita.bernales@gmail.com
Nicola North (main supervisor in New Zealand), Telephone: 64-9 373 7599 x 82931 email n.north@auckland.ac.nz
Lilian Ferrer (academic adviser in Chile), Telephone: 56-2 3545838 email lferrerl@uc.cl
For any queries regarding ethical concerns you may contact the Chair, The University of Auckland Human Participants Ethics Committee, The University of Auckland, Office of the Vice Chancellor, Private Bag 92019, Auckland 1142. Telephone 09 373-7599 extn. 83711.
Or in Chile you may contact Claudia Uribe, Coordinator of the Human Participants Ethics Committee at School of Nursing, Pontificia Universidad Católica de Chile, Vicuña Mackenna 4660, Macul, Santiago de Chile. Telephone 56-2 354 5838.

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 17 MARCH 2010 for (3) years, Reference Number 2010/078
CONSENT FORM
Head Primary Health Care Centre

THIS FORM WILL BE HELD FOR A PERIOD OF 6 YEARS

Project Title:
CHILEAN MEN’S HEALTH: PERCEPTIONS AND RELATIONSHIPS WITH THE PUBLIC HEALTH CARE SYSTEM
Researcher: Margarita Bernales Silva

I have read the Participant Information Sheet, have understood the nature of the research and why I have been selected. I have had the opportunity to ask questions and have them answered to my satisfaction.

- I agree/ do not agree to allow the participation of this healthcare centre in this study.
- I understand that the collected information will be confidential.
- I understand that the participation of this healthcare centre will involve:
  1. Interviews with some health care employees, about their perceptions related to Chilean men’s health.
  2. Observations in waiting rooms regarding men as users. Field notes and digital photographs will be used to document information on walls, illustrations, posters, etc.
- I understand that health employee participation will be voluntary, and give assurances that their decision to participate in this study will not affect in any way the relationship they maintain, as employees, with this healthcare centre.
- I understand that I will not receive information about the perception and specific opinions made by the health care employees.
- I understand that observations will not identify, in any way, this healthcare centre.
- I understand that I have the right to review all photographs, and that any person or situation that could help identify this healthcare centre will be electronically altered on my request.
- I understand that I am free to allow the participation of this primary health care centre and its staff (it is my choice). I may also withdraw at any time from the study without any adverse effect. I am also able to access any information or data collected at this healthcare centre (excluding data collected from employees). The period in which I will be able to withdraw that information will be between July 2010 and February 2011.
- I understand that all gathered information will be kept for 6 years, after which they will be destroyed.

Name ____________________________________________
Signature ___________________________ Date __________

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 17 MARCH 2010 for (3) years, Reference Number 2010/078
Appendix B: Demographic Information Form
INFORMACION DEMOGRAFICA: Hombres

Título
HOMBRES CHILENOS Y SALUD: PERCEPCIONES Y RELACIÓN CON EL SISTEMA DE SALUD PÚBLICO
Investigadora: Margarita Bernales Silva

Por favor recuerde que su información es confidencial, y usted puede dejar de responder preguntas en cualquier momento o decidir no contestar alguna pregunta en particular.

1. ¿Cuál es su edad? _____________

2. ¿Cuál es su estado civil?
   A. Soltero, nunca casado
   B. Casado
   C. Separado
   D. Divorciado
   E. Viudo

3. ¿Cuántas personas viven en su casa?
   Adultos: _________
   Niños: ________

4. ¿Tiene hijos?
   A. Sí
   B. No (por favor vaya a la pregunta 6)

5. Si usted tiene hijos, ¿cuántos tiene? _________

6. ¿Estan sus padres vivos?
   A. Sí
   B. No (por favor vaya a la pregunta 8)
Appendices

7. Si sus padres están vivos, ¿viven con usted?
   A. Sí
   B. No

8. ¿Están saludables sus padres?
   Madre: Sí  No
   Padre: Sí  No

9. ¿Cuál es el nivel más alto de educación que usted ha completado?
   __________________________________________

Situación de Empleo

10. ¿Esta usted actualmente...?
    A. Trabajando por temporadas
    B. Trabajando en forma particular
    C. Sin trabajo, en búsqueda de uno
    D. Sin trabajo, actualmente no estoy buscando
    E. Dueño de casa
    F. Estudiante
    G. Retirado
    H. Inabilitado para trabajar  (¿Por qué? __________________________)

11. ¿Cuál es su ingreso mensual? CH$________________

12. ¿Cuál es el ingreso mensual total de su hogar, incluyendo el ingreso de todos quienes contribuyen? CH$___________
INFORMACION DEMOGRAFICA: Trabajadores de la Salud

Título
HOMBRES CHILENOS Y SALUD: PERCEPCIONES Y RELACIÓN CON EL SISTEMA DE SALUD PÚBLICO
Investigadora: Margarita Bernales Silva

Por favor recuerde que su información es confidencial, y usted puede dejar de responder preguntas en cualquier momento o decidir no contestar alguna pregunta en particular.

1. ¿Cuál es su edad? _____________

2. ¿Cuál es su género?
   A. Masculino
   B. Femenino

3. ¿Cuál es el nivel más alto de educación que usted ha completado?
   ______________________________

4. ¿Cuántos años ha trabajado en el Sistema de Salud? ______________

5. ¿Cuántos años ha trabajado en este centro de atención primaria? ______________

6. ¿Cuál es su rol/posición en este centro de atención primaria?
   ______________________________
DEMOGRAPHIC INFORMATION : MEN PARTICIPANTS

Project Title:
CHILEAN MEN’S HEALTH: PERCEPTIONS AND RELATIONSHIPS WITH THE PUBLIC HEALTH CARE SYSTEM
Researcher: Margarita Bernales Silva

Please remember that your information is confidential, and you can stop answering questions at any time or you can decide not to answer a particular question.

1. What is your age? _____________

2. What is your current marital status?
   A. Single, Never Married
   B. Married
   C. Separated
   D. Divorced
   E. Widowed

3. How many people are living in your home?
   Adults: _________
   Children: ________

4. Do you have children?
   A. Yes
   B. No (please go to question 5)

5. If you have children, how many do you have? _______

6. Are your parents still alive?
   A. Yes
   B. No (please go to question 8)

7. If your parents are alive, do they live with you?
Appendices

A. Yes
B. No

8. Are they in good health?
   Mother: Yes  No
   Father: Yes  No

9. What is the highest level of education you have completed?
   _______________________________

**Employment Status**

10. Are you currently...?
    A. Employed for wages
    B. Self-employed
    C. Out of work and looking for work
    D. Out of work but not currently looking for work
    E. A homemaker
    F. A student
    G. Retired
    H. Unable to work  (Why? _______________________________)

11. What is your own monthly income? CH$______________

12. What is your total household income, including all earners in your household?
   CH$______________
DEMOGRAPHIC INFORMATION : HEALTH WORKERS

Project Title:
CHILEAN MEN’S HEALTH: PERCEPTIONS AND RELATIONSHIPS WITH THE PUBLIC HEALTH CARE SYSTEM
Researcher: Margarita Bernales Silva

Please remember that your information is confidential, and you can stop answering questions at any time or you can decide not to answer a particular question.

1. What is your age? _____________

2. What is your gender?
   A. Male
   B. Female

3. What is the highest level of education you have completed?
   ____________________________

4. How many years have you been worked in Health Services? _______________

5. How many years have you been worked in this Primary Health Care Centre?
   ____________________________

6. What is your role/position in this Primary Health Care Centre?
   ____________________________
Appendices

Appendix C: Interviews and Focus Group Guides
Guía de Entrevista: Hombres

Introducción

Usted ha aceptado participar hoy en una entrevista acerca de la salud de los hombres, que tomará aproximadamente 60 a 90 minutos de su tiempo. Esta entrevista será grabada digitalmente, ya que es difícil recordar o escribir todo lo que usted diga. Después de nuestra conversación, escucharé la grabación y escribiré palabra por palabra lo que usted mencione. Luego la grabación será destruida. Ningún nombre u otra información que pudiera identificarlo a usted o otra persona serán incluidos en las notas escritas.
Usted es libre de decidir si desea o no participar, y esto no le afectara de ninguna manera.
¿Tiene alguna pregunta? ¿Está de acuerdo en participar? [Dar la oportunidad de que la persona se retire si así lo desea] ¿Podemos comenzar la entrevista?

I. Primero, me gustaría hacerle algunas preguntas acerca de su salud:
1. ¿Cómo define usted el *estar saludable*?
2. ¿Cómo definiría su salud? ¿Por qué?
3. ¿Es importante para usted estar saludable? ¿Por qué?
4. ¿Qué hace usted para estar saludable?
5. ¿Qué lo motiva a tener esas conductas?
6. ¿Tiene usted alguna conducta o estilo de vida que pudiera afectar su salud? (efectos positivos/ efectos negativos)
7. ¿Podría contarme alguna experiencia o situación que usted haya vivido y que haya tenido un impacto en su salud?
8. ¿Quién es responsable por el cuidado de la salud familiar en su casa?
9. ¿Quién era responsable por el cuidado de la salud familiar en su casa cuando usted era niño?

II. Ahora me gustaría hacerle algunas preguntas acerca de cuando usted está enfermo o se siente mal.
10. Por favor, déme un ejemplo de la última vez que usted estuvo enfermo.
11. ¿Qué acciones tomó?
12. ¿Qué hace usted generalmente cuando está enfermo?
13. ¿Alguna vez ha tenido algunos de los siguientes problemas de salud? (Mostrar la lista)
   - ¿Algún problema cardiovascular?
   - ¿Algún problema respiratorio?
   - ¿Algún problema relacionado con estrés o ansiedad?
   - ¿Algún problema relacionado con el uso de alcohol?
14. ¿Qué hace usted para aliviar sus síntomas o sentirse mejor?
15. ¿Cómo se siente usted acerca de sí mismo cuando está enfermo?
16. ¿Qué piensan sus amigos cuando usted está enfermo?
17. ¿Cómo le afecta a usted estar enfermo?
18. ¿Piensa usted que para un hombre es diferente tener una enfermedad física a una enfermedad mental? ¿Por qué?
19. ¿Cuál es la opinión de otros hombres cuando un hombre está enfermo? ¿En el trabajo? ¿En el vecindario?
III. Finalmente me gustaría hacerle algunas preguntas acerca de los servicios de salud.
20. ¿A quién consulta usted por sus problemas de salud o está preocupado por algún síntoma? ¿Consulta diferentes lugares o personas dependiendo de su problema de salud? ¿Podría darme algunos ejemplos?
21. ¿Dónde va cuando usted se siente realmente enfermo?
22. ¿Está usted inscrito en un centro de salud primario o consultorio?
23. ¿Qué tan a menudo usted va al centro de salud primario o consultorio?
24. ¿Se siente cómodo yendo a ese lugar?
25. ¿Me podría contar acerca de la última vez que usted fue al centro de salud o consultorio? ¿Por qué fue?
26. ¿Podría describirme el proceso para tomar una hora en el centro de salud o consultorio?
27. ¿Cómo describiría su relación con el centro de salud o consultorio? ¿Por qué?
28. ¿Tiene alguna sugerencia para mejorar el servicio de salud dirigido a hombres en el centro de salud o consultorio?

Resumen y Preguntas
Ahora que hemos conversado todos los temas que queríamos discutir hoy ¿Tiene algún nuevo comentario o sugerencia acerca de lo que hemos discutido?
NOTA: Preguntas no-directivas serán utilizadas a lo largo de toda la conversación para clarificar respuestas tales como: a) Dígame más sobre eso; b) ¿Puede usted explicarme?; c) Deme un ejemplo; d) ¿Cómo se siente usted al respecto?; e) ¿Alguna otra cosa?
Introducción
Ustedes han aceptado participar hoy en un grupo focal acerca de la salud de los hombres, que dura entre 90 y 120 minutos. Me gustaría recordarles algunos aspectos que ya discutimos cuando ustedes decidieron participar.

El grupo conversará acerca de algunos temas sensibles, relacionado con la salud de los hombres. No les hará preguntas acerca de sus conductas personales. Si hay alguna información que usted no quiere que otros miembros del grupo sepan o que las compartan con otras personas, por favor no las mencione. No puedo prometerles que cada persona del grupo mantendrá nuestra conversación en privado. Les pido además que sean cuidadosos de no discutir con otras personas los asuntos personales que otros miembros del grupo hayan compartido, para proteger su privacidad.

Esta conversación será grabada digitalmente, ya que es difícil recordar o escribir todo lo que usted diga. Después de nuestra conversación, escucharé la grabación y escribiré palabra por palabra lo que usted mencione. Luego la grabación será destruida. Ningún nombre u otra información que pudiera identificarlo a usted u otra persona serán incluidos en las notas escritas. Usted es libre de decidir si desea o no participar, y esto no le afectara de ninguna manera. ¿Tienen alguna pregunta? ¿Están de acuerdo en participar? [Dar la oportunidad de que la persona se retire si así lo desea]

I. Primero, me gustaría hacerle algunas preguntas acerca de la salud:

1. ¿Cómo definen ustedes el estar saludable?
2. ¿Cómo describirían la salud de los hombres en Chile? ¿Por qué?
3. ¿Es importante para un hombre estar saludable? ¿Por qué?
4. ¿Qué cosas hacen los hombres para estar saludables?
5. Por lo general ¿Quién está a cargo de preocuparse de la salud de la familia en una casa?
6. ¿Cómo perciben los hombres su propia salud en relación a la salud de la familia?
7. ¿Cómo perciben los hombres sus responsabilidades en relación al bienestar de la familia?
II. Ahora me gustaría hacerles algunas preguntas acerca del concepto de enfermedad.
8. ¿Qué hacen los hombres cuando están enfermos?
9. ¿Qué hacen los hombres para sentirse mejor o aliviar sus síntomas?
10. ¿Cómo le afecta a un hombre el estar enfermo?
11. ¿Cuál es la opinión de los otros hombres cuando un hombre está enfermo? In the workplace? ¿En el trabajo? ¿En el vecindario?
12. ¿Piensan que para un hombre es diferente tener una enfermedad física a una enfermedad mental? ¿Por qué?

III. Finalmente me gustaría hacerles algunas preguntas acerca de los servicios de salud.
13. ¿Podrían describirme el proceso para tomar una hora en el centro de salud o consultorio?
14. ¿Se sienten cómodos y/o bienvenidos en el centro de salud o consultorio?
15. ¿Qué les gusta acerca del centro de salud o consultorio? ¿Qué no les gusta?
16. ¿Cómo describirían la relación entre los hombres y el centro de salud o consultorio? ¿Por qué?
17. ¿Tienen alguna sugerencia para mejorar el servicio de salud dirigido a hombres en el centro de salud o consultorio?

Resumen y Preguntas
Ahora que hemos conversado todos los temas que queríamos discutir hoy ¿Tienen algún nuevo comentario o sugerencia acerca de lo que hemos discutido?
NOTA: Preguntas no-directivas serán utilizadas a lo largo de toda la conversación para clarificar respuestas tales como: a) Dígame más sobre eso; b) ¿Puede usted explicarme?; c) Deme un ejemplo; d) ¿Cómo se siente usted al respecto?; e) ¿Alguna otra cosa?
Guía de Entrevista: Trabajadores de la Salud

Introducción
Usted ha aceptado participar hoy en una entrevista acerca de la salud de los hombres, que tomará aproximadamente 60 a 90 minutos de su tiempo. Esta entrevista será grabada digitalmente, ya que es difícil recordar o escribir todo lo que usted diga. Después de nuestra conversación, escucharé la grabación y escribiré palabra por palabra lo que usted mencione. Luego la grabación será destruida. Ningún nombre u otra información que pudiera identificarlo a usted u otra persona serán incluidos en las notas escritas.

Usted es libre de decidir si desea o no participar, y esto no le afectara de ninguna manera. ¿Tiene alguna pregunta? ¿Está de acuerdo en participar? [Dar la oportunidad de que la persona se retire si así lo desea] ¿Podemos comenzar la entrevista?

I. Primero, me gustaría hacerle algunas preguntas acerca de la salud de los hombres en general.

1. ¿Cómo define usted el estar saludable?
2. ¿Cómo describiría la salud de los hombres en Chile? ¿Por qué?
3. ¿Cuáles son las motivaciones de los hombres chilenos para mantenerse saludable? ¿Por qué?
4. ¿Cuáles son las necesidades específicas en salud de los hombres?
5. ¿Cómo perciben los hombres su salud en relación a la salud de sus familias?
6. ¿Cómo perciben los hombres su responsabilidad en relación al bienestar de la familia?

II. Ahora me gustaría hacerle algunas preguntas acerca de los hombres y el proceso de enfermar, basándose en sus experiencias.

7. ¿Qué hacen los hombres cuando están enfermos?
8. ¿Qué hacen los hombres para aliviar sus síntomas o sentirse mejor?
9. ¿Cómo le afecta a un hombre el estar enfermo?
10. ¿Piensa que para un hombre es diferente tener una enfermedad física a una enfermedad mental? ¿Por qué?
11. ¿A quién consulta un hombre por sus problemas de salud?
12. ¿Podría describirme cómo es el proceso de toma de decisiones que los hombres hacen cuando desean buscar ayuda si es que se sienten enfermos?
III. Finalmente me gustaría hacerle algunas preguntas acerca de los servicios de salud.

13. En su opinión, ¿Cuáles son los grupos de la población que más se atienden en este centro de salud? ¿Por qué piensa que esto es así?
14. ¿De qué forma este centro de salud se organiza para responder a las necesidades específicas de cada grupo de la población?
15. ¿Podría describirme el proceso para tomar una hora en el centro de salud o consultorio? ¿Son procesos diferentes para los distintos grupos de la población?
16. ¿Cómo describiría la relación entre los hombres y el centro de salud o consultorio? ¿Por qué?
17. ¿Tiene alguna sugerencia para mejorar el servicio de salud dirigido a hombres en el centro de salud o consultorio?

Resumen y Preguntas
Ahora que hemos conversado todos los temas que queríamos discutir hoy, ¿Tiene algún nuevo comentario o sugerencia acerca de lo que hemos discutido?

NOTA: Preguntas no-directivas serán utilizadas a lo largo de toda la conversación para clarificar respuestas tales como: a) Dígame más sobre eso; b) ¿Puede usted explicarme?; c) Deme un ejemplo; d) ¿Cómo se siente usted al respecto?; e) ¿Alguna otra cosa?
Appendices

Interview Guide: Men

Introduction
You have agreed to talk with me today for about 60-90 minutes about men’s health. This interview will be digitally recorded, because it is difficult to remember or write down everything you say. After the discussion, I will listen to the recording and write down what it says. Then the recording will be destroyed. No names or other discussion that might identify you or someone else will be in the written notes.

You are free to decide that you do not want to participate, and this will not affect you in any way.

Do you have a question? Do you agree to participate? [Provide opportunity for people to leave if they wish] Can we start the interview?

I. First, I would like ask you some questions about your health.

1. How do you define to stay healthy?
2. How do you define your health?
3. Is it important for you to stay healthy? Why?
4. What do you do to stay healthy?
5. What motivates you to do these things?
6. Do you have any behaviors or lifestyles that you think can affect your health? (Positive effects/ negative effects)
7. Could you tell me about some experiences you have had that had an impact on your health?
8. Who is responsible to worry about family’s health in your house?
9. Who was in charge to worry about family’s health in your house when you were a child?

II. Now I would like to ask some questions about when you get ill.

10. Give me an example of the last time you become ill?
11. What action did you take?
12. What do you do generally when you become ill?
13. Have you ever had one of the following health problems? (Show the list)
   - A cardiovascular problem?
   - A respiratory problem?
   - Some problems related with stress or anxiety?
   - Some problems related with alcohol use?
14. What are you doing to relieve symptoms or feel better?
15. How do you feel about yourself when you get ill?
16. What do your mates think of you when you get ill?
17. How does it affect you to be ill?
18. Do you think it is different to have a physical illness or a mental illness for a man? Why?
19. What is the opinion of other men when a man is ill? In the workplace? In the neighborhood?
III. Finally I would like to ask some questions about the health services.

20. Who do you consult for your health problems or if you have worrying symptoms? Do you consult different places or people for different health problems? Could you give me some examples?
21. Where do you go when you feel really ill?
22. Are you enrolled in a primary health care centre?
23. How often do you go to a primary health centre?
24. Are you comfortable going there?
25. Could you tell me about the last time that you went to a primary health centre? Why did you go?
26. Could you describe for me the process to make an appointment in a primary health centre?
27. How do you describe your relationship with the healthcare centre? Why?
28. What are your suggestions to improve the service for men in the primary health care centre?

Summary and Questions Now we’ve talked about all the topics that I wanted to discuss today. Do you have any new thoughts, comments or suggestions about any of what we’ve discussed? NOTE: Non-directive probes will be used throughout to clarify responses such as: a) Tell me more about that; b) Can you explain?; c) Give me an example; d) How do you feel about that?; e) Anything else?
Focus Group Guide: Men

Introduction
You have agreed to talk with me today for about 90-120 minutes about Chileans men’s health. Now I want to remind you some of the things we already discussed when you agreed to participate earlier.
The groups may talk about some sensitive issues, related to men’s health. You won’t be asked about your own health or behaviors. If there are things about yourself that you don’t want the group to know or to tell other people, you should not mention them in the group. I cannot promise that everyone in the group will keep your discussion private. Also, you should be careful not to talk to others about any personal things group members may talk about, to protect their privacy.
This discussion will be digitally recorded, because it is difficult to remember or write down everything you say. After the discussion, I will listen to the recording and write down what it says. Then the recording will be destroyed. No names or other discussion that might identify you or someone else will be in the written notes.
You are free to decide that you do not want to participate, and this will not affect you in any way. I have talked to everyone here privately about what we will be doing today. Does anyone have any questions? Do you all agree to participate? [Provide opportunity for people to leave if they wish]

I. First, I would like ask you some questions about health:
1. How do you define to stay healthy?
2. How would you describe Chilean men’s health? Why?
3. Is it important for a man to stay healthy? Why?
4. What things do men do to stay healthy?
5. Who is in charge to worry about a family’s health in a house?
6. How do men perceive their health in relation to family health?
7. How do men perceive their responsibility for their family well being?

II. Now I would like to ask some questions about illness.
8. What do men do when they are ill?
9. What do they do to relieve symptoms or feel better?
10. How does it affect a man to be ill?
11. What is the opinion of other men when a man is ill? In the workplace? In the neighborhood?
12. Do you think it is different to have a physical illness or a mental illness for a man? Why?
Appendices

III. Finally I would like to ask some questions about the health services.

13. Could you describe for me the process of making an appointment in a primary health centre?
14. Do you feel comfortable or welcome in a primary health centre?
15. What do you like about a primary health centre? What do you dislike?
16. How do you describe the relationship between men and primary health centre? Why?
17. What are your suggestions to improve the service for men in the primary health care centre?

Summary and Questions
Now we’ve talked about all the topics that I wanted to discuss today. Does anyone have any new thoughts, comments or suggestions about any of what we’ve discussed?

NOTE: Non-directive probes will be used throughout to clarify responses such as: a) Tell me more about that; b) Can you explain?; c) Give me an example; d) How do you feel about that?; e) Anything else?
Interview Guide: Health workers

Introduction
You have agreed to talk with me today for about 60-90 minutes about Chileans men’s health. This interview will be digitally recorded, because it is difficult to remember or write down everything you say. After the discussion, I will listen to the recording and write down what it says. Then the recording will be destroyed. No names or other discussion that might identify you or someone else will be in the written notes.

You are free to decide that you do not want to participate, and this will not affect you in any way. Do you have a question? Do you agree to participate? [Provide opportunity for people to leave if they wish] Can we start the interview?

I. First, I would like ask you some questions about your perspective on men’s health generally:

1. How do you define to stay healthy?
2. How do you define Chilean men’s health? Why?
3. What motivates men to stay healthy?
4. What are the specific health needs in men’s groups?
5. How men perceive their health in relation to family health?
6. How men perceive their responsibility for their family well being?

II. Now I would like to ask some questions about men and illness, based on your experiences.

7. What do men do when they are ill?
8. What do they do to relieve symptoms or feel better?
9. How does it affect a man to be ill?
10. Do you think it is different to have a physical illness or a mental illness for a man? Why?
11. Who do men consult for their health problems?
12. Can you describe for me men’s decision- making process about health care seeking when they are ill?

III. Finally I would like to ask some questions about the health services.

13. In your opinion, which population groups are the main groups seen at this healthcare centre? Why do you think this is?
14. In which ways is this healthcare centre organized to meet the needs of those populations groups?
15. Could you describe for me the process for patients (including men) to make an appointment in a primary health centre? Are different processes for different populations groups?
16. How do you describe the relationship between men and the healthcare centre? Why?
17. What suggestion do you have to improve the service for men in the primary health care centre?
Appendices

Summary and Questions

Now we’ve talked about all the topics that I wanted to discuss today. Do you have any new thoughts, comments or suggestions about any of what we’ve discussed?

NOTE: Non-directive probes will be used throughout to clarify responses such as: a) Tell me more about that; b) Can you explain?; c) Give me an example; d) How do you feel about that?; e) Anything else?
Appendix D: Approval Certificate from University of Auckland Human Participants Ethics Committee
Appendix F: Approval Certificate from The Chilean Ethic Committee
Subject:
Translation from the Approval Certificate from the Chilean Ethic Committee

PONTIFICIA UNIVERSIDAD CATOLICA DE CHILE
School of Nursing
Research Department
Ethic Committee

APPROVAL CERTIFICATE

The Research Department Ethic Committee belongs to the School of Nursing at the Pontificia Universidad Catolica de Chile; it has evaluated the following documents from the research project entitled “CHILEAN MEN’S HEALTH: PERCEPTIONS AND RELATIONSHIPS WITH THE PUBLIC HEALTH CARE SYSTEM”, which represents the Margarita Bernales’ thesis project to obtain the Doctor of Philosophy degree:

- Full research proposal
- Support letters from the participating organizations
- Participants Consent Forms (men and health workers)
- Transcriber confidentiality agreement

This Ethic Committee has taken the following determination:

In relation to the methodology, the qualitative design –specifically the ethnographic approach and the data collection strategies- is appropriate to answer the research question, considering the ethical standards during all the process.

The documents have incorporated all suggestions emitted by this Ethic Committee, according with norms demanded for the research participant protection.

Therefore, this approval certificate is provided to Margarita Bernales Silva, since her thesis project has considered the scientific and ethical standards of our institution, and the national and international ethical norms.

Caludia Uribe T.
Coordinator
Ethic Committee

Santiago, 19 January 2010
Appendices

Appendix G: Participant Information Sheet and Consent Form
FORMULARIO DE INFORMACION A PARTICIPANTES
Entrevistas Hombres

Título:
HOMBRES CHILENOS Y SALUD: PERCEPCIONES Y RELACIÓN CON EL SISTEMA DE SALUD PÚBLICO
Investigadora: Margarita Bernales Silva

Introducción
Mi nombre es Margarita Bernales, soy académica de la Escuela de Enfermería de la Pontificia Universidad Católica de Chile; y actualmente me encuentro estudiando un programa de doctorado en la Escuela de Salud de la Población, en la Universidad de Auckland. Mis estudios en la Universidad de Auckland son financiados por una beca del gobierno chileno. Este proyecto de investigación representa mi tesis para obtener el grado de Doctor en Filosofía en Salud Comunitaria. Por esa razón, durante todo el proceso de investigación seré supervisada por un comité académico, perteneciente a la Universidad de Auckland.

Descripción del Proyecto e Invitación
Actualmente, la situación de salud en Chile presenta diversos desafíos. Frente al constante aumento de las condiciones crónicas, el sistema de salud debe estar preparado para entregar atención a diferentes comunidades con necesidades específicas. En Chile, actualmente no hay información acerca de las creencias de salud de los hombres. En este contexto, es central aumentar y mejorar nuestro entendimiento acerca de la relación que establecen los hombres con su propia salud y con el sistema de salud.

Los objetivos de este proyecto de investigación son:
- Describir las percepciones y conductas en salud de los hombres chilenos, y su relación con el sistema público de salud.
- Desarrollar un modelo explicativo de la relación entre el estado de salud percibida, las conductas en salud y el acceso a los servicios de salud, en hombres chilenos.
- Generar recomendaciones que permitan a los servicios de salud desarrollar estrategias que respondan a las necesidades específicas de los hombres.

Los resultados de este estudio serán un aporte para lograr un mejor entendimiento acerca de cómo los hombres chilenos perciben su propia salud y su relación con los servicios de salud. Esta información podrá ser usada para diseñar e implementar futuras intervenciones dirigidas hacia esta población.

Este proyecto se focaliza en hombres chilenos mayores de 18 años, que participen en un club de futbol en Santiago, Chile; y que además sean usuarios del sistema público de salud (FONASA). Este estudio contempla la realización de observaciones en este club de futbol, para lo cual se utilizarán notas de campo y fotografías electrónicas, dichas observaciones estarán focalizadas en describir la relación entre los hombres y el sistema público de salud, sin embargo, las notas de campo no identificaran de ninguna forma a este club. Además todas las fotografías serán examinadas por el Director de este club deportivo, y cualquier persona o cualquier situación que pudieran ser identificadas serán electrónicamente alteradas.
Adicionalmente, 20 a 30 hombres serán entrevistados acerca de sus percepciones en relación a la salud de los hombres chilenos, sus conductas y como ellos se relacionan con el sistema de salud primario.
Hoy día me gustaría invitarlo a usted a participar en una entrevista acerca de estas temáticas.
Appendices

Procedimientos
Si usted está de acuerdo en participar en este entrevista, su participación consistirá en responder un cuestionario que contiene preguntas sobre algunos datos demográficos (edad, ocupación, etc), y luego le haré algunas preguntas sobre el significado de los conceptos de salud y enfermedad para usted, incluyendo sus opiniones y percepciones acerca de la relación entre los hombres y el sistema de salud público. Usted no será fotografiado en ningún momento durante la entrevista.
La entrevista tomará alrededor de 60 a 90 minutos de su tiempo, y será grabada digitalmente, ya que es difícil recordar o escribir todo lo que usted diga. Luego de nuestra conversación, escucharé la grabación y escribiré todo lo que usted diga. Luego, la grabación será destruida. Ningún nombre u otra información que pudiese identificarlo a usted u otra persona, será incluidas en la información escrita o transcripción.
Un riesgo de participar en este estudio es que usted puede sentirse incomodo respondiendo algunas preguntas, ya que algunas de ellas son bastante personales. Por esa razón, usted puede dejar de responder preguntas en cualquier momento o puede decidir no responder a una pregunta en particular. Además, usted puede solicitar que la grabación de la entrevista se detenga en cualquier momento. Otro riesgo posible, es que pudiese ser un problema si otras personas se enteraran de nuestra conversación. Por esa razón, me aseguraré de que cuando conversemos no haya nadie alrededor que pudiese escucha sus respuestas.
Usted no obtendrá un beneficio directo por participar. Sin embargo, la información obtenida será de gran utilidad para el diseño de estrategias que apunten a las necesidades en salud de los hombres, pudiendo mejorar de alguna forma las políticas y la entrega de servicios de salud. 
Una vez finalizado el estudio, usted recibirá un resumen general de los resultados.
Su participación es voluntaria, usted es libre de decidir si desea o no participar y esto no le afectara de ninguna forma. Además, el director de este club de futbol me ha asegurado por escrito que su decisión de participar o no en este estudio NO afectara de ninguna forma la relación que usted mantiene con este club de futbol.
Si usted está de acuerdo en participar, recibirá $ 2000 para cubrir sus gastos de transporte. Además, durante la entrevista se le ofrecerán algunos refrigerios.

Almacenamiento de datos/retención/destrucción/futuro uso
Para asegurar su confidencialidad, el consentimiento informado que usted firme será guardado bajo llave en forma separada de la información escrita correspondiente a la transcripción de su entrevista, y cualquier información personal será removida de dichas transcripciones. El consentimiento informado que usted firme será guardado por 6 años en una oficina de la Universidad de Auckland. Sólo la investigadora principal tendrá acceso a él. La transcripción de su entrevista será almacenada electrónicamente por 6 años, sin ningún nombre u otra información que pudiese identificarlo a usted u otra persona. Las transcripciones de su entrevista serán realizadas por el investigador principal, con la ayuda de un asistente de investigación, quien deberá firmar un acuerdo de confidencialidad. La entrevista será realizada en español, y las transcripciones se harán en el mismo idioma. La investigadora principal traducirá las transcripciones al idioma inglés. Solo la investigadora principal y el comité académico de la Universidad de Auckland tendrán acceso a las entrevistas traducidas.

Derecho a renunciar o retirarse del estudio
Usted tiene la libertad de elegir participar o no en este estudio. Usted también puede negarse a responder alguna pregunta si no se siente cómodo haciéndolo. Usted puede retirarse en cualquier momento de este estudio, sin ninguna consecuencia negativa asociada. Además usted podrá retirar cualquier dato que lo identifique. El período en que podrá retirar dicha información en caso de que usted desee suspender su participación, corresponderá al periodo de recolección de datos de este estudio, es decir, entre Julio 2010 y Febrero 2011.

Confidencialidad
Toda la información que usted entregue en esta entrevista será confidencial, solo yo y el comité académico tendremos acceso a las transcripciones. Cualquier información que yo comparta o escriba acerca de esta entrevista será solo a través de resúmenes generales. La información no identificará lo
emitido por cada participante en forma individual. De esta forma, usted puede estar seguro de que todas sus respuestas serán privadas.

**Contactos**

Si usted desea discutir cualquier detalle acerca de este proyecto o acerca de sus derechos como participante, usted puede contactar a:

Margarita Bernales (Investigadora Principal), [margarita.bernales@gmail.com](mailto:margarita.bernales@gmail.com), Fono: 56-2 3547268

Nicola North (Supervisora Principal en Nueva Zelanda), [n.north@auckland.ac.nz](mailto:n.north@auckland.ac.nz), Fono: 64-9 3737599 x 82931

Lilian Ferrer (Asesor Académico en Chile), [lferrerl@uc.cl](mailto:lferrerl@uc.cl), Fono: 56-2 3545838

Cualquier pregunta acerca de las consideraciones éticas de esta investigación usted puede contactar a The University of Auckland Human Participants Ethics Committee, The University of Auckland, Office of the Vice Chancellor, Private Bag 92019, Auckland 1142. Telephone 09 373-7599 extn. 83711.

O en Chile, usted puede contactar a Claudia Uribe, Coordinadora del Comité de Ética de la Escuela de Enfermería, Pontificia Universidad Católica de Chile, Vicuña Mackenna 4660, Macul, Santiago de Chile. Telefono 56-2 354 5838.

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Proyecto aprobado por UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE el 17 de Marzo de 2010, por (3) años, Reference Number 2010/078
CONSENTIMIENTO INFORMADO
Entrevista Hombres

Esta forma será guardada por un periodo de 6 años

Título
HOMBRES CHILENOS Y SALUD: PERCEPCIONES Y RELACIÓN CON EL SISTEMA DE SALUD PÚBLICO

Investigadora: Margarita Bernales Silva

He leído el formulario de información a participantes, he comprendido la naturaleza de esta investigación y por qué yo he sido seleccionado para participar. He tenido la oportunidad de hacer preguntas y éstas han sido respondidas en forma satisfactoria.

• Estoy de acuerdo/ en desacuerdo en participar en esta investigación.
• Entiendo que esta entrevista tomará alrededor de 60 a 90 minutos.
• Entiendo que no seré fotografiado en ningún momento durante la entrevista.
• Entiendo que puedo dejar de responder preguntas en cualquier momento o puedo decidir no responder a una pregunta en particular, y que además podré solicitar que la grabación de la entrevista se detenga en cualquier momento.
• Entiendo que soy libre de participar en este estudio y que puedo retirarme en cualquier momento, pudiendo retirar cualquier información o dato recolectado, entre Julio 2010 y Febrero 2011.
• Entiendo que esta entrevista será grabada digitalmente.
• Entiendo que al participar en esta entrevista recibiré $ 2000 para cubrir mis gastos de transporte.
• Entiendo que una tercera persona que firmará un acuerdo de confidencialidad podrá transcribir la grabación digital de mi entrevista.
• Entiendo que una vez finalizado el estudio recibiré un resumen general de los resultados.
• Entiendo que mi información será guardada por 6 años, y que luego de este periodo será destruida.

Nombre Participante ___________________________ Firma ___________________________
Fecha _________________
PARTICIPANT INFORMATION SHEET
Men’s Interview

Project Title:
CHILEAN MEN’S HEALTH: PERCEPTIONS AND RELATIONSHIPS WITH THE PUBLIC HEALTH CARE SYSTEM

Researcher: Margarita Bernales Silva

Researcher introduction
My name is Margarita Bernales. I am an academic at the Nursing School, Pontificia Universidad Catolica de Chile; and I am a PhD student at the School of Population Health, University of Auckland. My studies at the University of Auckland are financed by a scholarship from the Chilean Government.

I am conducting this research project as my thesis to obtain the degree of Doctor of Philosophy in Community Health. Hence, I will be supervised during the whole process by an advisory committee from the University of Auckland.

Project description and invitation
The health situation in Chile currently presents several challenges. There is a constant rise in chronic conditions and the health care system must deliver attention to different communities with particular needs. In Chile there is no information about how men see their health and their health needs. Hence, it is important to improve our understanding of men’s relationships with their health and with the health system.

Therefore, the aims of this project are:
- To describe Chilean men’s perceptions of their health status and their health behaviors, and their relationship with the public health care system.
- To develop a model to explain the relationships between perceived health status, health behaviors and access to health services.
- To make recommendations for service development in order for the health system to be more responsive to men.

The results of this study will help to better understand how Chilean men perceive their own health and their relationship with the health system. This information can be used to design and implement future interventions directed towards this population.

This project is focused on Chilean men over 18 years old, who are part of a soccer club in Santiago, Chile; and who belong to public health system (FONASA).

This study involves observations at the soccer club, including field notes and digital photographs. Observations will be focused on describing relationship between men and the public health care system. However, field notes will not identify, in any way, this soccer club or its members. All photographs taken at the club will be digitally altered by me to obscure identities, and then examined by the head of the soccer club to ensure that no person or situation could be individually identified.

Additionally, 20 to 30 men will be interviewed concerning their perceptions about men’s health status and health behaviors, and their relationship with the public health care system.

Today I would like to invite you to participate in an interview about these issues.
Appendices

Project Procedures
If you agree to participate in this interview, your participation will consist in answering a questionnaire with some of your demographic data (age, occupation, etc), and then I will ask some questions about the meaning of health and illness for you, including your opinions and perceptions about the relationship between men and the public health care system. You will not be photographed, at any moment, during the interview.
This interview will take about 60-90 minutes of your time. This will be digitally recorded, because it is difficult to remember or write down everything you say. After the discussion, I will listen to the recording and write down what it says. Then the recording will be destroyed. No names or other information that might identify you or someone else will be in the written notes.
One risk of participating is that you may feel uncomfortable answering some questions, because some of them are quite personal. For that reason, you can stop answering questions at any time or you can decide not to answer a particular question. In addition, you will be able to ask to stop the recording of the interview at any moment.
Another risk is that it could be difficult for you if other people were to know this private information. I will make sure that when we talk, there will be no one else around who can hear your answers.
There is no direct benefit to you for participating. However, the information obtained could be really useful to design health strategies for men’s specific needs, improving health policies and health care services.
Once this study has finalized, you will receive a general summary of the results.
Your participation is voluntary, you are free to decide that you do not want to participate, and this will not affect you in any way. The Head of this club has given written assurances that your decision to participate—or not—in this study will not affect, in any way, the relationship you maintain with the soccer club.
If you are agree to participate, you will receive CH$ 2000 (NZ$ 5.00) to cover your transport expenditures. Also during the interview refreshments will be offered to you.

Data storage/retention/destruction/future use
To ensure your confidentiality, the informed consent form will be stored in locked cabinets, separate from your interview transcript, and any personal information will be removed from the interview transcriptions.
The signed informed consent forms will be stored for six years in an office at University of Auckland and only the principal investigator will be able to look at them.
The transcription of your interview will be stored electronically also for six years, without your personal name or other information that might identify you or someone else.
The transcription will be done by the principal investigator, with the assistance of a research assistant, who must sign a confidentiality agreement. The interview will be done in Spanish, and the transcription will be done in the same language. The principal investigator will translate the interview transcription to English. Only the researcher and her advisory committee from the University of Auckland will have access to the translated interviews.
At the conclusion of the study a summary of results will be made available to you.

Right to Withdraw from Participation
You are free to choose to participate in the study. You may also refuse to answer some or all of the questions if you don’t feel comfortable with those questions. You may withdraw at any time from the study without any adverse effect, and to withdraw any data traceable to you. The period in which you will be able to withdraw that information, in case you wish to suspend your participation, will be between July 2010 and February 2011.

Confidentiality
All the information that you give me in the interview will be confidential, only myself and the advisory committee will have access to the interview transcriptions. Any information we tell others
or write about this interview will have only general summaries. The information will not identify what any individual person said. That way you can be sure that all of your answers will be private.

**Contact Details and Approval Wording**
If you want to discuss anything about this project or your rights as a participant, you can contact:
Margarita Bernales (principal investigator), Telephone: 56-2 3545838 email margarita.bernales@gmail.com
Nicola North (main supervisor in New Zealand), Telephone: 64-9 373 7599 x 82931 email n.north@auckland.ac.nz
Lilian Ferrer (academic adviser in Chile), Telephone: 56-2 3545838 email lferrerl@uc.cl

For any queries regarding ethical concerns you may contact the Chair, The University of Auckland Human Participants Ethics Committee, The University of Auckland, Office of the Vice Chancellor, Private Bag 92019, Auckland 1142. Telephone 09 373-7599 extn. 83711. Or in Chile you may contact Claudia Uribe, Coordinator of the Human Participants Ethics Committee at School of Nursing, Pontificia Universidad Católica de Chile, Vicuña Mackenna 4660, Macul, Santiago de Chile. Telephone 56-2 354 5838.
CONSENT FORM
Men’s Interview

THIS FORM WILL BE HELD FOR A PERIOD OF 6 YEARS

Project Title:
CHILEAN MEN’S HEALTH: PERCEPTIONS AND RELATIONSHIPS WITH THE PUBLIC HEALTH CARE SYSTEM

Researcher: Margarita Bernales Silva

I have read the Participant Information Sheet, have understood the nature of the research and why I have been selected. I have had the opportunity to ask questions and have them answered to my satisfaction.

• I agree/ do not agree to take part in this research.
• I understand that this interview will take about 60-90 minutes.
• I understand that I will not be photographed, at any moment, during the interview.
• I understand that I can stop answering questions at any time or I can decide not to answer a particular question.
• I understand that I will be digitally recorded and that I may request the recorder to be turned off at any moment during the interview.
• I understand that I am free to withdraw participation at any time, and to withdraw any data traceable to me. The period in which I will be able to withdraw that information, will be between July 2010 and February 2011.
• I understand that I will receive CH$ 2000 (NZ$ 5.00) to cover my transport expenditures.
• I understand that a third party who has signed a confidentiality agreement will transcribe the digital recording.
• I understand that data will be kept for 6 years, after which they will be destroyed.

Name ___________________________

Signature ___________________________ Date _________________

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 17 MARCH 2010 for (3) years, Reference Number 2010/078