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Mental Suffering in Men Living in Rural Cities: Expanding Care and Building Knowledge in Mental Health

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ABSTRACT

Research says that the male population has little use of health services, especially at the level of basic care, which has been a cause for concern, seeking treatment for their health problems generally when it is already demanded services of a specialized nature. Mental illness, especially Mental Disorders (CMD), is one of the major problems facing us today, which compromises the health of the population and represents a high burden on public health. Nonetheless, the incipience of studies focusing on male health needs in primary health care is notorious. This study aims to analyze aspects of vulnerabilities to common mental disorders in men living in the rural context in municipalities in Paraiba, associated with socioeconomic factors, lifestyle, search for care, and mental health. A set of instruments was applied: SRQ-20 (tracking of non-psychotic mental disorders); sociodemographic questionnaire and semi-structured interviews, based on the method of scenes, to understand the meanings people attribute to the different dimensions of their daily life and, thus, to decode the dimensions of vulnerability, as a method of analysis was used the thematic analysis. It is evident that a great part of the non-adherence to the measures of integral attention, on the part of the man, stems from cultural aspects. When they feel strong, resistant, and invulnerable, they may not adopt preventive behaviors or access health services. They seek medical and psychological help when they no longer support them, feeling intensely affected by illness, especially when the socioeconomic situation is unfavorable.

INTRODUCTION

We are facing a field of recent discussions in Psychology, although it is important to highlight that the contributions produced so far are unquestionable, we cannot forget the need for studies and research aimed at the rural population. Historically, Psychology has turned its gaze almost exclusively to the urban population. It appears that the inhabitants of large cities have been a constant target of their professional intervention, in addition to becoming the object of studies and research in the psychological field.

According to data from the Brazilian Institute of Geography and Statistics-IBGE (2010), the current male population of Paraíba is 1,824,495, of which 794,310 are aged between 21 and 59 years and, of these, 163,107 live in the capital. First, the organization of health care in Paraíba was taken into account. In the context of the organization of health care, the state territory of Paraíba, according to data from the state government, Paraíba (2015), is currently divided into 04 health macro-regions and 16 Health Regions.

According to Fortes, Villano, and Lopes (2008), there is an increasing number of people in the world population who suffer from mental illnesses, whose consequences, individual and social, reinforce the need for early identification to guide individual and collective interventions.

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Goldberg and Huxley (1992) to include non-psychotic depression, anxiety, and somatoform symptoms conceptualized Common Mental Disorders (CMD). CMDs cover symptoms such as insomnia, fatigue, forgetfulness, irritability, concentration difficulties, somatic complaints, and feelings of worthlessness, which demonstrate disruption of the individual's normal functioning. Common mental disorders are commonly found in individuals with low socioeconomic class, women, and separated (COSTA; LUDEMIR, 2005). Tobacco and alcohol users, as well as sedentary behavior also showed associations with CMD (PINHEIRO; MONTEIRO, 2007). Studies have found relationships between CMD and social vulnerability such as low education, fewer assets, poor housing conditions, low income, and unemployment.

Ludemir (2000) indicates that often found in the community, these disorders represent a high social and economic cost, as they are disabling, they are an important cause of lost workdays, in addition to increasing the demand on health services. However, among the public and collective health problems, the Common Mental Disorders (CMD), studies carried out by Brazilian

researchers, such as Miranda, Carvalho, Fernandes, Silva, and Sabino (2009), point out that the disorders Mental disorders represent four of the top ten causes of disability worldwide and affect 25% of the population at some stage of their lives.

In the context of vulnerability, as highlighted by Ayres, Paiva, and França Jr. (2012), the individual is understood as intersubjectivity and as an active constructor, and not just the result (effect) of social relations, which must then be remodeled to ensure “healthy behavior”. The concept of vulnerability designates a set of individual and collective aspects related to the greater susceptibility of individuals and communities to illness or disease and, inseparably, less availability of resources for their protection (AYRES; CALAZANS; SALLETI-FILHO; FRANÇA JR, 2016). From the perspective of vulnerability, the individual, social and programmatic dimensions - policies, services, health actions - of any health-disease-care process will be identified and interrelated by the subjects who are somehow involved in this process and seek to understand what he means.

Another aspect that deserves to be discussed is the models of masculinity and how male socialization takes place, which can weaken or even remove men from concerns about self-care and the search for health services. The male care perspective can follow a positive path when it incorporates the idea that men are also allowed to pay attention to themselves. On the other hand, this care can also distance him from his health in general when he reaches the limit of the extreme worship of the body. Some men, when they promote the care of their body, cultivate extreme bodybuilding and, in this aspect, the care of themselves can become a risk of illness (GOMES, 2010).

MATERIALS AND METHODS

A set of instruments was applied: *Self Report Questionnaire* 20- SRQ-20 (screening for non-psychotic mental disorders); Sociodemographic Questionnaire, Lifestyle, and violence, Mental health care, Access and care in health services, applied with 432 participants. Furthermore, based on the results obtained in the SRQ-20, semi-structured interviews were carried out with 07 men from the rural context, aged between 24 and 59 years old, based on the method of scenes, to understand the meanings that people attribute to the different dimensions of their daily life and, thus, decode the dimensions of vulnerability.

As a method of analysis, thematic analysis was used (MINAYO, 2010). The research was approved by the Research Ethics Committee (CEP), of the University Center de João Pessoa/UNIPÊ-JP, receiving a favorable opinion nº 316.559/13 and fulfills all the determinations of Resolution nº 466/2012 of the National Health Council. Participants received information about the phases of the investigation and its objectives and signed the Free Informed Consent Term. After approval by the ethics committee, the field research began.

RESULTS AND DISCUSSIONS

Through the application of the SRQ-20 and the questionnaires: sociodemographic, lifestyle and violence, mental health care, access and care in health services, a prevalence of 46.3% (N=74) in the male population in the city of João Pessoa/PB, most participants with CMD were between 30 and 49 years old. In the Brazilian literature, the prevalence of CMD in the general population varies between 22.7% and 35% (LUDERMIR; MELO FILHO, 2002), in men, this rate is 12.5% to 17%(LOPES; FAERSTEIN; CHOR, 2003). Next, the main thematic classes mentioned will be presented in general, namely: Symptomatology (main complaints); Perception or trivialization of suffering; Lifestyle; Family problems and family care; Economic crisis/Financial difficulties; Problems with self-esteem and social interaction; They seek health care late or in an emergency; the loss of physical vitality; long periods of drought and drought.

The Common Mental Disorder, as previously explained, is non-psychotic, involves a set of signs and symptoms related, mainly, to somatic complaints and depressive and anxious symptoms, generally associated with living conditions and occupational structure. Despite covering a series of symptoms, in general, its main complaints involve physical symptoms, of a somatoform nature, associated with symptoms related to the decrease in vital energy and, mainly, somatic complaints and depressive thoughts, as can be seen in the participant's speech: "I sleep poorly and I don't feel like eating, I also have a headache. Financial difficulties make me very worried, sad, with no desire to live. I even thought about taking my own life" [Part. 05 – 50 anos].

Mental health is at the heart of the debate about inequalities and inequities in health, since mental disorders currently present one of the greatest burdens of morbidity, significantly impacting the daily lives of individuals and families, culminating in social and economic difficulties in society in general.

When it comes to men's health in rural contexts, this situation is even more aggravating. The appalling living conditions, associated with the economic situation, social inequalities, the precariousness of access to education, health, and safety services at work, housing, basic sanitation, and drinking water supply, in the Brazilian rural context, instigates the reflection on the impacts of such conditions on physical and mental health, in addition to the effects of these conditions about the prevalence of common mental disorders, in the rural context in Brazil. Factors such as low education and gender, when associated with poverty, increase the prevalence of CMD. It was found in the present study that in the rural context men have somatic symptoms (poor digestion, hands shake, headache, sleep poorly, fatigue, etc.).

As a result, there are some studies focused on CMD screening, a terminology widely used in the psychiatric epidemiology literature for the characterization of symptomatic conditions that do not have associated organic pathology(PINHO; ARAÚJO, 2012; COSTA; LUDERMIR, 2005), in addition, the manifestation of somatic and depressive/anxious symptoms was the one that most marked the presence of CMD among the men investigated. Such denominations according to Maragno et al. (2006) and Fonseca et al. (2008), refer to very similar clinical settings, linked to nonspecific somatic complaints such as body aches, malaise, headaches, nervousness, insomnia not always classifiable in major psychiatric syndromes.

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Another aspect observed in the interviews was the perception or trivialization of suffering at home, among friends, and in health services. In the rural context, through the interviews, it was observed that the men interviewed cannot easily express what they feel, not demonstrating their subjectivity, demonstrating firmness, masculinity, and virility. Although the symptoms presented by men are similar, it cannot be said that they suffer in the same way and with the same intensity. The way these symptoms will affect their lives will depend on the experiences of each one, as well as on each life context, the existence of support, and the resources (internal and external) they have to face the difficulties of everyday life. -day. Another aspect that deserves to be highlighted is that the demonstration of these varieties of symptoms according to Zanello (2014) can be both a cause and a consequence of suffering. For example, we can see in the participant's speech, when he mentions that men do not cry, especially when they go through difficulties in their daily lives.

A macho man doesn't cry, that's a woman thing. Even if I wanted to, I couldn't, I'm hard to cry, even when someone in my family dies I find it hard to cry" [Part. 05 – 50 years].

This result reinforces the findings of studies (Dinizet al., 2003; Figueiredo, 2008) on invulnerability as one of the axes of masculinity construction. Associated with this is the difficulty that men in the rural context have to verbalize what they feel because talking about their health problems can mean a possible demonstration of weakness, of feminization towards others (GOMES; NASCIMENTO; ARAÚJO, 2007).

In addition, it is clear that gender issues are much more present in rural areas, rural men avoid expressing their feelings because they think that crying is part of the female universe. Gender issues such as the expression of specific symptoms by women can contribute to the process of trivialization and vulnerability. According to Zanello (2014), symptoms are not motivated and immediate signs, they depend on their semiotics, in which gender relations are fundamental factors, present in their patio plastic aspect, that is, in a society where the differences between sexes are striking, it is common for men and women to express their feelings differently, which points to the gendered character of the symptoms, that is, how it manifests itself(p.108). According to the author, crying – as it is intrinsically linked to emotions, sensitivity – is accepted since childhood in women's behavior, but deeply repressed among men as a sign of weakness, which would put them in check as "real men". This is to say that crying can be the manifestation of sadness in a woman, but even if a man does not cry, this does not indicate that he is not sad.

Understanding that the process of becoming ill involves different aspects, in which health emerges as a phenomenon that must be taken into interface with the social context and its conditioning, in the objective and subjective planes. However, mental health is intrinsic to the health and well-being of the individual, being the result of the interaction of several factors (PATEL et al., 2010), namely genetic, biological, psychological, social, and environmental.

Thus, in the rural context, different lifestyles were observed. The bucolic and sedentary life is more present, as well as the consumption of alcoholic beverages and tobacco use. Men do not practice physical exercises regularly, nor do they try to maintain a healthy diet, they claim lack of time, laziness, and the act of exercising and taking care of the body is aimed at women.

Healthy behaviors, although desired, are described in rural areas as something that most men do not incorporate into their daily lives due to personal or social difficulties.

“I don't do any exercise, I don't have time. This is bullshit. This is left for the young people who have time for it (...) my wife goes for walks, women like to take care of the body (...) take care of the body, this is more for women” [Part. 05 – 50 years].

“This thing about doing physical exercise is for those who don't work. I'm also lazy you know. Sometimes I play soccer, at least I move (...) it's already exercise” [Part. 07 – rural, 42 years].

Through the speeches of participants 05 and 07 from the rural context, cultural and individual issues can be seen as explanatory factors of the little care given by men to health. What corroborates the studies by Santos, Almeida, Maravilha, and Oliveira (2011), on the one hand, the lack of care is justified due to individual characteristics of male nature. Men, by their nature, are afraid and lazy to avoid excesses, be concerned about healthy eating, and maintain regular physical activities. On the other hand, some discourses attribute this lack of care to cultural characteristics. According to the authors, society builds prejudice against male subjects regarding body care, which makes health care difficult. Everything happens as if the subjects naturally suffer the social influence in the construction of prejudice about the care of the body. The social idea of masculinity would imply avoiding care for the body, which is interpreted as aesthetic care. Between culture and nature, explanations are constructed both for the human being and to justify the lack of health care.

Currently, all health organizations are aware that most illnesses are linked to the style and quality of life. Among the most recommended habits for a healthy life in contemporary societies is physical activity, an essential ally to achieving and maintaining good health. A sedentary lifestyle, which the World Health Organization (WHO) defines as the expenditure of calories below 2,200 points per week, on the contrary, is associated with several health problems (GOMES; MINAYO, 2016).

There was also a greater emphasis placed by men on day-to-day concerns, situations in everyday life that cause stress as causes for their suffering, highlighting in both contexts, family problems, and family care. The interviewees mentioned health problems in the family with close relatives, as well as child care. This place of the man as responsible for the family, therefore, was not only

situated in the financial field, as our field study showed but also as responsible for the care of its members.

"my parents are already very old, health problems, this has worried me a lot. My son from his first marriage, 23 years old, is sick with his eyesight, had a detached retina, had hasty eye surgery. I also worry about the future of my children" [Part.03 – 44 years old].

It is worth mentioning some associations, made by men, between the incidence of CMD and stressful situations in everyday life, such as, for example, migration of children to large urban centers or other cities in search of employment; health problems (personal and family); hospital admission of relatives; marital problems; vulnerabilities (financial difficulties, unemployment), in the urban context: crime (robberies or robberies); traffic violence; marital problems; bereavement/death of a close relative; serious health problems; health problems (personal and family); vulnerabilities (low wages; financial difficulties, unemployment). These stressors were identified as the cause of headaches, depression, insomnia, lack of appetite, tiredness, nervousness, worry, etc., symptoms that were tracked by the SRQ-20 and confirmed by the interviewees.

Among the reasons cited by most participants as a cause of the illness was the economic crisis/financial difficulties experienced in recent years in the Brazilian context, affecting family dynamics, due to socioeconomic conditions, causing financial problems, an increase in the number of unemployed; as well as urban violence (insecurity, robberies, robberies, congestion and fights in traffic) which leads to an increase in social isolation. See the speech of the participants below: "The lack of money is great, the lack of jobs too. I have a son who went to study in another state, the job opportunities are better than here" [Part.03 – 44 years old].

Reports of concerns about economic insecurity and debt, displacement of relatives to other regions of the country in search of employment, financial difficulties that prevent the acquisition of material goods, food, medical appointments, and medicines, are frequent among the men interviewed. However, family dynamics are affected by socioeconomic conditions, which produce negative impacts on the daily lives of men, in both contexts, resulting in concerns, sadness, and dissatisfaction with life. This corroborates the studies by Antunes (2015), Pinheiro, and Monteiro (2007), such aspects, associated with the precariousness in the offer of

professionals and health and social assistance services in these territories, produce an increase in vulnerability and have a strong impact on mental health. The increase in alcohol consumption and mental suffering in times of economic crisis with increased unemployment, precarious work, and the unstable and competitive structuring of economies are aspects reported in the literature (ANTUNES, 2015; PINHEIRO; MONTEIRO, 2007).

The emergence of many mental illnesses is related to the places and environments in which people live and the stages of their life cycle (WHO; CALOUSTE GULBENKIAN FOUNDATION, 2014). Therefore, it is related to characteristics of urbanity and rurality (LOUREIRO; COSTA; ALMENDRA; FREITAS, 2015). Unemployment, combined with financial difficulties, lead men from rural cities and the urban context to greater social vulnerability, leading to male illness.

In an attempt to understand this web of factors that affects the lives of millions of people around the world (DIMENSTEIN; LEITE; MACEDO; DANTAS, 2016) they highlight that in economically unfavorable scenarios, there is a resurgence of feelings of insecurity, lack of protection, uncertainty, instability, fear, which weaken the protective factors of mental health and change the pattern of use of health services, with a considerable increase in consultations and hospitalizations.

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The environmental characteristics of territories (where people are born, grow up, live, work and age) can produce positive or negative impacts on individual and collective mental health, functioning as their "environmental determinants" (WHO; CALOUSTE GULBENKIAN FOUNDATION, 2014; WHO, 2011).). These represent higher risks of mental illness in some social groups, considering their greater exposure and vulnerability to unfavorable social, economic, physical, and built environments (WHO; CALOUSTE GULBENKIAN FOUNDATION, 2014).

The World Health Organization (WHO, 2011) has emphasized the relationship between situations of vulnerability and mental health problems. Isolation and daily exposure to violence and abuse can cause psychosomatic symptoms, abuse of alcohol and psychoactive substances, etc. Likewise, mental health is negatively impacted when civil, cultural, political, and social rights are violated, or when social groups are excluded from income generation or education

opportunities, which has particular implications for rural populations that historically suffer from poverty and precarious living conditions.

The importance that works assumes in the constitution of the person's subjectivity, their characteristics, as well as their life and work history, are fundamental to understanding the problems that affect the physical and mental health of the worker. In addition, the detailed description of the work situation, involving the environment, organization, and the perception of the influence of work on the process of becoming ill, can also cause problems in self-esteem and social life, as can be seen in the participant's speech:

“I work in the fields, planting sugar cane, I come home tired, I don't have the energy to exercise, to go out for a walk with the woman, I just want to stay at home, rest, to start all over again the next day. It is heavy work, it requires a lot of resistance from us, under the hot sun, and they don't value our work, they think it is easy, anyone can do it. The woman calls me to go for a walk in the square and I don't go” [Part. 07 – 42 years].

Faced with work difficulties, there is low self-esteem among the interviewees and the need for an emotional balance to perform the activities due to the overload and pressure at work, dissatisfaction, and lack of recognition, in addition to tiredness/indisposition. The statements above show that the effects that CMD causes in men's lives go beyond symptoms. Low self-esteem, losses in social and work relationships, feelings of worthlessness, are just a few examples.

However, it appears that the care for this disorder is not simply linked to the control or remission of symptoms, but directly involves the way men deal with this phenomenon in their daily lives and the meaning they assume in their lives. Individual, social and programmatic aspects can be verified in these contexts. Interdisciplinary and intersectoral actions thus emerge as primordial devices, of great relevance for the development of new practices aimed at the integral care of men.

For this, a powerful network of community services is needed, acting in the different contexts through which people in psychological distress circulate. In this way, the Psychosocial Care Centers - CAPS have become a strategic device in the operationalization of psychosocial care,

significantly reducing long hospitalizations in psychiatric hospitals through an expanded, territorial, and community direction of care (DIAS; AMARANTE, 2022).

In Brazil, the construction of “men's health” as a target of policies and research is recent. Its promotion remains a challenge for Primary Health Care (PHC) services. The National Policy for Integral Attention to Men's Health (BRASIL, 2008) highlights that men may be at greater risk and die earlier than women, but they resort significantly less to health services, particularly primary care. According to the Policy, men's health must be promoted in line with the national guidelines for the Unified Health System, which give a central and ordering place to Primary Care and the Family Health Strategy. Let's see in the interviewee's speech: “I'm not one to go to the doctor. I go for a blood test or when the plant asks” [Part. 05 – 50 years].

Given this reality, the National Policy for Integral Attention to Men's Health (PNAISH), instituted on August 27, 2009, through Ordinance GM/MS nº 1944, guided the formulation of guidelines and actions aimed fundamentally at integral, intending to prevent and promote health, quality of life and education, as strategic devices to encourage behavioral changes (BRASIL, 2008). Additionally, health promotion and disease prevention have been focused on as priority axes in the Family Health Strategy.

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However, there are many propositions and/or justifications for the low presence of men in primary health care services. According to Figueiredo (2005), on the one hand, the absence of men or their invisibility in these services is associated with a characteristic of male identity related to their socialization process. In this aspect, the male identity would be associated with the devaluation of self-care and the incipient concern with health. On the other hand, however, it is stated that men prefer to use other health services, such as pharmacies or emergency rooms, which would respond more objectively to their demands. In these places, men would be attended to more quickly and would be able to expose their problems more easily.

Men often seek care late or in an emergency, prioritize the logic of cure or immediate relief of symptoms, looking for a doctor when they already have a manifest disease, Capilheira and Santos (2006) and Fernandes et al. (2009) claim that there is greater use of services by individuals who perceive their health as fair or poor.

In the field of mental health in Brazil, since the emergence of the psychiatric reform movement in the mid-1970s, there has been a plurality of knowledge and production. Dias and Amarante (2020) consider that the paradigm of psychosocial care, a practical-theoretical reference built from the reform, is also potentially counter-hegemonic by distancing itself from a mental health perspective exclusively based on biomedical rationality, represented by psychiatry and by hospitalization, which has historically been consolidated as hegemonic care technologies.

Health care articulated with the demand for services, cited by most interviewees as being the last resort sought when one is already very weak. Such placements can be observed in the speech below.

“the man only leaves to go to the doctor in the last days, when he can't take it anymore, he goes to the doctor. I am like that (...) women like to go to the doctor (...) women take care of themselves more than men. When I needed to go to the doctor, I saw more women in the PSF, I hardly see men” [Part. 05 – 50 years].

In research carried out to explain the low demand for health services by men, Gomes, Nascimento, and Araújo (2007) reveal that the explanations elaborated by the interviewees revolve around a single structuring axis: roles to be played to attest to the masculine identity or the what is meant by being a man. Caring is associated with the feminine, that is, “the woman takes care of herself more than the man” or “the man was not created to take care of himself”.

About the interviews carried out with men in rural areas, the categorization process allowed us to point out another important aspect: the loss of physical vitality. It can be seen in the speeches of participants 02 and 03, below.

“I get very tired, my hands shake. I can't do anything, I get tired easily, I feel useless. Everything I do I get tired of nothing, I get tired. I played ball, I let it, because I can't stand to run anymore, I get tired too fast, I wasn't like that” [Part. 02 – 35 years].

“I am tired, I get tired easily. So unwilling to do things, I don't know, but that's it, I feel so tired” [Part. 04 – 30 years].

It is noticed that men in the rural context have a higher incidence of somatic symptoms and a decrease in vital energy (feeling tired easily) indicating such dimensions as triggering factors for

mental illness. This lack of vitality would be an aspect linked to the emergence of diseases - mainly due to the wear of work in agriculture and advancing age, men in rural cities due to living conditions, excessive exposure to the sun, and climatic variations suffer faster wear, compromising physical and mental health.

Due to the aging process, according to Nardi (1998), rural workers decrease their work capacity, especially for activities that require physical strength and exposure to the weather, causing absence from work, therefore, it implies the experience of impotence, as well as as a feeling of shame.

It is worth mentioning that residents of rural cities indicate in their speeches the long periods of drought and drought. Observed in the speech of participants 02 and 06.

"During this period of drought, the land is bad for planting. It doesn't rain, without rain we can't plant. Animals die of hunger and thirst, without having water to drink. I have never seen such a drought, my God, only God to have mercy on us. Very sad to see" [Part. 02 – 35 years].

"drought has greatly harmed the farmer, we are unable to plant and live off of it" [Part. 06 – 56 years].

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In rural areas of northeastern Brazil, drought has been blamed for the misery and poverty of the workers, but it cannot be considered the only cause of suffering for the participants, considering that other factors, as explained above, such as low education, difficulty in access to formal work evidence the vulnerability of this population, concomitant with climatic variations. It was found through interviews with men in the rural context that the difficulty in production and harvesting, especially in years of drought, as well as in the marketing of products is an aggravating factor that generates uncertainty, stress, and many financial difficulties for residents of rural cities.

The impacts of the drought affect both the social, economic, and political formation of the region (objective/social dimension), as they influence the development of the psyche and the way of life of the residents (subjective/psychological dimension). Based on this dialectic, it is possible to perceive that the drought has psychosocial implications in the lives of the subjects, which interferes with healthy life processes and contributes to the development of illness in the rural

population. Given this reality, the analysis of mental health in the rural context makes it possible to understand these psychosocial implications (XIMENES; CAMURÇA, 2016).

The scientific literature brings some considerations when it comes to coping with drought in rural cities, highlighting insecurity and stress in the face of the threat of loss of resources invested in production and the non-return of this investment, causing material and symbolic losses (FAVERO; SARRIERA; TRINDADE; GALLI, 2013; XIMENES; NEPOMUCENO; CIDADE; MOURA JÚNIOR, 2016).

Specifically, about CMD, it is believed, under these precepts, that the development of its set of symptoms is not a fixed, immutable process and the result of specific causes, but it is a form of development that must take into account the subjective dimension that develops throughout life, presenting different meanings, based on experiences in the context in which people are inserted and incorporated.

CONCLUSIONS

In the more specific scope of mental health, there is a growing interest in understanding psychic suffering in its various dimensions, in the face of problems faced in everyday life, especially with population segments that escape hegemonic codes and for which there are no clear answers within of the biomedical model. The illness process is also an intersubjective process, in which it emerges as a phenomenon that must be taken at the interface with the social context and its conditioning factors, at the objective and subjective levels. It is worth mentioning the need for early identification of the common mental disorder in the male population, to guide individual and collective interventions, in the prevention and promotion of mental health.

We cannot be silent when it comes to male mental health, health teams must be attentive and qualified to receive the male population in health services, especially when it comes to masculinity experiences. Do men come to the services, and are we, as health professionals, prepared to receive them? Can we reach these men?

It is necessary to initiate investments in men's health, with the commitment of different levels of management, taking responsibilities and competences in mental health care to the smallest municipalities, carrying out activities in health services, in points of great movement in the cities,

in a way to encourage men to take care of their physical and mental health. It is of great importance to seek to expand the dissemination of this policy, either through actions in health services, or through disclosures with printed materials (banners, pamphlets) and/or with advertisements on radio, in the media, in public and private schools, public and private universities, lectures, weekly meetings with health professionals, encourage families to participate and disseminate as much information on men's health in urban and rural contexts. And, with that, inform with clarity and accessible language about the importance of taking care of men's mental health.

It is intended with this study is to contribute to research related to men's mental health, as well as to a more comprehensive health policy aimed at the male population, based on the gender dimension itself, which advocates an approach also for men, since both men and women need to be seen in their uniqueness and diversity within the broader social relationships they establish.

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