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Identity (re)construction of the male ethos and masculinities in men's health home care

(Re)construção de identidade do ethos masculino e masculinidades na atenção domiciliar em saúde do homem

(Re)construcción de la identidad del ethos masculino y de las masculinidades en el cuidado domiciliario en salud del hombre

ABSTRACT

Objective: to understand the masculinities of men in home care based on male *ethos* construction. **Method**: qualitative research aligned with Raewyn Connell's conception of masculinities and critical discourse analysis based on Norman Fairclough's theoretical-methodological framework. A total of 58 users were interviewed between patients and caregivers of a home care public service. **Results**: two discursive centralities were identified: hegemonic masculinity and its ideologies; and the new male ethos: the admission of dependency. The presence of a non-hegemonic masculinity is perceived among the men in home care, whose particular home experiences favor historical, social, and cultural changes, giving rise to new concepts, meanings, and experiences. **Conclusion**: the masculine *ethos* of men cared for at home is marked by the condition of differentiation, it is aligned with a subordinate masculinity, although it is based on dominant ideologies. This new masculine *ethos* allows, in other analyses, to recognize the needs and the behavior of men in home care.
Descriptors: Masculinity; Men's Health; Home Care Services; Home Nursing; Caregivers.

RESUMO

Objetivo: compreender as masculinidades de homens em cuidados domiciliares a partir da construção do *ethos* masculino. **Método:** pesquisa qualitativa tendo o referencial teórico-metodológico de Norman Fairclough para análise crítica de discurso e a concepção teórica de masculinidades segundo Raewyn Connell. Entrevistou-se 58 usuários entre pacientes e cuidadores de um serviço público de atenção domiciliar. **Resultados:** identificou-se duas centralidades discursivas: masculinidade hegemônica e suas ideologias e o novo ethos masculino: a admissão da dependência. Percebeu-se a presença de uma masculinidade não hegemônica entre os homens em cuidados domiciliares, cujas circunstâncias específicas do domicílio favorecem mudanças histórico-sociais e culturais, fazendo emergir novos conceitos, sentidos e experiências. **Conclusão:** o *ethos* masculino dos homens cuidados no domicílio é marcado pela condição de diferenciação, alinha-se a uma masculinidade subordinada, embora se referenciem em ideologias dominantes. Esse novo ethos masculino permite, em outras análises, reconhecer as necessidades e o comportamento de homens em atenção domiciliar.
Descritores: Masculinidade; Saúde do Homem; Serviços de Assistência Domiciliar; Assistência Domiciliar; Cuidadores.

RESUMEN

Objetivo: comprender las masculinidades de los hombres en la atención a domicilio a partir de la construcción del ethos masculino. **Método**: investigación cualitativa basada en el marco teórico-metodológico de Norman Fairclough para realizar el análisis del discurso y en el concepto de masculinidades de Raewyn Connell. Se realizaron entrevistas a 58 usuarios entre pacientes y cuidadores de un servicio público de atención domiciliaria. **Resultados**: se identificaron dos centralidades discursivas: la masculinidad hegemónica y sus ideologías; y el Nuevo ethos masculino: la admisión de la dependencia. Se constató que hay una masculinidad no hegemónica entre hombres en atención domiciliaria cuyas circunstancias específicas del hogar proporcionan cambios históricos, sociales y culturales, lo que permite surgir nuevos conceptos, significados y vivencias. **Conclusión**: el ethos masculino de los hombres en atención a domicilio está marcado por la condición de diferenciación y se alinea con una masculinidad subordinada, aunque se asiente en ideologías dominantes. Este nuevo ethos masculino permite reconocer, en análisis futuras, las necesidades y el comportamiento de los hombres en atención a domicilio.
Descriptores: Masculinidad; Salud del Hombre; Servicios de Atención de Salud a Domicilio; Atención Domiciliaria de Salud; Cuidadores.

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INTRODUCTION

Men's health gains greater prominence in its specificities in 2009 from the emergence of the National Policy for Integral Attention to Men's Health (PNAISH) as one of the strategies to deal with the high rates of mortality and morbidity resulting from sufferings and diseases prevalent in the male population, whose magnitude configures public health problems. The understanding of health phenomena linked to this population group articulates the numerous issues involving, among other aspects, the biological, sociocultural and economic determinants of health; sociocultural barriers as a gender stereotype; institutional barriers; and the prematurity of discussions regarding health demands[1-2].

As a socio-cultural aspect that influences men's health care, masculinity can be understood as a practical configuration around the position of men in the structure of a society's gender relations, which are produced in different social contexts, including relations between men, domination, marginalization and complicity[3-4]. The model of hegemonic masculinity survives to the present day, however, to a lesser extent, as it has brought harm to men, especially to their health[4]. Hegemonic masculinity is a recurring set of articulated elements, such as beliefs, attitudes and practices, which serve as a reference for the definition of what it is to be the ideal man in a given context[5].

Masculinity assumed as an ideal is permeated by a chimerical idea of socially constructed invulnerability[6-7]. Thus, when men get sick, they endure the disease or only request, as a last option, assistance, entering the health system due to the urgency, outpatient and hospital care of high complexity, valuing the cure and not recognizing the need for preventive guidelines[8-9]. Thus, masculinity is a symbolic space that structures the identity of human beings, modeling behaviors and emotions that have the prerogative of models to be followed, including its health, denying the existence of pain or suffering, of vulnerability, to strengthen the idea of virility and strength[10].

Thus, being a man is determined by patterns of masculinities that make up a masculine *ethos* and influence ways of life that have repercussions on men's health, among other aspects. The *ethos* identifies ways of saying and ways of being in language as a representation linked to subjectivity[11]. Therefore, hegemonic models of masculinity may make it impossible to adhere to healthier habits and convictions, commonly aligned with hegemonic gender ideologies[12].

It is not uncommon to identify male users who are in urgent/emergency or hospital services who could have their condition cared for in primary care or specialized outpatient care[6]. Among the services that promote care for men in order to guarantee their specificities, there is Home Care (HC), which has an intrinsic relationship with the Health Care Networks (HCN) in the search for integrality in its three directions: vertical, horizontal and transversal[13].

Home Care presents itself as an alternative to hospital care, with the possibility of returning to the home as a space for the production of care and as an instrument for the production of deinstitutionalization of care and new technological arrangements for health work, bringing great potential for innovation[13]. Given this statement, it is questioned: how the construction of the *Ethos* of masculinities imposes obstacles to the home care of men. Thus, this study aims to understand the masculinities of men assisted in HC from the construction of the identity of the male *ethos*.

METHOD

Qualitative study based on the theoretical-methodological framework of Critical Discourse Analysis[14]. The theoretical conceptions of masculinities and *ethos* adopted in this study

were, respectively, Connell[3-4] and Magalhães[16]. The structuring of this manuscript followed the recommendations of the COnsolidated criteria for REporting Qualitative research (COREQ) instrument, a version translated and validated for Brazilian Portuguese[15].

The research was carried out in the city of João Pessoa, capital of the state of Paraíba, with all the teams that worked in home care, seven multiprofessional home care teams and a multiprofessional support team. The population universe was composed of 39 men and 39 caregivers. Men who met the following inclusion criteria were included: being in the age group between 18 and 59 years, covered by the principles of the PNAISH; residing in João Pessoa; being registered in the home care service at the time of collection; presenting preserved verbal capacity and without cognitive deficit. For inclusion of caregivers, the criteria were: to be the formal guardian or responsible for the care offered to men and to be 18 years of age or older.

After adopting the criteria eligible for the research, 15 men were not included in the sample, of which eight did not verbalize, four had cognitive impairment and three refused to participate. Regarding caregivers, five were excluded, one due to refusal to participate in the research and four due to absence, since the assisted men did not have a caregiver.

The production of the empirical material took place at the men's homes through open interviews guided by script, as well as by participant observation of the men and their caregivers at home by the researcher. It is noteworthy that this had no link with the study participants. We used open interview scripts for men and caregivers, prepared by the researcher and with a previous pilot test. Both began by collecting socioeconomic and demographic information. Then, for men, the following guiding question was presented: can you tell me about your health needs and how they are cared for here at home? For the caregivers, the question was: can you tell me about the care that is offered at home to meet the patient's health needs. As for the limitations related to the strategies for producing empirical material, the influence of the observer on the situation and the people observed was excluded, as his presence modifies the situation and can affect the behavior of the individuals observed. In this study, the researcher accompanied the home care team and carried out the observation when the participants experienced care.

Data collection was carried out in January and February 2017, the mean duration of the interviews was 40 minutes and 49 seconds. The testimonies were recorded in audio and transcribed in full with the aid of the InqScribe® Software. The anonymity of the participants was respected, using alphanumeric codes denominated by the letters "M" for men and "C" for caregivers, listed by the sequence of collection of testimonies and, finally, fictitious names were adopted to designate participants of the study. As for the empirical data observed, audios were recorded by the researcher and then documented through transcription in a field diary.

From readings and re-readings of the data, the speeches that responded strongly to the research objectives were cut. The discursive excerpts of each participant were separated in text form and compiled through their analytical impact. The discourses were submitted to Critical Discourse Analysis (CDA) according to Norman Fairclough, based on the three-dimensional model of discourse, which interrelates descriptive textual analysis, the interpretation of discursive practice as something elaborated and shared by people, and the interpretation of social practice in relation to social structures[14]. After this stage, a cross-sectional analysis of the texts was carried out, seeking to identify the convergent

and non-convergent elements. The analysis of the empirical data was reevaluated together with the transcripts and the field diary, allowing the understanding of the construction of the identity of the male *ethos*, the central category of the study.

This study followed all ethical aspects provided for in Resolution number 466/12 of the National Health Council. The project submitted via Plataforma Brasil (CAEE: 61343716.2.0000.5149) and approved by the UFMG Ethics and Research Committee (COEP/UFMG), under Opinion number 1.829.326 of November 22, 2016. All participants signed the Informed Consent Form

RESULTS

Fifty-eight (58) participants were interviewed, 24 men and 34 caregivers. As for the demographic social characteristics of men, most were aged between 26 and 45 years, brown, single, with incomplete elementary school education, evangelical religion, retired, residing with their parents, with family income below a minimum wage and with paraplegia due to different etiologies. Among the caregivers, there was a predominance of females, aged between 41 and 60 years, brown, married, with education at the level of complete high school, Catholic and evangelical, "housewives" and full-time caregivers.

After reading and analyzing the empirical data, when considering the homogeneity of the discourses to answer the objectives of the study, two discursive centralities were identified, described below.

Masculinities revealed in the context of Home Care

The patterns of masculinities revealed in the context of home care are hegemonic associated with the relationship of power through women; however, the counter-hegemony is configured in the absence of freedom, in the differentiation by the chronic condition and in the adoption of fragile and dependent postures.

The pattern of hegemonic masculinity is based on power relations, especially of men in relation to women, on the association of power with sex and virility. João, 51 years old, quadriplegic, expresses characteristics of hegemonic masculinity, although in a situation of dependence on his professional caregiver, which reveals a contradiction between power and dependence:

"[...] then I ask Cristiane to change my clothes for a walk and I go to a bar to have a really nice drink, have a cachaça [...] oh! I was a alcoholic, a womanizer, a girl [...] But to do that you have to have an erection. I don't have it, if the girl takes it, she shakes my penis, but it doesn't happen [...] it doesn't hold the erection. Then it's complicated; then you just think that, there is no sex [...]. The guy feels really bad, the guy feels like less of a man. Wow! I don't like this situation. [...]". (João, 51 years old, quadriplegic, interviewed in the home environment)

The conception of masculinity related to freedom also denotes an exercise of power ideologically related to men. Leonardo, 22, a paraplegic, highlights this male pattern endowed with characteristics of a free being, with freedom to come and go. However, in a chronic condition of dependence, his sad and crestfallen speech makes it clear that, in the current condition, he feels trapped:

"[...] [sigh] yeah! It changes a lot, right, a lot. I don't even know how to tell you this (sigh). It's very difficult to talk about this situation for me, as I no longer have the freedom I had before. Now I need someone to help me, right? To help me with many things. Sometimes I want to poop, sometimes I want to pee. It's a little difficult [...] I no longer have freedom because we always need someone to do these things and I used to be independent. What I wanted to do, I did and that was it, right? [...]". (Leonardo,

22 years old, paraplegic, interviewed in the home environment)

The chronic condition of dependence that is imposed on the hegemonic male archetype is discursively represented by men, caregivers as a condition of differentiation to overcome segregations, exclusions, comparisons with "normal men" and low self-esteem in the face of a dependent life. In this sense, the caregiver Mariana, brown and evangelical, in her speech, built a sense of abnormality for her husband after the disease. Mariana weaves a temporal comparison of her husband before and after the disease, while he, a quadriplegic, stuck in a sharp spasticity, shed discreet tears from his eyes:

"[...] oh he was perfect, he was a perfect person, then after 28 years he found out, he started to lose weight, go into depression, then we went to the hospital and discovered that he had Wilson's Disease; he was perfect. [...] he did everything like a normal person [...] he is sorry, he feels sad for being in this situation; for seeing his daughter, for not being able to participate in her life, because he sees her, but it's not the same thing as a person who is healthy, right; he does not participate in the life of his son or daughter." (Mariana, wife and caregiver of a young man, with Wilson Syndrome, interviewed in the home environment).

For Francisca, 54, Catholic and wife, the differentiation reconfigures the marital relationship determined by the needs of the husband who receives care as if he were a child. This man, husband and now "son", had sequelae due to a stroke, was bedridden, with atrophies and a pressure cutaneous lesion that caused pain. The infantilization brings him closer to masculinity divergent from that expected for a man-husband, because the needs he presents reposition him as a man-child:

"[...] now I treat him better than before, right. I certainly treat him much better than before because I think that everything I do for him is still not enough [...] I sometimes treat him like a son, a baby [...] I call him my little boy, things like that [...]." (Francisca, wife and caregiver of a bedridden man due to stroke sequelae, interviewed in the home environment).

The abnormality and differentiation attributed to men with a high degree of dependence are a way of concealing processes of exclusion of fragile and dependent men, deficient in the masculine attributes expected by society. In this sense, freedom for José, 30 years old, paraplegic, single, occupies a prominent place in his speech:

"[...] dependency [...], you say that because you don't just hold me, you also hold many people, right. You stop me from going out, from having fun too. It's difficult [...] it's very sad [...] before I worked, I dated, not today, this was certainly important for my health [...]." (José, 30 years old, paraplegic, interviewed in the home environment).

The new male ethos: the admission of dependency

The reconfigurations of the male archetype according to the needs of men with a high degree of dependence or totally dependent make a new male *ethos* emerge, given the impossibility of responding to the standards hegemonically attributed to men by society. The presence of the non-dominant *ethos* attributes new meanings to the male *ethos* for dependent men in home care. Sebastião, 58, married, in the postoperative period of prostate cancer, and Fábio, 43, married, obese, describe the assumption of different patterns.

"[...] before I was used to leaving home every day, at my grandmother's house, and in the city center. I solved my business. Nowadays I have to depend on people, there's nothing worse than depending on others. I was a person used to sorting things out [...] I worked at the Post Office, right, but unfortunately they retired me with just one salary. The Post

Office says it's wrong. The INSS said it was wrong but no one resolved anything. Before I was solving it, now I'm not even able to do that [...]." (Sebastião, 58 years old, married, post-operative for prostate cancer, interviewed at home).

"[...] I worked and didn't live at home; I lived more on the street, working I brought what was my duty, I fulfilled all my duties, but now, let's say, nowadays in the situation I'm in [...] it's very different; I had a dynamic life, today my life is at a standstill [...] today it's depression, anxiety, several things happen, attempted suicide several times, countless things [...] in terms of sexuality, I worry about that a lot. Not for the wife, but for me, she doesn't charge me, but I charge myself [...]." (Fábio, 43 years old, married, obese, bedridden, interviewed in a home environment).

However, in the composition of this new *ethos*, despite the admission of dependence and its related aspects, the desire of the man prevails as an order over the others as a characteristic of the hegemonic male stereotype, as explained by Ângela, 43, married, wife:

"[...] look, he's a good person, sure, but he's a man. So as head of the house he doesn't want to be taken away; He gives the order, do you understand? He wants things his way, he decides them. He's sick, he's so bedridden, but nowadays he gets up [...] he doesn't walk in the middle of the street, right, but he walks around the house, but even so, he's the head of the house. He solves everything. We always say that he is the head and I am the body, right; He solves everything and tells me to do it. I go, I do it, you understand. But everything goes through him first [...] now that he is taking medication and is questioning this medication; the medication is not working. [Whispered voice]. So, he interrupts a little, but calmly. He has tried to stop taking it, but when he realizes he has taken the medication again. (Angela, Fabio's wife and caregiver, interviewed in the home environment).

Changes in the understanding of what it is to be a man due to the situation of dependence expose conflicts and contradictions. The dominant and determinant '*ethos*' of conduct and behavior in social micro spaces also interferes with macro spaces, not admitting limited men, with dependence on others. For Cristiane, 37, divorced and a formal caregiver, men are proud, sovereign, do not recognize their weaknesses and have freedom for everything they want, even if they depend on others to live:

"[...] in relation to daily life here, I think there is a lot to be desired? Why? That's how he is, he likes to feel important; It's not that he likes it, it's because he's a little proud. If he's in a lot of pain, he'll only talk if he can't take it anymore [...] Yeah! because before he didn't stop at home. Before he lived in the world he only came home to sleep and now he had to learn again to stay locked up at home [...] but because he's a man, when he gets something in his head that's it and it's over and so on [...]." (Cristiane, João's formal caregiver, interviewed at home).

Thus, the configuration of the new *ethos* does not fail to expose conflicts of non-acceptance of vulnerability, which reproduce hegemonic values historically related to normal men, with aversion or concealment of male dependence, as can be seen in the speeches of Francisco, 40 years old, single, paraplegic.

"[...] I already told you to abandon me but you don't want to [...] leave me so I can die soon [...] this is how everything ends [...] it will be ten years on April 26th that I've been here, finished, heartbroken [...] my soul is disintegrated [...] if I could walk I wouldn't think like that [...]." (Francisco, 40 years old, single, paraplegic, interviewed in a home environment).

DISCUSSION

These discourses include hegemonic and counter-hegemonic masculinities and

their relationship with the (re)construction of the male *ethos* in a contradiction between freedom and male dependence. The *ethos* is characterized by a process of modeling verbal and non-verbal behaviors and inter-textual directions[16]. In this sense, the discourses of the participants of this research portrayed a remodeling in the personification of the male due to the needs they presented in the face of chronic health problems. It was noticed that the non-dominant *ethos* brought particular signs to this man with such specific needs, but that it did not extinguish characteristics of a dominant and, therefore, patriarchal *ethos*.

Differentiation is represented in discourses by an explicit distinction between one group of social actors and another, creating a difference between them[14]. In the discourses of men assisted in HC, the differentiation emerges from the recognition that these men assume and transition from a condition of healthiness to a condition of dependence, which distinguishes them as social actors. The transition is represented in the discourses by the temporality with comparisons between before and after the illness and that culminateS in home care.

Temporality is also evident as a main resource in discursive constructions that reproduce the behavior of men resembling that of their ancestors, rooted in ideologies of paternalistic origins, reverberating in social relations in the spaces in which they live. In these spaces, practices that reproduce hegemonic masculinities are established.

It is noteworthy in the participants' discourses that the contradiction expresses, in the context of HC, in which female care historically prevails, even if in confrontation with the dominance of hegemonic patterns of masculinity, present in the male *ethos*. Thus, the private space of the home, before the scenario of dominance of women's care, is reconfigured when the actor who is under care are the dependent men. Thus, not only is the male *ethos* (re)built, but also the social practice of home care is reconfigured under the influence of masculinity patterns.

Thus, it is recognized that in the care of men assisted in HC there is the (re)construction of the male *ethos*. The signs attributed to the masculine interfere in power relations and how these relations determine the positions adopted in social macroprocesses. The discourses and images of the reality of men living in HC allow us to identify the ideologies and contradictions inserted in the construction of the male *ethos* from the meanings of multiple masculinities.

This perspective of the construction of the male *ethos* is based on the gender category, whose dynamic character covers the following aspects: power relations in which female subordination and male domination constitute the main division of power in the configuration of genders; production relations in which gender ordering occurs at work and in the sexual division of tasks; emotional investment in the relations established between the desiring object and the desired object[3]. In this sense, gender can be understood as a social structure that encompasses expectations in the roles of men and women[17].

Hegemonic masculinity constitutes the heritage of patriarchal culture, guaranteeing male domination and the submission of women, occupying a position of dominance in a given pattern of gender relations[3]. The stimulated male model is that of a strong, virile, powerful man, who needs the woman-object to faithfully exercise his role[18]. The findings of this study confirm the existence of hegemonic masculinity associated with virility, power and strength.

It was evident in this study that the signs of power and virility attributed to men, even in HC and dependent on caregivers, who were mostly women, were linked to situations such as: the man in need of the caregiver ordered how he wanted to be dressed and where he would like to remain after basic hygiene care; and the man determined the moment he wanted to have

sexual intercourse with the caregiver (wife), even if he did not have erection capacity.

Men and women are socialized in a culture marked by gender inequalities, which go beyond family and kinship relations, in which the social roles of each one are delimited due to the sexual differences that are crossed by power relations[19]. The closer to the male normative ideal, the more power is attributed to men, thus configuring spaces and processes of privileges and/or punishments[20].

Men experience living a sexuality without limits as opposed to sexuality, historically repressed for women[21]. However, men who experience chronic conditions that affect their bodies, in particular their sexuality, need to have deconstructed this ideology of sexuality without limit, as these men access sexuality as a veiled, hidden, forbidden theme that is kept in the silence of their sick bodies that need care[22]. The male inherits in society traditions that touch on issues of patriarchy and machismo, which gives him privileged positions[18]. Among these traditions, the need to be and be free to be a man stands out. However, the condition of dependence of men identified in this study directly affects the prerogative of "being free".

While hegemonic masculinity is that which attributes to men a position of dominance; subordinate masculinity refers to the inequality built between men themselves[20,23]. Those who have disabilities are subordinate to and excluded from those who do not. Subordination is related not only to physical disability, but to the lack of any other attributes linked to the male stereotype, reference of the family, marital relationship, provider and worker.

Men, in a different positions, assume behaviors that were not previously part of their male performances, especially those related to the expression of emotions. In this sense, gender, as a category, allows us to understand the hierarchical relations between masculinities and femininities, between men and women, women and women, and between men, as well as between hegemonic and non-hegemonic masculinities, like the subordinate one[24]. In subordinate masculinities, the male individual does not necessarily behave in a way that assumes feminine characteristics, implying a discourse that attributes to men a potential privilege of domination and social ascendancy[22].

By recognizing changes in the hegemonic male *ethos*, the existence of new and ideological masculinities is admitted, attributing new signs and meanings to the male *ethos*. Thus, an emerging crisis of hegemonic masculinity is recognized, whose pillars support the hierarchy of races, classes and genders[18]. In HC, the explanation for this crisis is the new profile of men associated with chronic and limiting health conditions.

Contradictorily, the new *ethos* does not conform to the overcoming of the hegemonic '*ethos*', but to the impossibility of living and experiencing its attributes, assuming the condition of dependence. Thus, a new male *ethos* comes from the lack of freedom, dependence, reconfiguration of marital and sexual relationships, as well as the possibility of expressing feelings. The new *ethos* approaches subordinate masculinities, however, in the relationship with caregivers, behaviors affiliated with hegemonic masculinity stand out.

Even though the practices are interpreted as resistant, they favor ideological changes, they will not necessarily be aware of the details of their ideological significance[14]. In this sense, this study recognizes that the new *ethos* of masculinity, being a resistant ideological practice, presents in its rear old hegemonic ideologies, which behave like conventions and which, in the text, can be seen in the temporality of discourses.

Regardless of the ability of men to meet the expectations of society, in the first instance, man is seen as a universal subject,

the result of a historical process of naturalization that involves forgetting the origins of his construction[25]. Conceiving the existence of a masculine *ethos* that is different and sometimes contrary to the hegemonic one of what is socially fertilized and accepted, leads to reflections that refer to the effects of hegemony and ideological struggles.

It is in the articulation, disarticulation and rearticulation of the elements of a social practice involved in ideologies that changes appear, particularly in men who are in home care, living together and living daily with needs common to their material existences, once different from those they would never have imagined needing. A new male *ethos* understood in the discourses can be understood as a subordinate masculinity, marked by new paradigms guided by still hegemonic ideologies, but consolidated in a non-hegemonic or counter-hegemonic masculinity.

FINAL CONSIDERATIONS

A new male *ethos* is understood in a form of subordinate masculinity, whose new paradigms are still referenced in dominant and hegemonic ideologies. However, in relation to hegemonic masculinity, it is established as a non-hegemonic or counter-hegemonic masculinity.

The male *ethos* of these men cared for at home is marked by the: condition of differentiation that they live; existing hegemonic ideologies, but felt and lived in specific circumstances that favor historical-social and cultural changes, giving rise to new concepts and experiences. This new male *ethos* allows, in other analyses, to know the health needs of these men assisted by home care.

This research contributes to a theoretical construction about the practical implementation of public policies from the perspective of PNAISH and home care guidelines, focusing on equitable and comprehensive care to offer timely home care to meet men's health needs and, thus, support improvements in the living conditions of men in home care.

For nursing practices, this study contributes with knowledge that can be applied to the production of care that considers the changes in the male *ethos* in the face of the care needs of men in home care, reinforcing the importance of the care process, considering, among other aspects, the history, culture, socioeconomic condition of each man, in addition to relationships with caregivers and their needs.

As a possible limitation, the participation of the researcher is highlighted, represented by his presence during data collection, among the participants' homes, as well as the interference of the participants' personal, sociocultural, historical and political domains in the research results and the circumscription in a capital of the Brazilian Northeast.

Other studies that address the theme in other scenarios are necessary to expand knowledge that support practices aimed at comprehensive care for men's health throughout the health care network. Therefore, it is considered important to carry out studies with other methodological approaches, in order to subsidize the practice of caregivers and professionals, as well as their training.

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