

Brazilian Men's Integral Health Attention: using indicators for monitoring health's promotion and attention

Uso de indicadores para o monitoramento das ações de promoção e atenção da Política Nacional de Atenção Integral à Saúde do Homem (PNAISH)

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Abstract *This article presents and discusses the initial actions of Brazilian National Men's Health Policy (PNAISH) concerning indicators used for monitoring promotion and assistance actions of men's health. This multiple case study was developed among five Brazilian cities which had implanted the PNAISH: (Goiânia (GO), Joinville (SC), Petrolina (PE), Rio Branco (AC) and Rio de Janeiro (RJ)). A questionnaire was applied to verify the use of data and information required to calculate the indicators recommended by the PNAISH, concerning health's promotion, implementation and expansion of the men's health assistance system, according to the planned goals contained in the cities' local action plans. The results revealed a critical situation concerning monitoring of the activities through the proposed indicators taking into account the lack of standardized procedures to calculate them. Another specific limitation encountered was the limited access to or availability of data by age and sex in the health information systems. These results point out a lack of necessary indicators to define a base line situation, which weakens the systematic monitoring and future evaluation of the actions.*
Key words *Men's health, Indicator, Monitoring Information system, Policy, Evaluation*

Resumo *O presente artigo tem por finalidade apresentar e discutir os resultados da avaliação das ações iniciais da Política Nacional de Atenção Integral à Saúde do Homem (PNAISH) quanto ao uso de indicadores de monitoramento das ações de promoção e atenção à saúde do homem. Estudo de caso múltiplo foi realizado em cinco municípios brasileiros que implantaram a PNAISH: Goiânia (GO), Joinville (SC), Petrolina (PE), Rio Branco (AC) e Rio de Janeiro (RJ). Foi utilizado um questionário para verificação do uso de dados e informações necessárias para a construção dos indicadores propostos na PNAISH, referentes à promoção da Saúde, implantação e expansão do Sistema de Atenção à Saúde do homem, previstas nos planos de ação dos municípios. Os resultados apontam para uma situação crítica no que diz respeito ao componente de monitoramento das ações por meio dos indicadores propostos tendo em vista a falta de padronização na sua construção e limitações inerentes à disponibilização/acesso de dados, desagregados por faixa etária e sexo, dos atuais sistemas de informação em saúde. A ausência de informações, necessárias para definição de uma linha de base, compromete o monitoramento sistemático e futuras avaliações de efetividade das ações.*
Palavras-chave *Saúde do homem, Indicador, Monitoramento, Sistema de informação, Política, Avaliação*

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Introduction

In 2009, the Ministry of Health (MoH) launched the Brazilian National Men's Health Policy (PNAISH), aiming to promote health actions which would allow the understanding of men's particular reality in their various contexts. The basic principle of PNAISH is the guidance of health actions and services for the male population between 20 and 59 years old, with guaranteed integrality, equality and humanization of the attention. The PNAISH guidelines are grounded in a set of actions for health promotion, prevention, assistance and recovery, at the different levels of health services attention, prioritizing primary health attention, in particular that provided by the Family Health Strategy – the FHS¹.

The National Plan for the three-year period of 2009 - 2011 made it possible to implant the PNAISH in all 26 Brazilian states and the Federal District. In addition to financial resources, the Plan provided the Planning Matrix, which defines nine lines of action² and which formed the basis for the cities in the elaboration of their own plans, and which emphasizes the importance of: “improving the information systems so as to allow better monitoring, which will permit rational decision-making” as well as providing key indicators which would make it possible to determine a baseline for monitoring actions and supporting processes of evaluation. The lines of action which comprise the PNAISH, for this three-year period, were: I – implantation of the PNAISH, II – health promotion, III – information and communication, IV – participation, institutional relationships and social control, V – implantation and expansion of the system for men's health attention, VI – capacitation of health attention professionals, VII – inputs, equipment and human resources, VIII – information systems, and IX – evaluation of the pilot project.

Evaluation of the initial actions of the PNAISH's implantation allows the identification of advances and limits of the programmed actions. In this sense, this article aims to describe the strategies and limitations referent to lines of action II and V, reported by the cities for calculating the indicators proposed by the national program for monitoring the actions and goals scheduled in the cities' plans referent to health promotion and to the implantation and expansion of the PNAISH, in which the principal indicator is the proportion of men between 20 and 59 years old attended by the health services.

Method

The present study is an integral part of wide research, whose objective was to evaluate the initial actions of the implantation of the PNAISH, undertaken by the Fernandes Figueira National Institute for Women's, Children's and Adolescents' Health, of the Oswaldo Cruz Foundation, with resources from the Department for Science and Technology (DST) in the Ministry of Health's Secretariat for Science, Technology and Strategic Input (SSTSI) and carried out in 2011.

Five cities were selected, based on four criteria: 1) representativity by region of the country, with one municipality for each region; 2) the municipality was to have responded to a questionnaire about the Action Plan (AP) for Men's Health; 3) this questionnaire was to present defined and specified actions, focusing on integrality; 4) the municipality was to present clear and well-defined actions in its AP. The municipalities selected as a result were Goiânia (in the state of Goiás), Joinville (Santa Catarina), Petrolina (Pernambuco), Rio Branco (Acre) and Rio de Janeiro (Rio de Janeiro).

The objectives of the research included “estimate the percentage of the male population between 20 and 59 years of age attended in the different levels of health attention, using as a parameter the size of the male population as estimated by the Brazilian Institute for Geography and Statistics (IBGE)”, which corresponds to the principal indicator for coverage proposed by PNAISH.

To respond to the objectives of this research, a self-applied questionnaire was elaborated, to be filled out by the managers responsible for implanting the policy or by the technical staff responsible for the activities for monitoring the actions, addressing aspects referent to the actions or goals planned in the municipal AP, concerning the plans' implantation, expansion of the care system and health promotion regarding men's health, besides questions related to obtaining the data and calculation of indicators of two of the PNAISH lines of action: line of action II, which is to do with health promotion, in particular with the strategies for increasing the demand among men for primary health attention services, and line of action V, which is about the implantation and expansion of the men's health attention system. The indicators evaluated (and the goals, where relevant) in this study, are the same as proposed by the National Action Plan².

So as to include the aspects related to the actions and goals planned in the AP, the following

questions were asked: 1- ***Does the AP schedule actions directed towards increasing the number of men seeking primary health attention? - If yes, do the actions scheduled include a) initiatives in the areas of education, information or communication, directed at sensitizing the male population and raising their awareness? b) management of the offering of services facilitating and broadening access for male health service users and reducing the time they spend waiting? c) adaptation and/or flexibilization of the opening hours for male health service users? d) receptiveness for male health service users in health centers? e) visits from Family Health Strategy (FHS) teams to places where there are high concentrations of men? f) organization by FHS teams of educational groups for men? g) others? (give details) and 3- What is/are the goal(s) to be achieved, according to the AP?***

To meet line of action II, the percentage of men between 20 and 59 years old who were attended by the primary health attention services was selected as the single indicator. Six indicators were selected for line of action V: 1) percentage of primary health attention centers which used the Care Guidelines (CG), if the municipal Action Plan (MAP) included actions directed at incorporating the CG into the routines of the primary health attention centers), and for carrying out attendance actions in line with the same; 2) percentage of men between 40 and 59 years old attended, at least once per year, in the primary health attention centers; 3) percentage of men attended at the second level in relation to the men referred, in accordance with the CG, should the MAP include actions directed towards promoting integrative attention for the men referred by the primary attention services for secondary attention, at an outpatient level; 4) number of vasectomies done, should the MAP include actions directed towards promoting the offer of voluntary contraceptive surgery for men at an policlinic level; 5) number of transrectal ultrasounds carried out, should the MAP include actions directed towards promoting the number of consultations and procedures for diagnosis and treatment of diseases of the genital tract; and, 6) number of surgical operations carried out for pathologies and cancers of the male genital tract.

For each indicator, the respondents were asked about the method used for its construction, the sources of the data necessary for its construction, the limitations found and the estimates for the years 2009 and 2010.

This part of the study, in addition to the approaches described, aimed to identify if there was

in the municipality some technician responsible for the collection and systematic analysis of data for the situational diagnosis of the municipality, regarding men's health (principal causes of illness and death), in addition to checking the periodicity of the analysis of the data and the dissemination of the information obtained.

This study was approved by the Ethics Committee for Research on Human Beings, of the Fernandes Figueira Institute (Oswaldo Cruz Foundation - FIOCRUZ).

The responses to the items addressed in the questionnaires were evaluated by three researchers, noting the frequency and description of the data and information provided by each of the five participating municipalities. The results were evaluated respecting the local and national context as regards the process of implanting the Policy.

Results

Parties responsible for the information provided

The information was provided by civil servants of the respective Municipal Health Secretariats, with a minimum length of service in their posts at the time of the research of ten months, and a maximum of 36 months. It was possible to identify that in two municipalities, the person responsible for filling out the questionnaire was a professional linked either to the area of men's health or to its technical management (coordinator and sub-manager, respectively). In the other three municipalities, the questionnaire was filled out by the Coordinator of Health Promotion, a nurse from the Adult Health Program, and the district supervisor for the Family Health Strategy (FHS), with the support of a member of the technical staff from the Division for Women, Children and Adolescents' Health.

Actions and goals envisaged in the MAPs

The five municipalities evaluated (Rio Branco, Petrolina, Rio de Janeiro, Joinville and Goiânia) plan initiatives in the areas of education, information and communication directed at sensitizing the male population and raising their awareness, but where the other actions are concerned the different cities do not present unanimity. The management of the offer of services is considered in only three municipalities, as is the adaptation/flexibilization of opening hours. Receptive-

ness, visits to places with high concentrations of men and the organization of specific educational groups are cited by four localities. Only two municipalities (Rio de Janeiro and Goiânia) developed all of the activities prescribed.

However, when questioned about the MAP's goals, Joinville (annual goal) and Goiânia (goal for 2010/11) refer to the attendance of a minimum of 20% of the male population between 40 and 59 years of age, and Rio Branco (goal for 2011/13) to 30% of the male population between 20 and 59 years of age; Rio Branco (2011/13) and Rio de Janeiro (2010/13) refer to the training of 100% of the FHS professionals; Rio de Janeiro refers to the implantation/expansion of 10 early detection centers for prostate cancer and to the widening of the offer of vasectomy to 2,400 by the year 2013. The remaining statements are vague, providing neither the agreed values nor a period for completion.

Estimates of the population attended

Regarding primary health attention, none of the localities was able to specify the percentage of men between 20 and 59 years of age who were attended in the health services for the years 2009 and 2010. This result would correspond to the indicator proposed in the PNAISH for monitoring the coverage and result of the strategies of health promotion and prevention concerning the principal problems which affect the male population, strategies which, further, aim at increasing the number of men requesting primary health attention services. Regarding the criteria for the construction of the indicator, the number of attendances by men between 20 and 59 years should have been considered as the numerator and the total number of the male population resident in the municipality in the determined periods, and between 20 and 59 years of age, as the denominator. However, the data used by the municipalities for the numerator were: 1) number of attendances of the total population between 20 and 59 years old, 2) the total population of men between 20 and 59 years of age and 3) number of attendances by men between 20 and 59 years old. For the denominator, the following were considered, respectively: 1) total population between 20 and 59 years of age, 2) number of attendances made by people between 20 and 59 years of age and 3) total population of men between 20 and 59 years old. One municipality did not define the criteria for the calculation, and another did not estimate the indicator. When the municipalities were asked

about the sources of the information used for obtaining the data necessary for constructing the indicator, a range of responses was received, which included: the Unified Health System's database (DATASUS), the Polyclinic and Hospital's Information System, the Primary Attention Information System, data from the Department for Control, Regulation and Evaluation (DCRA), data from the Local Information Managers, and the files or systems set up by the municipalities themselves. It is worth noting that none of the municipalities identified the Brazilian Institute for Geography and Statistics as the source of the data for estimates of population classified by sex or age range. Among the principal limitations brought up by the municipalities for the construction of the indicator, one finds the restricted availability of access to data and the lack of records disaggregated by sex or age in the Primary Attention Information System, the Local Information Manager and the Polyclinic/Hospital Information Systems, as well as the absence of a means of differentiating if the user was being attended for the first time or whether it was a subsequent visit. In a few cases, it was possible to estimate only the ratio of consultations to the total population of men between 20 and 59 years old (1.2 in 2009 and 1.7 in 2010 in the municipality of Goiânia) and not the ratio of men who had in fact been attended for the first time.

Strengthening of primary attention

All the municipalities stated they had incorporated the CG into the daily routine of the primary health attention centers and into the carrying out of attendance in line with the same. The percentage of Primary Health Attention Centers (PHAC) which used the CG was 18.8% in Rio Branco, 30.6% in Goiânia and 100.0% in Joinville. Petrolina and Rio de Janeiro do not have information about this data, although in Rio de Janeiro all the centers had been instructed to use the Guidelines.

In relation to the indicator for monitoring actions referring to the implantation and expansion of the system, what was considered was the proportion of men between 40 and 59 years old who were attended a minimum of once a year in the primary health attention centers. Three municipalities provided data about attendance; however, with little concreteness about the source of the data and the method of calculation, as they used different units of measurement (percentage and absolute numbers) for the calculations. Rio

de Janeiro presented partial data (23.8% coverage in 38.3% of the Primary Health Attention Centers in 2010, a value which cannot be extrapolated for the other centers, which did not record this information). Goiânia only provided information about the average concentration of consultations: 3.0 in 2009 and 3.7 in 2010. Two municipalities did not calculate the indicator; one because they considered the program to be in the process of implantation and the other because they did not have the information. As with the previous indicator, the number of men between 20 and 59 years old attended for the first time should have been considered the numerator, and the total number of the male population between 20 and 59 years old, resident in the municipality in the specified periods, should have been the denominator. However, none of the municipalities detailed how the numerator was defined – apparently, in the perception of the local managers, it corresponded to the total number of consultations. The cities of Rio de Janeiro and Goiânia referred to the absence of an instrument which might permit the direct consultation of the indicator, it having been necessary to develop specific programs for recording the data, respectively the Local Information Manager and PNAISH systems built by the Municipal Health Secretariat.

In relation to the indicator ‘proportion of men attended at the secondary level in relation to the men referred’, in accordance with the CG, only three of the municipalities noted that the local MAP called for actions directed at promoting integrative attention for men referred by primary health attention for secondary attention at a Polyclinic level (Rio de Janeiro, Goiânia and Petrolina). The municipality of Rio Branco considers these actions to be a responsibility at a state level and the municipality of Joinville made it clear that such actions are not planned in the local MAP, providing neither information nor data referring to the indicator related to the monitoring of said actions. Rio de Janeiro emphasizes that 80% of the men are booked for the secondary attention center and Goiânia only provided the absolute number of consultations specialized in urology (1336, in 2009 and 1746, in 2010). Petrolina did not provide details on this matter. Rio de Janeiro defines the indicator as the ratio between the number of referrals made and the number of consultations undertaken in the secondary centers and Goiânia defines it as the absolute number of consultations specialized in urology, despite this being a relativized indicator. When asked about the sources of the information used for

obtaining the data necessary for the construction of the indicator, two different sources were indicated: the Municipal System for Regulation of Appointments (MSRA) and the Computerized System for Polyclinic Consultations and Care (CSPCC).

The number of vasectomies carried out was 406 in 2009 and 176 in 2010 in Goiânia, and 941 and 721 respectively in Joinville. Rio Branco stated that this is a state indicator and Petrolina stated that this action was not prescribed. Rio de Janeiro stated that it did not have reliable data due to under-notification in the municipal information system

Rio de Janeiro stated that 929 and 689 transrectal ultrasounds were done, respectively, in 2009 and 2010. Goiânia reported 1398 and 1920, and Joinville reported 10 and 7. All these municipalities reported that they use the records from the Polyclinic/Hospital Information Systems for obtaining data, but that there were limitations due to under-recording, the unavailability of the local database in PDF format (the case in Joinville) or difficulties in accessing the information.

Regarding the number of surgical operations undertaken for pathologies and cancers of the male genital tract, Rio de Janeiro stated that 902 had been carried out in 2009 and 1058 in 2010, but did not specify the types of pathology. Goiânia stated that 66 and 72 prostatectomies had been done in 2009 and 2010, respectively; for the same years Joinville reported 1413 and 1239, respectively, of which 31 and 29 corresponded to suprapubic prostatectomies. The limitations referred to have to do with the difficulty of accessing the databases and the restriction to prostatic pathologies, in some cases. Rio Branco reported that this is a state indicator and Petrolina reported that this action was not prescribed.

Regarding the indicator ‘proportion of primary health attention centers which use the Health Guidelines’, all the municipalities mentioned that the local AP call for actions directed at incorporating CG into the daily routines of the Primary Health Attention Centers. For the construction of the indicator, the municipalities identified the total of primary health attention centers in the municipality and, among these, the number of centers which used the Health Guidelines. The percentages referred to of PHAC which used the CG were 18.8% in Rio Branco, 30.6% in Goiânia and 100.0% in Joinville. Petrolina and Rio de Janeiro did not have information about this data, although in Rio de Janeiro all the centers had been instructed to use the Guidelines.

One relevant piece of information to be emphasized is the absence of the Health Guidelines specifically drafted for men's health by the PNAISH. This fact is evident from the replies which the municipalities of Rio de Janeiro, Rio Branco and Joinville supplied when asked about the sources of information and/or limitations for constructing the indicator, and which are transcribed below: the municipality of Rio de Janeiro uses as its guideline those already existing for adult attention actions: ***The adult attention actions are included in the basic list of services, namely: family planning and tracking of prostate cancer; tracking of dyslipidemia; tracking and treatment of Diabetes Mellitus and hypertension; treatment for smoking cessation; tracking for counseling for alcoholism, management of cardio-vascular diseases, management of chronic illnesses and of illnesses which are more prevalent among adults, and of tuberculosis and leprosy.*** The municipality of Rio Branco notes that ***as there isn't a mechanism for qualitatively evaluating whether the attention is taking place as defined by the guidelines, we can only quantify the number of teams trained/sensitized'*** while the municipality of Joinville notes ***"the ineffective implantation of the men's health guideline in the Municipal Health Secretariat, which will be in November 2011.***

No municipality has technical staff in place responsible either for the systematic analysis of the data which create the indicators mentioned above, or – with the exception of Rio de Janeiro and Petrolina – for the situational diagnosis of men's morbidity and mortality in their municipalities. However, some refer to a periodicity for the analysis of the data and the dissemination of the information. This varies from three months, in the case of Rio Branco, up to one year in the case of Petrolina. The municipality of Rio de Janeiro carries out the analyses upon request and notes a lack of integration between the systems. Goiânia and Joinville do not carry out the periodical analyses due to the lack of a technician assigned for this duty. In fact, there were no technicians trained for systematic analysis of the data referring to men's health in any of the municipalities evaluated.

Discussion

Monitoring is fundamental to the process of planning and programming health interventions. Although there are various definitions of the concept of monitoring, the definition proposed by

the Development Assistance Committee Working Party on Aid Evaluation³ is easy to understand. Monitoring is defined as ***a continuing function that uses systematic collection of data on specified indicators to provide management and the main stakeholders of an ongoing development intervention with indications of the extent of progress and achievement of objectives***.

Indicators, which frequently have a quantitative character, are defined as a ***...factor or variable that provides a simple and reliable means to measure achievement, to reflect the changes connected to an intervention, or to help assess the performance...*** They may also be defined as a ***synthesis-measure which contains relevant information about specified attributes and dimensions of the state of health, as well as of the health system's performance***⁴. An indicator may be simply a count of events or a structure based in various sources of data which requires calculation of proportions, ratios, coefficients, and may even be comprised of varying dimensions, such as the rates^{4,5}. The process of monitoring can only be the product of a process of planning and programming which is based on the clear identification of the problem(s), itself based on the identification of health needs, on the surveying of actions/interventions which allow the problem(s) identified to be resolved, which indicate the strategies to be implemented through actions/activities which permit one to respond to the clearly defined objectives and goals. Monitoring involves, therefore, the definition of instruments for following up the carrying out of these actions; instruments which can ultimately constitute an essential part of the process of evaluating results and strategies' impacts⁶.

Based on the concise conceptual milestone specified above, it may be ascertained that the PNAISH incorporates into its guidelines a series of indicators which are directed at the monitoring and evaluation of the programmed actions. However, the results point to a critical situation as regards the component of monitoring the actions referent to line of action II – Health Promotion – and to line of action V – Implantation and expansion of the system of men's health attention, as shown by the analysis of the information and data provided by the municipalities for the indicators selected for this evaluation.

In the case of the majority of the indicators proposed in the PNAISH, the data provided by the municipalities does not allow the monitoring of the actions, bearing in mind the lack of consistency in the provision of values for the years 2009

(the baseline) and 2010. In the case of line of action II – Health Promotion - it may be seen that the strategies elaborated by the municipalities for increasing the demand among men for health services were insufficient in Joinville and Rio Branco, while Petrolina and Rio de Janeiro do not specify goals for the widening of health attention. In any event, none of the five municipalities was able to evaluate this goal, as none of them knew the total number of men attended before (or even during) the Policy's implantation. All of the municipalities cite the lack of data as a limit on the calculation of the coverage. The existing health information systems, such as the Primary Attention Information System and the Polyclinic Information System, do not allow access to precise records about the clients by area of residence (an area which may or may not be linked to the Primary Attention Center), sex, age, reason for seeking treatment, or the treatment's outcome; neither do they require records for individuals, considering each episode of attendance in isolation and not considering individuals' multiple episodes of attendance. This limitation directly affects the calculation of relativized indicators - the proportion of men between 20 and 59 years of age attended by the primary health attention services, and the percentage of men between 40 and 59 years old attended at least once a year in the primary health attention centers - which was designed for dimensioning the coverage and access of the men in the age ranges at most risk of illness to health promotion programs and to primary health attention services, respectively⁷⁻¹⁰.

The limitations of information systems where access to precise records about clients is concerned, pointed out in this study, corroborate the results of the study by Rodrigues et al.¹¹, in which, on evaluating the Primary Attention Information System in three municipalities in the state of Minas Gerais, the researchers identified the system's failure to include some of the information about the clients contained in the handwritten notes. This aspect impacts specifically on the consistency of the reports produced and consequently on the monitoring of health promotion actions in primary health attention. It is necessary to raise awareness among the local managers on the need for continuous updating of this data. It is also necessary for the Primary Attention Information System to report if the team is not complete in any period, as only complete teams are permitted to add data to the system, although teams which become temporarily incomplete have a period of three months' toler-

ance in recording data on the system and transference of financial resources.

Regarding the proportion of men between 20 and 59 years old treated by the primary attention services – considered the principal indicator for the Policy's coverage – the data reflects the respondents' lack of understanding of the concept, shown by the multiplicity of responses referent to its construction and calculation. Such an indicator would allow the quantification of the demand from men between 20 and 59 years old in relation to the population and would require knowledge of the total number of attendances and of the total population of men in this age range who are resident in the municipality (whose principal source of data corresponds to the IBGE's estimates of population) in a specified time period (usually annual). It is worth emphasizing that no municipality holds the basal values (before the Policy's implantation).

A situation similar to that mentioned above happened with the calculation of the proportion of men between 40 and 59 years attended at least once in the year in the primary health attention centers, with the aggravating factor of greater difficulty in obtaining data referent to the attendances according to reason for the first and subsequent consultations. Considering the diversity in the origin of the data provided and the distinct ways of calculating the numerator, it was not possible to obtain information concerning this indicator.

In respect to the proportion of men between 40 and 59 years of age who were attended at the secondary level of attention, in relation to the men referred, the results point to the calculation of attendances, according to the local context and the availability of data. Only two of the five municipalities in the study presented data: one presented the percentage of bookings for the secondary unit and the other, the absolute number of consultations specialized in urology. The indicator was also defined differently in each of the aforementioned municipalities, with one considering the relationship between referrals and consultations carried out in the secondary units and the other, the absolute number of urology consultations. It should be noted that the indicator has as its purpose to evaluate the integrative attention given to men referred by primary health attention services for secondary level, at a polyclinic level; and once again one can see the lack of clarity in the conceptualization of the indicator and the unavailability of the data in the current sources of information.

The difficulties pointed out above for the construction and calculation of the relativized indicators were not observed for the indicators referent to diagnostic procedures (transrectal ultrasound) and surgical operations (vasectomies and those for pathologies/cancers of the genital tract), in which the calculation of the indicators (absolute numbers) was seen to be easy to understand. However, a series of limitations is identified, among which the following stand out: the unavailability of the data, the under-reporting of procedures, and, in some cases, the procedures mentioned being limited to prostatic pathologies, or the difficulty of obtaining data for the surgical operations which has been disaggregated according to the various pathologies.

The apparent discrepancy, observed between the number of transrectal ultrasounds, although this is a diagnostic and complementary procedure for prostate cancer, and the number of surgical operations undertaken for pathologies and cancers of the male genital tract, may be interpreted by the direct relationship between the number of transrectal ultrasounds and the number of surgical operations. Considering that the transrectal ultrasound is indicated for suspected prostate cancer, in particular to guide the prostatic biopsy, the low values observed in Goiânia and Rio de Janeiro were explained as the result of under-reporting of the procedures. In the case of Joinville, the low values were recognized by management as a problem, so much so that as a result of the research process an investigation into the quality of the information available and the procedures carried out was initiated by the Municipal Health Secretariat. As far as the number of surgeries for pathologies and cancers of the male genital tract is concerned, it is important to take into account that the indicator includes other pathologies apart from prostate cancer. Thus, Joinville indicates that 1,413 and 1,239 operations were carried out in 2009 and 2010 respectively, of which only 2% correspond to prostatectomies. These findings point to the need to revise the indicator referring to the number of surgeries for pathologies and cancers of the male genital tract. If the objective is to evaluate the integrality, adaptation and continuity of actions related to the early diagnosis of prostate cancer and its treatment, it is suggested that the indicator for the number of operations for prostate cancer be modified.

Another relevant piece of information to be emphasized in this analysis is the absence of health attention guidelines elaborated by the municipalities evaluated specifically for men's health at-

tion, including general advice on receptiveness, triage, care for their needs and patient referral flow. However, all the municipalities refer to having incorporated the NPIHCM's guidelines into the routines of their services.

The results made it possible to ascertain that the managers and technical staff responsible for the program were not including among their activities those which refer to the monitoring of the process of its implantation, besides the monitoring of events and hazards related to men's health (morbidity and mortality) which might make it possible in the future to evaluate the effectiveness of interventions through the construction of indicators concerning their results, impact, and the analysis of their tendencies.

Generally speaking, evidence was shown for the following: lack of clarity in conceptualization and standardization of the indicators' construction criteria, difficulties in obtaining the data, and absence of baseline information in the municipalities studied, which weaken the monitoring of the PNAISH's implantation.

The instrument applied allowed the identification of a series of limitations which point to factors which may be determinant in the above situation, both political-managerial and technical, although clearly envisaged in the National Action Plan as actions/activities to be undertaken for the effective implantation of the program, on national, state and municipal levels. Among the limiting factors, the authors highlight the following:

1) Lack of definition, at a national level, of a technical guidance instrument defining the concepts, the criteria adopted, the interpretation and uses, the limitations, the method of calculation, the sources of data and the periodicity for each indicator proposed in the National Action Plan –

The lack of definition shows in the results when one notes that the municipalities are using different criteria for defining the numerators and/or denominators, when relevant, for the same indicators. The lack of standardization in the criteria for construction of indicators makes it difficult to calculate them and to determine a base-line which permits the monitoring of changes and tendencies over time, in addition to making it impossible to compare the results in the same geographical area over time, or in different geographical areas.

2) There is a lack of dissemination, at a national level, of the National Guidelines for Men's Health Attention – Basically, all the actions directed towards the expansion of the system for men's health attention are related to the elabora-

tion of general advice regarding actions for the promotion of health and attention, with general advice about receptiveness, triage, caring for their needs and patient referral flow. As agreed in the National Action Plan, the Guidelines were published in 2009 (Goal E.1.2.1), although the Primary Health Attention Manual, scheduled for June 2010 (Goal E. 1.2.2), has still not been published, being under preparation, with publishing expected in 2013.

3) Limited insertion, in the planning and scheduling processes, of the actions which are aimed at integrative health attention for men at a municipal level, as a priority and/or strategic planning action/area as noted in the Guidelines for the Integrated Program for Health Attention at all levels of health attention⁶. In this aspect, further, it is worth noting the importance of the agreement and insertion as a priority programmatic area in the municipal and state health plans, as well as in the Integrated Program for Health Attention (Goal A.1.6.1), with a view to ensuring the necessary mechanisms for the organization of services and to promoting integrative attention for the target population, in agreement with the goals and objectives of the Pact for Health 2010 – 2011¹².

4) A lack of adaptation, at a national level, of health information systems which produce the data necessary for constructing the indicators – In addition to the limited comprehension at a municipal level of the proposed indicators – as shown by the variability in the methods of calculation, principally for the relativized indicators – the municipalities point to a series of limitations concerning the sources of data. The following stand out: the impossibility of producing data disaggregated by sex and age range in local information systems (the Primary Health Attention Information System and the Local Information Manager); the limited availability and quality of the data produced by the health information systems, principally the Polyclinic Information System and the Hospital Information System, both of the Unified Health System. Problems related to the quality of data, the opportunity and under-reporting, besides the appropriate definition of the indicators, constitute one of the main challenges in the initial process of the implantation of interventions. In the face of these limitations, some municipalities opted to create and/or adapt alternatives for obtaining data referent to primary attention, as in the case of Rio Branco (attendance forms in the PHAC) and Rio de Janeiro, with specific computer programs which permit the generation of data in the Local Informa-

tion Manager. Regarding polyclinic and hospital attendance, which are of medium complexity, alternative systems to the Polyclinic/Hospital Information Systems were used, such as the Municipal Computerized System for Regulation of Appointments (MCSRA) used by Rio de Janeiro and the Computerized System for Consultations and Polyclinic Attention in Goiânia.

One can see the need to viabilize the implementation, at a national level, of the actions and goals established to viabilize the adaptation of the information systems to the demand required for the effective implantation of the Policy relating to the line of action VIII – Information Systems. The goal stipulated corresponds to the **elaboration of a list of information systems and of the indicators used, including the Health Situation Room by the end of 2010** (H.1.1.1.) and the objectives **to the study and use of these indicators for decision-making and correction of trajectory** (H.1.1.1.1.) and **support for studies related to the Local Information Manager Project such that the same may take into account information related to integrative attention in men's health** (H.1.2.1.1.). The indicator proposed corresponds to the list finalized by the end of 2010 (H.1.1.1.1.). It should be stressed that a simple report of the information systems and of the proposed indicators is not enough to solve the challenge, with discussion and elaboration of training manuals (technical guidance) being necessary for the indicators which detail the concepts, the criteria adopted, the interpretation and uses, the limitations, the method of calculation, the sources of data and the periodicity for each indicator, as well as the flexibilization of the existing information systems, in particular the Local Information Manager. It is recommendable that during the process of adaptation, one should take into consideration the inclusion of result indicators and impact indicators, which would permit the measuring of the program's effectiveness on the target population's profile of morbidity and mortality.

Further, it is important to consider carrying out specific research bearing in mind the recognized limitations of the data produced from routine sources of information (secondary data) in "capturing" certain dimensions of performance, such as the quality of care given, user satisfaction and the adaptation, continuity and capacity for resolution of the services rendered^{13,14}. It seems appropriate to remember that the National Health Survey is in the process of being planned to be undertaken in 2013, in which there is a module specifically on men's health.

The data reflect a limited capacity on the part of the municipalities to meet the demands imposed by the implantation of the strategy and by the critical situation of monitoring the actions of health promotion and expansion of the system of men's health attention. One may observe a lack of synchrony among municipalities and the national government, responsible for the elaboration of the basic guidelines (both for care and the monitoring of actions) necessary for the organization of services on the municipal level which directly affects the component of monitoring of actions.

Collaborations

EC Moura, AMP Lima e M Urdaneta participated equally in all stages of preparation of the article.

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