Charting the Brazilian Comprehensive Healthcare Policy for Men (PNAISH), from its formulation through to its implementation in local public health services

O percurso da Política Nacional de Atenção Integral à Saúde dos Homens (PNAISH), desde a sua formulação até sua implementação nos serviços públicos locais de atenção à saúde

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Abstract ***The scope of this article is to see how the Brazilian Comprehensive Healthcare Policy for Men (PNAISH) has been implemented in the Unified Health System, from the standpoint of health professionals. A case study, involving five cases (each from a different macro region of Brazil) conducted using ethnographic techniques of data collection charted the progress of PNAISH implementation based on an anthropological approach using Lipsky's idea of street-level bureaucracy. PNAISH is contextualized in historical terms with national and international documents. Acknowledging the inevitable gap between the formulation and the implementation of any policy, an attempt is made to see how this gap has evolved by analyzing the transition of PNAISH into city Action Plans (PAs). It was revealed that the implementing agents had little knowledge of PNAISH, of the local health care network for men, of the techniques required to meet men's specific needs and of the concept of gender. It faced institutional obstacles, such as lack of an organizational structure, of a consolidated healthcare network – where the user receives services with different degrees of complexity within the system – and resources in general, especially human resources.***

Key words ***Men's health, Healthcare policy, Public healthcare policy, Anthropology, Qualitative research, Brazil***

Resumo ***O artigo tem como objetivo compreender como a Política Nacional de Atenção Integral à Saúde dos Homens (PNAISH) chega aos serviços da Atenção Básica do Sistema Único de Saúde, a partir do ponto de vista dos seus profissionais. Acompanhamos o caminho trilhado pela PNAISH com um estudo, etnográfico, de cinco casos (de cada Macro Região do país). A análise está ancorada no referencial da Antropologia e emprega a ideia de street-level bureaucreacy, de Lipsky. A formulação da PNAISH é contextualizada em termos históricos e da produção de documentos internacionais e nacionais. Reconhecendo a distância entre formulação e implementação de qualquer política, buscamos compreender como tal distância foi se construindo, na tradução da PNAISH para Planos de Ação (PA) municipais. Observou-se desconhecimento dos agentes implementadores sobre a PNAISH, a rede local de atenção à saúde do homem, as técnicas para atender às especificidades dos homens e o conceito de gênero. A implementação esbarrou na ausência de condições institucionais, como uma estrutura organizacional, uma rede consolidada de atenção – em que o usuário seja atendido por serviços com diferentes graus de complexidade dentro do sistema – e recursos em geral, especialmente humanos.***

Palavras-chave ***Saúde do homem, Política de saúde, Políticas públicas de saúde, Antropologia, Pesquisa qualitativa, Brasil***

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Introduction

The national strategy for health, formulated by the Brazilian government in 2008, the "More Health Program", included 73 measures and 165 goals, totaling an investment of nearly 90 billion Brazilian ***reais***, or nearly U$40 billion at the time. Among the Lines of Intervention, we read under 'Health Care', the goal of "implementing actions directed at Men's Health Care"[1]. This effectively ensured the necessary financial resources needed to consolidate such a measure in the three-year period 2008 – 2011. The Ministry of Health (MoH) created the Men's Health Technical Area in 2007[2]. The principles and guidelines of the Brazilian National Men's Health Policy (PNAISH) were published in 2008, with the policy being officially launched in 2009, with the publication of a Ministerial Order[3]. A policy aimed specifically at men is an innovation, as historically men have not been singled out in health interventions undertaken by the Brazilian state[4].

The PNAISH's National Action Plan (2009-2011)[5] marked the start, effectively, of its implementation, as it guides the formulation of Action Plans (APs) in the state and municipal spheres; it also envisages the development and financing of 26 Pilot-Projects in selected municipalities. The National Action Plan (NP) guides managers in local planning of actions based on the memorandum of goals, actions and strategies such that the health services may be receptive to and attend men between 20 and 59 years of age, listing "priority actions" for each line of intervention. In Line of Intervention I, "Implantation of the PNAISH", such actions refer to the transference of 75,000 ***reais*** in one-off payments for each State and for each of the 26 Municipal Health Secretariats selected, being passed on via the National Health Fund, with the aim of "incentivizing the elaboration and the implementation of health strategies and actions focused on the male population, inserted in their respective Health Plans"[5].

These 26 Pilot-Projects are the starting point for the analysis here developed of how a policy, formulated at a national level, is implemented at the local level in the municipalities. This is not a matter of simply measuring the distance between the objectives and directives set out in the Policy documents and their translation into the interventions that are then implemented in the health services: such a distance is a contingency of any implementation[6]. As Marta Arretche explains, the distance between formulators and implementers is owed, in large part, to "the decisions taken by a chain of implementers in the economic, political, and institutional context in which they operate"[6].

Michael Lipsky shows that policies must be understood in the context of their implementation and that the implementation of a public policy has to do with the people who actually do the implementing[7]. He argues that the "street-level bureaucrats" – the agents in charge of implementation, the people who exercise a role in public services dealing directly with the citizens – have significant autonomy in taking decisions on a daily basis, based on their own values and preferences[7]. Their autonomy is relative, because as agents in the service of the state, their activities are regulated, but even so, they can make decisions on the quantity and quality of the services they offer, based on their personal convictions. It is in this respect that the agents in charge of the implementation are at the same time policy ***makers***, that is, in effect, they make the policy.

The implementation of the PNAISH, accordingly, involves decisions taken by a whole chain of agents in any determined context: from the decisions taken by the formulators, down to the decisions taken by those in charge of the implementation – with the latter including not only the Secretary of the Municipal Health Secretariat but also the local health staff designated to work with men's health, and the health care professionals who provide the services at outpatient clinics or hospitals. The doctors, nurses, and community health workers have their own perspectives on men's health; while these may, possibly, originate in the PNAISH, the fact remains that they are filtered and interpreted through the knowledge that these professionals have of the local reality in which they operate, as well as their own theories and concepts.

An anthropological study of the implementation of a policy allows us to map, using ethnographic techniques, the policy's material effects and to observe the policy's practical existence at the local level – within the health services. With this methodological strategy, we aim to show, first and foremost, the view from the daily life and experience of the people directly involved in the implementation of any program. As this is an ethnographic account, it is not an attempt to make a comprehensive record of the PNAISH's implantation, but rather to observe a historic moment within an ongoing institutional process – so as to offer a perspective on the policy and on the practice, in a specific context. As Laura Nader explains, ethnography is never a mere description: it is a ***theory*** of description[8].

Ciência & Saúde Coletiva, 17(10):2607-2616, 2012

Our analytical perspective is anchored in the theoretical stance of Anthropology, aiming to understand how a policy's legitimacy is constructed, and how participants are called to take part in a program[9,10]. Thus, the route followed by the PNAISH emerges, from its formulation in a document through to the production of protocols, practices, and routines in the municipalities' public health services.

The objective is to investigate how the PNAISH arrives at the health services, in particular at the Primary Care services (which are considered the 'entrance point' to the Unified Health System [SUS], from the point of view of health care professionals, and by observing their routine practices.

Methods

This study presents data which is part of a wider research project, titled Evaluation of the Initial Actions of the Implantation of the Brazilian National Men's Health Policy (PNAISH), carried out from 2010 to 2012, approved by the Ethics Committee of the Fernandes Figueira National Institute for Women, Children and Adolescents' Health of the Oswaldo Cruz Foundation (Fiocruz). The detailed description of the methods employed in the wider research project, along with its principal results, is found in its final report[11], as well as in an article published in this volume[12].

The data analyzed in this study was collected through the analysis of documents, narrative techniques, in-depth interviews and on ethnographic observation. It is, therefore, a research that has a qualitative approach, with a case study design – more specifically, with a set of five cases, where each case is a municipality.

The analysis of the 26 action plans (AP) developed by the municipalities selected as Pilot Projects, in combination with criteria listed in the wider research project[11], involving geographical locality and the initiation of the implementation of the PNAISH, allowed the selection of five localities, one in each macro-region of Brazil, for the collection of primary data: Goiânia (in the state of Goiás), Petrolina (Pernambuco), Rio Branco (Acre), Rio de Janeiro (Rio de Janeiro) and Joinville (Santa Catarina).

Five teams were trained for the collection of the data, so as to ensure its quality, uniformity, and comparability on one hand, and the concomitant collection of data in all different locations on the other. For each municipality, the research's general coordinator made contact with either the Secretary of the Municipal Health Secretariat or the manager responsible for the technical department named as responsible for men's health (according to data indicated in the municipalities' APs or by the Ministry of Health's Technical Area). Following this, a letter of invitation was sent expressing interest in that municipality, ascertaining appropriate dates and periods for undertaking fieldwork. At this point, the managers in the municipalities suggested persons who would act as "local support". The field supervisors contacted these persons so as to construct the logistics and the agenda for the fieldwork (an initial list of services to be visited and observed, as well as key professionals to be interviewed).

Six narratives with managers and 21 in-depth interviews with health care professionals were undertaken in the five municipalities. We also conducted ethnographic observation, based on a script, in the health services, with the research teams remaining in each locality for one week. In all, observations were made in 11 health services (3 in Goiânia, 2 in Petrolina, 2 in Rio Branco, 1 in Rio de Janeiro and 3 in Joinville). Of these, eight are Primary Care – characterized as the entrance to the health care network – and three are Specialized Health Care.

All the empirical material produced over the week of fieldwork was duly recorded in audio form (narratives, interviews, and some informal conversations with health care professionals) or in field diaries (notes describing the environment of the services visited, of the care activities witnessed, of the meetings of the teams of professionals observed, and of the impressions concerning the fieldwork as a whole). The audio recordings were later transcribed verbatim, and the transcriptions were reviewed by the interviewers. Authorization for recording was always sought and all those involved consented by signing a Consent Form; anonymity was guaranteed to all involved.

Data on how the PNAISH was inserted into the municipalities' actions, and on how it was appropriated by the research subjects, who interpreted it and translated it into actions, has been outlined from the narratives, the interviews, and the observations.

Ethnographical writing does not follow the logic of a report, nor of evaluative research: it is not intended (and does not claim) to judge the success of the local implementation of the PNAISH, nor to explain results observed locally in terms of planning, nor to conclude with rec-

ommendations. Its aim is, rather, to analyze the relationship between what is called for in the policy and the practices that arise (or are legitimated) in particular contexts, by those who are responsible for implementing the Policy.

On the construction of a document which sets out the PNAISH's principles and guidelines

Historically, those who formulate and carry out public policies have been men, who have devised policies and programs which have almost always ensured symbolic and material privileges to men – or, at least, to some groups of men. In recent decades, the Feminist Movement successfully argued for the inclusion of ***gender*** as both an analytical category in the evaluation of public policy, and as a political strategy for formulating policies and programs that aim to reduce the inequalities between men and women.

Two international agreements of recognized importance clearly note the need to focus on men's particularities through public policy: the International Conference on Population and Development (Cairo, 1994), and the IV World Conference on Women (Beijing, 1995). The documents ratified in Cairo and Beijing discuss sexual and reproductive health and rights, taking a stance toward gender equality promotion, recognizing explicitly that power relations between men and women are unequal. These initiated an international consensus that men must be involved in sexual and reproductive matters, being called to participate and become responsible in terms of sexual behavior and reproductive decisions; the consequence of such participation would mean another step in the direction of women's empowerment.

Gender mainstreaming (that is, bringing gender to the front of the agenda) involves, in practice, the association of 'gender policies' with programs established by women, for women[13]. In the first decade of the twenty-first century, the idea that men should be considered not as a human category but as a gendered category gained impetus – a gendered category is one that involves unequal power relations-not just between men and women, but also between men themselves. Thus an approach involving gender has developed, one that does not focus exclusively on women; this is exemplified by the publication of reports and books by bodies of international cooperation, agencies of the United Nations and the World Health Organization[14-16].

The announcement of a health policy directed at men, in the More Health Program[1], dates from this period. The PNAISH was formulated in line with the National Policy for Primary Health Care, founded on agreements constructed based on a discussion that involved, besides the MoH itself, civil society organizations (medical associations, social movements, community based and non-governmental organizations), academic researchers, and representatives of health councils (National Council of Health Secretariats and the National Council of Municipal Health Secretariats)[17]. The process also involved a public consultation, opened by the MoH, over the Internet[18]. The insertion into a health policy of the idea of men's health is less important here for its content (by which it defines what it is) than for the fact that it is capable of bringing together and mobilizing a set of social actors – uniting specialists, academics and activists – but also provoking division and criticism.

Despite the involvement of different social groups and a public consultation in the forming of the PNAISH, the policy received criticisms, for failing to incorporate discussions of gender[19], for "victimizing" men by subjecting them to a specific policy as if they need to be protected against themselves[4,19], for representing yet another step in the "medicalization" of the male body[4], and for its excessive focus on the prostate[20]. The proposal still met with some limitations on its acceptance: when it was launched, for example, it was observed that neither transsexual women nor transvestites wanted their particularities to be included in or dealt with under the PNAISH[21].

The development of actions plans in the municipalities

Once the document explaining the PNAISH's principles and guidelines had been produced, it was necessary to translate those into actions. This was no easy task, the policy having been formulated in the governmental sphere for the entire national territory, which pre-supposes connections between the three spheres of government in Brazil – National, State and Municipal. The NP[5] contains institutional processes that make up as much a structure of incentives as an organization of time in the form of a calendar, aiming at the local production of action planning processes. The states, the Federal District, and the 26 municipalities elaborated their own APs so as to receive financial resources from the government.

The APs of the 26 municipalities selected as Pilots were analyzed, starting from the assump-

Ciência & Saúde Coletiva, 17(10):2607-2616, 2012

tion that, due to the complexity of implementing this policy, there would be "a certain degree of uncertainty concerning the convergence of the implementing agents' actions and, by extension, the perfect match between original formulation and effective implementation"[6].

Repetition of the text of the PNAISH itself is recurrent in the rationales presented in the municipal APs, supporting the catalytic role of the process set in motion by the central authority. There are few references in the APs to the actual social, economic, demographic, or epidemiological conditions found in the localities: neither is there much reference to the reality of the municipal health services or men's access to them.

In the structure of incentives created by the MoH, a model of AP was anticipated which would encompass some of the goals specific to the NP at the local level. The first goal was the implantation of the PNAISH, such that the APs should explain which actions were to be implemented, for whom, and what the timescale was to be. For this goal, the actions foreseen in the APs are generally related to raising awareness among managers and health care professionals, as well as publicizing the PNAISH – for the population in general or in the local health services system.

Not all of the APs presented the second goal, that of attending a minimum of a fifth of men aged between 40 and 59 years of age. Few documents planned actions for tending to the population directly. Where such actions are mentioned, they refer to a generic attendance, lacking focus on specific problems and with no prevision of spatiality for the actions (that is, in which services or places they are to take place) and no reference to when the service would be offered. The APs rarely mention a system of hierarchy of the health services for this attendance, such as referral (and counter-referral) between the primary care and the specialized care within the health system.

The third goal is related to surgeries – the suprapubic prostatectomies. The plans are not limited to men's health care, announcing activities such as the collection of "diagnosis data" and "data about the undertaking of prostatectomies" in order to achieve the third goal. Those plans that presented actions do not have data on the prevalence of prostate cancer in the local population or on the procedures carried out at the time in the network.

The inclusion of the third goal reinforced the centrality of a network of specialized tests and health services, linked to the male genitalia. In a way that is relevant to the privilege given to the prostatectomies, in the APs, this issue is central to the training planned for health care professionals (for implementing the first goal).

The municipalities, managers and health care professionals meet the PNAISH

The designation of a team or other party responsible for a new area – Men's Health – is pinpointed as a fundamental requirement for the PNAISH's implementation. Thus, some narratives see the absence of specific management at a municipal level (as found in other, already consolidated areas such as women's health, which might act as a benchmark for the promotion of actions directed at men's health) as a challenge.

Expressing agreement with the PNAISH's rules, which state that Primary Care (especially Family Health) is to be prioritized[3], the managers understand that the Family Health Strategy (FHS) is to be privileged. However, the narratives show that Primary Care emerges more as an ideal scenario than as a physical space where actions for men were carried out effectively. The majority of managers had not followed the implementation of the PNAISH since its arrival in the municipalities, as the people who had been responsible for the initial development of the APs – which ensured its resources – were not the same people holding the position of Men's Health Coordinator at the time of the research, reflecting the high turnover among health professionals who occupy management positions.

A great difference was observed in all five municipalities regarding the managers' and health care professionals' knowledge of the guidelines contained in the PNAISH; the difference was also observed in relation to the policy's implantation into the services' routines. The interviewees had little or no familiarity with the policy. Some made it clear that they had never read any document referent to the PNAISH. By far the majority affirmed that they had not participated in any specific training pertaining to men's health. During the ethnographic observations, informal conversations with the professionals who work in the units indicated that the health care professionals had received no training (formal or informal) either to learn about the PNAISH or to attend men.

The comments point to a pattern in which there is a strong impetus from the management for disseminating the Policy among the health care professionals through an event – which is then considered ***insufficient***. It is a "consciousness raising event" or "training", in which professionals are invited to

engage with the implementation of the PNAISH. The absence of guidelines or protocols for the actions was mentioned by various interviewees. In none of the municipalities did the health care professionals mention the Health Secretariats distributing printed material about the PNAISH.

The consciousness raising sessions and the training were offered, in general, to those professionals with university-level qualifications, working in the health services. In the narratives, however, consistent with the prioritization of the FHS as the 'entrance' point to the health care system and with plans directed into the future, the managers expressed that the principal protagonists in the PNAISH's implantation were to be the Community Health Workers.

The interviewees regretted that training was not being offered for their work in the health services: and they affirmed that the absence of capacity development was the biggest difficulty in the implantation of the PNAISH, followed by the lack of a basic understanding of men's health care (including how men's health functions, and where the patients were to be referred to). The absence of teaching and support material for guiding their actions within outpatient clinics was also mentioned as a difficulty. The information they had on men's health, and on the PNAISH itself, was rather superficial; the interviewees did not feel enabled to deal with the subject in the scope of the services. Often, the publicity materials about the PNAISH were the only source of information on the issue for the health care professionals.

The sensitization of the professionals on questions of men's health, even without the structuring of specific activities, may have an important impact on receptivity to men and on their access to health services, especially those who seek, in the health centers, programs which are fully operating, such as the Hypertension & Diabetes Program (Hiperdia), the STD/HIV/AIDS program or the Family Planning program. By far the majority of the interviewees stated that they had not been specifically prepared on how to approach the male population regarding issues that affect men's health most frequently, such as sexually transmitted diseases and AIDS, violence, obesity and prostate cancer, among others. In the view of the professionals working in the services, whether they were familiar or not with the PNAISH, planning and guidance for the actions to be carried out were lacking.

The professionals who were familiar with the PNAISH emphasized that the policy calls for men's health care without setting up the mechanisms necessary to put it into practice. In those localities where there was greater guidance, the professionals criticized the emphasis put on urological problems, to the detriment of other risks to men's health. In the managers' narratives, there is an emphasis on prostate cancer, which is referred to as an entity that embodies male health problems. This emphasis reproduces the one given by the NP itself in its initial goals.

Gender

The concept of gender is central to the PNAISH. Thus, it is to be hoped that the professionals who will be working in the policy's implementation at a local level might have grasped the central aspects of this discussion. The interviews, however, indicate that the training of the people who are directly linked with the PNAISH has significant shortcomings. Several mentioned not having had any training on this subject; the two interviewees who stated that they had some notion on the issue of gender explained that this had been gained in other trainings, previous to the ones regarding the PNAISH. Without training, interviewees link gender to women's health issues, particularly to family planning or to discrimination against women, making it more difficult to identify issues of gender regarding men's health.

We observed the presence of men in the health services, and there were reports from staff that approximately one third of the people there are men. The health professionals describe the men as ***companions***: that is, they are accompanying pregnant wives or taking their children or elderly parents to see the doctor; or, alternatively, they are there as ***mediators***, going to outpatient clinics to book appointments or exams for other people. Rarely are the men described as service users, seeking care for their own health needs. Even so, ethnographic observations in the health services identified a considerable presence of men who were there alone, which indicates their invisibility – that is, the difficulty that health staff have in seeing men there – is also, in itself, a gender issue[22, 23].

Finally, managers and some health care professionals complained of the absence in Primary Care of a records system containing the variable 'sex'. The absence of data about the number of men who have consultations or exams complicates both the planning and the defense of the policy as a priority. Neither was there any mention of local health staff surveying the areas where the FHS teams were to act – a prescribed task for professionals working within the FHS program.

Ciência & Saúde Coletiva, 17(10):2607-2616, 2012

Overloaded teams

In the managers' narratives, one can sense a concern about the accumulation of tasks: a new policy means new demands on a municipal health system that, often, cannot meet the current existing needs. For this reason, managers had to negotiate at the local level with the Municipal Health Councils, seeking to demonstrate the PNAISH's importance, in order to obtain the Councils' approval. The managers also recognize that the Primary Care teams are, often, overloaded.

The health care professionals mention a problem on the part of management; they lack skill in motivating the health care professionals to participate. Management seeks to implement a policy, and expects greater dedication, widening both the responsibilities and the workload of the professionals who deal directly with the public, while offering nothing in return. In the interviewees' opinion, a health care professional who has the initiative to promote actions at work receives little material or financial support, relying instead on colleagues' good will or on their own resources.

The interviewees' discourses refer repeatedly to the shortage of medical professionals – who are often shared with other teams or outpatient clinics – and to the high number of activities to which all the professionals are subject. Activities directed at the male population are therefore extra activities, which are generally taken on by a limited number of professionals (two or three at the most) within the health staff – to whom these are yet one more activity in an already busy routine.

The PNAISH and men in the Health Care Services

The PNAISH local managers also publicized the PNAISH to the general public, stimulating demand for health services among men. Publicity was made through mass media, when managers gave interviews, with radio advertising campaigns, and billboards. Nevertheless, in most cases, there was a failure to follow up the publicity with concrete actions in the outpatient clinics and hospitals, so that the health staff received neither information nor specific training; and the services received neither human nor material resources for meeting such demand as was created.

In some health services, the health care professionals themselves publicized the PNAISH, by making leaflets available or putting posters up on the walls, thus defining physically and symbolically a moment and a space within the clinic for men's health care. Almost all of the posters were handmade, on sheets of card or on the back of old posters, betraying the lack of material resources set aside for publicizing the PNAISH (not even the MoH's informational or publicity materials had arrived at the services). The homemade posters are indicative of the mobilization of the health care professionals themselves, using the means available to them, to disseminate information that they themselves had sought about the PNAISH.

Very few activities specifically directed at the male population aged 20 to 59 were observed in the five municipalities' health services, especially in relation to activities aimed at health promotion or at prevention of health risks, with activities being directed rather at clinical care actions. This data is of great relevance when one takes into account that the health services (Primary Health Care and Specialized Care) had been deliberately selected for the ethnography. Health services had been selected based on information given by local staff working with Men's Health and/or at the suggestion of the person identified as the research's "local support" because this was a place where actions related to the PNAISH were carried out. A large part of the actions are short-term in nature, such as the "Men's Fair" or the "Men's Week", or are commemorative activities based around dates, such as "Father's Day".

Managers and health care professionals alike refer to the health services' opening hours as a barrier to attending men, owing to the fact that Primary Care services function during the hours that the majority of men aged between 20 and 59 are at work. This being so, alternative, or extended opening hours were offered in some localities for men, as an action linked to the implementation of the PNAISH; from an administrative perspective this extension implies making human and financial resources available.

A point known to be critical is the inadequate network of health care provision services. There seem not to be any workflows or protocols for men as a result of the PNAISH. This may be why various interviewees working in Primary Care mentioned not knowing which services male patients in need of specific procedures or exams are referred to. The majority of problems related to chronic illnesses, such as hypertension or diabetes, are treated in the outpatient clinics (Primary Care health centers), which have the necessary health care professionals and resources. However, health needs requiring diagnostic tests, consultations with specialists or surgical procedures

need to be referred to other Specialized Health Care services, at a secondary or tertiary level. A major problem is that Specialized Care services are already overwhelmed with the large number of demands and usually have a long waiting line, countering male expectations regarding an effective and rapid solution to their health problems. The interviewees believed that the long waiting period aggravates the patient non-attendance problem. Supervisors refer to the non-availability of medium-level complexity exams – the prostate biopsy being particularly mentioned – as a major difficulty in implementing the PNAISH. The inadequacy of the network of health care provision in terms of patient referrals and the criteria adopted for the appointments are identified as the principal difficulty in tending to the male population. Interviewees believe that the difficulty in resolving men's health problems impacts directly on the work credibility of both the health professionals and the outpatient clinics.

Final considerations

The authors have sought to understand how the PNAISH arrives at the health services; to this end, we followed the policy, from its formulation, at the government level, through to its local implementation in the municipalities, understanding its implementation as a network of relationships between those who formulate the policy and those who translate it into action[6]. The authors sought the point of view of the people who work directly in the policy's implementation at the local level, recognizing that the implementing agents are situated differently, ranging from those in managerial positions through to the health care professionals who directly attend the population in the outpatient clinics. The implementing agents routinely take decisions and, in this sense, are also policy-makers.

Managers and health care professionals have their own ideas and representations about men (and about what is offered for this population). In the narratives and interviews, men are represented as a fairly homogenous group. The non-recognition of men's diversity – in terms of age groups, stage in life, race/ethnicity, socio-economic conditions, religion and sexual practices – implies the failure to recognize that different groups of men have different access to (and control of) resources and exercise different degrees of power. Differences between men also reflect inequalities that make different groups have unequal conditions of access to health goods and services. The homogeneity pre-supposed by the generic category "men" impedes the recognition of inequalities between men in different contexts and hampers the consequent planning of actions, particularly for those who are in marginalized contexts and/or are socially excluded – such as migrants, refugees, or prisoners, among others. The recognition of such diversity must be related to the idea that actions outside of the health sector influence and determine the health conditions of different social groups and to the consequent inclusion, in planning, of different sectors, beyond health.

In the local context in which the PNAISH is implemented, through individuals' routine practices, in a defined territory, the presence of the State may well be somewhat fluid and contradictory – apart from the health sector, the State is evident in police actions, in the presence of schools, or in the courts. As the authors observed, the APs and the managers did not investigate the context where the policy was to be implemented, neither did they make any use of the territorial mapping for which the FHS staff is responsible. The result is ignorance of services, entities, and organizations (public and private) which could act in partnership with the health sector in the implementation of the PNAISH.

Recognizing that a distance between the formulation of any policy or program and its implementation is inevitable, the authors sought to understand how such a distance is constructed. In the five cases studied, we have shown that, first, the majority of implementing agents were not, in fact, familiar with the policy[6]. As they are unfamiliar with the PNAISH, they operate with their own objectives and references for the policy implementation, and with their own priorities as a performance benchmark. Thus, in some places emphasis was placed on addressing integrality in men's health care, while in others efforts were made to increase exams for prostate cancer.

What cannot be seen gradually becomes invisible: the professionals responsible for setting up information systems at the local level explain that this is precisely what has happened with information on patient's sex in Primary Health Care. Data produced does not objectively differentiate men and women, with regard to health service access and use. Furthermore, any disparity ends up being interpreted in terms of generic cultural differences between men and women, based on the idea that men resist seeking care, especially preventive care, in a simplistic and simplified version of gender relations. Failure to re-

Ciência & Saúde Coletiva, 17(10):2607-2616, 2012

spect the differences between men and women who seek Primary Care health services reinforces the invisibility of the smaller male presence in those same services – those services that should be the preferential entry point into the UHS (SUS).

The authors also point to the absence of institutional conditions for the PNAISH's implementation. In one case, we indicated the absence of an organizational structure, as there was no system for managing the local implementation, as no coordinating body had been established for men's health. The absence of a consolidated network of health care provision services, in which the user might be tended to by services with different degrees of complexity within the system, was stressed by managers and health care professionals. Various interviewees, who also emphasized the lack of resources and equipment in general for implementing the Policy, remarked upon the lack of human resources – particularly of doctors –. The authors therefore note the lack of an appropriate structure of incentives[6], which might induce the implementing agents to put into place, or adhere to, the objectives of the PNAISH.

Collaborations

AF Leal, WS Figueiredo and GS Nogueira da Silva participated equally in all stages of preparation of the article.

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