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THE BRAZILIAN NATIONAL POLICY OF COMPREHENSIVE HEALTHCARE TO MEN

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This article builds upon and broadens reflections first made by the authors for MenEngage's 2nd International Symposium, held in New Delhi, in 2014.

ABSTRACT

The National Policy of Comprehensive Healthcare to Men (PNAISH) was established within the Brazilian Unified Health System (SUS) in August 2009. Despite the growing recognition that men's lower life expectancy is strongly influenced by the social construction of gender and that their aloofness from the arena of care and health can also impact women's and children's health, so far, similar policies only exist in Ireland (2008) and in Australia (2009). This paper intends to introduce the scenario surrounding PNAISH's development, implementation and also shed light on some of its main obstacles and successes, based upon a scientific literature and policy review and the insight of privileged informants, partners and researchers.

The Ordinance nº 1,944, of August 27th 2009, officially created the *National Policy of Comprehensive Healthcare to Men* (PNAISH) and stated its goals of improving the health conditions of adult men (20 to 59 years old) in Brazil, and reducing their morbidity and mortality. According to this document, the main path to achieve this is to identify and tackle known risk factors and to facilitate men's access to comprehensive healthcare services and actions.[1]

In spite of its innovativeness, being the first of such policies in the American continent and the third in the world (after Australia, also in 2009, and Ireland, in 2008), and the fact that Brazil's geographical and socio-economical landscape provide it some unique contours, detailed information about PNAISH are hard to obtain in the English language.[2]

A recent Case Study by Spindler lessened this gap by sharing some important insights on PNAISH, described as a *compelling case* in the field with the capacity to serve as a guide to global policy makers, practitioners and researchers not only on men's health, but also, as a "…*platform to improve gender transformative healthcare for both men and women, and to advance gender equality more broadly.*"[3]

The overall context of men's health in Brazil and of PNAISH presented in this article is drawn from a literature and health policy review and analysis, and also, from the authors' first-hand experience. Eduardo Schwarz was a member of the National Men's Health Unit (CNSH) – which is the office within the Ministry of Health (MoH) that carries out the responsibility of implementing this policy –, since its inception, being its coordinator for five years, and Daniel Costa Lima was a Technical Assistant at CNSH for two years.

To illustrate this scenario, the article briefly describes the Brazilian Unified Health System (SUS); makes an overview of the state of adult men's health in Brazil; draws an overall insight into PNAISH's origin, implementation, main obstacles and successes; and, as a conclusion, indicates a few directions that might contribute to a more efficient policy.

THE BRAZILIAN UNIFIED HEALTHCARE SYSTEM (SUS)

SUS emerged at the same time as Brazil's Federal Constitution, in 1988, following a military regime that had lasted 24 years. To a country marked by social and economical inequalities, its overall vision of "*Health as a right to all and a responsibility of the State,*" represented a bold ideal.[4]

Being the largest state public policy in Brazil and one the biggest and most complex healthcare systems in the world, its execution has been an intricate process from the onset. Serving as the pillars to this unremitting process, are SUS's three main principles of universality, equity and comprehensiveness.[5]

With a population of a little over 200 million people, at least 70% of Brazilians exclusively relies on SUS for healthcare,[6] be it routine check-ups, dental care, surgeries, organ transplants, among many others initiatives. SUS is also responsible for various actions towards disease prevention and health surveillance for the entire population, such as vaccination campaigns, food inspection and drug registration.

Being a continental sized country composed by five regions with significantly diverse cultural, economical and geographical characteristics, presents a variety of challenges to SUSs execution. In accordance to what is determined by the Constitution, decentralization has been a key factor to lessen these challenges and so, Brazil's 5.570 municipalities have increasingly gained a central role.[7]

SUS's financial sustainability has always been at the forefront of the advocacy agenda towards its full and adequate implementation. The fact that the MoH possesses the federal government's biggest budget, one that has slowly but steadily increased in the past 12 years, demonstrates that the amount of money directed to this system is extremely important, however, not by far, the only factor to be considered. This is especially true in moments of political and economical turmoil, which has been the case for Brazil since 2015.[i]

Given the understanding that when provided with adequate resources, investments and management, primary care can offer much better value for money than its alternatives,[8] the choice of having a preventive care model at the centre of this free and universal system, is as much ideological, as it is financial. Diverse efforts have been made to strengthen SUS's primary care actions since 1988 and currently, 62.54% of the population is reached by the almost 4,000 Family Health Units that are present in over 90% of Brazilian cities.[ii,iii]

Nonetheless, as pointed out by the 2006 Sanitary Reform Forum, besides removing hospitals and specialists from the centre of the healthcare model and placing primary care in its place, the focus has to be directed to the user-citizen "(…) *as an integral human being, abandoning the fragmentation of care that transforms people in organs, systems or illnesses*."[9] Applying the principle of equity, recognizing the differences in living conditions and health needs of particular populations and offering more, or specific care to those who need the most, has been a consistent strategy to accomplish this focus.

Due to the extremely high rates of infant, child and maternal mortality observed in Brazil during the first years of SUS[iv], its primary care policies were especially targeted to maternal and infant care. In this early sce-nario, where feminist movements were demanding a comprehensive care to women's health, and not just to the health of pregnant women, to approach and direct attention and resources to the specific health needs of men was perceived – as it considerably still is – as a reinforcement of male privilege, rather than as a right.[10]

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* On August 31st 2016, President Dilma Rousseff was impeached through a process acknowledged by many national and international experts as a "parliamentary coup d'état". Since then, a strong neoliberal agenda has been put in place, with the privatization of different state companies and services being debated, something that directly threatens the very existence of SUS. https://theintercept.com/2016/09/23/brazils-president-michel-temer-says-rousseff-was-impeached-for-refusing-his-economic-agenda/

ii Consultation made on the MoH's *Portal de Saúde (Health Portal), in March 17th 2016. http://dab.saude.gov.br/portaldab/ historico_cobertura_sf.php*

iii Each Family Health Unit is comprised of at least one doctor, one auxiliary nurse and a maximum of 12 Community Health Agents.

iv In 2015, Brazil reached and surpassed the UN's Mil-lennium Development Goal for infant and child mortality. Despite promising, the 50% reduction of maternal mortality was still below the goal of reducing it by 75% from 1990 to 2015. Source: http:// www.odmbrasil.gov.br/o-brasil-e-os-odm

This is o0ne possible way of explaining why PNAISH only came to exist in 2009, when other specific national health policies had been designed and executed since the 1980s: women of all ages (1984 and 2004); children (1988); adolescents (1989); elders (1999) and people with disabilities (1999).

THE STATE OF MEN'S HEALTH IN BRAZIL

In 2012, the average life expectancy (LE) of the Brazilian population was 74.5 years. Men's LE went from 66.4 years in 1991 to 70.8 years in 2012, an increase of 6.2%. In the same period, women's LE increased 5.1%, going from 74.2 years to 78.2 years.[11]

Despite having the strongest economy in the region, Brazil's LE is slightly below the Latin American average, including neighbouring countries such as Argentina, Uruguay, Paraguay, Chile, and Peru. On a global perspective, the gap between men's and women's LE in Brazil stands out, with men living an average of 7.4 years less than women, while the world's average is 4.6 years.[12]

Being one of the major public health problems in the world, non-transmissible chronic diseases (NTCD) were responsible for 63% of deaths around the world in 2008 and 72.7% of deaths in the Brazilian population in 2011.[13]

Recognizing that a small group of preventable risk factors are responsible for the majority of death caused by NTCD, the MoH implemented *Vigitel* (Telephone-Based Surveillance of Risk and Protective Factors for Chronic Diseases) in 2006. Since then, over 50 thousand men and women from the 26 state capitals and the Federal District of Brasília, have been interviewed every year, helping to delineate the epidemiological profile of the population, contributing to the formulation of public health policies and to their monitoring and evaluation.[14] Some of the findings from the latest survey, in 2014 (Brazil, 2015), are shared below, in Tables 1, 2, and 3.

The percentage of adult tobacco users in Brazil has been on a strong decline in the past decades due to a number of actions promoted by the National Policy of Tobacco Control.[v] In 1989, users were 34.8% of

TABLE 1 Use of Tobacco and Alcohol

Category	Men	Women
Tobacco use (independent of amount)	12.8%	9%
Tobacco use (20+ cigarettes per day)	4.1%	2.1%
Abusive use of alcohol (binge drinking)	24.8%	9.4%

Vigitel[14]

TABLE 2 Self-Reported Diabetes, High Blood Pressure, and High Cholesterol or Triglyceride

Category	Men	Women
Has a doctor ever told you that you have diabetes?	7.3%	8.7%
Has a doctor ever told you that you have high blood pressure?	22.5%	26.8%
Has a doctor ever told you that you have high cholesterol or triglyceride level?	17.6%	22.2%

Vigitel[14]

TABLE 3 Weight, Physical Activity, and Eating Habits

Category	Men	Women
Excess weight	56.5%	49.1%
Does physical activity during free time	42%	30%
Regularly eats fruits and vegetables	29.4%	42.5%
Regularly eats fatty meat	38.4%	21.7%
Regularly drinks soft drinks	23.9%	18.2%
Excess use of salt	17.4%	14.1%

Vigitel[14]

v Higher taxation; total prohibition of advertising; 100% smoke-free public or private collective use environments, among others.

the population over 18 years old, in 2014, this number reached an all time low, 10.9%. Researchers estimate that the 46% decline witnessed in the period of 1989 to 2010 resulted in the prevention of 420 thousand deaths.[15,16]

In contrast, similar policies were not implemented towards the reduction of alcohol consumption, which continues to grow in the population, as well as its damaging health results. Death rates due to alcoholic liver disease, for example, have risen from 2.8 per 100,000 people in 1996 to 5.2 in 2010, being men *seven* (07) times more likely to die from this cause.[17]

Given the data made available in Table 3 and the overall morbidity and mortality rate of adult Brazilians, the numbers above are probably a reflection of men not going as regularly to preventive healthcare appointments, and not of their better health status, when compared to women. That is precisely why one of PNAISH's main objectives is to facilitate access to these services.

In the above table, the only category that men appear to have a more favourable condition relates to physical activity, which can probably be linked to the fact that women have less free time due to their greater workload at home. Still, it is worth noting that 58% of the male population is not involved in physical activities during their free time. In Brazil, women with children dedicate 25.9 hours/week to house chores, while men with children work an average of 15.5 hours/week.[18]

Adult Brazilian men have double the death rate as compared to women – 4.1/1,000 and 2.0/1,000 –, and when you look at young adults (20 to 34 years), that figure jumps to four times as much.[19] In this context, nothing conveys the gender *disparity* clearer than the mortality rates due to external causes – violence, suicide, traffic accidents and work-related accidents – that represent the 6th cause of death among women and the 2nd overall cause among men (approximately five times as much).

In 2012, 437,000 people lost their lives due to violence around the world, a rate of 6.2 per 100,000 inhabitants, 78% of which were male.[20] In the same year, 56,337 people died from this cause in Brazil – 28.3 per 100,000 – being 91.5% of them male,[21] almost 60% of them, young (15–29 years old) and poor black men. Brazil houses less than 3% of the world's population and almost 13% of its total homicides. Traffic related accidents are also a major morbidity and mortality factor among men, accounting almost 85% of the more than 40,000 deadly victims due to this cause every year in Brazil.[13] According to Vigitel,[14] 10.7% of adult men and 1.7% of adult women had engaged in drinking and driving in the prior year.

It is crucial to know this panorama in order to identify the priorities and develop PNAISH's actions, and as important to acknowledge that men are as much different among themselves, as they are to women. On the other hand, Medrado, Lyra, Azevedo and Noca,[22] alert that a rhetoric use of epidemiological data might serve the purpose of artificially establishing *victimized adult men* as a new subject of care and attention for public policies. On a more assertive note, Carrara, Russo and Faro[23] argue that, in a way, PNAISH:

> (…) asserts the "insalubrious" attribute of a certain masculinity, being men presented as the victims of their own masculinity, that is, victims of the beliefs and values that presumably constitute the "social barriers" against medicalization. This program's main objective is to weaken men's resistance to medicine in general, that is, to medicalize men.[23]

These *warnings* are important as a reminder that PNAISH's implementation should not be based upon a simplistic and/or stereotyped view of adult men, but on a complex sociocultural comprehension of this population, one that also takes in account issues of race, ethnicity, age, class and sexual orientation. Also, having a gender relational perspective as one of the policy's backbones contributes to the construction of a comprehensive healthcare network that has the potential of generating well-being not only for men, but also to women and children. Finally, SUS's main locus of attention, primary care, is precisely guided to evade a strict biomedical and medicalization model, as it seeks to strengthen bonds between health professionals and users and to implement a comprehensive, continuous, equitable and humane care process.[24]

ORIGIN OF PNAISH

The second half of the 1990s witnessed the foundation of the Brazilian Civil Society Organizations (CSOs) Instituto Promundo (Rio de Janeiro) and Instituto

Papai (Recife) and of the academic research groups, GESMAP (Study Group on Sexuality, Masculinity and Fatherhood, São Paulo) and Gema/UFPE (Research Group on Gender and Masculinities, Recife), institutions that have since done groundbreaking social interventions, campaigns, researches and advocacy work on the issue of gender, masculinities and gender equity, raising social awareness and capturing the attention of health policy makers.

In one of the pioneer Brazilian articles on the issue, Gomes[25] questioned the importance of specifically discussing about male sexuality and men's health:

> One possible argument that we can draw on to answer this question concerns the understanding that people – men and women – have to be addressed in their singularities, as much as in their relational attributes and their ampler cultural background. This way, focusing on men's singularities does not necessarily lead us to lose sight of the relational perspective denoted by *gender*.[25]

A couple of years later, Schraiber, Gomes and Couto (2005) expanded this argument when responding to a similar inquiry "*Is it worth it to bring the issue of men and masculinities to the agenda of health and gender studies?"*[26] Their affirmative answer took into consideration that this would bring at least three new perceptions to the field:

> 1) It requires researchers and policy makers to address issues of inter-gender relations, with immense effects on preventive practices and especially, in health promotion, leaving individualized approaches behind; 2) it brings new subjects to women's health studies and policies, imposing new (gendered) insights to old health issues of both women and men; 3) it highlights the links between health, citizenship and human rights.[26]

In spite of the recent interest towards men's health shown by Brazilian researchers during the first half of the 2000's, Braz alerted that, during that period, the lack of awareness demonstrated by public health policies and agents reinforced a certain social stigma towards this population.[27] Calling upon the ethical principle of equity, the author advocated that more attention should be directed towards men's health.

In a 2009 article, Carrara, Russo and Faro described the role played by the Brazilian Urology Association (SBU) in the years prior to PNAISH's launch, shedding important light on that period and also, on more recent events that will be later exposed.[23] The authors stated that SBU had devoted itself to the issue of "men's health" since 2004 and described their efforts to pressure politicians, different governmental segments and specific health councils within SUS. According to the authors, in addition to influencing the future policy's guidelines and principles, SBU's actions also targeted class interests, such as increasing urologists' remuneration and requiring urologists working for SUS to be members of their association.

This information is supported by Rohden, when describing how the message "*Sexual health is the portal to men's health,*"[28] was widely disseminated by SBU and pharmaceutical companies through different national media pieces and in diverse debate arenas in 2007 and 2008.

It was influenced by this intricate scenario, and being coherent to the MoH's history of acknowledging specific health needs within the population, that the idea of a men's health policy began to be structured "(…)*through a unique top-down participatory process that was initiated on the part of a MoH political decision.*"[3]

As outlined by Spindler (2015), this debate, that had gained strength within the MoH since 2006, was formalized by the Minister of Health Dr. Temporão.[3] In his inaugural speech, he made a commitment to 22 principles and proposals, with the 10th to create a "*National Policy of Comprehensive Healthcare to Men.*" One year after assuming office, and even before the policy's official launch, an informal Men's Health Coordination Unit (CNSH) was created.

To Carrara, Russo and Faro, the selection of a well-known gynecologist and sexologist to manage CNSH and the signing of a technical cooperation agreement between the MoH and SBU,[23] in July 2008 (that was never put to practice), indicated a path towards a biomedical perspective on men's health. Nevertheless, the design of PNAISH would not be left solely in the hands of SBU and other medical associations.[29]

Being created over a period of three (03) years, a group of experts from governmental, non-governmental, academic backgrounds, international cooperation agencies, National Health Councils, medical

associations, and *Comissão Intergestora Tripartite*/CIT[vi] was gathered to draw the outlines of PNAISH. Also, a series of public discussions were held, through national and local seminars.

According to Spindler, the tense debates revolved around the medical representatives pushing for a biomedical perspective and CSOS and academics encouraging a "(…) *more gendered and sociological lens (focused on social class, race, youth, and sexual orientation).*"[3] In brief, the core reasons identified by these experts and debates to justify a specific policy to adult men, were:

- Recognition that health indicators demonstrated that men's mortality rates were considerably higher than women's throughout the ages in the life cycle;
- Considering that men usually access the health system when diseases are already present and sometimes in advanced stages, resulting in poorer treatment results, in suffering to these men and their families and also, to a higher cost for SUS;
- Considering the need to support comprehensive actions and health promotion activities to facilitate and expand access to health services for this population;
- Considering the need to support the qualification of health professionals to recognize and meet the specific health needs of the male population.[30]

By 2008, when the national men's health plan of action was put together, it started to gear toward a more sociocultural model and one that envisioned primary care as the policy's main locus, something that became clearer when CNSH's coordination was changed in 2011. However, this does not mean that biomedical initiatives were not relevant to the policy and also, that they did not, at times, play a central role.

These, among many other inputs, resulted in the Ordinance nº 1.944,[1] in 2009, that established PNAISH's overall guideline as the promotion of health actions that significantly contribute to the understanding of men's specific health needs, based upon a gender perspective, recognizing the relevance of various sociocultural and political-economic contexts, and respecting the different levels of development and organization of municipal health systems.

IMPLEMENTATION OF PNAISH

After its principles and guidelines were declared in 2008 and the policy launched in 2009, the MoH released PNAISH's first *National Action Plan* (2009-2011), establishing goals, priority actions and strategies to improve the engagement and assistance of adult men in local health services.[31] Overall, the document encompassed the formulation of state and municipal action plans and the financing of 26 pilot-projects – one city per state –, with specific guidelines on how they should be designed.[32]

To monitor and evaluate these 26 pilot-projects, a partnership was established with *Instituto Nacional de Saúde da Mulher, da Criança e do Adolescente Fernandes Figueira*/IFF/Fiocruz, one of the most prominent science and technology health institutions in Latin America. Professor Romeu Gomes, of IFF/Fiocruz, one of the leading scholars and researchers on men's health in Brazil was appointed to coordinate the initial research that covered the years of 2010-2012.

One of the first articles to be published from this endeavour, by Leal et al,[32] focused on these pilot-projects and on the intricacies of locally applying a policy that was formulated on a national level. Their idea was to comprehend how PNAISH reaches the health services and workers, with special attention to primary care services, considered SUS's *entrance door*.

The authors emphasized that public policies can only be comprehended in the context of their execution, meaning that you must pay close attention to the people actually implementing them, or, as Lipsky (2010, In. Leal, Figueiredo and Nogueira-da-Silva[32]) calls them, the *street-level-bureaucrats.* With that in mind, an ethnographic research was conducted in five (05) selected cities – one from each Brazilian region –, where secretariats of health, teams of local men's health units and professionals from local health services were interviewed. Presented below, are three (03) of this research's key findings:

6 Entity composed by managers from the three levels of government – Federal, State/Federal District and Municipalities – that acts in the national management of SUS.

FIG. 1 First PNAISH poster. A man that cares for himself does not miss out on the best of life"; in the poster, a white man pushes away things like hypertension, diabetes, smoking, alcoholism and cirrhosis.

- Lack of information about PNAISH, leading subjects to create their own objectives, work references and priorities;
- Insufficient information about gender and masculinities, contributing to the comprehension of adult men as an homogeneous group, which subsequently conceals specific vulnerabilities brought on by race, ethnicity, sexual orientation, age and socioeconomic status;
- Subjects criticized the lack of training regarding PNAISH's implementation and how to approach and deal with specific men's health issues.[32]

By 2014, all 26 Brazilian States, the Federal District of Brasília and over 1,000 cities[vii] had established local Men's Health Units, indicating that PNAISH's launch and the work developed by CNSH managed to increase awareness and interest towards men's health throughout. However, these numbers must be read with caution, since, as Leal, et al. stress,[32] in order for the policy to be properly implemented, it must not only increase in quantity/representation, but also, in quality, which strongly relates to the way that the MoH disseminates information and trains the *street-level-bureaucrats*.

Despite the obvious gap in knowledge by health professionals around men's specific health needs and about this newly launched policy, the MoH made the choice of initially focusing its efforts and resources on the male users of SUS, seeking to generate awareness towards adopting a healthier lifestyle and trying to bring them closer to the preventive healthcare services. This choice was based on information assembled by the MoH over the years – such as the ones provided by the aforementioned Vigetel[14] – and on studies that showed that although men and women use these units with similar frequency, women's use is more usually directed to routine exams and preventive measures, while men's use is more likely due to already existing illnesses, to accidents and injuries and to orthodontic care.[33,34]

vii Estimate based upon information gathered during the last national public selection of men's health projects organized by the CNSH and MoH, in 2014.

The first campaign developed by the MoH, in 2009, was comprised of a one (01) minute video[viii] that was aired on national television for several months and also of posters and pamphlets that were distributed throughout the country. Below, is the description of this video and *Figure 1*, with the campaign's main poster:

Scene 1: A mother picks her baby from the crib, the father is by her side, he looks emotional, and then he fades away and disappears; Scene 2: Three young men talk and laugh inside a car; the one in the back seat disappears and the other two go silent; Scene 3: Four friends sitting on the floor happily going over old pictures; one of them suddenly vanishes. Scene 4: A girl sadly sits on a swing by herself; her father emerges from behind her to give her a push and they both laugh in joy.

> Audio: *Two out of every three people that die are men. To every five people between 20 and 30 years old that die, four are men. Men live on average seven years less than women. Do you know why? Because men do not take care of their own health. A man that cares for himself does not miss out on the best of life. National Policy of Men's Health*. Seek your nearest Primary Healthcare Unit (Underline by the authors).

Looking back at this first – and, by far, best known – PNAISH campaign, it is striking how all characters shown in the video and poster were white, supposedly heterosexual and portrayed people from Brazil's middle-class, when SUS's users are mostly African-Brazilians and from more impoverished segments of the population. This fact went apparently unnoticed by researchers, but, on the other hand, the idea that this campaign (and for some, PNAISH, as a whole) blames men for their poor health, implies the existence of an intrinsically unhealthy masculinity and that men must be *saved from themselves*,[23] is something that has permeated different analysis since then. Also, despite the fact that CNSH's agenda grew increasingly apart from what was originally envisioned by SBU, by other medical associations and by pharmacological companies,[3] the understanding that PNAISH did not alter the traditional biomedical model of attention and that it ultimately serves the purpose of medicalizing men has remained a continuous source of critic and debate.[23,35]

As CNSH moved away from its early biomedical partners, it moved closer and strengthened partnerships within the MoH – women's health; children's health; elder's health, among others – with other governmental institutions; with CSOs like Instituto Promundo, Instituto Papai and MenEngage; with UNFPA, PAHO and UNICEF; with university/research groups; and with other institutions, such as the German Agency for International Cooperation/GIZ.

Ultimately, it has been with these institutions that CNSH has tried to establish, develop, improve and evaluate its main initiatives in the past years, directed to five (05) strategic areas targeting adult men:

1. Mobilization and access to health services, with a focus on primary care;
2. Engaging men in sexual and reproductive health;
3. Engaging men in fatherhood and caregiving;
4. Prevention of morbidity and mortality by external causes (violence, accidents and suicide);
5. Prevention of chronic diseases.

More recently, after the results of IFF/Fiocruz's evaluation research, the educational aspect (trainings and educational material) acquired a prominent position/role within CNSH, something that will be addressed shortly.

MAIN OBSTACLES OF PNAISH

According to Mendes,[36] there are many reasons to celebrate SUS, among them, the fact that it has achieved a truly universal reach, granting a wide range of services to over 140 million people, making it Brazil's largest ever social inclusion policy. Paim, Travassos, Almeida, Bahia and Macinko list the following advances witnessed by this system: "(...) *investments in human resources, science and technology, and primary care, and a substantial decentralization process, widespread social participation, and growing public awareness of a right to health care.*"[37]

However, in spite of the many advances brought by SUS over the past 28 years, it still faces innumerous obstacles that put its viability at risk and keep it from fulfilling its role of guaranteeing not only a universal

viii Available at: https://www.youtube.com/watch?v=Qekw4jPAnP0

health attention, but a *quality* universal health attention to Brazil's population.

Some of these obstacles are equally faced by PNAISH, for instance, the concentration of health services in larger cities and more developed regions of the country and chronic underfunding.[37] To both SUS and PNAISH, the main challenge seems to be achieving a long-term sustainability, while maintaining their core principles intact.

Despite its innovative character, PNAISH is still a work in progress,[38] and most of the few research papers that have so far been released about it only cover the first couple of years of its eight (08) year existence. As indicated by Emerge's Case Study, some significant changes have occurred in the past few years, for example, the already mentioned shift from a biomedical to a more gendered health focus:

> (…) the priority of the PNAISH coordination, and in particular of the PNAISH Coordinator (Eduardo Schwarz), has largely entailed pushing a more gender transformative discourse on men's health and well-being at the federal, state, and municipal levels.[3]

However, this shift does not translate into an immediate change, nor does it mean that there is no resistance to it. For instance, one cannot forget that the pharmaceutical companies and different medical associations have huge financial interests in this *new frontier* called "men's health," and have been investing heavily towards this field.

Initiates such as the *Parliamentary Front for the Comprehensive Health of Men*, launched by Brazilian congressmen, in 2013 and the campaign *Blue November,* are a good example of this *investment*, and of challenges to PNAISH's full and adequate implementation, as they are able to mobilize resources and political will towards a *limited* view of men's health.

This Front's first ever event happened concomitantly to one by *Blue November*, a prostate cancer awareness campaign inspired by Australia's "Movember," and spearheaded by SBU. During the event, the congressman who coordinates this initiative – who happens to be a urologist –, affirmed that the Front's main objective is to combat prostate cancer.[39] Instead of being allies of PNAISH, these initiatives can be best represented as a reaction to the shift made by the coordination in the past years,[3] serving as a lobby strategy towards men's medicalization and to the dissemination of the erroneous idea that prostate cancer is men's biggest health problem.

The trainings, educational materials and advocacy efforts put together by CNSH in the past years have tried to inform health professionals and the male population in general that men's health must be viewed comprehensively, and not limited to a *healthy* prostate; that their *entrance door* to SUS should be the primary healthcare services; that their doctors of reference should be the family health physicians and not urologists; and that health means much more than the absence of illnesses. Unfortunately, in many cases, these messages are not embraced by state and city health secretariats throughout the country.

Another threat to PNAISH's initiatives is represented by a strong backlash witnessed in the past years in Brazil against gender policies, coordinated by an ultra conservative neo-charismatic movement that has established a strong lobby and representation in all levels of governance[9]. Despite this backlash being especially targeted to women's and LGBTI rights and educational policies, in case it continues to grow, it will have the potential to impact, or even terminate any policy that is focused on debating and constructing a more gender equitable society.

Baker's (2015) review of Ireland's Men's Heath Policy points out that the Health Service Executive (HSE) should institute a "(…) *transparent and ring-fenced annual budget to support a range of local and national activity on men's health, including the development of Men's Health Forum in Ireland*."[2] Brazil's policy faces a similar challenge, as its annual (inconsistent) budget has been constantly diverted in the past years (sometimes, with a cut of up to 70%) to other areas and programs of the MoH that have stronger *political recognition*. In practice, this has made CNSH unable to fund important projects from several municipalities and, even more noteworthy, kept it from editing, printing and publicizing crucial educational material.

In addition to making it nearly impossible for CNSH to follow a minimum annual action plan, these

9 https://www.theguardian.com/cities/2017/nov/30/exhibition-nudity-brazil-culture-wars-sao-paulo-mam-masp-modern-art

cuts also evidence that PNAISH is still not viewed as a priority inside the MoH. The *unstable* and *weak* status of this Coordination – and consequently, of this policy – can be frequently noticed in high level federal meetings, where men's health is rarely brought to the table.[3]

Another relevant challenge has been the way that federal, state, and municipal Men's Health Unit teams are formed and also, their constant turnover. Usually, professionals are selected to coordinate and work at these units through political appointment or because of their administrative expertise, and not due to their previous experience or interest with the issue of gender and/or men's health. This implies that they have to be trained to work with these themes, which takes time and resources, making the constant turnover even more prejudicial to the policy's proper implementation.

As observed by Martins and Malamut,[38] PNAISH was launched and has since been implemented *on behalf of men*, however, with little room for male user's of SUS to participate in the policy's deliberative and decision making processes, a fact that might hinder its chances of success. What the authors apparently fail to notice is that despite the growing interest of CSOs and researchers in the field of gender, masculinities and health, there is still no such thing as an organized "men's movement for health" in Brazil – at least, nothing that comes close to the level of organization, reach, complexity and legitimacy of feminist and women's rights groups and movements.

The existence of a *ground-level* organization by male users of SUS would certainly contribute to resolve some existing gaps in the policy's actions, among which: a weak response towards the prevention of urban violence against young black and poor men; the frequent use of heteronormative language, obstructing the integration of gay, bisexual and transgender men; and the still shallow comprehension and debate of men's mental health, such as, suicide, alcohol, and drug abuse.

MAIN SUCCESSES OF PNAISH

Despite the difficulties surrounding the evaluation of PNAISH – largely due to its youth and challenges in collecting local data in such a large country – Emerge's case study acknowledges that CNSH has *"(…) actively fought to engrain a gender transformational lens to men's health*."[3] Given the pressure faced by CNSH, as previously described, the efforts made in the past years to increasingly embrace a sociocultural paradigm to men's comprehensive health is certainly one, if not the biggest success story of PNAISH.

Within this story, the issue of fatherhood and caregiving has stood out, proving to be the most effective at capturing the attention of policy makers, health professionals and the general population towards men's health and its relation to gender equality. This approach is supported by the findings of the "*State of the World's Fathers,*" the first global report on fatherhood and care, that asserts:

> (…) *engaging men and boys in care work contributes to gender equality, supports women's and girl's empowerment, enhances de well-being and rights of children, and improves the health and well-being of men themselves*."[40]

Recognizing this scenario and taking advantage of the fact that Brazil houses two of the world's most prominent NGOs in this field – Instituto Promundo (Rio de Janeiro) and Instituto Papai (Recife) –, alongside a growing group of academic researchers, since 2013, fatherhood and caregiving has established itself as CNSH's flagship. The fact that the MoH views this as an inexpensive strategy and also one that is able to integrate children, women and men, has also contributed to its growing priority status within CNSH.

An innovative approach to the issue has been the "*Partner's Prenatal Care*", a strategy that aims to raise awareness to the importance of future father's/partner's active involvement in all sexual and reproductive health initiatives and actions and to pregnancy, birth and the overall care of children. In addition to strengthening the future father's bond with their partners and newborn babies, the strategy also intends to act as a *positive entrance door* to men in primary care services, taking specific steps to engage them with healthier lifestyles and measures of health promotion. Applied as a pilot experience with promising results in several states and municipalities since 2008,[41] the "Partner's Prenatal Care Guide to Health Professionals." was released in 2015 and since then, CNSH's team has developed direct trainings in several states and cities.

In co-authorship with Instituto Promundo, CNSH developed the free and open online education course "*Promotion of Men's Involvement in Fatherhood and Care*", targeting health professionals from primary care services.[10] This 60-hour course presents theoretical and practice based content directed to: Exercise of fatherhood and caregiving; health, gender and masculinities; sexuality; sexual diversity; and gender-based violence. Released in November 2015, the course has so far reached over 2,800 participants.

The objective of increasing and improving men's use of primary care services is central to PNAISH and despite being an interesting strategy, tackling the issue of fatherhood and care will not solve this matter by itself. Throughout the country, many Family Health Units have extended their opening hours to attract working men, and even started to open on Saturdays. CNSH supports this initiative, however, as long as the facilities are also open to women. In 2008, the state of São Paulo launched the "Men's Health Reference Centre," a hospital focused on urological exams and procedures, especially relating to prostate problems. CNSH does not publicize this as a success story, as it comprehends that, with the correct training and direction, the Family Health Units and other health facilities from SUS and their professionals are capable of embracing and attending all health needs of men.

As a response to the constant requests made by men's health policy makers from different state and municipal secretariats, and to the findings of the evaluation research of Fiocruz/IFF, much of the work developed by CNSH's small team, that was never comprised of more than eight people, has been directed to disseminate the content of PNAISH, through trainings and campaigns. So far, the largest effort towards this goal has been the elaboration and dissemination of the online education course "Men's Health", focused on the overall content of PNAISH and with specific modules on its five pillars and also, on men's mental health, and men's health related to work issues. Launched as a pilot in 2016, in partnership with the Federal University of Santa Catarina, this 150-hour course has so far reached 500 health professionals out of the 3,000 projected.

Since 2014, CNSH has built a closer dialogue with the MoH's Communication Department, resulting in the elaboration of a number of short *pieces* concerning men's health that have been constantly made available in the ministry's site, blog, Twitter and Facebook page. According to reports by this department, they have been extremely well received by the public, reaching shares and views that are well above average. This serves as a strong indicator that there is high demand and curiosity for information concerning men's health and also, shows the importance of these inexpensive *tools* to disseminate PNAISH through a continental sized country like Brazil.

Similar to what was observed in Ireland, with the release of their men's health policy, PNAISH has had a significant impact in legitimizing and attracting attention to the issue of men's health.[2] To illustrate this, a search for scientific articles was undertaken in the online library *SciELO Brazil*[11], between March 20th and 24th 2016, using the key words, "men's health," "male health," "gender and masculinities," and "fatherhood." In total, 125 articles were identified, being the earliest from 2002 and the latest from 2015. Twenty-two articles were released in the period of 2002 to 2008, the year before the official launch of PNAISH; and 103 articles were released from 2009 to 2015. Despite the fact that some of these articles were not inspired by or directly refer to PNAISH – this was more frequently the case for the articles on fatherhood and caregiving –, and the absence of funding opportunities towards this goal spearheaded by the MS, it is clear that this policy's launch has given a boost and legitimized this field in Brazil.

CONCLUSION

Throughout the context observed during PNAISH's formulation and implementation, the introduction of gender and masculinities as social determinants of health has contributed to the search of a more critical and complex stance to men's health, trying to recognizing the plurality and diversity that resides within masculinities, thus seeking to overcome a limited

10 A shorter (12 hour) version of this online course has been recently made available for fathers and fathers to be.

11 http//www.scielo.br

and limiting comprehension of this population by health policy makers and professionals. In the midst of a historical backlash, when the terms "gender" and "sexual orientation" are being *hunted down* and excluded from Brazilian public policies – especially ones from the educational sector –[12] it is still too soon to know how this search initiated by CNSH will be impacted.

In this scenario, it is interesting that one of CNSH's main weaknesses might end up helping its team. Being a coordination with very little political support and recognition, which, as said before, translates into a small and fluctuating budget, has always allowed its team to work with a fair amount of freedom. Hopefully, CNSH will continue to use this freedom to improve and deepen its initiatives not only towards gender as a cross-cutting issue, but also to race, ethnicity, sexual orientation, class, age, religious beliefs and others that have so far been only superficially approached.

The issue of fatherhood and caregiving and its main strategy, the "Partner's Prenatal Care" have gradually gained more space and attention within CNSH and the MoH. Since 2013, it has been the only theme/pillar of PNAISH to be granted with a specific campaign "Father: a new life needs you," disseminated to health facilities throughout the country. This has proven to be an interesting strategy to bring some men closer to health services and multiple studies have shown that involved fatherhood can make men happier and healthier and that engaging men in all stages of pregnancy and birth can bring lasting benefits to women and children.[40] Nevertheless it is worthy of notice that having fought to defy the notion that men's health is synonymous to a healthy prostate, CNSH and the MoH should be careful not to reduce PNAISH to the issue of fatherhood and caregiving, thus neglecting its other pillars and also, potentially excluding gay and transsexual men.

For example, since 2009, Brazil has witnessed a gradual reduction in AIDS cases in women and an increase in men, especially among young men who have sex with men. Between 2003 and 2008, there were 15 cases in men for every 10 cases in women, however, since 2009, this has increased to 21 to every 10.[19] It is comprehensible (and welcomed) that fatherhood is used as a strategy to tackle this issue, however, if almost all of CNSH's efforts towards STI, HIV and AIDS prevention are going towards this direction, it is obvious that a great deal of men will be left out.

If implemented keeping in mind the *comprehensive* aspect of PNAISH, as stressed by Spindler,[3] this policy provides a *"(...) toolbox full of strategies, considerations, complexities, and lessons learned that can help guide other policy makers globally*."[3] Due to the geographical proximity and also language and sociocultural similarities, this has been especially true to other Latin American countries, like Chile, Paraguay, Uruguay, Argentina and Costa Rica, who have all signalled the intention of developing similar men's health policies.

A great deal of data collecting and evaluation still has to be put together to measure the impact of the *Brazilian National Policy of Comprehensive Healthcare to Men,* and only time will show if it will be implemented in its entirety and adequately within SUS, but what has been presented in this article shows that important steps towards this goal have been identified and are slowly being taken.

12 This has notoriously happened since the early 2010's with educational public policies. More recently, in 2017, the terms were excluded from the Common National Curriculum Parameters. On April 13th, 2017, the Mandates of the Special Rapporteur on the right to education; the Special Rapporteur on the promotion and protection of the right to freedom of opinion and expression and the Special Rapporteur on freedom of religion or belief of the United Nations Human Rights Office of the High Commission formally addressed the Brazilian government concerning two Projects of Law (PL) PL 867/2015 and PL 193/2016, called the federal "School without party programme" bills, which contain provisions that unduly restrict the right to freedom of expression of students and teachers in Brazil, specially regarding the issues of gender and sexual orientation. http://www.ohchr.org/Documents/Issues/Opinion/Legislation/OLBrazileducation.pdf

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