

Beyond the Prostate: Brazil's National Healthcare Policy for Men (PNAISH)

EMERGE Case Study 1

By Esther Spindler

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Engendering Men
Evidence on Routes to Gender Equality

Cover photograph: Father, mother and newborn baby after delivery in an emergency care unit (UPA - Unidade de Pronto Atendimento do Sistema Único de Saúde [SUS]) in Brasilia-DF.

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Abbreviations

Fiocruz	Fundação Oswaldo Cruz (research arm of the Ministry of Health)
IFF	Instituto Nacional de Saúde da Mulher, da Criança e do Adolescente Fernandes Figueira (Maternal and Child Health Research unit of Fiocruz)
IMAGES	International Men and Gender Equality Survey
MoH	Ministry of Health
NGO	Non governmental organization
PAISM	Programa de Assistência Integral à Saúde da Mulher (Program for Integrated Assistance to Women's Health, part of the Ministry of Health)
PNAISH	Política Nacional de Atenção Integral à Saúde do Homem (National Comprehensive Healthcare Policy for Men, part of the Ministry of Health)
PNAISM	Política Nacional de Atenção Integral à Saúde da Mulher (National Comprehensive Healthcare Policy for Women, part of the Ministry of Health)
RHEG	Rede de Homens pela Equidade de Gênero (Network of Men for Gender Equality)
SBU	Sociedade Brasileira de Urologia (Brazilian Urology Association)
SUS	Sistema Único de Saúde (Unified Health System)
STI	Sexually transmitted infection
UN	United Nations
WHO	World Health Organization

Abstract

There are only three countries in the world – Australia, Ireland, and Brazil – with national men’s health policies. The Brazilian case is particularly compelling. In 2009, the Brazilian Ministry of Health, along with civil society, medical associations, and academic actors, created the pioneering National Comprehensive Healthcare Policy for Men (PNAISH). This case study shares PNAISH’s evolution, exposing its challenges and successes. It aims to guide global policy makers, practitioners, and researchers, on promoting men’s health as a platform to improve gender transformative healthcare for both men and women, and to advance gender equality more broadly.

Lessons learned for adaptation and scale up include:

- Develop political and advocacy strategies early on to ensure political commitment and sustainability
- Partner with civil society and academics to develop a gender transformative approach to men’s health
- Include practical guidance and trainings for state and municipal health administrators to implement the policy on the ground
- Include gender transformative indicators in the impact evaluation plan

1 Introduction

There are only three countries in the world – Australia, Ireland, and Brazil – which have introduced men’s health policies as part of their Ministry of Health (MoH) agendas (Couto and Gomes 2012). This begs the question – is men’s health a blind spot for many national health policies? Does men’s health matter for gender equality? Does it matter for women’s health and well-being? And if so, how? This case study details the evolution of Brazil’s National Comprehensive Healthcare Policy for Men, exposing its challenges and successes (PNAISH: Política Nacional de Atenção Integral à Saúde do Homem). As highlighted in EMERGE’s Summary of Evidence Report, national policy change provides an important framework to facilitate work with men and boys for gender equality (Edström and Shahrokh 2015). PNAISH provides a response to many policies that have traditionally focused on individual women’s or girls’ empowerment rather than on gender relations or structural perspectives (Edström and Shahrokh 2015). Much can be learned from PNAISH’s birth and survival thus far, and this case study serves to map best practices for adapting and scaling the men’s health policy to other settings.

PNAISH was officially launched in 2009 by the MoH after years of tense debates with medical associations, health professionals, civil society, and academics. In addition to disputes around a biomedical versus gendered and sociological framing, there were strains around the prioritisation of men’s health in relation to women’s health needs. The policy aims to improve the health needs and outcomes of men (aged 20 to 59 years old), by facilitating men’s access to healthcare services and promotion. PNAISH’s implementation has been complex, multifaceted, and full of challenges. Evidence of PNAISH’s impact on gender transformational outcomes is still relatively limited, and constricted by the MoH’s limited resources to collect, monitor, and evaluate data across thousands of diverse Brazilian municipalities. What is clear, however, is that the policy has been instrumental in pushing for a gender-transformational approach to men’s health within the Brazilian public health landscape, while gaining targeted attention towards men’s health needs.

Why should we care about men’s health? Research points to the widening of a ‘men’s health gap’, meaning that globally, men have lower life expectancies and a higher burden of disease than women (Baker *et al.* 2014; Hawkes and Buse 2013). Men are also more likely to die from external causes, including automobile and occupational accidents, violence, and substance abuse (Couto and Gomes 2012; Müller 2012). There is clear and ample evidence that gender – specifically how gender norms are perceived, constructed, and acted upon – has a significant impact on health behaviours and outcomes for both women and men (Hawkes and Buse 2013). However, health research and programming rarely address the association between men’s morbidity and harmful masculine norms, such as risk taking or lack of help-seeking behaviours.

Research shows two important benefits of engaging men – in gender transformative ways - through the health sector. First, involving men in family planning, maternal, newborn, and child health, non-violent caregiving, and early child development is key to improving the health and wellbeing of women and children. Second, it has health benefits for men themselves.

As part of the Engendering Men: Evidence on Routes to Gender Equality (EMERGE) project, this case study addresses the links between masculine norms and men’s health, builds the knowledge base on men’s health policies, and offers insights into the processes of how a men’s health policy can be designed and implemented to have gender transformational effects, beyond biomedical and narrowed ‘prostate’ outcomes with benefits for gender equality as well as for the health of men (Stern 2015: 103). It also suggests that the needs of men need not be pitted against the needs of women, but in fact are complementary.

First, this case study provides a background on men's health issues, followed by an investigation of the policy's conception, implementation, and evolution. Finally the case study provides lessons learned, and recommendations for, other policy makers, researchers and practitioners.

2 Background

The inclusion of men in the global public health discourse, and in particular in sexual and reproductive health, is far from a new concept. However, thinking has shifted over the past 20 years, from a focus on men solely as allies in women's and children's health to the need to address men's health needs more explicitly. Noteworthy events include the 1994 Conference on Population and Development in Cairo and the 1995 World Conference on Women in Beijing, which helped bolster attention toward the inclusion of men in improving sexual and reproductive health outcomes of women and families (Medrado and Lyra 2012; Müller 2013; Nascimento and Carrara 2012). More recently, there has been an increasing shift among global actors, including the World Health Organization (WHO), and the UN, to incorporate men's health promotion as a strategy to not only benefit women and families, but also men themselves (Hawkes and Buse 2013; Couto and Gomes 2012).

Like in many other countries, Brazilian healthcare policies have historically focused on health care for mothers and children (Knauth *et al.* 2012). With the transition to re-democratisation in the 1980s, Brazil experienced a surge of feminist civil society movements, pushing the creation of several public policies¹ geared toward advancing women's rights and gender equality (Couto and Gomes 2012). During this time, the health needs and experiences of men were largely excluded since men's health was still very much seen (and continues to be seen) as a privilege rather than as a right (Knauth *et al.* 2012). The one exception to this is the field of HIV and AIDS, where policies focused on the gender-related needs of men who have sex with men.

By the 1990s and 2000s, epidemiological statistics of morbidity and mortality showed that Brazilian men were dying of unnecessary and external causes – and in particular, from violence and chronic diseases – which the MoH saw as a high cost to the healthcare system (Interview with Schwarz 2015). Under the leadership of then MoH Minister, José Gomes Temporão, discussions were initiated with medical associations, health professionals, civil society, and academics, to develop a policy strategy that could address men's health needs and outcomes.

It was under this context that the Brazilian MoH officially launched PNAISH by administrative rule, on 27 August 2009. At the time it was created, the policy's general objective was to address the health needs of men (aged 20 to 59 years old), a group traditionally excluded from healthcare, in order to facilitate their access to comprehensive health care services and reduce their morbidity and mortality risk factors. As part of this overarching goal, the original policy included two specific objectives: (1) Implement PNAISH in the entire Brazilian territory, improving men's primary healthcare services and provider training and; (2) Implement men's sexual and reproductive health services among primary healthcare units, including services related to infertility, responsible parenting and caregiving, family planning (vasectomies), and prevention of sexually transmitted infections (STIs), among other service categories.

¹ The MoH created the Program for Integral Assistance to Women's Health (Programa de Assistência Integral à Saúde da Mulher: PAISM) in 1984, as the first public health policy on women's health, followed by the National Policy for Integral Attention to Women's Health (Política Nacional de Atenção Integral à Saúde da Mulher; PNAISM), which placed higher priority on sexual and reproductive rights, HIV and AIDS, and sexual violence issues among minority groups, such as black Brazilians, indigenous populations, lesbians, and sex workers (Couto and Gomes 2012).

2.1 What are the problems related to men's health in Brazil?

The problems related to men's health in Brazil are complex, dynamic, and at the centre of continuing debates among academic and civil society circles. Since the late 1980s and 1990s, global data has shown that men continue to be at higher risk of morbidity and mortality due to preventable and so called 'external causes' such as violence and accidents (Couto and Gomes 2012; Müller 2012). Similarly, in Brazil, traffic accidents and violence are the most common pathways that lead men into the health care system, in particular through emergency and hospital services (Moura *et al.* 2014). Health burdens as a result of violence are particularly troublesome. In 2012, 91.6 per cent of 56,337 homicide victims in Brazil were men, with 73 per cent of total homicide victims being black (male and female) (Waiselfiz 2014:17). However, external causes of death have rarely been addressed through a gendered lens, considering norms of power and violence or how men are brought up in Brazilian society.

Furthermore, masculinity norms have been explored, even less so, in relation to socio-economic determinants of health, such as race, poverty, education, and access to health services. Some have argued that under Brazil's public health system, men's health has more often than not been identified as 'homogeneous, associated with white, heterosexual health needs' (Interview with Nascimento 2015). Recent MoH policies² have been created in order to address diversity issues related to masculinities, but the implementation of such policies is still very much limited.

A common complaint among the Brazilian health sector is the 'invisibility of men' altogether – among users of primary health care services (Moura *et al.* 2014: 430). Brazilian 'machismo' (like in other Latin American countries) is often pinned as a socio-cultural problem, which has taught men that taking care of one's health is a sign of weakness and submission (Interview with Nascimento 2015). Although men aged 20 to 59 years old made up 27 per cent of Brazil's total population in 2009 (Ferreira de Andrade and Bentes Monteiro 2012: 79), they accounted for a yearly average of 0.06 consultations per man/year in 2010 (Moura *et al.* 2014: 430). Reasons for men's absence from primary health care services include: women's health as a priority under the national women's health policy (PNAISM); the inability of health care providers to identify and mobilise men; or their inability to address health issues raised by them when they do come in (Knauth *et al.* 2012).

As discussed in more detail in Stern (2015), problems related to men's health are multi-layered and complex, and affect not only men's lives, but those of women and children as well. Healthcare policies such as PNAISH in Brazil face many challenges in addressing the diverse health needs and opportunities for men's engagement. These include balancing curative responses to external and biomedical causes of morbidity and mortality, with preventive measures that question and challenge harmful masculine norms, and address socio-economic determinants of health.

2.2 How does this case study explore the policy related to men's health in Brazil and what implications does this have for other settings?

This case study provides an overview of PNAISH, from policy formulation to implementation, highlighting the lessons learned and challenges found in shifting the original priority of addressing male body diseases to a more gendered focus on male and female health and wellbeing. In particular the study aims to answer the following questions:

² These include the National Comprehensive Healthcare Policy for Populations of Colour (2007) and the National Comprehensive Healthcare Policy for LGBT Populations (2013).

- How does the policy address the relationship between men and health while also addressing gender transformational health outcomes of women and children?
- What are the complexities behind formulating and implementing men's health policies from paper to practice?
- What are the challenges and lessons to be learned from PNAISH's implementation so far?

By answering these questions, this case study explores gender informed care and prevention for men in the context of the health sector, both through attention to men's health and its potential for gender transformational health outcomes for women and for children.

2.2.1 Methodology

The case study methodology includes a review of key PNAISH primary documents and published academic studies, in addition to five key informant interviews conducted with government, civil society and academic actors. Please refer to the annex for a list of key informant interviewees.

2.2.2 Strengths and limitations

The strength of the study methodology includes the availability of information, and in particular published studies, which provide rich and diverse perspectives on the PNAISH formulation and implementation. Key informant interviews also provide in depth information on the processes and challenges of the policy, which were triangulated across civil society, academic, and government perspectives. Interviews were particularly relevant in obtaining insider information on the construction of the policy and ensuing tensions between the medicalisation of men's health and a more gendered discourse on men's health and wellbeing. Since the policy is only six years old, there exists limited quantifiable evidence on PNAISH's impact on gender transformational health outcomes. Therefore, this study does not provide data on large scale health outcomes and impacts. It instead provides a unique insight into the processes, evolution, and lessons learned of the policy thus far. Given time and length constraints, this case study is focused on the formulation and implementation of PNAISH, but does not capture in depth information related to local health unit implementation. Issues related to PNAISH local implementation have been subject to a number of published studies in Brazil, some of which are available in English.

3 Findings

This section highlights: (1) The policy objectives, structure and activities aimed at promoting men's health and wellbeing from federal to local-level implementation; (2) PNAISH's evolution and shift from a biomedical to a gendered health focus, and; (3) Recommendations and lessons learned.

3.1 How does PNAISH address men's health issues?

3.1.1 The birth of PNAISH

In his inaugural speech in 2007, incoming Minister of Health, José Gomes Temporão announced the idea of creating a 'national assistance policy towards men's health' among the MoH line items to be implemented during his first term as Health Minister (Carrara *et al.* 2009: 662). Discussions around the idea of a men's health policy had already begun a year earlier in response to epidemiological statistics of morbidity and mortality among men (aged 18–59) due to preventable and external causes (violence, accidents, and chronic diseases). These discussions were formalised with the entrance of Minister Temporão, who paid particular attention to the importance of men and fathers as key agents to improve not only men's health but also overall family health and wellbeing (Interview with Schwarz 2015). By

March 2008 and prior to the official launching of the policy, a Men's Health Coordination Unit was informally created under the coordination of a well known gynaecologist and founder of modern Brazilian sexology (Carrara *et al.* 2009; Interview with Schwarz 2015). On 27 August 2009, the policy was officially launched by administrative rule (Ministry of Health PNAISH 2009).

PNAISH was created over a period of three years, through a unique top-down participatory process that was initiated on the part of a MoH political decision. From 2008 to 2009, the MoH disseminated the national plan for the policy's implementation, involving different actors from civil society, academia, and health associations, (cardiology, urology, mental health, gastroenterology, and pulmonology) through a series of public seminars and debates (Gomes *et al.* 2012; Interview with Schwarz 2015). These debates involved tense discussions between civil society, academics, and medical associations. While medical representatives pushed for a biomedical perspective of men's health and wellbeing, civil society and academics encouraged a more gendered and sociological lens (focused on social class, race, youth, and sexual orientation) to address men's mortality and morbidity (Interviews with Müller and Nascimento 2015):

We weren't talking about a generic man, about a generic representation of the man, we were talking about a man, who crosses upon different questions of social classes, questions of ethno-racism, questions of sexual orientation, because that's also the dilemma right?
(Interview with Nascimento 2015)

As a result of these public discussions, the MoH shifted and re-positioned the national plan toward a more gender transformational focus, but these generally remained secondary to biomedical focuses such as erectile dysfunction as an indicator for men's sexual and reproductive health outcomes (Carrara *et al.* 2009: 671; Interview with Gomes 2015).

3.1.2 PNAISH on paper

PNAISH was created in response to epidemiological statistics of men's mortality and morbidity, which at the time were seen as high costs (both in terms of financial and human burdens) within the healthcare system (Interviews with Gomes and Schwarz 2015). External causes of men's health problems such as violence and accidents, in addition to preventable chronic diseases, were not being addressed at the time by the four MoH prioritized population age groups (children, adolescents, women, and the elderly). The prioritisation of a fifth population age group – made up of men aged 20 to 59 years old – could reduce the high costs related to preventable and external causes of morbidity and mortality (Interview with Schwarz 2015). Albeit secondary, men's engagement in the healthcare system was also seen as a key opportunity to engage men in sexual and reproductive health, both in terms of their own health, and in the health and wellbeing of their partners and families.

According to official documents, the policy's overarching goal aims to improve the 'health conditions of the male population in Brazil, contributing effectively to the reduction of morbidity and mortality through the rational confrontation of risk factors and by facilitating access to actions and services for comprehensive health care' (Ministério da Saúde 2009a: 53). PNAISH has nine priorities as per its 2009–2011 implementation plan, including:

1. Implement PNAISH strategies as part of state and municipal level health plans
2. Develop health promotion strategies to increase men's health service demands
3. Increase access to information and communication to men and their families, motivating self care and healthy habits
4. Align government actions with civil society initiatives around men's health
5. Expand and strengthen comprehensive health services for men at the primary and municipal health care level

6. Improve the training and education of health care professionals in attending men's health needs
7. Monitor and evaluate human resources, equipment, and supplies needed to offer adequate health services for men
8. Improve health information and data collection systems related to men's health
9. Conduct research and studies of pilot municipal projects (Ministério da Saúde 2009b: 8–9)

3.1.3 PNAISH at the federal level

At the federal level, PNAISH is led by a Men's Health Coordination Unit, composed of approximately six to eight team members, who implement and guide activities both at the federal and state/municipal levels. Since PNAISH is a relatively young policy, a vast majority of PNAISH activities include 'reaffirming' PNAISH's position within the MoH among competing health priorities of women, adolescents, children and youth (Interview with Nascimento 2015). These tensions in finding space to address men's health also come in a context with limited resources, where PNAISH's implementation is often added on to the responsibilities of those coordinating women's health or other priority health actions. As one former PNAISH coordination unit team member explained, this includes constant reminders during high level federal meetings, 'And the health of men? And the health of men? And the health of men?' (Interview with Lima 2015).

Other key activities include:

- **Trainings** and courses with local health workers and state level administrators on PNAISH, gender and men's engagement in health. Last year, a long distance learning course for 3,000 health workers on gender-based violence was launched as a partnership between the MoH and the Federal University of Santa Catarina, and this year, another longdistance learning course will be launched in partnership with Instituto Promundo, Instituto Papai, and Instituto Noos, to train health workers on men's engagement in sexual reproductive health, fatherhood, and gender-based violence (Interviews with Schwarz and Lima 2015).
- **Launching of guidelines and manuals** for health administrators, including guidelines for health practitioners on engaging men around gender-based violence prevention, and an imminent manual on engaging men as partners during women's prenatal consultations, as part of the Prenatal Care for Partners Strategy (Interview with Lima 2015).
- **Public campaigns and production of materials** including pamphlets and posters on PNAISH and men's engagement for health professional training courses, distribution at the municipal level and national level campaigns (Interview with Schwarz 2015).
- **Support to state and municipal health units** in implementing PNAISH funds and projects, as further described below.

3.1.4 From federal policy to local implementation

To date, approximately 1,000 out of all 5,570 municipalities in Brazil have implemented some type of action around men's health (Interview with Schwarz 2015). At the state level, PNAISH has a modest, albeit dwindling budget to disburse funds to municipal health units to implement PNAISH projects. In 2013 for instance, PNAISH financed 80 projects in local municipalities, with each municipality receiving approximately US\$12,540 for that given year (CONASS Nota Técnica 2013). To guide projects at the municipal level, PNAISH's Men's Health Coordination Unit team provides a 'menu of options' to apply for funding and implement projects according to the following five strategic areas (Interview with Schwarz 2015):

1. Mobilisation and access of male populations to health services
2. Engaging men in sexual and reproductive health
3. Engaging men in paternity and caregiving (via Prenatal Care for Partners Strategy)
4. Violence and accident prevention among male populations
5. Prevention of chronic diseases among male populations

There is still much to be done to institutionalise PNAISH as a priority within the MoH. In some state secretariats, PNAISH is consolidated with other health departments (women's, children's or the elderly's) or simply ignored (Interview with Lima 2015). Although gender transformative outcomes of men's health have been a large focus of PNAISH's Men's Health Coordination Unit at the federal level, implementation at the local health unit level has been more limited to biomedical outcomes. In an effort to understand PNAISH implementation on the ground, the MoH, Fundação Oswaldo Cruz (Fiocruz) and Instituto Nacional de Saúde da Mulher, da Criança e do Adolescente Fernandes Figueira (IFF) launched the first process evaluation and large-scale study of PNAISH in 2012, which revealed a certain 'disconnect' between the policy's vision and municipalities' use of funds, in which:

Administrators submitted their proposed plans, and then could receive financial support from the Ministry [PNAISH] to implement them. But quickly we realized that there were certain disconnects because many of these action plans were presenting activities that were already part of routine care, without defining [or aligning] these activities with aspects of the [PNAISH] policy.
(Interview with Gomes 2015)

Among the five municipalities sampled as part of the evaluation, the results showed that the policy had very different meanings and interpretations across different contexts, whereas different municipalities fell along a continuum, from having little knowledge of the policy to a comprehensive understanding of the policy:

- **Little to no knowledge at all of the policy** and were not implementing actions;
- **Brief activities** surrounding 'Men's Health Day/Week' or 'Father's Day' including expert panels, local media, and distribution of brochures;
- **Urological focus** on men's health, focusing primarily on prostate cancer prevention;
- **Comprehensive care to men's health**, viewing men's health promotion as equal to health promotion of children and women (Gomes *et al.* 2012; Knauth *et al.* 2012).

The 2012 process evaluation also showed that the implementation and dissemination of PNAISH was very limited and had very few resources (Interview with Schwarz 2015). Municipal level activities aimed at engaging men appeared to be isolated, focused on clinical care actions, and with few connections to the PNAISH guidelines (Knauth *et al.* 2012). Some health municipalities referred to the policy as vague and unclear in providing mechanisms or tools to bring men into health services and developing men's healthcare programs (Gomes *et al.* 2012). These included the absence of basic guidelines from PNAISH for health information systems and monitoring, such as segregating data by sex and age range and obtaining basic data on the number of men accessing health services (Moura *et al.* 2012).

As a result of the 2011–2012 evaluation, a follow up study was conducted by IFF/Fiocruz the next year. This time, the study focused on how to strengthen the policy based on the evaluation findings, and in particular, explored issues related to implementation, and perspectives of health care professionals at the local municipal levels. The study helped to redirect PNAISH's implementation toward a more comprehensive and gender transformational perspective toward men's health in the following years.

3.2 What has changed? Shifting from ‘urology’ to gender perspectives

3.2.1 *Shifting the discourse*

In the last few years, the priority of the PNAISH coordination, and in particular of the PNAISH Coordinator (formerly Eduardo Schwarz), has largely entailed pushing a more gender transformative discourse on men’s health and wellbeing at the federal, state, and municipal levels. As discussed already, this entails continuous efforts at the federal MoH level to sensitise leadership and health care professionals to incorporate issues related to gender and masculinities. In addition, key partnerships between PNAISH, civil society, and academics have also helped to create visibility around a more nuanced and gendered health discourse on men’s health and wellbeing. NGOs active in the masculinity field in Brazil since the late 1990s such as Instituto Papai, Instituto Promundo, Instituto Noos, and the Rede de Homens pela Equidade de Gênero (Network of Men for Gender Equality: RHEG) have helped to strengthen projects and advocacy around men’s health and masculinities. RHEG, Papai, and Promundo, for instance, were instrumental in formalising and disseminating guidance toward a more comprehensive approach of masculinities and health during the construction of the PNAISH policy in 2009 (Medrado *et al.* 2009). Today, these partnerships include advocacy efforts related to increasing paternity leave for fathers (in collaboration with the Brazilian MenCare campaign) and online training courses for health workers on health, gender, and masculinities. Partnerships between the MoH and research institutions, and in particular the aforementioned IFF/Fiocruz studies, have been key in building evidence and ensuring the survival of PNAISH:

The researchers, state and municipal leaders, health administrators, civil society, everyone united themselves around the men’s health field. So I think that this unified movement was very important for the policy to continue existing. Or that is, PNAISH’s survival is largely due to the projects that we realized with Fiocruz.
(Interview with Schwarz 2015)

3.2.2 *Balancing biomedical and gender transformative strategies*

To date, PNAISH has a mix of gender transformational and biomedical focuses, which can best be understood by examining PNAISH’s five strategic areas:

1. **Mobilisation and access of male populations to health services:** The Men’s Health Coordination Unit partners with small teams at the state department level to work with local health professionals, through campaigns and trainings. These include deconstructing health professionals’ views of machismo, power, and ‘hegemonic’ dominant masculinities (Interview with Schwarz 2015). The presence of state health secretariats is key in this process:

...at the end of the day, it’s the municipalities really who are going to train, monitor and accompany the implementation of the policy. That’s how the SUS [Sistema Único de Saúde] works, it’s impossible for the PNAISH national coordination to do all this work.

(Interview with Lima 2015)

One example of such active state health coordination is in Rio de Janeiro, where the MoH state secretariat, a municipal government-headed committee, *Comite Vida*, in partnership with non governmental organizations (NGOs), developed criteria – such as having trained professionals, flexible hours, health promotion activities, among others – to incentivise and certify health units as ‘Partners of Fathers Health Units’ (*Unidades de Saúde Parceiras do Pai*; Interview with Nascimento 2015; Branco *et al.* 2009).

2. **Violence and accident prevention among men:** Issues related to intimate partner violence have advanced over the last few years. Strategies to address this have included long distance courses and guidelines to train healthcare professionals in prevention and counselling of intimate partner violence. However, there still exists a large gap in addressing men’s health, masculinities, and power dynamics related to

urban violence, which is a common problem in Brazil, and could be more effectively addressed by working and training health professionals on preventive approaches in emergency and hospital units (Interview with Lima 2015).

3. **Prevention of chronic diseases among men:** This is still one of the least advanced strategic areas of PNAISH, despite the rising prevalence of chronic diseases in Brazil, and in particular among the male population. These include preventive actions around screenings and promotion such as nutrition, which remain heavily focused on women, rather than men (Interview with Schwarz 2015).
4. **Engaging men in sexual and reproductive health:** Men's reproductive and sexual health needs, in addition to the outcomes of their partners and children, are being advanced in part of PNAISH's Prenatal Care for Partners strategy (further elaborated below). The question of men's sexual health however is still very much taboo within the municipal health level, and narrowly defined to issues of prostate and erectile dysfunction among health professionals (Interview with Schwarz 2015).
5. **Father involvement and Prenatal Care for Partners:** The Prenatal Care for Partners strategy has two objectives: (1) Involve men as active agents in the health and wellbeing of their partners and children and; (2) Create a space for men to take preventive tests and have check ups (Interview with Gomes and Schwarz 2015). The strategy was created due to evidence that prenatal visits could be a key entryway to involve men in preventive care, paternity, and caregiving, and as a strategy to increase STI testing and reduce vertical transmission of syphilis and HIV (Interview with Schwarz 2015). The strategy also capitalised on existing MoH initiatives.³ As seen in the MoH poster in Figure 3.1, the campaign aims to encourage men as active and positive participants within prenatal, delivery and post-partum care, as a way to engage them in the health and wellbeing of their partners and children.

Figure 3.1 PNAISH Fatherhood Campaign Poster 2013



Caption: 'Be a father, be a partner. Prenatal, birth, and post-partum care are also men's issues.'

Source: MoH website, <http://portalsaude.saude.gov.br/images/pdf/2015/abril/10/Cartaz-Lei-do-acompanhante-SejaPai-SejaParceiro-46x642-baixa.pdf>

³ These include the Stork Network (*Rede Cegonha*) initiative, which focuses on ensuring women's rights to reproductive planning and humanised childbirth, and a 2005 national law (*Lei do Acompanhante no. 11.108*), which ensures women's right to be accompanied by a partner during childbirth (Fiocruz 2014).

Preliminary evaluation findings⁴ of the strategy in three municipalities show that participating health units can be effective in engaging men in consultations around family planning, and in particular vasectomies, while promoting preventive exams and check ups for men. Data from one municipality where the program has been implemented with the municipal public health sector (Ribeirao Preto) shows a steady increase in men/partners accompanying women to at least one prenatal visit, during which exams to detect syphilis, hepatitis B and C, and HIV are offered. The average percentage increased from 37.5 per cent of partners in 2013 to 38.5 per cent in 2014, and up to 40.7 per cent from January to March 2015 (Municipal Health Secretariat of Ribeirao Preto, 2014 and 2015).

After the first visit, partners are encouraged to continue their involvement in prenatal visits, pregnancy groups, delivery, and in the caregiving of the newborn, but their participation in these activities is not officially registered. Although data is not gathered on the issue, health officials report that the prenatal visit has been one of the most successful strategies to encourage heterosexual men to come for HIV and STI testing. However, discussions around fatherhood and caregiving are not as evident among participating health units (Interview with Gomes 2015; *results to be published in November 2015*):

Some [health units] had protocols when pregnant women came in right? And the health worker would ask her to invite her husband or partner, and they had specific protocols and [health] exams to give to the partners. From what we observed, this part had a type of structure and planning. What's more lacking really, like I told you, is to incorporate questions related to changes in identity [of the man] and work with fatherhood and paternity as a theme, beyond just maternity.
(Interview with Gomes 2015)

These preliminary findings suggest that the strategy has been successful, but does have room to improve, in particular in providing guidelines to take up more gender transformative approaches in engaging men in the prenatal, delivery, and post-partum care.

3.3 What can we learn from PNAISH about men's health policies?

A number of these key lessons, although not all, are summarised below. These lessons learned are valuable, not only for the future of Brazil's programming, but also for the vast majority of low, middle and high income countries that have not yet prioritised or successfully implemented men's health outreach in their national strategies. A few **recommendations for gender transformative men's health policies** include:

- **Develop a strategy to ensure political commitment and sustainability.** Despite being fragile, the construction of PNAISH as a participatory initiative from the MoH, helped to ensure political legitimacy at the federal and state levels. Several key components can help ensure this legitimacy:
 - A participatory process including civil society, academics, and medical association actors. In Brazil, the involvement of these actors during the drafting of the policy, helped to ensure a collective construction and to legitimise the policy once it was created and implemented (Interview with Schwarz 2015).
 - A strategy, either through advocacy or lobbying efforts, to ensure political ownership and support at the Ministry of Health leadership level.
 - The explicit inclusion of the policy within MoH priorities to assist future participation in strategic initiatives and networks.

⁴ As part of the third Fiocruz/IFF and MoH study collaboration, the Prenatal Care for Partners strategy is currently being evaluated among three municipalities in Rio Grande do Norte, São Paulo and Paraná, Brazil.

- **Create and formalise civil society and academic partnerships to help catalyse a shift from medicalisation of men's bodies to a more comprehensive gendered approach.** In Brazil, some of these strategies have included:
 - Initiatives and partnerships with civil society, academia (IFF/Fiocruz), and regional networks (MenEngage network and regional governments), which helped to build visibility in relation to issues of masculinities and health.
 - PNAISH's Coordination Unit's active reaffirmation role within the federal level MoH and locally, through trainings and courses for health workers, in addition to campaigns around key dates such as Father's Day.
 - The involvement of media, through news and radio reports, in promoting issues around men's health and masculinities (Interview with Gomes 2015).
- **Include clear guidance for state and municipal health administrators to ensure smooth implementation.** Two key lessons learned in Brazil include:
 - The use of formative/process evaluation during the initial pilot implementation of the policy at the local level. For instance, the PNAISH evaluation done in 2012 showed a basic lack of information at the health service level on men's attendance and consultations, including disaggregation of health data by sex and age, which helped PNAISH to develop indicators for monitoring the program (although as discussed below this is still a gap of the policy).
 - Provide specific guidelines for accessing and gearing health services toward men's health needs. For example, PNAISH is in the process of developing specific guidelines to be published in 2015 for health workers on engaging men on topics of fatherhood, violence, mental health, and including issues related to race, age, socio-economic background (in collaboration with several partners, among them the NGO Papai), and a manual on engaging community health agents in accessing men, a part of the MoH's Family Health Strategy (Interviews with Lima and Gomes 2015).
- **Implement trainings, trainings, and more trainings for healthcare managers and professionals,** in order to help deconstruct health workers' own gender norms and stereotypes, such as categorising men as either 'uncooperative' or 'victims' of their own masculinities, or as 'instruments' to improve the health and wellbeing of women and children (Carrara *et al.* 2009; Müller 2013: 51; Interview with Lima and Schwarz 2015). Although well crafted policies and supportive institutions can provide the base for more equitable gender norms, change also requires addressing institutional cultures (Edström and Shahrokh 2015). In Brazil, approaches have included:
 - Long distance online courses for health workers in collaboration with the women's health department, which have already reached 3,000 health workers and provide a space to educate workers on issues related to gender and masculinities not traditionally part of their medical education.
 - Other suggestions include the use of more 'reflexive' spaces within health centres for men of different age ranges and identities to discuss their relationships not only with women, but within their personal and professional lives, including the stigma they may have encountered in healthcare settings (Interview with Müller 2015).
- **Formalise an evaluation plan to learn how the policy is impacting gender transformative outcomes for men, women and families.** This includes:
 - Developing both process and impact evaluation plans. The process evaluations from Brazil have been primarily focused on implementation processes and policy outreach at the municipal level. Data from Brazil shows that over 1,000 municipalities are now implementing some type of men's health action, but the impact of such actions on gender transformative outcomes (in addition to defining what these actions are), is very much limited.
 - Pushing for a budget allocation of formal impact evaluations can be key in learning about the policy's effects on men, women and children. Pursuing academic partnerships as was done in Brazil with IFF/Fiocruz can be key. As

well, the use of randomised control trials (RCTs) have been common among conditional cash transfer (CCT) programs in Latin America, and can also be instrumental when rolling out men's health policies at the municipal level. Recognising that RCTs are expensive and resource intensive, alternative methods such as quasi-experimental evaluations, using intervention and control groups, can also be explored.

- **Implement strategies and programmes addressing the diversity of men and their differing health needs**, both on paper and in practice. As highlighted in EMERGE's Summary of Evidence Report, it is essential to recognise the diversity of men, as well as to link work to advance gender equality with other issues of social injustice (Edström and Shahrokh 2015).
 - Men's diversity health needs to be incorporated as part of the policy construction and as part of the founding document. PNAISH's founding National Policy Plan recognises the need to 'promote comprehensive health care for all men including indigenous, Afro-Brazilian, quilombola (descendants of autonomous communities of escaped African slaves), gays, bisexuals, transsexuals, rural workers, those with disabilities, men with specific risks, men in prison, among others' (Ministério da Saúde 2009a: 54).
 - Devise a strategy to translate the importance of diverse men's health needs to practice despite the challenges in doing so on the ground. In Brazil for instance, accessing these groups and addressing their different health needs is still very much limited, especially among health centres who are already overburdened with improving health access among the general population (Couto and Gomes 2012; Gomez Interview 2015).
- **Integrate both forms of violence, including gender based and urban/contextual violence, as a men's health strategy.** The issue of violence in health may focus particularly on gender based violence, and is rarely addressed in the context of Brazilian urban violence, masculinities and power dynamics, particularly among black and adolescent youth (Interviews with Müller and Lima 2015). Potential opportunities to address these contextual factors include:
 - Increased coordination with ambulatory and emergency services, in addition to psychosocial services (CAPs), as a space to engage and educate men on issues related to urban and gender based violence, and mental health.
 - Increased collaboration with the education sector could also help focus working on health and wellbeing with men and boys at a younger age, training a new generation on the importance of health and wellbeing (Interview with Nascimento 2015).

4 Conclusion

The PNAISH's Men's Health Coordination Unit exists as a formal department, but at the same time it appears to be an informal one within the MoH. So there are a lot of challenges. At the same time, leaving this imprint of having to discuss the health of men from a gender relational perspective, well that has been a great victory.
(Interview with Lima 2015)

As shown through the PNAISH example, the development and effective implementation of policies around men's health – particularly those that are gender transformative – takes time. Given the infancy of the policy and difficulties in collecting local data, it is still too early to judge whether the policy has been successful in spurring/achieving large scale gender transformative outcomes for men, women, and families. However, under the leadership of former coordinator Eduardo Schwarz, the PNAISH Men's Health Coordination Unit has actively fought to engrain a gender transformational lens to men's health, opening

discussions around new ideas such as paternity and caregiving, a topic which is now 'catching on' among health professionals (Interviews with Lima and Schwarz 2015). To date, the policy has reached over 1,000 municipalities, but implementation still depends on local interpretations of the biomedical to gendered spectrum of men's health and wellbeing. In a country as regionally diverse as Brazil – and in considering the implementation of such a policy in other countries – one of the key challenges is to expand the policy in a manner which is consistent, yet representative of the diverse health needs of local men and health services.

In expanding and scaling up policies such as PNAISH, it is essential to pursue dialogues and seek strategies to retain and improve gender transformative approaches. In the case of PNAISH, the gender transformative elements of the policy emerged from the active participation and consultation of civil society and academics in the field of men and masculinities. Implementing and upholding this gender relational focus is very much dependent upon local health units and providers' deconstructions of their own gender norms around men's health and engagement (Interview with Müller 2015). PNAISH's work in this regard has been exhaustive in the face of limited resources and overwhelming municipal demands. In the face of increasing resource cuts, the challenges related to PNAISH's survival are two fold: first, ensuring that the policy is institutionalised and sustained at the federal level, and; second, that it is effectively implemented at the local level at a larger scale and in a gender transformative approach.

Brazil's PNAISH has helped to catalyse a men's health movement in Brazil and the Latin American region, removing men as outsiders of the health realm and placing them as protagonists of their own health demands and that of their partners and families.

In Latin America, PNAISH has generated visibility and vibrant responses among government, civil society, and academics on men's health, masculinities, and gender, in the face of on going tensions among biomedical, gendered, and sociological perspectives. More recently, PNAISH's promotion of paternity and prenatal consultations as entryways to engage men in the promotion of their own health has already become central to nascent programs and studies. Despite PNAISH's limitations in accessing and scaling up its programs to other regions and municipalities, the policy is helping to mobilise and provide evidence to a growing field around men's health.

PNAISH provides a toolbox full of strategies, considerations, complexities, and lessons learned that can help guide other policy makers globally. Chile and Paraguay are among a number of countries with governments now looking to PNAISH as they begin developing their own men's health policies. They are joining the growing movement, affirming that *men's health matters*.

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Annex 1 List of key informants

- **Marcos Nascimento** – Researcher at IFF/Fiocruz and former Executive Director of Instituto Promundo
- **Rita Flores Müller** – Post-Doctoral Researcher at Universidade Federal do Rio de Janeiro
- **Romeu Gomes** – Researcher and Faculty Professor at IFF/Fiocruz
- **Daniel Costa Lima** – Consultant and former PNAISH Men’s Health Unit member
- **Eduardo Schwarz (Chakora)** – Consultant and former PNAISH Men’s Health Unit general coordinator

Annex 2 Key informant interview guide

Background

- Can you tell me a little bit about yourself and what you do, and what your involvement has been, if any, with PNAISH?
- In your opinion, what is the problem in the world/Brazil that PNAISH is trying to address? How is it (or not) addressing the problem?
- How has the policy caused men to challenge stereotypes related to caring for their own health? What has been the impact of the policy on gender transformations and relations between men and women (e.g. girl's health, school attendance, violence, etc.)?

Evolution

- When and how was PNAISH created? What kind of actors were involved (civil society, NGOs, government, etc.)? How have these roles and relationships changed over the years?
- What kind of things were happening locally, nationally and/or internationally, that helped or (complicated) its creation?
- How has or hasn't PNAISH changed over the years? How has it adapted to the realities and issues present in Brazil over the years? How have different programs shifted? Has there been any shift in human / financial resources and/or partnerships?
- Do you have any interesting moment, memory or story that stands out in your mind?

Implementation

- In your opinion, how has the policy been implemented on the ground? How has it (or not) been effective? What kind of challenges and responding strategies have been undertaken?
- At the local health unit level, how is the policy solving the problem you mentioned earlier? How are different health units implementing PNAISH? Are there any similarities or differences, and to what are these due (in your opinion)?
- What else could be done at the local level to help PNAISH implementation? What kind of shift, if any, do you think is needed to help the implementation process?
- How has PNAISH coordinated implementation with other MoH departments? What about NGO/civil society or other actors? Are there any actors that have not been involved, but should be more involved in the implementation process?

Lessons learned and recommendations

- In your opinion, what would be the three to four actions that could improve PNAISH and its effectiveness in addressing the problem? What kind of recommendations would you make to the Brazilian Ministry of Health? What about other Ministries of Health interested in implementing similar policies?
- In your opinion, what would be the three to four key lessons and/or challenges to highlight about PNAISH as part of this case study? If you were the author of the case study, what kind of messages or best practices would be important to convey to others doing similar work?

Engendering Men: Evidence on Routes to Gender Equality' (EMERGE) is a two-year project to build an openly accessible basis of evidence, lessons and guidance for working with boys and men to promote gender equality, by early 2016. Supported by the UK Department for International Development (DFID) Leadership for Change Programme, a consortium of the Institute of Development Studies (IDS), Promundo-US and Sonke Gender Justice Network collaborates in reviewing and analysing existing evidence, in documenting lessons from the field and in developing guidance for improved learning, policy and practice.

Institute of Development Studies: www.ids.ac.uk/, Promundo-US: <http://promundoglobal.org/>,
Sonke Gender Justice: www.genderjustice.org.za/

Learn more about EMERGE, our work, our findings and our free resources on: <http://menandboys.ids.ac.uk/>



This publication is available on the Men, Boys and Gender Equality website at:
<http://menandboys.ids.ac.uk/evidence>