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Bárbara Fabrícia Silva¹ Girlene da Silva Alves²
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Challenges and perspectives in the implementation of the National Policy for Comprehensive Men's Health Care

Desafios e perspectivas na implementação da Política Nacional de Atenção Integral à Saúde do Homem

Desafíos y perspectivas en la implementación de la Política Nacional de Atención Integral a la Salud del Hombre

Bárbara Fabrícia Silva¹, Girlene da Silva Alves²

RESUMO:

Objetivo: Analisar a implementação da Política Nacional de Atenção Integral à Saúde do Homem, no município de Juiz de Fora, Minas Gerais. **Metodologia:** Trata-se de um estudo de natureza qualitativa. Participaram 33 gerentes das Unidades Básicas de Saúde, através de uma entrevista semiestruturada. O método de análise temática proposto por Bardin foi selecionado para o tratamento dos depoimentos. **Resultados:** Os achados foram organizados na categoria Atenção Primária à Saúde: desafios e perspectivas na implementação da Política Nacional de Atenção Integral à Saúde do Homem, que contemplou a invisibilidade da política de saúde do homem, bem como a organização da atenção básica para incorporar a referida política no sistema. **Considerações finais:** Percebeu-se que não basta, somente, a existência de um programa específico com propostas abrangentes de atendimento à saúde do homem, mas é preciso compreender e ajustar os caminhos e os desafios presentes nos locais onde as ações devem ser implementadas.

DESCRITORES:

Pesquisa qualitativa; Saúde do homem; Atenção Primária de Saúde; Saúde da família.

ABSTRACT:

Objective: To analyze the implementation of the National Policy for Integral Attention to Men's Health, in the city of Juiz de Fora, Minas Gerais. **Methodology:** This is a qualitative study. 33 managers of Basic Health Units participated, through a semi-structured interview. The thematic analysis method proposed by Bardin was selected

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¹Centro Universitário Presidente Tancredo de Almeida Neves, Faculdade de Enfermagem, Faculdade de Medicina. Endereço: Avenida Jose Caetano de Carvalho, N° 2199 - Jardim Central - São João Del Rei/MG CEP 36.307-251.

²Universidade Federal de Juiz de Fora, Faculdade de Enfermagem. E-mail: girlenealves.silva@ufjf.edu.br

for the treatment of the testimonies. **Results:** The findings were organized in the Primary Health Care category: challenges and perspectives in the implementation of the National Policy for Comprehensive Men's Health Care, which included the invisibility of the men's health policy, as well as the organization of primary care to incorporate the referred policy in the system. **Final considerations:** It was noticed that the existence of a specific program with comprehensive proposals for men's health care is not enough, but it is necessary to understand and adjust the ways and challenges present in the places where the actions must be implemented.

DESCRIPTORS:

Qualitative research; Men's Health; Primary Health Care; Family Health.

RESUMEN:

Objetivo: Analizar la implementación de la Política Nacional de Atención Integral a la Salud del Hombre, en la ciudad de Juiz de Fora, Minas Gerais. **Metodología:** Este es un estudio cualitativo. Participaron 33 gerentes de Unidades Básicas de Salud, a través de una entrevista semiestructurada. Para el tratamiento de los testimonios se seleccionó el método de análisis temático propuesto por Bardin. **Resultados:** Los hallazgos se organizaron en la categoría Atención Primaria de Salud: desafíos y perspectivas en la implementación de la Política Nacional de Atención Integral a la Salud del Hombre, que incluyó la invisibilización de la política de salud del hombre, así como la organización de la atención primaria para incorporar la política referida en el sistema. **Consideraciones finales:** Se percibió que la existencia de un programa específico con propuestas integrales para la atención a la salud del hombre no es suficiente, sino que es necesario comprender y ajustar las formas y desafíos presentes en los lugares donde las acciones deben ser implementadas.

DESCRIPTORES:

Investigación cualitativa; Salud del Hombre; Atención Primaria de Salud; Salud de la Familia.

INTRODUCTION

The issue of men's health in Brazil has been treated as a real public health problem based on statistics that showed higher rates of morbidity and mortality among men than among women. Men tend to adopt less healthy lifestyle habits than women, i.e., smoking, alcohol, sexuality, stress and work, which have a significant impact on the health of men⁽¹⁾.

The male resistance to primary care is responsible for the increase of financial costs with health, for the decrease of the quality of life of men and their families and for the impediment of avoiding aggravations that could be solved early in primary care⁽²⁾. In addition, health can suffer complications from any external or internal impairment that occurs in the life of a person and, Thus, men who do not regularly seek a basic unit have difficulties to feel supported and do not feel comfortable to attend these environments⁽³⁾.

Recognizing the context of male injuries as a public health problem, the Ministry of Health, SUS managers, scientific societies, organized civil society, academic researchers and international cooperation agencies presented, together, the National Policy of Comprehensive Health Care for Men (PNAISH) in 2008.

Yet men are still demonstrably dying more than women. According to the Mortality Information System (MIS), 874,167 men and 682,027 women died in Brazil in 2020. The main cause of death among men in the same year were diseases of the circulatory system, followed by infectious and parasitic diseases and neoplasms.⁽⁴⁾

It is worth remembering that in recent years, the Brazilian male mortality from chronic non-communicable diseases (NCDs), such as hypertension and diabetes mellitus, has been increasing. One of the justifications for this scenario is the fact that men do not have the habit of periodically attending medical appointments for routine health examinations, which makes them more vulnerable to death caused by diseases or conditions that could be prevented or treated early by the care provided by professionals involved in primary care⁽⁵⁾.

The national debate on the need for a field of men's health care originated in the United States in the late 1970s, when researchers compared men and women in both health and social issues. The disadvantage in high rates of male morbidity and mortality signaled health problems for men and contributed to gender debates⁽⁶⁾.

Men's health began to gain space in academia and politics in different countries – Australia and Ireland being considered pioneers in the formulation of focused policies aimed at men – in the second half of the 1990s. In Brazil, the theme of men's health gained visibility in the 2000s, with the participation of the Brazilian Society of Urology (BSU) in the control of prostate cancer. In 2005, the Science & Public Health Journal published a special edition discussing gender and masculinities⁽⁷⁾.

According to the PNAISH, sociocultural and institutional issues remove male users from health services. Gender stereotypes judge man as an invulnerable being and disease represents a weakness for him, who is afraid to discover that his health is not perfect. Men have difficulty recognizing their health needs because they feel unable to get sick. Given the concept of masculinity, society frames the man in the role of provider and the woman in the role of caregiver, a fact that contributes to the lack of demand for health services by men. In this perspective, the hours of operation of the BHU, queues and the immediate low resolution of health services are also pointed out as barriers to the demand for the health service⁽²⁾.

As for the guidelines, we have completeness, feasibility, coherence and feasibility. Comprehensiveness corresponds to continuity of care, considering the individual's unique situation. The feasibility refers to the availability of material, financial and human resources for the implementation of the recommended actions. In turn, coherence ensures compatibility with the principles of the SUS, while viability is related to the responsibility of the three management levels (Union, states and municipalities) and social control with the possibility of implementing the proposals present in the policy in question. Inter-

institutional articulation, reorganization of health actions and permanent education of SUS workers are proposed for the inclusion of men in health services⁽²⁾.

This Policy presents, as a general objective, the improvement of the health conditions of the male population, aiming at reducing morbidity and mortality among men and prioritizing primary care as a gateway to a universal, integral and egalitarian health system⁽²⁾.

The evaluation of the implementation and implementation of PNAISH is interesting to verify its effectiveness and influence on the quality of life of the male population, despite its weaknesses, contributing to improve the actions related to this policy. This process occurs according to the deliberations defined at the federal, state and municipal level, in addition to the plans, programs and projects resulting from the policy. It is also important to evaluate the contribution of this policy to the reaffirmation of the principles and guidelines of the SUS established⁽²⁾.

In this context, this article aims to analyze the implementation of PNAISH in the city of Juiz de Fora, Minas Gerais, from the perspective of managers.

METHODOLOGY

Type of study and methodological procedures

Considering the object of this research, we chose to carry out a qualitative approach on the implementation of PNAISH in the municipality of Juiz de Fora - MG, since the study intends to investigate subjective processes of a social phenomenon involved in the health-disease in the male perspective.

The qualitative approach considers that there is a dynamic relationship between the real world and the subject, that is, an inseparable link between the objective world and the subjectivity of the subject⁽⁸⁾. Thus, qualitative research explores a reality that is not allowed to quantify, but rather to understand subjectivity from a universe of meanings, motives, aspirations, beliefs, values and attitudes⁽⁹⁾.

Anchored in the qualitative approach, it was intended to achieve a thorough understanding of the perspectives, anxieties, expectations, frustrations, beliefs, desires, behaviors, attitudes and representations of the FHS teams of the city of Juiz de Fora - MG about the health of man.

The guide adopted to carry out the structuring of the research was the Standards for Reporting Qualitative Research (SRQR).

Place of study

The study was conducted in the city of Juiz de Fora – MG. To meet the proposed objectives, the data collection sites were the BHU that have FHS. Of the 63 BHUs, 21 of them were excluded from the study because they did not have FHS. The study scenario was composed of the remaining 42 BHUs with FHS, chosen for convenience.

Data source

The study participants were 33 managers of the FHS teams deployed in the city of Juiz de Fora - MG. Among the individuals able to participate in the research, three professionals who were absent at the research site were excluded, because they were enjoying the vacation period and/or medical certificate during data collection, two for not being present at the place and scheduled time, in addition to two who refused to participate and two who could not establish telephone contact.

Data collection and organization

The instrument used to collect data from municipal managers was a semi-structured interview, questioning the situation of implementation and effectiveness of PNAISH in the city of Juiz de Fora - MG. The principles, guidelines and objectives proposed in the PNAISH were included in the questions.

Data were collected in the first half of 2022. The interviews were recorded in order to ensure the reliable reproduction of the participants' speeches and will be held by the researcher for a period of five years. After that time, they will be destroyed.

Work stages

After the approval of the project by the Ethics Committee, the telephone contact was initially made with the managers of the BHU to schedule the field interviews. In a second moment, the project was presented personally by the facilitators to the study subjects, in order to clarify the objectives and any doubts that might exist regarding their participation in the process. Subsequently, data were collected.

Data analysis

Within the modalities of content analysis, thematic analysis was chosen, following the three stages described, proposed by Bardin: Pre-analysis: Exploration of the material; Treatment of the results obtained and interpretation⁽¹⁰⁾.

Following the propositions for data analysis and interpretation, the following category was constructed and named: Primary Health Care: challenges and perspectives in the implementation of PNAISH. In order to organize the analysis and detail the proposed theme, the following subcategories were also constituted: invisibility of PNAISH to face the health issues of men and organization of primary care to contemplate the PNAISH.

Ethical aspects

In order to preserve the confidentiality of the participants, they were identified by the letter G, followed by consecutive Arabic numbers, in ascending order, according to the number of respondents (G1 to G33). Data collection took place after the approval of the project by the Research Ethics Committee of the Federal University of Juiz de Fora, under the Opinion N 5,016,739 of October 4, 2021.

RESULTS AND DISCUSSION

The proposition of a study on the implementation of actions in men's health in the city of Juiz de Fora - MG intended to understand how the PNAISH, released more than ten years ago, has mobilized the FHS teams and what are the challenges to meet their objectives.

Challenges and perspectives in implementing the National Policy for Comprehensive Assistance to Men's Health

Among the challenges and perspectives for the implementation of the PNAISH, the following questions were analyzed: invisibility of the PNAISH for coping with men's health issues and organization of primary care to contemplate the PNAISH.

Invisibility of the National Policy for Comprehensive Assistance to Men's Health coping men's health issues

In this subcategory, we will analyze the representativeness of the male health program in primary care when compared to other programs, such as those focused on the health of children and women. The clipping of the interview, then, brings a representation that distances the male audience from the practices of primary care:

I think there could be more content available for this population and for us employees, for us to organize more, because we think a lot about the health of women, a lot about the health of children and little about the health of men (G2).

For most respondents, the dichotomy between women's health and men's health is clear. The discussion is endorsed by saying that children, adolescents, women and the elderly are the preferred groups for the creation of public policies and, consequently, for comprehensive care⁽¹¹⁾.

In fact, men are usually served by programs already aimed at other segments of the community. There is no specific program for men, especially for young adults in the reproductive phase, making it difficult to exercise comprehensive care⁽¹²⁾. Other authors report that one of the factors that impairs the access of the male public to primary health care services is the direction of public policies, mostly to women and children⁽¹²⁾. This situation is reaffirmed by the following statement:

[...] So people in relation to the health of men we are very at the mercy, we have nowhere to refer I do not have a more specific service, a specific department, as I have a women's department, the children's department, we do not have a man's (G3).

The health professionals interviewed also highlighted that campaigns that involve the female audience are much more prominent when compared to those aimed at men, such as November Blue. In some reports, they said that interventions aimed at men are punctual and therefore do not continue as in women's health care:

And it is given importance in Blue November, in Blue November happens, now in addition we do not see poster very often so "man, take care of your health... man, it's important that you do this... man".

Now "woman, do prenatal care", this always has, always take care of it not only on a specific date (G26).

Even the ambience is mostly aimed at the female audience. As ambience also refers to humanization and interpersonal relationships, BHUs end up causing discomfort and lack of confidence in men⁽¹³⁾. The following statements support the assertions on the subject:

Gynecologist we have in the network, right? But the urologist is more complicated. (G9)
[...] I think that the issue of women's health has already been so discussed, that today, as the demand for BHU is much more for women, and there is a demand and supply also much greater in women's health than in men's health. [...] I realize that it is much more difficult for me to appoint an urologist or a proctologist than a gynecologist (G26).

Thus, the distancing of men from BHUs happens precisely because of the great offer of actions aimed at children, women and the elderly, characterizing men as supporting these spaces. It is worth remembering that one of the ways to ensure quality health care for men is to act jointly with other existing programs and policies⁽¹⁴⁾.

The negative representation of health services seems to interfere with the behavior of seeking and adherence to treatment, especially by men. PNAISH is considered, even after more than ten years of its publication, only a new policy that is beautiful in theory, but in practice is still discredited both by professionals and managers, as well as by men themselves.

Organization of primary care to comply with the National Policy for Comprehensive Assistance to Men's Health

In this subcategory, we will highlight the challenges that the PNAISH implementation process faces. It is possible to infer, in this case, that men who seek the health service often face difficulties to access it, which result from organizational and not only sociocultural accessibility, as emphasized by PNAISH.

According to the authors, the lack of reception or inadequacy of the same and the fragility of information about the services available in the health units are considered highlights among the factors that hinder the access of the male public to health services⁽¹⁵⁾. The following speech shows the difficulty of welcoming the man, ensuring the completeness of care:

The appointment of an urologist is difficult, even if we receive here in the unit right, which is the gateway. That way, the patient gets stuck in the system. Even if he has an enlarged prostate and needs a rectal touch, if he is already with something altered, we have difficulty in the city to be referring this patient, okay? (G14).

In this context, a significant number of participants admitted having access to the urologist only through partnership with public and private educational institutions in the city. Even so, these calls are sporadic, usually during campaigns such as Blue November. In the next passage, this difficulty of referring a man to a specialist is clear:

[...] one thing that has made it very difficult for us to develop this work November Blue is the help of professionals, specific professional with urologist another doctor who is clinical to be helping us meet a greater demand (G10).

Another difficulty is the lack of offers of exams of medium complexity, since the system is not able to absorb the great demand. Thus, men, who are usually immediate, need to wait and/or face long queues in the attempt to solve problems, a fact that contributes to disbelief in the work of professionals and in the health system⁽¹⁴⁾.

Another feeling found in the answers given is about the timeliness of actions aimed at the male audience. These actions are not part of the routine of the BHU, that is, there is no continuity of them after the events. The month Blue November was the intervention most related to PNAISH. This manager mentions the impasse described:

So in the question of theory, in the theoretical part of politics, we see that it is very good, but in reality the implementation is flawed, understood? Because we do not see, it is more in this period of Blue November, the rest of the year we deal more with the issue of groups, and see more comprehensive health issues (G5).

Actions aimed at the health of men are considered by some authors as sporadic. As stated, for this reason, they are not incorporated in man's daily life and are not associated with preventive actions of the Ministry of Health⁽¹³⁾.

Generally, the themes involving men revolve around the genital system and sometimes the circulatory system. Meanwhile, other scholars share the same opinion, commenting that both assistance and events related to sexual health and the male genital system are always centered on the prevention of prostate cancer⁽¹⁵⁾, as explained in the following reports:

[...] Blue November - but punctually related to prostate cancer, got it? Without doing that comprehensive health survey, that attachment of the user to the BHU (G31).

Some studies justify the failures related to the implementation of PNAISH from the professional preparation below the necessary to deal with specific issues of this public. As previously mentioned, managers do not know the principles and guidelines of PNAISH and training is not offered for teams to improve the quality of human assistance⁽¹⁶⁾.

The FHS professionals themselves are responsible for the gaps in the management and programming of actions to implement PNAISH. In fact, the proposals of the teams for incorporating men in primary care are non-existent and/or unattractive⁽¹⁴⁾. Still on the subject, there is a failure in the provision of services offered by the network focusing on the promotion of men's health⁽¹⁷⁾. During the interviews, this unpreparedness became clear among health professionals. The following speech illustrates the findings presented:

I think, both in relation to knowledge and professionals trained to be welcoming this population, right? I think it lacks physical structure, lack human structure, training to welcome these men, for us to get to them, right? (G25).

It is pertinent to highlight that the existence of specific departments for the organization of the system, contributes to the recognition of the demands of that portion of the population and, consequently, to the direction of the flow, besides facilitating the user's path. In the municipality where the study was carried out, there is no department of men's health and thus no specialized managers for the care of the male public, as explained in the following statement:

[...] in public policy toward man, it needs more investment, it needs a different look because it does not exist, it does not have a program that is specific to man (G23).

Regarding the turnover of professionals, interviewee G34 points out that, despite the difficulties, the team is aware of the need for improvement and still yearns for these changes. However, they encounter barriers that they often fail to overcome:

But I think there is a will, but I think that this way we are all much barred on the issue of weakening these teams, that usually they are constituted in a short time and are also undone always entering new professionals, always professionals joining a team (G34).

Another aspect commented is the lack of knowledge of the local reality, whether of the services and/or the community in which the teams are inserted, making joint actions and partnerships difficult.⁽¹⁸⁾ In this statement, for example, the interviewees point to the existence of several areas without coverage, which therefore do not have any type of situational diagnosis:

We serve a lot, we meet every day an exaggerated demand, we cannot keep separating this data because the teams are reduced, the territory is too wide for a very small number of professionals, we have twelve microareas and I have six community agents, that is, 50% is discovered (G23).

The deponents highlighted the scarcity of counter-reference and return of the data collected, that is, there is no compilation and interpretation of the information so that the team can dwell and plan for care. Sometimes, even, there is no intersectoral communication. This is also due to the computerization of the units, which is often precarious. These shortcomings are made clear in the following speech:

[...] we have daily service records, so these are the forms that we fill out and that we write down and these records go to the health department to be scanned and we do not have a return of these data, we do not have the consolidated service that we do (G12).

There are reports that mention the difficulty in obtaining materials and inputs for the realization of campaigns and events directed to man, in addition to referral to a specialized professional, because of the incompleteness of the team:

[...] resource for health always scarce always lacks something for us, equal at the moment lack material inputs for us to work, our structure is very precarious, and so it ends up failing in some things like this (G7).

[...] sexual dysfunction and infertility and responsible paternity this would then have to be referring to the gynecologist and the urologist we do not have (G9).

In contrast to the previous statements, the G32 participant comments that there are sufficient financial resources for the implementation of human health, but there is a lack of adequate allocation of them to ensure effective assistance:

The city receives money, receives this ability to attend, but we have to have the ability to organize, lack organization (G32).

The study participants also mentioned the issue of system scrapping, mainly related to work overload and accumulation of demands that arise without a specific orientation. The team ends up getting lost before the objectives to be met and do not achieve a satisfactory result. The following statement confirms these questions:

We have a lot of work overload in primary care that we do not have time to prioritize a group, and this ends up getting to be desired I think we could be better there (G4).

Even prevention, which is one of the central objectives of primary care, is difficult for professionals to implement, as the witness points out in the following speech:

Now for a healthy person, who sometimes have to do prevention so that it does not happen, for example, the father died with prostate CA or the father has, and do a follow-up of the child that may have a certain age and such... that's not. Follow-up is for the patient. Family prevention is not (G22).

When asked about the implementation of PNAISH in the municipality of Juiz de Fora over these 13 years since its publication, respondents were not very optimistic, as explained in the following excerpts:

Otherwise, the policy itself, the implementation of actions is still very precarious. [...] I do not see a policy being disclosed, an effort of a larger sphere to charge the State, charge the Municipality to be implemented even, to happen in practice, I do not see this charge (G28).

It is noticed that many professionals deny the existence of at least one attempt to implement PNAISH by federal, state and local managers. Some have highlighted the lack of a physical space intended as an exclusive reference for man:

[...] we have the health department of the elderly, the health department of the woman, the child and the adolescent, where in the health department of the woman, the child and the adolescent where the referrals for vasectomy are made and some other things. I do not know and if I do not know I believe that there is no department of men's health (G26).

The unavailability of inputs, equipment and educational materials was also recognized as an obstacle in the implementation process of the policy in question, even being one of the principles of humanization and quality to be complied with in accordance with the PNAISH. The evidence clippings make it clear that resources are lacking:

But, in practice, we cannot observe these resources and scientific and technical inputs, from support, qualification, training, even materials so that we can develop it – PNAISH –, right? (G25).

Health professionals pointed out that the actions that count on the participation of men are offered, but are not specific to the public. This fact inhibits the male user and, consequently, removes him from health care. From the speeches it is possible to notice that men are allowed to seek participation in educational groups, consultations, vaccination and other activities, but there is not the particularity necessary to achieve the solution of the problems that affect this portion of the population. This idea is described in the speech:

Unfortunately, what we get in this audience are groups of hypertensive, diabetic but we do not always get this focus, focusing on man in an integral way right (G3).

This policy is more a public policy with bias in social inclusion. It seeks to expand the rights of men and reduce the inequalities and weaknesses of this portion of the population with regard to health care⁽¹¹⁾. However, a significant part of the speeches mentioned the Blue November campaign as the only moment of exclusive welcome to the man inserted in the community. Thus, the professionals used this specific moment as a representation of the implementation of PNAISH:

So I work here will make three years right? But here I never saw the implementation, right? The question of Blue November, what seems that only part is seen right? From prostate cancer and does the task force, and asks for PSA, because when I did not have COVID I did the task force and lectures, but it was this November during the other months while I was here I never saw something specific (G6).

The members of the FHS still feel lost because they are not able to attract men to care and do not have enough time to develop effective strategies to attract this user to primary care services⁽¹⁹⁾.

In an attempt to undo the image that a sick man is a weak man, it is necessary to seek awareness of the importance of considering the user holistically and make him understand this need⁽¹²⁾. One of the clippings of the speeches recognizes the complexity of the masculine being and says that it is not only the alterations of the prostate, but other manifestations related to physical, social and mental well-being must be contemplated:

[...] not only the prostate, the health of the man does not symbolize that his health is a healthy prostate not, it is a whole process of the health of this man, everything that involves the body, the physical, the mind, the food, the housing, the sexual part, is all this, it has to be turned to the man, right? (G34).

For the implementation of PNAISH to be consolidated, a task force is needed by health professionals, managers and men. All agents need to be aware of the diagnosis, planning and implementation of actions in order to truly materialize⁽¹⁹⁾. Two participants disagreed with the others and were able to understand the implementation and implementation of PNAISH in the health units in which they operate, as indicated by the following passages:

Look, we here at BHU, we end up serving this population right? Because they seek BHU and the municipality offers, like other years right? Previous years, prostate examination, lectures and guidelines, then had a certain implementation yes this policy in the municipality (G7). [...] Today, you have a level of exams that you can ask for in primary care and more than 80% of diseases today, both by the level of medications that you have in primary care, more than 80% can be followed and treated in primary care (G34).

It is opportune to emphasize that, in general, the process of effectuation of PNAISH is still shy and below the initial proposals for this public. A sum of elements culminates in the stagnation of public policy, which has as general objective the promotion of the improvement of health conditions of the male population of Brazil.

Study limitations

The limitations of the study were due to the absenteeism of health professionals in the units. Several professionals presented medical certificates and were away from work at the time of data collection and the teams were incomplete, making it impossible to apply the questionnaire in all units of the municipality.

In addition, the COVID-19 pandemic was responsible for a series of changes in the routine of BHU and, at the time of data collection, primary care was not yet restructured in this sense, interfering with the data collected.

Study contributions

It is believed that the study could make clearer the way the managers of the FHS teams perceive the practices aimed at man as a user of a health system. This means that it is not enough just the existence of a specific program, verticalized and with comprehensive proposals for health care of man, but we need to understand the ways, the resources available and the needs of man so that the service is qualified and individualized.

FINAL THOUGHTS

The health of men is a theme that fosters expectations and controversies, involving the most diverse representations in the health and disease process of this public, both by health professionals and also by man as the protagonist of politics. To implement the PNAISH, it is necessary to break with the biomedical model of assistance. Therefore, men need to recognize the importance of disease prevention and also take responsibility for the care of their health, supported by the FHS.

Health professionals should be able to demonstrate to men that the presence or absence of health is closely linked to the social, economic and cultural factors that make up their lives. The BHUs

must be prepared to serve the man in all its completeness, both in relation to the human resources trained and also in relation to the financial and structural resources of quality and sufficient for this purpose.

Given the above scenario, it is clear that for the PNAISH to be consummated, SUS leaders, at the municipal level, need to understand the Policy and its propositions, since it is the scope responsible for its implementation, development and evaluation in line with the SUS regulation. In order to achieve these objectives, managers and FHS teams need to meet to discuss the health of men and stipulate goals to be met and action strategies, as well as calculate and provide adequate funding to achieve PNAISH. In addition, it is essential the practice of continuing education aimed at enabling health professionals to develop strategies to assist the male demands and problems of the SUS.

The speeches show that health professionals are aware of the weaknesses of the health system, but clash with institutional, organizational and financial barriers to follow the process, the implementation and implementation of PNAISH effectively in the municipality. In the study, it was found that the implementation of PNAISH in the municipality of Juiz de Fora is below the formality suggested in the policy and, therefore, its execution did not occur effectively in the health units addressed. It is necessary to rethink strategies capable of generating more significant results with regard to their implementation.

Given the information seized, it is considered that the results allowed us to answer the questions proposed in the study. However, it is suggested that the theme is not exhausted in this study. It is necessary to evaluate other components that contribute to the implementation of PNAISH, including in other levels of health care and in other Brazilian municipalities.

REFERENCES

1. Carrara S, Russo JA, Faro L. A política de atenção à saúde do homem no Brasil: os paradoxos da medicalização do corpo masculino. *Physis: Revista de Saúde Coletiva*. 2009;19(3):659–78. Disponível em: <https://doi.org/10.1590/S0103-73312009000300006>
2. Brasil. Secretaria de atenção à saúde departamento de ações programáticas estratégicas política nacional de atenção integral à saúde do homem (Princípios e Diretrizes) [Internet]. Disponível em: https://bvsms.saude.gov.br/bvs/publicacoes/politica_nacional_atencao_homem.pdf
3. Elias BK, Gervásio VL, Dell’Acqua MAQ, Silva JAT da, Lima MJ de, Silva NMMG. Avaliação do acesso e acolhimento de homens na atenção básica: revisão de literatura. *Brazilian Journal of Development*. 2021;7(3):22582–90. Disponível em: <https://ojs.brazilianjournals.com.br/ojs/index.php/BRJD/article/view/25845/20514>

4. Brasil. Informações de saúde. Mortalidade – Brasil. Óbitos por residência segundo sexo [Internet]. DATASUS. BRASIL; 2020 [cited 2021 May 15]. Disponível em: <http://tabnet.datasus.gov.br/cgi/tabcgi.exe?sim/cnv/obt10br.def>
5. Medeiros MF, da Paz Fernandes RA, Soares JR, Souza Thomaz M dos A, Araújo Gomes WL, Mascarenhas Xavier ZD. Programa de assistência à saúde do homem: dificuldades e relevância da ação da enfermagem. Revista Eletrônica Estácio Saúde [Internet]. 2021 Jan 28 [cited 2023 Apr 13];10(01):8. Disponível em: <http://periodicos.estacio.br/index.php/saudesantacatarina/article/view/6615>
6. Costa CRM da. A evolução histórica do debate sobre saúde do homem: a construção da saúde integral. Revista Eletrônica da Estácio Recife [Internet]. 2020 Oct 29;6(1). Disponível em: <https://reer.emnuvens.com.br/reer/article/view/429>
7. Hemmi APA, Baptista TW de F, Rezende M de. O processo de construção da Política Nacional de Atenção Integral à Saúde do Homem. Physis: Revista de Saúde Coletiva. 2020;30(3). Disponível em: <https://doi.org/10.1590/S0103-73312020300321>
8. Chizzotti A. Pesquisa em ciências humanas e sociais. São Paulo (Sp): Cortez; 2008.
9. Minayo MC de S. Análise qualitativa: teoria, passos e fidedignidade. Ciência & Saúde Coletiva [Internet]. 2012 Mar 1;17(3):621–6. Disponível em: <https://doi.org/10.1590/S1413-81232012000300007>
10. Bardin L. Análise de conteúdo. 5th ed. Edição 70, editor. Lisboa.
11. Pereira J, Klein C, Meyer DE. PNAISH: uma análise de sua dimensão educativa na perspectiva de gênero. Saúde e Sociedade [Internet]. 2019 Jul 1 [cited 2021 Nov 14];28:132–46. Disponível em: https://www.scielo.br/scielo.php?script=sci_arttext&pid=S0104-12902019000200011
12. Souza LPS e, Almeida ER, Queiroz MA, Silva JR da, Souza AAM de, Figueiredo MFS. Conhecimento de uma equipe da estratégia saúde da família sobre a política de atenção à saúde masculina. Trabalho, Educação e Saúde. 2014 Aug;12(2):291–304. Disponível em: <https://doi.org/10.1590/S1981-77462014000200005>
13. Vasconcelos ICB de L, Prestes JYDN, Ribeiro RRS, Lima SJL, Farias SDCF, Barbosa LD dos S, et al. Política nacional de atenção integral a saúde do homem e os desafios de sua implementação. Brazilian Journal of Development. 2019;5(9):16340–55. Disponível em: <https://ojs.brazilianjournals.com.br/ojs/index.php/BRJD/article/view/3418/3255>
14. PEREIRA SL. A invisibilidade da saúde do homem na Atenção Básica [undergraduate thesis]. Brasília: Faculdade de Enfermagem, Universidade de Brasília; 2017. 42 p. Disponível em: https://bdm.unb.br/bitstream/10483/23302/1/2017_ShirleyLopesPereira_tcc.pdf

15. Nobre J de P, Freitas CA de. Aspectos relacionados à implementação da Política Nacional de Atenção Integral à Saúde do Homem (PNAISH) no Brasil. Espaço para a Saúde - Revista de Saúde Pública do Paraná. 2021 Nov 23;22:1–7. Disponível em: <https://docs.bvsalud.org/biblioref/2022/01/1353787/794-texto-do-artigo-2667-1-10-20211123.pdf>
16. Lima CM de, Arruda HAA de, Rocha RPS, Silva RA da, Agulhó DLZ, Magalhães D dos SS. Desafios de enfermeiras frente à saúde do homem na atenção básica. Research, Society and Development. 2021 Jan 19;10(1):e38810111885. Disponível em: <https://rsdjournal.org/index.php/rsd/article/view/11885>
17. De Oliveira Meneses M, Ângela M, Cardoso D, Anjos, Verônica R, Carvalho S, et al. O planejamento estratégico situacional como ferramenta de gestão na atenção primária em saúde Situational strategic planning as a management tool in primary health care. Brazilian Journal of Surgery and Clinical Research -BJSCR BJSCR [Internet]. 2019;28(4):2317–4404. Disponível em: https://www.mastereditora.com.br/periodico/20191110_131936.pdf
18. Souza LV da SA de, Silva J de O, Nodari PRG, Alencar BT de, Silva RB, Aleixo MLM. Desafios da implementação da Política Nacional de Atenção Integral a Saúde do Homem em Mato Grosso. Research, Society and Development. 2022 Jan 18;11(2):e5311225354. Disponível em: <https://rsdjournal.org/index.php/rsd/article/view/25354>
19. Figueiredo SCG de, Santos CAM dos, Carminé LO do V, Ribas LF, Carmo W do SP do. Políticas públicas e saúde: Um direito de todos. Editora Poisson; 2020.