Review Article

Global challenges of health policies aimed at the male population: an integrative review

Desafios globais das políticas de saúde voltadas à população masculina: revisão integrativa

Desafíos globales de las políticas de salud dirigidas a la población masculina: revisión integradora

Cácia Régia de Paula[1] https://orcid.org/0000-0001-9781-2918
Flavio Henrique Alves de Lima[2] https://orcid.org/0000-0001-6109-5152
Bruno Bordin Pelazza[3] https://orcid.org/0000-0003-2245-6482
Marcos André Matos[1] https://orcid.org/0000-0001-8643-7032
Ana Luiza Lima Sousa[2] https://orcid.org/0000-0002-7566-3541
Maria Alves Barbosa[2] https://orcid.org/0000-0002-0861-9655

How to cite:
Paula CR, Lima FH, Pelazza BB, Matos MA, Sousa AL, Barbosa MA. Global challenges of health policies aimed at the male population: an integrative review. Acta Paul Enferm. 2022;35:eAPE01587.

DOI
http://dx.doi.org/10.37689/acta-ape/2022AR00015877

Keywords
Men's health; Health policy; Men; Police formation

Descritores
Saúde do homem; Política de saúde; Homen; Formação de políticas

Descriptores
Salud del hombre; Política de salud; Hombre; Formulación de políticas

Submitted
June 14, 2021

Accepted
April 25, 2022

Corresponding author
Cácia Régia de Paula
E-mail: cregia@ufg.br

Associate Editor (Peer review process):
Thiago da Silva Domingos
(https://orcid.org/0000-0002-1421-7468)
Escola Paulista de Enfermagem, Universidade Federal de São Paulo, SP, Brazil

Abstract

Objective: To analyze scientific publications regarding the challenges for the construction and insertion of health policies aimed at the male population in Brazil and in the world.

Methods: This is an integrative literature review with the inclusion of studies that discussed men's health policies. Search was performed in July 2020 and January 2022 in the Public/Publish MEDLINE (PubMed), Scopus, Embase and Web of Science databases. Articles in Portuguese, Spanish and English were included, without restriction of publication date. The searches were obtained by crossing the bases with the following descriptors: Men's Health, Health Policy, Men.

Results: A total of 1,709 articles were identified. After the selection and analysis process, 29 studies made up the sample. It was found that 79.5% of studies were conducted in Brazil, 6.9% in the United Kingdom, 3.4% involving countries on the Asian continent, 3.4% in Ireland and Australia, 3.4% in Scotland and 3.4% in the European Union. They were published between 2008 and 2021. From the analysis, the following categories emerged: *Lack of knowledge and recognition of male policies*; *(De)construction of male policies*.

Conclusion: Regardless of the country, gender stereotypes and the inability of managers, health professionals and men themselves to recognize the policy were the main challenges in the construction and insertion of policies for the male population. It is considered necessary to legitimize comprehensive care for men as a social movement and governmental policy, aiming at improving the quality of management and clinical practice.

Resumo

Objetivo: Analisar as publicações científicas quanto aos desafios para construção e inserção das políticas de saúde voltadas à população masculina no Brasil e no mundo.

Métodos: Revisão integrativa da literatura com inclusão de estudos que discorreram sobre políticas de saúde do homem. Busca realizada, em julho de 2020 e janeiro 2022 nas bases de dados: Public/PublishMedline (PUBMED), Scopus, Embase e Web of Science. Incluíram-se artigos nos idiomas português, espanhol e inglês, sem restrição de data de publicação. As buscas foram obtidas pelo cruzamento nas bases com os seguintes descritores: *Men's Health, Health Policy, Men*.

Resultados: Foram identificados 1709 artigos. Após o processo de seleção e análise, 29 estudos compuseram a amostra. Verificou-se que 79,5% dos estudos foram conduzidos no Brasil, 6,9% no Reino Unido, 3,4% envolvendo países do continente asiático, 3,4% na Irlanda e Austrália, 3,4% na Escócia e 3,4% União Europeia. Foram publicados no período entre 2008 e 2021. Da análise emergiram as categorias: Desconhecimento e reconhecimento da política masculina e (Des) construção da política masculina.

[1]Faculty of Nursing, *Universidade Federal de Goiás*, Goiânia, GO, Brazil.
[2]Faculty of Medicine, *Universidade Federal de Goiás*, Goiânia, GO, Brazil.
[3]Department of Nursing, *Universidade Estadual do Centro-Oeste*, Guarapuava, PR, Brazil.
Conflicts of interest: nothing to declare.

Conclusão: Independentemente do país, os estereótipos de gênero e a inabilidade dos gestores, profissionais de saúde e dos próprios homens em reconhecer a política foram os principais desafios na construção e inserção das políticas para a população masculina. Considera-se necessária a legitimação da atenção integral ao homem como movimento social e política governamental, visando à melhoria da qualidade da gestão e prática clínica.

Resumen

Objetivo: Analizar las publicaciones científicas con relación a los desafíos para la construcción e inserción de las políticas de salud dirigidas a la población masculina en Brasil y en el mundo.

Métodos: Revisión integradora de la literatura con inclusión de estudios que tratan sobre políticas de salud del hombre. Búsqueda realizada en julio de 2020 y enero de 2022 en las bases de datos: Public/PublishMedline (PUBMED), Scopus, Embase y Web of Science. Se incluyeron artículos en los idiomas portugués, español e inglés, sin restricción de fecha de publicación. Las búsquedas se obtuvieron por el cruce en las bases con los siguientes descriptores: *Men's Health, Health Policy, Men*.

Resultados: Se identificaron 1.709 artículos. Después del proceso de selección y análisis, 29 estudios compusieron la muestra. Se verificó que el 79,5 % de los estudios se condujo en Brasil, el 6,9 % en Reino Unido, el 3,4 % en países del continente asiático, el 3,4 % en Irlanda y Australia, el 3,4 % en Escocia y el 3,4 % en la Unión Europea. Fueron publicados en el período entre 2008 y 2021. Del análisis surgieron las categorías: Desconocimiento y reconocimiento de la política masculina y (Des)construcción de la política masculina.

Conclusión: Independientemente del país, los estereotipos de género y la falta de habilidad de los gestores, de los profesionales de salud y de los propios hombres para reconocer a la política fueron los principales retos en la construcción e inserción de las políticas para la población masculina. Se considera necesaria la legitimación de la atención integral al hombre como movimiento social y política gubernamental, con la finalidad de mejorar la calidad de la gestión y de la práctica clínica.

Introduction

The male population's health represents a problem of great global magnitude, which requires investment from government managers and the scientific area. Morbimortality rates in national and international epidemiological profiles have remained high, making the life expectancy of men, in 2016, 4.4 years lower than that of women, especially in low-income countries.[1-3]

The low adherence of men to health services seems to be related not only to gender issues themselves, but also to the influences of psychosocial and cultural aspects, denoting that the male public, it seems, is not the focus of action of existing health policies.[3-5]

The male population has not received specific attention from international regulatory bodies and managers of organizations that develop and implement strategies to improve global public health. Only Brazil, Australia, Ireland and Iran have specific policies for men and, even so, they are still incipient.[5,6]

Faced with the life expectancy of men, the growing increase in morbidity and mortality rates, the need to offer quality health services that cover men in their specificities, research on existing national and international health policies aimed at this population segment still lacking health care becomes of great importance.

Knowing the policies that deal with men's health can help to identify which policy dimensions need to be strengthened so that this group has its demands met in a comprehensive and equitable way. Additionally, it has the potential to strengthen existing policies as well as subsidize countries that do not have gender-based policies. This study proposes to analyze scientific publications related to the challenges for the construction and insertion of health policies aimed at the male population in Brazil and in the world.

Methods

This is an Integrative Literature Review conducted according to methodological steps in evidence-based practice proposed in the literature and the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) recommendations.[7,8]

The study followed six steps: research question elaboration; establishment of inclusion and exclusion criteria; definition of information to be extracted from the studies; assessment of included studies; interpretation of results and synthesis of knowledge.[8]

The guiding question formulation considered the acronym PVO,[9] where P: male population, V: National and international challenges and O: Implementation of public policies aimed at male

health. The review sought to answer the guiding question: What is the scientific evidence related to the challenges for the construction and insertion of health policies aimed at the male population in Brazil and in the world? The review sought to answer the guiding question: What is the scientific evidence related to the challenges for the construction and insertion of health policies aimed at the male population in Brazil and in the world?

The search was carried out in the Public/Publish MEDLINE (PubMed), Scopus, Embase, Web of Science databases, using the Portal of Journals of the Coordination for the Improvement of Higher Level Personnel (CAPES - *Periódicos da Coordenação de Aperfeiçoamento de Pessoal de Nível Superior*)/ Ministry of Education (MEC), which is a virtual library that stores and makes available to teaching and research institutions, national and international scientific production.[10]

Descriptors and terms were through the Descriptors in Health Sciences (DeCs)/Medical Subject Headings (MeSH): Men's Health, Health Policy, Men. The search strategy used for MEDLINE/ PubMed was as follows: (*Saúde do Homem* [Title/ Abstract] OR Men's Health [Title/Abstract] OR *Salud del Hombre*) [Title/Abstract] AND (*Política de Saúde* [Title/Abstract] OR Health Policy [Title/ Abstract] OR *Política de Salud*) [Title/Abstract] AND (*Homens* [Title/Abstract] OR Men [Title/ Abstract] OR *Hombres*) [Title/Abstract]. The survey was carried out in July 2020 and January 2022.

The articles were assessed according to title and abstract, by two independent researchers, who verified the presence of established inclusion criteria. In cases of divergence, a thorough study reading and discussion was carried out, and if there was no consensus, a third researcher decided on the inclusion or exclusion of studies. The PRISMA flowchart[7] was used to document the number of articles at each stage of screening (Figure 1).

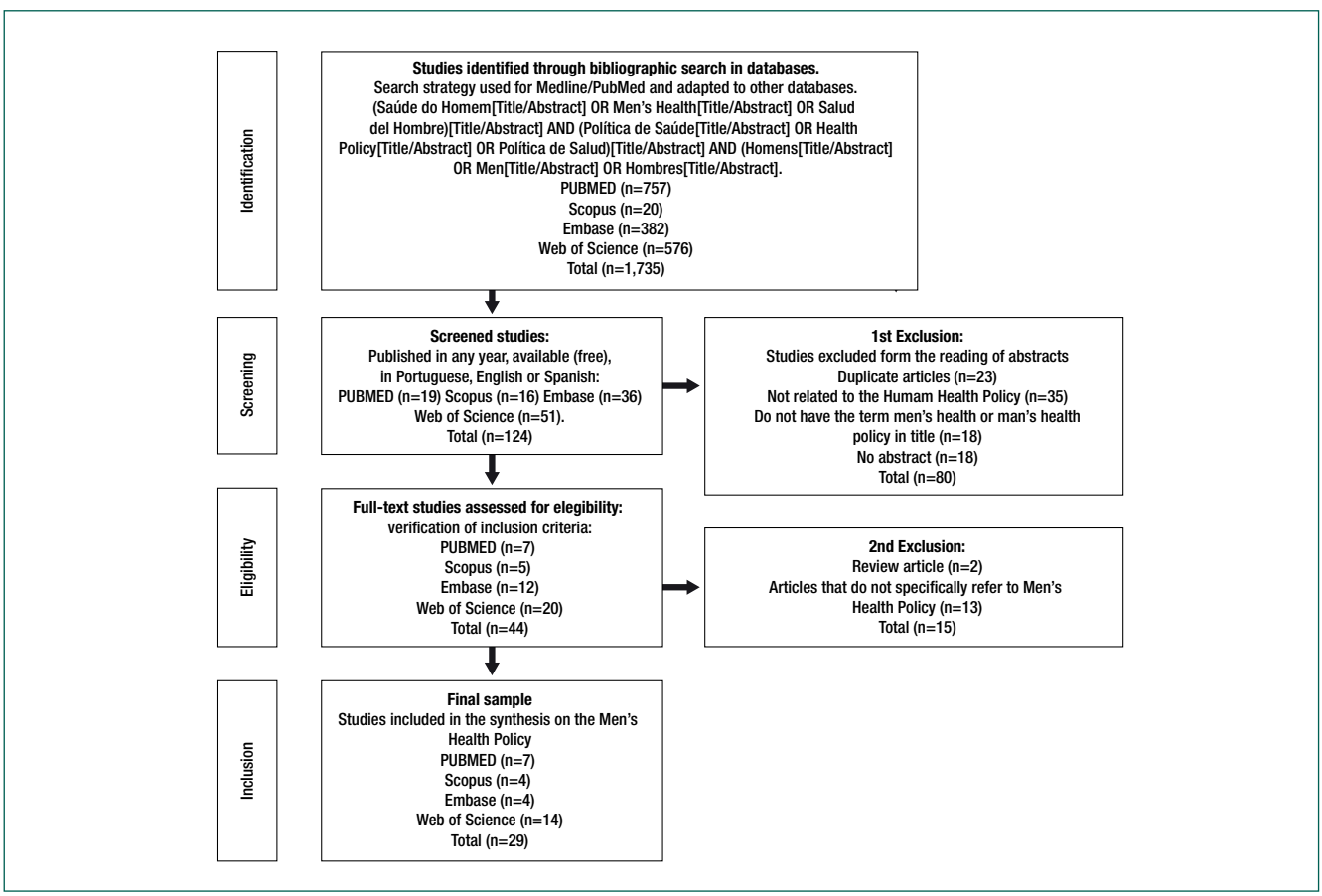

Figure 1. Selection flowchart of articles according to PRISMA

After selecting the articles and comparing the results between researchers, the information from the articles was extracted using a spreadsheet prepared by the authors in Microsoft Office Excel®. In this way, the research findings were refined, being presented in a descriptive way in a table containing the objective, study design and conclusions/final considerations (Chart 1).

Chart 1. Characteristics of articles on man-related health policy

Article	Objective	Study design	Conclusions/final considerations
A1[1]	Describe the specifics of men's health care within FHS, according to the manager's view, the demand of men assigned to the assessed units and the practices developed by the teams.	Product of a project entitled "*Fortalecimento e disseminação da Política Nacional de Atenção Integral à Saúde do Homem*". Qualitative research used interviews.	With regard to men's health, there is still much to be done: structure/ambience adequacy for primary care; motivation and development of promotion actions against the most frequent diseases in this population.
A2[4]	Check how male users assess first contact access in primary care.	Cross-sectional, analytical study, with a quantitative approach.	The man still does not see primary care as a gateway, and efforts are needed to ensure mainly first contact access.
A3[6])	Describe strategy (focused on social determinants, gender and health inequalities) and how this could make a difference for men's health.	Not mentioned.	Need to develop a robust evidence base to support work in men's health. If there is political will, the European strategy could clearly have a major impact across the European continent.
A4[12]	Trace the profile of men who sought care in the North Health District I units of the city of Natal/RN and verify the knowledge about the existence of PNAISH (*Política Nacional de Atenção Integral à Saúde do Homem* – Brazilian National Policy for Comprehensive Care to Men's Health.	Exploratory, descriptive, quantitative research.	Men do not seek services for preventive purposes. There is a need for greater dissemination of PNAISH and for it to be, in fact, implemented in health units, enabling the development of programs that contribute to the provision of comprehensive and humanized care, considering the uniqueness of the male universe.
A5[13]	Analyze patterns of changes in men's health from 2006 to 2010 through demographic and epidemiological indicators.	This is an epidemiological, descriptive study that used secondary data from indicators used as a diagnostic parameter for human health to create PNAISH, namely: demographic and morbidity and mortality indicators.	It was found that the most recurrent health problems in the male population are preventable. From the implementation of actions proposed by PNAISH, such as health education, it will be possible to modify the behavioral and cultural profile of this population, which, in turn, causes negative consequences to their health.
A6[14]	Analyze documents from the Municipal Health Department (MHD) of Cuiabá and actions of the management team member that guided the implementation of PNAISH, taking gender as a theoretical framework.	Descriptive study, with a qualitative approach, case study type.	The use of management instruments (Annual Work Plans (AWP) and Annual Management Reports (AMR)) signal their importance in conducting actions, through their coherence with PNAISH. Financial resources were identified as responsible for insufficient actions.
A7[15]	Describe the strategies and limitations, referring to axes II and V, reported by the municipalities to calculate the indicators proposed by the national program for monitoring actions and goals foreseen in the municipal plans referring to health promotion and the implementation and expansion of the men's health care system.	A part of a larger research, whose objective was to assess the initial actions of PNAISH implementation. Qualitative with the use of interviews.	The data reflect a limited capacity of municipalities to meet the demands imposed by the strategy implementation and the critical situation of monitoring health promotion actions and expansion of men's health care system. A lack of synchrony can be observed between the municipalities and the person responsible for the elaboration of basic guidelines, necessary to organize services at the municipal level, which affects the component of monitoring the actions.
A8[16]	Discuss the articulation between epidemiological information systems. Scientific production and health policies of human health care.	Quantitative-qualitative research (secondary database, official documents of the Ministry of Health and literature review in the SciELO virtual library)	Need for greater articulation between the use of epidemiological information systems with the field of scientific production, aiming at improving the elaboration, assessment and monitoring of policies aimed at men's health, as outlined in the methodology of the PNAISH legal document, and proceed to the critical incorporation of a relational perspective of gender.
A9[17]	Learn how health professionals interpret and implement national government health policy guidelines in actions aimed at improving men's health in Scotland.	Qualitative analysis of mixed methods (documentary and interview).	Health policies are formulated at the central level, without consulting professionals who are responsible for developing actions in the service.
A10[18]	Identify and analyze some of the discourses that support PNAISH.	Qualitative and documentary research.	PNAISH still presents itself as a transformative project under construction. It was implemented and has been implemented "on behalf of men". The victimization and blaming of men for their own illness are a striking feature of PNAISH. We must break with the concept of man, reduced to "bodies with penis and prostate" and rescue their social and political dimension as agents of social transformation and protagonists of their own care, having in health services allies for prevention and health promotion.
A11[19]	Discuss some of the ways in which the genre crosses the PNAISH propositions, taking as a reference a discursive context in which terms such as "comprehensiveness" and "equity" are used.	Documentary research, part of a master's research linked to an interinstitutional and multifocal research project inscribed in the fields of gender and cultural studies, discussing some of the ways in which gender crosses the PNAISH propositions.	The importance and originality of PNAISH in emphasizing men's health still show institutional barriers, cultural issues and care models heavily based on modes of care that explore the concepts of equity and comprehensiveness, both discursively and in daily practices.
A12[20]	Analyze the meanings attributed to PNAISH by the social subjects directly involved in the implementation of this policy.	Part of a larger research, whose objective was to assess the initial actions of PNAISH implementation. Triangulation of methods was used, articulating epidemiological and socio-anthropological approaches and using the techniques of questionnaire, narrative, semi-structured interview and observation based on ethnographic principles, in addition to document analysis.	PNAISH can be perceived as episodic, eventual, also having a temporary and casual involvement of professionals. It may be something that has little to do with it, being relegated to other specialties, or it may be seen as unnecessary as it would already be contemplated in the principles and guidelines of primary health care. It can also be understood as an additional demand, and difficult to achieve because it finds barriers in the same impediments as other health policies.

Continue...

Continuation.

Article	Objective	Study design	Conclusions/final considerations
A13[21]	Understand how PNAISH reaches health services, in particular, Primary Care services, considered the gateway to the Unified Health System (SUS - *Sistema Único de Saúde*), from the point of view of its professionals and observing their daily practices.	Research with a qualitative approach, with a case study design, and is part of a larger project entitled "*Avaliação das Ações Iniciais da Implantação da Política Nacional de Atenção Integral à Saúde do Homem*", developed from 2010 to 2012.	The implementation ran into the absence of institutional conditions, such as an organizational structure, a consolidated care network, in which users are served by services with different degrees of complexity within the system, and resources in general, especially human resources.
A14[22]	Analyze the male discourse about difficulties in self-care through the reports of male participants in a health education group, focusing on men's health.	Intervention research with men's testimony, of qualitative character of descriptive exploratory type.	The importance of developing strategic actions with the objective of promoting the approach of the male public to the health service and self-care of users, especially in the scope of primary care, within the scope of PNAISH. Giving new meanings to actions involving men's health and changing the professional attitude to serve this population can trigger in the male audience the feeling of belonging to the space of health promotion, protection and recovery.
A15[23]	Arguing that basing men's health within a broad gender discourse is important for building evidence base and advances in male health promotion.	Does not make reference.	It suggests that a critical lens on gender should be applied to the work of promoting men's health because it provides strategies for researchers, professionals and policies to move towards men's health.
A16[24]	Establish issues about men, health and public policies for the viability of the debate on the subject, based on theoretical and empirical references related to these issues.	Does not make reference.	It points to the complexity involved in the elaboration, implementation and assessment of health policies aimed at gender equity. The need for the Brazilian policy aimed at men's health to be articulated with other policies is highlighted so that the gender matrix is transversal in the field of health.
A17[25]	Problematize the incorporation of the dimension of masculinities as a promoter of management strategies in the Brazilian PNAISH.	Does not make reference.	It is essential to include a focus on gender identity, sexual orientation, generation, disability and ethnic-racial condition in the continuing education actions of public health workers and managers. Similarly, an intersectoral articulation between different policies and points of attention in health networks is necessary so that Latin American men are socially recognized as citizens based on their specificities and their historical and social context.
A18[26]	Analyze the conceptions that health professionals have about specific demands and behaviors of the male population assisted in health services.	Part of a project that used the triangulation of methods, articulating epidemiological and socio-anthropological approaches and using questionnaire, narrative, semi-structured interview and observation based on ethnographic principles.	The PNAISH's concept of gender is used by health professionals in order to justify socially expected standards in terms of men's behavior.
A19[27]	Describe and analyze the perception of FHS nurses about the importance of PNAISH, as well as their perspectives to implement this policy.	Qualitative, exploratory, descriptive and field study. A broader study that studied nurses' perception of FHS on male health care in the productive phase. Interview.	Nurses believe that men not only deserve but also need to be assisted by health programs that seek to reduce morbidity and mortality rates and their exposure to risk factors, strengthening the maintenance of the family structure, and, because they constitute a significant portion of the population, since the male age group contemplated by the policy forms the country's productive and political force.
A20[28]	Analyze men's health care strategies from the perspective of health professionals.	Part of a research that investigated male care promotion focused on sexual health, reproduction and fatherhood. Its methodological design was mixed (approaches and techniques from qualitative and quantitative perspectives).	It is difficult to involve men in the care of their health, so that professionals discuss three main strategies: (1) care for men in the shortest time, reducing waiting times and offering materials (condoms, hygiene material, etc.) in exchange for establishing bonds and services between men; (2) displacement of health professionals to care for men in their work spaces, adapting languages and materials; and (3) meeting the specific demand for contraception.
A21[29]	Analyze the relationship of men with the care to their health.	Qualitative research of descriptive exploratory nature that covers the collection and systematic appreciation of descriptive materials. Interview.	The culture of men as being strong hinders their search for health services. Men are unaware of the existence of PNAISH.
A22[30]	Describe the actions developed by the study and research group on masculinities and health at this university, during the first State Week of Men's Health Care, with the aim of contributing to the PNAISH implementation.	Qualitative: experience report with problematizing approach.	On the one hand, the male population's lack of knowledge in relation to health promotion and disease prevention, but, on the other hand, the great challenge to implement educational actions that aim to break the self-care deficits of these individuals, as well as those who work in the health area.
A23[31]	Explore the interfaces between the unenacted proposal of the Brazilian National Policy for Comprehensive Health Care for Adolescents and Young People (*Política Nacional de Atenção Integral à Saúde de Adolescentes e Jovens*) and the PNAISH.	Qualitative with documentary review.	Political texts express the interests and understanding of the field of knowledge of actors from each of the analyzed segments, constituting cultural policies with potential for establishing certain meanings in the attention and health care of different population groups.
A24[32]	Highlight the negotiations and disputes between knowledge and powers in the history of PNAISH.	A qualitative study used interviews taken from multicentric research entitled "*Homens e serviços de saúde II: rompendo barreiras culturais, institucionais e individuais*".	To analyze the irruptions of the man-subject of health rights is to perceive them also being launched at the "same" that is repeated by the threats that still keep their position of exteriority of public health services archived.
A2[5][33]	Review key data on men's health globally and explore explanations for men's outcomes, including health practices, service use, and health and masculinity literacy.	Does not make reference.	Human health policies and strategies are essential at local, national, regional and global levels. They can serve to raise the profile of the issue, provide a framework for action, and provide a benchmark for assessing impact and holding services accountable for their performance.
A26[36]	Reach consensus on human health policy based on the opinions and recommendations of leaders and people interested in men's health.	The Delphi research method was used.	The research findings require policy change and development and, more importantly, make a coordinated effort to elevate men's health in Asia by implementing the policy in places where it is not implemented.

Continue...

Continuation.

Article	Objective	Study design	Conclusions/final considerations
A27[37]	Describe the history of men's health policy development in Ireland and Australia, outline the objectives, methodologies and key principles used for policy development, and highlight key priorities for policy action.	Does not make reference.	The publication of national men's health policies in Ireland and Australia represents a significant milestone in the ongoing evolution of the field of men's health. Policies provide a clear plan and an unequivocal evidence base for dealing with human health in each country.
A28[44]	Analyze the challenges experienced by nurses in the implementation of PNAISH.	Descriptive, qualitative study	The challenges for the policy implementation are related to the inoperability of government actions, weaknesses in municipal management, underfunding and discontinuity of actions.
A29[45]	Analyze the process of building the PNAISH, with a view to recognizing the participation of the various social actors in the formulation of this public policy.	Qualitative research with documentary and interview	The conduction of the PNAISH construction process, when trying to seek a consensus, produced the erasure of differences and identities. In the process of policy construction, participation occurred in a fragmented way, without dialogue or exchange, with the removal of its agents from each other.

Thematic analysis was used for content analysis, whose method groups several relationships, and can be presented graphically through a word, phrase or abstract.[11] With this, the information included in each analyzed article was presented by grouping into categories, comparing the findings in differences and similarities. With the results synthesized, these were confronted with existing theoretical knowledge.

Original scientific articles available (free), in full, regardless of their nature (field research, opinion articles, documentary or secondary data), published in any year in Portuguese, Spanish and English were included. Articles without abstract, letters, editorials, theses, dissertations, reviews, documents repeatedly retrieved in different databases, book chapters and other non-scientific texts were excluded.

This article composes a doctoral thesis entitled "*Análise da morbimortalidade masculina por condições sensíveis à atenção primária à saúde e sua interface com a Política Nacional de Atenção Integral à Saúde do Homem*".

Results

Based on search strategies and selection process, 1,735 scientific articles were identified. Of these, 124 articles were eligible according to eligibility criteria related to publication in any year, available (free), in Portuguese, English, or Spanish. Next, with the analysis of titles and abstracts, 44 articles were selected for full reading of text, of which 29 composed the final sample. The articles included in this review are found in the Web of Science (14), PubMed (7), EMBASE (4) and Scopus (4) databases (Figure 1).

The studies included in the review were published between 2008 and 2021. There was a higher concentration of publication in 2012 (7) and 2015 (5), respectively. It is emphasized that in 2009, 2010 and 2017 there was a production gap. The researches were conducted in the following countries: Twenty-three in Brazil, two in the United Kingdom, one involving countries of the Asian Continent, one in Ireland and Australia, one in Scotland and one in the European Union. Regarding the language of publication of the articles, twelve were published in Portuguese, seven in English, one in Spanish and nine were published simultaneously in English and Portuguese. (Chart 1).

The prevailing research design was qualitative research, with eighteen articles, followed by three quantitative, two quantitative-qualitative and six did not refer to the methodology used to construct the articles. Regarding the eighteen qualitative studies, it was found that six used interviews, four used a mixed method (document analysis and interview), three performed document analysis, two carried out a case study, one used the Delphi method, one used an experience report and one used narrative and participant observation (Chart 1).

The challenges for the construction and insertion of health policies aimed at the male population are presented from categories, which are intertwined, regardless of the study's methodological design:

I) Lack of knowledge and recognition of male policies

It was found that three articles described as barriers to the policy construction and insertion,

the lack of knowledge and recognition, both by local managers and health professionals, as well as by the men themselves, especially with regard to the individual's first contact with the health service.[4,6,12,13-37] Of these, one cited that men do not recognize Primary Care as a gateway to SUS[4] and another reported that men are unaware of specific policy to meet their needs.[12] There is discrediting the male group for care, including negatively assessing health services, and it was unanimous the perception of that men are mostly invisible by health services.[4,12,20,22,29,31-33] Only two studies, both national, reported aspects that facilitate the insertion of man's policy, always focusing on the use and recognition of health services by men. They are: knowing health policy (p = 0.007); being over 40 years of age (p = 0.001); having religion (p = 0.018); having higher family income (p = 0.036); and having their health demands resolved.[4,12]

II) (De)construction of male policy

The (de)construction of male policy is characterized by the strengthening of centralizing management, strengthening gender stereotypes and by the financial and human resources impact, present since its construction, and which are perpetuated in its implementation and development.[1,2,4,6,14-16,19,20-27,30,35-44] For the success of any public policy, it is necessary to engage all actors involved in its construction and development, a fact not evidenced in several studies, which demonstrate that male health policy was constructed centrally.[4,19,21,26,30,35] Researchers showed that managers themselves do not have familiarity with policies, which in turn contributes to lack of incentive and difficulty of health professionals implementing it.[20,27]

For both authors from Brazil[12,14-16] and Scotland,[17] there are important flaws in centralized policy management. The lack of dialogue with the target audience during the policy elaboration and lack of clarity contribute to a centralized management, which was seen as a barrier in the policy implementation and fulfillment.[17]

Authors argue that policies came from partisan political decisions, and not from the demand of men, which contributes to merely decision-making and deliberative processes,[12,18] contributing to the lack of motivation of professionals involved in human care, lack of knowledge about policies, lack of infrastructure and organizational structure.[1,16,19-22]

In addition to this, a large portion of scholars believe that the lack of organizational priority of managers, in particular in the dissemination of policy aimed at men, harms their insertion in all governmental spheres.[12,21,22,27-30] One study stated that there is a lack of clarity from all policy implementing agents as well as care networks.[21,36]

Study with the theme "Policies? If you have them, I don't know!"[29] ratifies the lack of disclosure of this policy that has been instituted for more than a decade.

National and international articles have shown that the policy strengthens gender stereotype by ignoring the importance of aggregating sex, gender, sexual orientation, and social determinants in health in men's health policies.[6,23-25]

The ignorance about the skills to meet the specificities of men and the concept of gender, both of those who drafted the policy and those who execute or should execute them, are blatant.[13,21,32,45]

The construction of policy focusing on preconceived ideas that potentiate gender inequity and the perception of male invulnerability was present in several studies.[13,19,21,26,27,32,45] It was noticed that the victimization and blaming of men for their own illness is still remarkable, reducing them to the genital organ and the prostate, which in turn, ends up distancing them from health services, and it is necessary to give a new meaning to the men and workers of health units themselves regarding the concept and experience of a healthy masculinity.[12,18,19,22,28,45]

More than half of studies awaken to the imprudence of not assessing the financial and human resources impact on the implementation and development of men's health policy, given that without financial and/or human resources, the insertion of public policies is unlikely.[1,12,14-16,20-22,27-30,44] Resources made available for the policy implementation are insufficient to meet the biological demands inherent to male health, and it is not possible to meet other specificities. Such an example of management reinforces

the biomedical model, which reduces them to problems arising from their reproductive organs, such as prostate cancer, and gender inequities, which are related, among others, to the characteristics of male behavior, arising from social construction are not fully addressed.[13, 17,19,44]

Discussion

The results of the scientific production of this review, regardless of the country, evidenced the existence of converging challenges that facilitate or hinder the construction and insertion of men's health policies, and few are those that point out paths for their construction. The Brazilian policy for men was instituted in 2009, hereinafter referred to as PNAISH,[34] which could explain the fact that 23 studies were conducted in Brazil. The Brazilian policy has not yet been effectively implemented in all regions of the country, nor is there any evidence as to its effectiveness.[36] The rest of the studies were carried out in the countries of the Asian continent, the United Kingdom, the European Union, Scotland, Ireland and Australia, ratifying the inequities in care for the male population and the need for incentives in global government policies.[17,23,33,34,36,37]

Pioneers in human policy making are Australia, Ireland, Brazil and Iran, being reference for other countries.[6,33-38,45] It is emphasized that, with the promulgation of PNAISH, Brazil was pioneer in Latin America in instituting a specific health policy for men, although it is not yet effective and there are no scientific and so little governmental studies to assess its impact.[18]

Men's knowledge about the existence of their own health policy and predictors of knowledge, such as sociodemographic aspects (age, family income, among others) of men were significant factors for its effectiveness.[22] Men who know of the existence of a specific policy for themselves are more likely to use health services and have their health needs resolved.[4,12] On the other hand, there is a barrier to the lack of communication and clarity in the dissemination of this policy, associated with the lack of knowledge of men and the population in general about the existence of a policy aimed at the male segment,[4,12,13,21-23,27,29,30,37] demonstrating to be indispensable investment for wide dissemination of it.

Several studies indicate that managers and health professionals also share this information gap.[23,37] It is to be expected that the lack of knowledge about male policy interferes with the development of their actions, since the transfer of information is hierarchical. Possibly, the inability of managers and health professionals to recognize policies begins in academic training, and is perpetuated in the inefficiency of continuing and permanent education, as well as in clinical practice.

In relation to policy governance and local and higher-level work processes, the studies analyzed point to the absence of popular participation during the elaboration of policies, a fact that goes against the guidelines for the construction and assessment of public policies. This "absence of the male voice" may have induced men not to participate in preventive health actions, strengthening the lack of knowledge of their rights regarding care focused on sex/gender.[4,12,14-17,45]

It is believed that if men were heard, as well as outside the construction of other public policies, other vital cycles (from the child to the elderly), factors that hinder men's access to services (lack of andrology consultation; alternative hours of care; feminization of health units; inability of professionals to care for men; ineffective self-care; others) could have been minimized or alternative proposals had been proposed.[1,14,17,19,28,32,36,45]

Furthermore, there is a lack of intersectoriality between existing public health policies.[3,24,25,33,45] This lack of dialogue with other policies, such as policies aimed at lesbian, gay, bisexual, transgender, queer, intersex, asexual (LGBTQIA+), black, indigenous, *quilombola* (common designation for slaves who are refugees in quilombos, or descendants of black slaves whose ancestors in the period of slavery fled the sugar cane mills, farms and small properties), and others, make male health care fragmented, and therefore not resolute.

To know in the vision of men their real needs and the health system dynamics is essential, because

the implementation of policy strategies largely depends on decisions and assessments taken jointly, where men, managers and professionals must be heard.

The strengthening of gender stereotypes, related to the inability regarding the concepts of sex and gender, show the gender linked to the genital organ. There are also other studies that warn about the importance of including these concepts in policies.[6,13,19,21,23-27,40,41] It is emphasized that sex refers to biological characteristics, while gender is related to roles associated with being a woman, man and relationships with each other, with culture and social.[3,41] Also, several studies point to the importance of gender, ethnicity and race as an element of social determinants in health that trigger social inequities, which interfere in men's health.[6,23-25,41] In this regard, it is expected that specific policies for the black population, LGBTQIA+, among others, are articulated with male policies.

Iran, Ireland and Australia built their policies with a focus on sex and gender differences and encompassed marginalized or vulnerable male subpopulations.[38,39] On the other hand, Brazil did not give visibility to these subpopulations, nor did it address gender issues.[40]

National and international research based on gender issues confirm that men generally do not seek health care, on purpose, on the premise that their masculinity is linked to invulnerability to illness,[13-21,26,31,32] phenomenon enhanced by the support network, co-workers, friends and even the social imagination. Thus, such pejorative ideas potentiate the culture of hegemonic masculinity, contributing to the high rates of morbidity and mortality, particularly due to causes sensitive to primary care.[4,12,22,30,37] It is essential to work on the current culture of masculinity with professionals, managers, men and among the female population, and that this movement is transversal in all policies, whether those aimed at life cycles, those specific to vulnerable groups.

The actions carried out in the Brazilian male health policy are formulated with a view to preventing sex-related injuries through campaigns, unfortunately welfarist, aimed at male genital organs, sexually transmitted infections and paternity.[1,14,15,17,19-21,26-28,30,32,45]

Placing men's health restricted to urological aspects may be associated with the process of construction of PNAISH, which was influenced by the Brazilian urology society.[18,21,24,25,32,37,45] Brazilian campaigns take place in November, which differs from international policies, which are continuous.[37,38] Possibly, If Brazilian campaigns were continuous, as in fact the text of PNAISH describes, men would feel that they belong to policies, and it would have visibility in the agendas of teaching academies and in clinical practices, thus improving assistance to men. It is urgent that those responsible for the male segment in Brazil dialogue with other countries that have effective policies in order to strengthen care for this underserved and vulnerable group.

The financial and human resources impact and the engagement of stakeholders (men, social movements, professionals and managers) demonstrate the lack of synchrony between the municipalities and the Union. This disarticulation between those responsible in fact and in law for the policies of man affects the organization of local services and the monitoring of interventions, reinforcing the current welfare model.[12,15,16,18,29]

Moreover, there is disagreement between planning and practical measures, whether nationally or internationally, making it impossible to hire qualified human resources, create feasible protocols and strategies that encourage stakeholder engagement.[1,12,14-17,19-23,26-30,32,36,37]

Ireland and Australia develop ongoing training on comprehensive men's health for all health professionals, and specific qualifications for primary care nurses, considering male specificities,[42,43] unlike Brazil, which still has a biomedical model, technical and lacking in incentives in academic and professional qualification.

The fact that Australia and Ireland have continuous training may explain the success of their policy and, at the same time, show that with mutual efforts it is possible to break with the model of invulnerable and imagination masculinity in which men do not care about their health.

The studies point to the need for extensive research and discussions both for the elaboration of policies for the male public and for their implementation, and subsequent assessment. European Union and Latin American countries (with the exception of Ireland and Brazil), the United States of America (USA), Asia, Denmark, New Zealand, Germany, Malaysia and Canada have already started discussions on the importance of having a specific policy for men.[6,33,36,39,40] It is expected that this research will contribute to such discussions and encourage researchers to develop research in this area of knowledge.

The studies that composed this investigation did not present concrete proposals for the construction and insertion of man policies. Some suggestions were described, namely: strengthening Primary Care; consolidate a network of specialized care; invest in health education; give new meaning to care, strengthening the man-service relationship; discuss sex and gender and move health professionals to care for men in their workplace.[15,21,22,28,30,33,38] However, such suggestions are still focused on a fragmented care model that does not attend men in their entirety, as well as not implementing, in practice, the guidelines established in the official policy document.

The importance of men's health policy in Ireland and Australia is reinforced, as it contains elements to assist in the construction and insertion of policies in other countries.[37] The exchange of experience between countries in the formulation of policies can be an alternative, as they all share the difficulty of access and care for the male public in health services.

As limitations of this study, we point out the fact that it was developed with the researchers' own resources and did not include paid articles; however, there is progress amidst subject so scarce of research and successful experiences in all continents. Further research is suggested to assess the actions of men's health policies.

Scientific evidence indicates the need to improve and adapt public health care policies for the male population, confirming that nurses, as they play a leading role in the interrelationship with men in Primary Care, the gateway to men in SUS, is indispensable. It is hoped that from this investigation we can stimulate the creation of innovative and problem-solving proposals and technologies for care, research and management that make it possible to respond to the specific needs of this social group.

Conclusion

Health policies aimed at the male population are still incipient, and existing ones face numerous similar challenges everywhere. Some countries such as Australia and Ireland have made greater progress, although morbidity and mortality profiles remain characterized by high rates of illness, hospitalizations and deaths, confirming the need for dialogue between government agencies globally. Regardless of the country, gender stereotypes and the inability of managers and professionals to recognize the policy were the main challenges in the construction and insertion of policies for the male segment. There are consensuses that for formulating effective public policies, from their conception to assess, the particularities of men must be considered. Furthermore, they must be built with the involvement of men themselves, government agencies, health professionals, teaching academies and civil society, aiming at improving the quality of management and clinical practice.

References

1. Moura EC, Santos W, Neves AC, Gomes R, Schwarz E. Atenção à saúde dos homens no âmbito da Estratégia Saúde da Família. Cien Saude Colet. 2014;19(2):429-38.
2. World Health Organization (WHO). World health statistics 2019: monitoring health for the SDGs, sustainable development goals. Geneva: WHO; 2019 [cited 2021 Jan 25]. Available from: https://www.who.int/publications-detail-redirect/world-health-statistics-2019-monitoring-health-for-the-sdgs-sustainable-development-goals
3. Griffith DM, Sharma G, Holliday CS, Enyia OK, Valliere M, Semlow AR, et al. Men and COVID-19: A biopsychosocial approach to understanding sex differences in mortality and recommendations for practice and policy interventions. Prev Chronic Dis. 2020;17:200247.

4. Alves NA, Coura AS, França IS, Magalhães IM, Rocha MA, Araújo RS. Access of first contact in the primary health care: an evaluation by the male population. Rev Bras Epidemiol. 2020;23:e200072.
5. Nuzzo J. Bias against men's issues within the United Nations and the World Health Organization: a content analysis. Psychreg J Psychol. 2020;4(3):120-50.
6. Baker P. European men's health strategy: here at last. Trends urology men's health. 2019;10(1):21-24.
7. Mother D, Liberati A, Tetzlaff J. Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. PLoS Med. 2009;6(7):e1000097.
8. Whittemore R, Knafl K. The integrative review: updated methodology. J Adv Nurs. 2005;52(5):546-53.
9. Biruel E, Pinto R. Bibliotecário um profissional a serviço da Pesquisa. XXIV Congresso Brasileiro de Biblioteconomia, Documentação e Ciência da Informação. 07 a 10 de agosto de 2011. Maceió: CBBD; 2011 [citado 2021 Jan 25]. Disponível em: https://www.academia.edu/9594560/Bibliotec%C3%A1rio_um_profissional_a_servi%C3%A7o_da_pesquisa
10. Coordenação de Aperfeiçoamento de Pessoal de Nível Superior (CAPES). Ministério da Educação. Brasília (DF): CAPES; 2020 [citado 2021 Jan 25]. Disponível em: https://www-periodicos-capes-gov-br.ez333.periodicos.capes.gov.br/index.php?
11. Bardin L. Análise de conteúdo. São Paulo: Edições 70; 2016. 288 p.
12. Santiago FP, Souza PR, Machado FC, Fernandes ER. Perfil dos homens na atenção primária à saúde. Holos. 2015;31(5):430-9.
13. Santos VC, Santos MG, Vilela AB, Nery AA, Casotti CA, Boery EN. Padrões de mudanças na saúde do homem a partir de indicadores demográficos e epidemiológicos. Rev Pesq Cuid Fundamental Online. 2015;7(2):2569-81.
14. Mozer IT, Corrêa AC. Gerenciando o processo de implementação da política de saúde do homem. Rev Enfer UERJ. 2016;24(1):e9483.
15. Moura EC, Lima AM, Urdaneta M. Brazilian Men's Integral Health Attention: using indicators for monitoring health's promotion and attention. Cien Saude Colet. 2012;17(10):2597-606.
16. Schwarz E, Gomes R, Couto MT, Moura EC, Carvalho SA, Silva SF. Política de saúde do homem. Rev Saude Publica. 2012;46(1):108-16.
17. Douglas F, Van Teijlingen E, Smith C, Moffat M. Implementing health policy: lessons from the scottish well men's policy initiative. AIMS Public Health. 2015;2(4):887-905.
18. Martins AM, Malamut BS. Análise do discurso da Política Nacional de Atenção Integral à Saúde do Homem. Saude Soc. 2013;22(2):429-40.
19. Pereira J, Klein C, Meyer DE. PNAISH: an analysis of its educative dimension from the gender perspective. Saude Soc. 2019;28(2):132-46.
20. Gomes R, Leal AF, Knauth D, Silva GS. Meanings attributed to policy directed to Men's Health. Cien Saude Colet. 2012;17(10):2589-96.
21. Leal AF, Figueiredo WS, Silva GS. Charting the Brazilian Comprehensive Healthcare Policy for Men (PNAISH), from its formulation through to its implementation in local public health services. Cien Saúde Colet. 2012;17(10):2607-16.
22. Neto FT, Sandreschi PF, Dias MS, Loch MR. Dificultades del autocuidado masculino: discursos de hombres participantes en un grupo de educación para la salud. Salud Colect. 2020;16(27):1-11.
23. Smith JA, Robertson S. Men's health promotion: a new frontier in Australia and the UK? Health Promot Int. 2008;23(3):283-9.
24. Couto MT, Gomes R. Men, health and public policies: gender equality in question. Cien Saude Colet. 2012;17(10):2569-78.
25. Cesaro BC, Santos HB, Silva FN. Masculinidades inerentes à política brasileira de saúde do homem. Rev Panam Salud Publica. 2018;42:e119.
26. Knauth DR, Couto MT, Figueiredo WS. The standpoint of professionals on the presence and demands of men on the healthcare services: perspectives for the analysis of the implementation of the Comprehensive Healthcare Policy for Men. Cien Saude Colet. 2012;17(10):2617-26.
27. Alvarenga WA, Silva SS, Silva ME, Barbosa LD, Rocha SS. Política de saúde do homem: perspectivas de enfermeiras para sua implementação. Rev Bras Enferm. 2012;65(6):929-35.
28. Moreira MC, Gomes R, Ribeiro CR. E agora o homem vem?! Estratégias de atenção à saúde dos homens. Cad Saude Publica. 2016;32(4):e00060015.
29. Viana ME, Costa LM, Santos RM, Anjos DS. La atención de la salud de la población masculina en los tiempos de la Política Nacional de Atención Integral a la Salud de los hombres: lo que ellos hablan. Rev Enferm Human Cultura Cuidados. 2015;19(41):135-46.
30. Fontes WD, Barboza TM, Leite MC, Fonseca RL, Santos LC, Nery TC. Attention to human health: education and dialogue between service. Acta Paulista de Enfermagem. 2011;24(3):430-3.
31. Lopez SB, Moreira MC. Políticas brasileiras de atenção integral à saúde de adolescentes, homens jovens e a saúde do homem: debates políticos e masculinidade. Cien Saude colet. 2013;18(3):743-52.
32. Müller RF, Birman J. Negociando sabers e poderes: a Política Nacional de Atenção Integral à Saúde do Homem e a Sociedade Brasileira de Urologia. Hist Cien Saude-Manguinhos. 2016;23(3):703-17.
33. Baker P. Men's health: time for a new approach. Physical Therapy Reviews. 2018;23(2):144-150.
34. Brasil. Ministério da Saúde. Portaria nº 1.944, de 27 de agosto de 2009. Institui no âmbito do Sistema Único de Saúde (SUS), a Política Nacional de Atenção Integral à Saúde do Homem. Brasília (DF): Ministério da Saúde; 2009 [citado 2021 Jan 25]. Disponível em: https://bvsms.saude.gov.br/bvs/saudelegis/gm/2009/prt1944_27_08_2009.html
35. Griffith DM. Biopsychosocial approaches to men's health disparities research and policy. Behavioral Med. 2016;42(3):211-5.
36. Teo CH, Ng CJ, Ho CC, Tan HM. A consensus on men's health status and policy in Asia: a Delphi survey. Public Health. 2015;129(1):60-7.
37. Richardson N, Smith JA. National men's health policies in Ireland and Australia: what are the challenges associated with transitioning from development to implementation? Public Health. 2011;125(7):424-32.
38. Esmailzade, H, Mafimoradi S, Mirbahaeddin SE, Rostamigooran N, Farshadfar F. Devising a National Men's Health Policy Document: the Current Challenges to Men's Health in Iran. Int J Mens Health. 2016;15(2),174-93.
39. Griffith DM, Semlow AR, Leventhal M, Sullivan C. The tennessee men's health report card: a model for men's health policy advocacy and education. Am J Mens Health. 2019;13(5):1557988319882586.
40. Aguayo F, Nascimento M. Dos décadas de Estudios de Hombres y Masculinidades en América Latina: avances y desafios. Sex Salud Soc (Rio J). 2016;22:207-22.
41. Organización Panamericana de la Salud. Masculinidades y salud en la Región de las Américas. Resumen. Washington (DC): OPS; 2019 [cited 2021 Jan 25]. Available from: https://iris.paho.org/handle/10665.2/51667

42. Rizio TA, Thomas WJ, O'Brien AP, Collins V, Holden CA; Andrology Australia Practice Nurse Reference Group. Engaging primary healthcare nurses in men's health education: a pilot study. Nurse Educ Pract. 2016;17:128-33.

43. Osborne A, Carroll P, Richardson N, Doheny M, Brennan L, Lambe B. From training to practice: the impact of ENGAGE, Ireland's national men's health training programme. Health Promot Int. 2018;33(3):458-67.

44. Sousa AR, Oliveira JA, Almeida MS, Pereira A, Almeida ES, Escobar OJ. Implementação da Política Nacional de Atenção Integral à Saúde do Homem: desafios vivenciados pelos enfermeiros. Rev Esc Enferm USP. 2021;55:e03759.

45. Hemmi AP, Baptista TW, Rezende M. O processo de formulação da política nacional de saúde do homem. Rev Saúde Coletiva. 2020;30(3):e300321.