

On “Men, health and public policies: gender equality in question”

Sobre “Homens, saúde e políticas públicas: a equidade de gênero em questão”

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In the article written by Maria Thereza Couto (USP) and Romeu Gomes (FIOCRUZ), the authors investigate the problem of the connection between health and public policies, focusing specifically on men's health and the implications for the promotion of gender equality. The article contains reflections on three levels of analysis: (1) the construction of the gender aspect in public policies, (2) the perspective of gender in public health policies, and (3) a questioning of the relationship between gender equality and male health policy.

We should like to begin with some reflections on the variations in current terminology for talking about men and health: male health, men's health, comprehensive healthcare policy for men, policy for male health. These variations certainly do not occur purely by chance. The picture is complex and gives rise to a series of questions: what men are we talking about, what types of men are health policies aimed at, what connections are there between policies designed for men and other policies in the field of health, what is the place of men in the area of health, what discussions follow the introduction of a health policy for men.

The article provides some clues for thinking about these questions, first of all the definition of the actual field for investigation and intervention with regard to men in the area of health. In the last 20 years we have seen an intense debate on male participation in matters relating to sexual and reproductive health and sexual and reproductive rights. The action programs at the Conferences on Population and Development¹ and on Women² stressed the need to include men and boys in the debate on reproductive planning. We should point out that, at the time, as Arilha³ reminds us, the involvement of men was listed under male “(ir)responsibility” with regard to questions of sexuality and reproduction.

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Even during the 1990s, certain works noted by the authors already contained levels of male morbidity and mortality in Brazil. However, it is necessary to stress the part played by external causes in these figures for morbidity and mortality; firstly, violence (including fatal incidents) in which men usually figure as both killer and victim, and secondly, road traffic accidents. These facts seem to point towards the idea that "risk taking" continues to be prized in the concept of an idealized type of "real man," in which possible points of vulnerability are cast aside in favor of the insignia of maleness⁴.

If on the one hand the aspect of gender is so structured that we think of male rites and attributes, it is profoundly connected with other social markers, such as color/race, class, generation, sexual orientation, gender identity. The connection between different markers is fundamental for any analysis which takes into consideration the plurality of male experience and its relationship with the promotion of gender equality in health.

In seeking to follow the levels of analysis suggested by the authors, we have identified certain problematical points which seem to us relevant. At the first level of analysis, the authors stress the role played by social movements in building a political gender program, notably the movements of feminists, women and LGBT (lesbians, gays, bisexuals, transvestites and transsexuals). Through the activism of these groups, gender inequality played an important part in the construction of agendas for public policies, including in the field of health. In this sense, as Couto and Gomes point out, "it is not possible to conceive of the existence of public policies which are neutral in terms of gender".

But with regard to men, as the authors point out, there is no organized movement demanding specific policies. In this context, one must be aware that, when speaking of men without any other qualification (as a generic category), the discourse invariably presupposes heterosexuality. To be a man means, among other things, to be heterosexual. To put it another way, masculinity assumes and encompasses heterosexuality⁵. How should we think of this construction of gender programs to which the authors refer? In fact, men have been on the scene for a long time (in the LGTB, black, aids movements among others). In a conception of male health which is still structured on a heteronormative basis, there is always a risk in not qualifying men (or male), the risk of falling into the error of assuming heterosexuality and heterosexual maleness as natural.

On the second level of their analysis, the authors draw attention to the dimension of power in

gender analyses in the health field. The search for a transformation of gender in this field, as the authors point out, may result simply in the substitution of the word "sex" for the word "gender," thereby failing to take into account the complexity of the concept. It runs the risk of ignoring the questions of power, of asymmetry, of inequality, which are fundamental for thinking about and discussing gender. This point seems to us important for an analysis which proposes to consider gender equality, understood here as parity in the development of the lives of women and men, recognizing their different interests and needs, and redistributing power and resources on the basis of this recognition⁶.

It is appropriate here to recall the comments of Arilha³ on the role of men in the field of health and the interrelationship with women's health, sexuality and reproduction: "absent man," "problem man," "accessory man." It seems to us fundamental to examine what is said about men in the field of health and the viewpoint used to talk about men and health. If, on the one hand, discussions about male absence are common among professionals and managers⁷, on the other hand their presence is seen from the point of view of the "problem man" (which must be corrected) or that of "accessory man" (as a platform for an improvement in the quality of life and the health of women). At what moment does the "man with rights" appear in the field of health? What does it mean when we refer to rights in the field of health, in particular for men? These are some of the challenges in this debate.

Finally, are male health policies favorable towards gender equality in this field? At the end of the day, what do men say about these policies and what debates are produced by it? In the last five years we have seen an intense debate between researchers, activists and medical associations with regard to the creation of the National Comprehensive Healthcare Policy for Men (PNAISH). As the authors point out, despite the theoretical basis involving the reasons for the policy apparently recognizing the diversity of male experience, there is "an institutional attitude that encourages uniformity". To put it another way, the plan of action is based on a line of argument which refers to victimization (men are vulnerable and need to be taken care of), homogeneity (men as a generic category), and fundamentally linked to the subject of reproductive health. As Barker⁸ has already made clear, to think about gender equality in health matters means to think about male particularities, stemming from male socialization, without forgetting the various possible interrelationships with questions relating to women's health.

However, it seems to us that even though the subject of sexuality/reproduction is a central theme in the promotion of gender equality in health, it is not without its problems. As Muller⁶ writes, the policy appears to highlight a family-style provision of bio-power. It posits a man, a place and an argument which are profoundly linked to family planning, where the vasectomy is the male sign of participation in this sphere.

It needs to be noted that the inclusion of men in health is not restricted to the sexuality/reproduction theme. The theme of production occurs at various times, even though it is not seen as central. Muller stresses in his interviews with managers that we are not dealing with health, “only with the right to health”⁶. With a specific age group (20 to 59), the theme of work becomes central to the discussion. Work is behind the productive force of the country, becoming an important sign of male identity. Finally, the saving of financial resources in cases of preventable male illness is an important matter for the health system. Although the “health of the worker” (the male gender termination of the word [in Portuguese] is significant) and men’s health are seen as distinct topics in the field of collective health, it seems to us that exploring their possible connections and understanding their relative isolation might contribute both to clarify the place of men in current health policy and to understand how different theoretical perspectives on power relationships, stressing now the class aspect, now the gender aspect, succeed each other and are superimposed on each other, without their overlapping being actually explored.

References

1. *Conferência Internacional de População e Desenvolvimento (CIPD) Cairo, 1994*. Brasília: CNPD, FNUAP; 1997.
2. IV Conferência Mundial sobre a Mulher; 1995; Beijing, China.
3. Arilha M. *O masculino em Conferências e Programas das Nações Unidas*. para uma crítica do discurso de gênero [tese]. São Paulo: USP; 2005.
4. Nascimento M. *Improáveis Relações*. produção de sentidos sobre masculinidade no contexto de amizade entre homens homo e heterossexuais [tese]. Rio de Janeiro: IMS, UERJ; 2011.
5. Nascimento M, Segundo M, Baker G. Juventude, masculinidades e exclusão social: reflexões sobre a saúde dos homens jovens. In: Gomes R, organizador. *Saúde do homem em debate*. Rio de Janeiro: Fiocruz; 2011. p. 11-128.
6. Reeves H, Baden S. *Gender and Development*. Concepts and Definitions. Brighton: Institute of Development Studies; 2000.

7. Muller RCF. *A constituição de uma política de saúde para homens no Brasil (2009-2011)*: bases simbólicas e lugares de enunciação [tese]. Rio de Janeiro: UFRJ; 2012.
8. Barker G. *What about boys?* Geneva: WHO; 2000.