

CONTEMPORARY CHALLENGES AND PERSPECTIVES ON COMPREHENSIVE MEN'S HEALTH CARE WITHIN BRAZIL'S UNIFIED HEALTH SYSTEM

 <https://doi.org/10.63330/aurumpub.070-002>

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Abstract

Men's health remains a contested field at the symbolic, institutional, and health care levels within Brazilian public policy, even though Brazil is the only Latin American country to have a national policy specifically targeting the male population, the National Policy for Comprehensive Men's Health Care (Política Nacional de Atenção Integral à Saúde do Homem, PNAISH). This article aims to analyze, in light of contemporary scientific literature, the advances, obstacles, and opportunities for improving comprehensive men's health care within the Brazilian Unified Health System (Sistema Único de Saúde, SUS), with particular emphasis on the strategic and frequently underestimated role of the multiprofessional team in this process. This qualitative study consists of a narrative literature review based on national and international publications from recent years, supplemented by official documents from the Ministry of Health. The results show that, more than fifteen years after the establishment of the PNAISH, cultural barriers associated with hegemonic constructions of masculinity persist, as do weaknesses in the organization of Primary Health Care (PHC) services and the pronounced symbolic and material devaluation of the professionals who make up multiprofessional teams, even though,

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paradoxically, they bear primary responsibility for the day-to-day implementation of care initiatives. It is concluded that overcoming this situation requires not only reaffirming the policy's five organizing pillars, but also securing institutional, financial, and symbolic recognition of multiprofessional work as an indispensable component in the delivery of comprehensive, equitable, and gender-sensitive care.

Keywords: Primary Health Care, Men's health, Masculinities, Multiprofessional team, Public health policies.

INTRODUCTION

For many years, the historical development of health services in Brazil was guided by a care model centered on women's and children's health. As a collateral effect, this created a significant gap in care directed toward the male population. This absence does not stem from men's purported biological invulnerability, but rather from a complex interplay of social constructions of gender, cultural patterns of hegemonic masculinity, and the organization of public health services themselves, which historically have been unable, or unwilling, to engage with men's particular needs (Schraiber; Gomes; Couto, 2005).

In this context, hegemonic masculinity, understood as a set of cultural values that associate virility with invulnerability, self-sufficiency, and the denial of vulnerability, operates as one of the primary determinants of men's disengagement from health services (Gomes, 2008; Couto; Gomes, 2012).

This disengagement is not neutral. It has tangible epidemiological consequences, reflected in morbidity and mortality indicators that have historically placed men in a position of greater vulnerability than women, particularly with regard to external causes of death and chronic noncommunicable diseases.

In response to this situation, the Ministry of Health established the National Policy for Comprehensive Men's Health Care (Política Nacional de Atenção Integral à Saúde do Homem, PNAISH) in 2009, making Brazil the only country in Latin America to have a public health policy specifically directed toward the male population (Brasil, 2009).

The PNAISH was created to reduce male morbidity and mortality by addressing, from a broad perspective, the risk factors and vulnerabilities affecting this population, promoting access to high-quality health actions and services, and recognizing and respecting multiple expressions of masculinity.

However, more than a decade and a half after its enactment, the specialized literature has shown that the policy still faces significant structural challenges to its effective implementation, particularly within Primary Health Care, the preferred point of entry into the Brazilian Unified Health System (Sistema Único de Saúde, SUS) (Silva; Oliveira, 2023).

Among these challenges, particular attention should be given to an aspect frequently relegated to the background in discussions of men's health: the role played by multiprofessional teams, comprising physicians, nurses, psychologists, social workers, nutritionists, physical education professionals, physical therapists, and other professional categories, in the day-to-day implementation of care, as well as the simultaneous symbolic, financial, and institutional devaluation to which these professionals are subjected (Souza et al., 2024).

Unlike approaches centered exclusively on physicians, comprehensive men's health care presupposes, by definition, a multiprofessional and interdisciplinary care model capable of integrating the biological, psychological, social, and cultural dimensions of illness and care (Aquino et al., 2022). Nevertheless, there is a disconnect between the official discourse advocating comprehensive and intersectoral care and the actual working conditions provided to the teams expected to deliver it. This disconnect undermines the sustainability and effectiveness of men's health initiatives.

Against this backdrop, the general objective of this study is to analyze, based on the most recent national and international scientific literature, the advances, obstacles, and opportunities for improving comprehensive men's health care within the SUS, with an emphasis on the strategic role, and recurring devaluation, of the multiprofessional team in this process.

More specifically, the study sought to: (i) revisit the five organizing pillars of the PNAISH in light of current evidence; (ii) systematize the contemporary epidemiological landscape of men's health in

Brazil; (iii) discuss the sociocultural barriers that distance men from health services; and (iv) critically examine the position occupied by multiprofessional teams in the delivery of care, highlighting the mechanisms of devaluation affecting this workforce.

The social relevance of this study lies in the urgent need to advance public debate on gender equity in health, recognizing that promoting men's health is not solely the responsibility of men, but rather a shared responsibility among administrators, professionals, and civil society.

From an academic perspective, this research contributes to updating a field of knowledge that, although well established from a regulatory standpoint, requires greater theoretical depth regarding the labor dimension of health care and the processes through which the professional categories involved in men's care are valued, or devalued. This subject remains underexplored in an integrated manner in Brazilian literature.

METHODOLOGY

This is a narrative literature review employing a qualitative, descriptive-analytical approach. Its purpose is to systematize, interpret, and critically examine the scientific knowledge produced on comprehensive men's health care in Brazil, with particular attention to the role of multiprofessional teams in this process.

The methodological choice of a narrative review is justified by the nature of the research subject, which requires a broad integration of theoretical frameworks from the social sciences in health, official epidemiological data, and recent empirical evidence, thereby allowing greater interpretive flexibility than strictly protocol-driven systematic review models (Rother, 2007).

The documentary corpus was constructed through searches of electronic databases recognized by the public health scientific community, namely: the Virtual Health Library (Biblioteca Virtual em Saúde, BVS), Scientific Electronic Library Online (SciELO), Latin American and Caribbean Health Sciences

Literature (Literatura Latino-Americana e do Caribe em Ciências da Saúde, LILACS), and the National Library of Medicine (PubMed/MEDLINE).

The following health descriptors (DeCS/MeSH) were used in combination with the Boolean operators “AND” and “OR”: “men’s health,” “masculinities,” “primary health care,” “multiprofessional team,” and “health policy,” together with their Portuguese equivalents (“saúde do homem,” “masculinidades,” “atenção primária à saúde,” “equipe multiprofissional,” and “política de saúde”).

The inclusion criteria were: (i) scientific articles, doctoral theses, master’s dissertations, technical reports, and official documents published preferably between 2018 and 2025, while allowing the inclusion of classic and foundational works published before this period when indispensable to constructing the study’s theoretical and conceptual framework; (ii) publications in Portuguese, English, or Spanish; and (iii) full-text publications directly related to the subject under study. Studies duplicated across databases, publications without a direct thematic relationship to the subject investigated, and abstracts from scientific events for which no corresponding full text was available were excluded.

The selected material was analyzed through a critical-interpretive process organized into three complementary stages: an exploratory reading of the retrieved texts to identify recurring thematic areas; an analytical reading aimed at identifying convergences, divergences, and gaps among the authors consulted; and a synthetic-integrative reading, during which the findings were organized into thematic categories capable of engaging both with the organizing pillars of the PNAISH and with the specific issue of multiprofessional work in health care.

As this was a narrative review, no claim was made to bibliographic exhaustiveness. Instead, the study sought to achieve qualitative representativeness of the contemporary scientific debate on the subject while complying with the ethical principles governing citation and attribution of authorship under current academic standards.

It should be noted that, because this was bibliographic and documentary research, submission to a Research Ethics Committee was not required under Resolution No. 510/2016 of the National Health Council, since the study did not involve the direct collection of data from human participants.

RESULTS AND DISCUSSION

EPIDEMIOLOGICAL LANDSCAPE OF MEN'S HEALTH IN BRAZIL: PERSISTENT TRENDS AND EMERGING DIMENSIONS

The most recent epidemiological data reaffirm a historical trend that has been extensively documented in the literature: on average, Brazilian men die earlier and from more preventable causes than women. According to data compiled by the Ministry of Health and researchers in the field of public health, male life expectancy remains, on average, six to seven years lower than female life expectancy. External causes, including traffic accidents, interpersonal violence, and suicide, account for a substantial proportion of deaths among young and adult men (Brasil, 2023; Malta et al., 2021).

Compounding this situation is the relative increase in chronic noncommunicable diseases, particularly cardiovascular diseases, prostate and lung cancers, and conditions related to the harmful use of alcohol and other substances, which affect men at significantly higher rates than those observed among women (Souza et al., 2024).

Also noteworthy is the underdiagnosis of mental disorders among men. This phenomenon is associated not with a genuinely lower prevalence of such conditions, but with longstanding difficulties in recognizing and articulating psychological distress and seeking help in a cultural context that associates masculinity with emotional restraint (Levorato et al., 2014; Couto; Gomes, 2012).

The COVID-19 pandemic, whose effects continue to reverberate throughout the organization of health services, exacerbated this situation by dramatically revealing the higher fatality rate of the disease among men. At the same time, it exposed the weakness of the ties between this population and Primary

Health Care, since a significant proportion of deaths occurred among individuals who were not receiving regular health monitoring (Silva; Oliveira, 2023).

This finding reinforces the hypothesis, already well established in the literature, that men's disengagement from health services is not merely a matter of geographical access or the availability of care, but fundamentally a symbolic and cultural issue shaped by patterns of masculinity that discourage self-care and the early pursuit of health services.

REVISITING THE FIVE ORGANIZING PILLARS OF THE PNAISH

The PNAISH is structured around five priority thematic pillars: (i) access and reception; (ii) sexual and reproductive health; (iii) fatherhood and caregiving; (iv) diseases prevalent among the male population; and (v) the prevention of violence and accidents (Brasil, 2009). A review of the recent literature indicates that progress across these pillars has been uneven and asymmetrical throughout Brazil.

The access and reception pillar, regarded as the strategic gateway to the others, continues to encounter concrete obstacles related to the operating hours of Primary Health Care Units (Unidades Básicas de Saúde, UBS), which are largely incompatible with the working hours of economically active men (Aquino et al., 2022).

Studies indicate that expanding alternative service hours, including evening and Saturday appointments, is among the strategies most frequently cited as potentially effective in increasing men's spontaneous use of health services, although implementation remains limited in most Brazilian municipalities (Souza et al., 2024).

The fatherhood and caregiving pillar, in turn, has experienced significant advances at the discursive level, particularly in light of the growing social appreciation of paternal involvement during prenatal care, childbirth, and the postpartum period. However, the literature indicates that this discursive shift has not yet been consistently translated into substantive changes in care practices. Many health

services continue to operate according to an institutional logic that centers maternal and child care on women, relegating men to a secondary and sometimes invisible role (Gomes et al., 2020).

Regarding the pillar of prevalent diseases, prostate cancer prevention campaigns have achieved relative prominence, particularly during November through the well-established “Blue November” campaign. This visibility contrasts with the more limited attention given to other equally relevant conditions, such as cardiovascular diseases, mental disorders, and occupational health conditions (Levorato et al., 2014).

This asymmetry suggests that the men’s health agenda, even when institutionally recognized, tends to reproduce fragmented and sporadic approaches that are inconsistent with the principle of comprehensive care advocated by the policy itself.

Finally, the prevention of violence and accidents remains one of the most challenging pillars, insofar as it extends beyond the exclusive scope of the health sector and requires intersectoral coordination with public safety, education, social services, and urban policy. Such coordination remains insufficiently established in the day-to-day operation of services (Malta et al., 2021).

HEGEMONIC MASCULINITIES AND SOCIOCULTURAL BARRIERS TO CARE

One of the most recurrent findings in the literature reviewed concerns the persistence of cultural patterns of hegemonic masculinity as the primary subjective barrier to men’s access to health services. Constructed and socially reinforced from childhood onward, these patterns associate seeking care with vulnerability, feminization, and, ultimately, the loss of virile status (Schraiber; Gomes; Couto, 2005; Couto; Gomes, 2012).

Recent qualitative studies conducted in different Brazilian regional contexts show that many men seek health services only after their conditions have already worsened, when pain or functional limitations make further postponement of care untenable (Aquino et al., 2022). This pattern of delayed care-seeking

directly undermines the effectiveness of prevention and early diagnosis initiatives, contributing to the deterioration of the morbidity and mortality indicators discussed above.

The international literature further indicates that this phenomenon is not exclusive to Brazil, although it assumes specific cultural characteristics in each national context. Studies conducted in Latin America, Europe, and North America converge in identifying hegemonic masculinity as a cross-cutting factor that distances men from health services, although strategies for addressing it vary according to the institutional arrangements of each health system (Baker et al., 2020 apud Souza et al., 2024).

Accordingly, overcoming these barriers necessarily requires health education strategies that engage directly with the meanings attributed to masculinity, fostering reinterpretations through which self-care is associated not with vulnerability, but with living one's own life fully and responsibly. This necessarily entails continuous, sensitive, and technically qualified work that, in the day-to-day operation of services, falls to the multiprofessional team.

THE STRATEGIC ROLE AND DEVALUATION OF THE MULTIPROFESSIONAL TEAM

It is at this point that the present review seeks to advance beyond the body of scholarship already established on the subject. Although the literature on men's health tends to focus on the policy's cultural, epidemiological, and regulatory dimensions, there is a significant gap in the specific discussion of the working conditions and institutional recognition afforded to the professionals responsible for implementing care on a daily basis.

The effective implementation of the PNAISH depends largely on the coordinated work of multiprofessional teams composed of physicians, nurses, psychologists, social workers, nutritionists, physical education professionals, physical therapists, community health workers, and other professional categories that form part of the Expanded Family Health and Primary Care Centers (Núcleos Ampliados de Saúde da Família e Atenção Básica, NASF-AB) and the Family Health Strategy (Estratégia Saúde da Família, ESF) teams (Souza et al., 2024).

In the day-to-day operation of services, these professionals translate the abstract principles of comprehensive care into concrete practices involving reception, skilled listening, health education, therapeutic groups, and health promotion and prevention initiatives specifically directed toward the male population.

Recent studies, however, reveal a structural paradox: the more creativity, sensitivity, and adaptability multiprofessional teams are expected to demonstrate in addressing the cultural barriers that distance men from health services, the less institutional, financial, and symbolic investment these professional categories have received (Souza et al., 2024; Ferreira; Lima, 2022). Precarious employment relationships, excessive workloads resulting from inadequate staffing, weak continuing professional development processes, and low salaries are among the primary factors undermining the sustainability of men's health initiatives.

This devaluation is not only material, but also symbolic. The literature and institutional documents analyzed reveal a tendency to attribute the leading role in men's health initiatives to physicians, relegating other professionals, particularly psychologists, social workers, and physical education professionals, to secondary or merely complementary roles. In practice, however, these professionals are frequently responsible for sustaining the longest-lasting relationships with service users, especially with regard to the psychosocial dimensions of care (Ferreira; Lima, 2022).

This invisibilization of multiprofessional work reproduces, within the organization of health services itself, a hierarchical logic that contradicts the principles of interdisciplinarity advocated by Primary Health Care. It also undermines the continuity of initiatives, since high professional turnover, largely resulting from precarious contractual arrangements, makes it difficult to build lasting relationships of trust between teams and the male population they serve. As the literature has already demonstrated, such relationships are essential to overcoming cultural barriers to access (Aquino et al., 2022).

The specific role of Community Health Workers (Agentes Comunitários de Saúde, ACS) should also be emphasized. These professionals are frequently identified in the literature as a strategic link

between health services and the community, particularly in territories marked by social vulnerability. Paradoxically, they constitute one of the professional categories with the most precarious working conditions within the SUS, clearly demonstrating the disconnect between the discursive centrality attributed to these workers and the actual conditions provided for the performance of their duties (Ferreira; Lima, 2022).

PERSPECTIVES AND POSSIBLE PATHWAYS FOR IMPROVING CARE

In light of the landscape outlined above, the recent literature identifies potential pathways for improving comprehensive men's health care within the SUS. To a large extent, these converge on the need to institutionally reposition multiprofessional work.

The most frequently cited strategies include expanding continuing professional development processes specifically addressing masculinities and designed to raise awareness among teams while enhancing their technical qualifications; reorganizing work processes to extend service hours and create dedicated spaces in which the male population can be heard; strengthening funding for Primary Health Care while ensuring adequate team staffing; and enhancing the symbolic and material recognition of professional categories historically subordinated within the hierarchy of health services (Silva; Oliveira, 2023; Souza et al., 2024).

In addition, the international literature increasingly recognizes the importance of intersectoral approaches integrating health, education, employment, and social services, based on an understanding that the social determinants of men's health extend far beyond the limits of the health sector acting in isolation.

Community-based initiatives involving local male leaders as disseminators of self-care practices have also produced promising results in different contexts, particularly when coordinated with the community-based work of Family Health Strategy teams (Baker et al., 2020 apud Souza et al., 2024).

FINAL CONSIDERATIONS

This review supports the conclusion that, more than fifteen years after the establishment of the National Policy for Comprehensive Men's Health Care, Brazil has consolidated a pioneering regulatory framework in Latin America, although the policy remains far from being fully implemented in practice. Cultural barriers deeply rooted in hegemonic constructions of masculinity persist, continuing to distance men from health services and adversely affect epidemiological indicators of preventable morbidity and mortality.

More importantly, this study sought to highlight a dimension frequently neglected in the debate on men's health: the central, yet paradoxically devalued, role of multiprofessional teams in the day-to-day implementation of care. Comprehensive care is impossible without full recognition of interdisciplinary work. Likewise, cultural barriers to access cannot be overcome without sustained investment in the training, recognition, and the stability of the employment relationships that put the policy's abstract principles into practice.

It is therefore concluded that improving comprehensive men's health care within the SUS requires a twofold movement. On the one hand, the five organizing pillars of the PNAISH must be reaffirmed and strengthened, with particular attention to fatherhood, the prevention of violence, and men's mental health. On the other, multiprofessional teams must receive institutional, financial, and symbolic recognition as an indispensable, rather than merely instrumental, component in the delivery of genuinely comprehensive, equitable, and gender-sensitive care. As a future research agenda, further empirical studies should investigate, from the perspectives of multiprofessional practitioners themselves, their perceptions of recognition, professional appreciation, and actual working conditions in men's health care.

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