Meanings attributed to policy directed to Men's Health

Sentidos atribuídos à política voltada para a Saúde do Homem

Romeu Gomes [1]
Andréa Fachel Leal [2]
Daniela Knauth [2]
Geórgia Sibele Nogueira da Silva [3]

Abstract ***This study analyzed the meanings given to the Brazilian National Men's Health Policy (PNAISH) by those involved in its implementation to find out how a policy formulated at national level is reflected in local contexts. In five cities, from each macro region of the country, a set of 6 narratives and 21 semi-structured interviews were held with health managers and professionals; the information on the Policy was developed according to the Meaning Interpretation Method. The Policy is generally perceived as positive. Among the meanings given, it is emphasized that the policy is seen, by some, as a comprehensive care that guides actions to address men as a whole in Primary Care; then again, others perceived it as a reduction to urological problems. The policy was also perceived as something vague, which does not detail how to proceed to take men to the services and to better assist them, or something episodic, being the policy reduced to the accomplishment of specific events rather than ongoing actions in everyday services. The different meanings guide practices and actions, which may signal the effective and continued engagement of the professional with the policy, being a key element for its monitoring and evaluation.***

Key words ***Men's health, Health policy, Public Health Policies, Gender and health, Qualitative research, Brazil***

Resumo ***Analisou-se os sentidos atribuídos à Política Nacional de Atenção Integral à Saúde do Homem (PNAISH) pelos envolvidos na sua implementação, buscando identificar como uma política formulada em nível nacional é significada nos contextos locais. Em cinco municípios, de cada macrorregião do país, realizaram-se 6 narrativas e 21 entrevistas semiestruturadas, com gestores e profissionais de saúde; as informações sobre a Política foram trabalhadas a partir do Método de Interpretação de Sentidos. A Política é percebida em geral com positividade. Dentre os sentidos atribuídos, destacamos que a Política é vista, por alguns, como uma atenção integral que norteia ações para abordar os homens como um todo na Atenção Primária; ao contrário, por outros, foi percebida como uma redução a problemas urológicos. Também foi vista como algo vago, não detalhando como proceder para trazer os homens aos serviços e melhor atendê-los, ou algo episódico, sendo a política reduzida à realização de eventos pontuais e não a ações continuadas, incorporadas no cotidiano dos serviços. Os diferentes sentidos orientam práticas e ações, podendo sinalizar o engajamento efetivo e continuado do profissional com a Política, sendo um elemento fundamental para seu monitoramento e avaliação.***

Palavras-chave ***Saúde do Homem, Política de saúde, Políticas públicas de saúde, Gênero e saúde, Pesquisa qualitativa, Brasil***

[1] Departamento de Ensino, Instituto Fernandes Figueira, Escola de Saúde Pública, Fundação. Av. Rui Barbosa 716/4º andar, Flamengo. 20550-011 Rio de Janeiro RJ. romeu@iff.fiocruz.br
[2] Programa de Pós Graduação em Epidemiologia, Universidade Federal do Rio Grande do Sul
[3] Programa de Pós-Graduação em Psicologia, Universidade Federal do Rio Grande do Norte.

Introduction

The term ***public policy*** is polysemic. Within such polysemy, meanings and significances originate from social processes of experimentation and of interactions placed in culture and in the historical interaction process[1]. The meanings may be understood as an appropriation of significances culturally established through subjectivity and intersubjectivity[2]. Thus, it can be considered - within the language - that significances relate more to denotation, while meanings are closer to connotation.

In the broad polysemic context, public policy is commonly understood as governmental actions idealized, formulated, and designed to the purposes of government agendas, permeated and exchanged with the desires and demands of groups in society, resulting in programs, actions, strategies, and plans that will impact and will search for positive and beneficial transformations and results for people in a certain reality[3].

Concerning ways of doing, it is a fact that one can undergo from major forms of normative offers, which strictness works toward modelization[4], to experimentation policies and creation of subjectivation processes, in which its production express an understanding that the social transformations desired rely on coherence and consistency of processes developed by them[5].

The anthropological perspective on public policies has grown in recent years, both in the sense of providing information for the development and assessment of programs and projects, and in the sense of producing a critical analysis of the concepts and impacts of these policies on society[6]. One of the important contributions of this perspective is to demonstrate that the definition and implementation of a public policy involves a set of interests and power relations, which are often in conflict. Moreover, the implementation of this policy takes place from social subjects and in a specific social context that must be taken into account in both planning and implementation and in the evaluation process of policies. Thus, the local realities and identities show specific settings to policies created as universal[7]. It is also in this direction that several recent analysis on public policies, particularly on health policies, have pointed out these, very often, turn out to increase or even generate social inequalities, by the privileged "target population" or by "operators" of this policy[7-9].

A public policy is the result of the confluence of many different factors (economic, social, cultural, political, etc.) and it mobilizes different social fields that, in turn, grasp this policy according to different logics. As suggested by Remi Lenoir[10], when analyzing the French family-centered policy (***familialisme***), the object of a policy is always reinterpreted according to the interests, rules, and values of each social field involved. Moreover, as noted by the author, a successful policy is related to the social legitimacy of the central category triggered, in the case analyzed by him the family category[11]. From this perspective, one can understand the formulation and implementation of a policy as seeking for the imposition of a ***doxa***, which implies in a standardization and, sometimes, in defining new professional specialties. This movement can generate rearrangements, restructuring, or even resistance by the social fields involved.

The Brazilian National Men's Health Policy (PNAISH) - established by Administrative Rule no. 1,944/GM, Ministry of Health, August 27, 2009 - has the general goal ***To promote the improvement of health conditions of the male population in Brazil, contributing effectively to the reduction of morbidity and mortality through the rational confrontation of risk factors and by facilitating access to actions and services for comprehensive health care***[12]. Therefore, the basic healthcare model to four population groups - children, teenagers, women, and the elderly - is not enough to turn the country healthier, as it leaves 25% of the population out of programmatic actions (men from 20 to 59 years old), with low visibility concerning health care public strategies[12].

PNAISH's establishment was preceded by several discussions involving several social players, institutions, and civil organizations. The product originated from these discussions was submitted to Public Consultation to increase the participation of society in general, but - unlike the National Policy on Women´s Comprehensive Health Care - it did not result in a motivation of the social movement, once such population is not is recognized as excluded or socially prescinded.

However, in spite of this process of democratic construction, the meanings of a healthcare policy cause different interpretations since its birth, and the attribution of meanings towards them will not always match with their actual purposes. These interpretations, in turn, are based in a set of ***habitus*** - understood as acquired knowledge, a happening, a capital that indicates an embedded provision[13,14] – which works as reference for the representation of agents involved in the implementation of PNAISH. Thus, listen-

Ciência & Saúde Coletiva, 17(10):2589-2596, 2012

ing to several voices and discourses that move around the "make see and make believe"[13] is vital to the construction course of this Policy.

According to this perspective, the purpose of this paper is to analyze the meanings attributed to the National Men's Health Policy, by social subjects directly involved in implementing this Policy. This study strives to identify what a policy formulated nationwide means in local contexts and how the different areas (political, professional), their rules and values , reinterpret this policy.

The result of this study can bring an overview of how the meanings attributed approach or move away from the meanings officially established on PNAISH, or can subsidize the monitoring of implementation actions of this Policy based on the negotiation among meanings and significances.

Methodological design

This study is part of a larger research project, which goal was to assess the first implementation actions of the Brazilian National Men's Health Policy (PNAISH), performed by the Fernandes Figueira National Institute of Women's Health, Child and Adolescent, part of the Oswaldo Cruz Foundation (FIOCRUZ)[15], with funds from the Department of Science and Technology (DECIT) of the Department of Science, Technology and Strategic Inputs (SCTIE) of the Ministry of Health (MS).

A broader study, approved by the Ethics Committee of the Institute mentioned, had as methodological reference the triangulation of methods[16,17], articulating the epidemiological and anthropological approaches and using questionnaires, narratives, semi-structured interview, and observation techniques based on ethnographic principles, and document analysis.

The questionnaires were directed to managers of the 27 federal units and 26 cities that initiated the implementation of the Policy. The other techniques were held in the following selected cities representing each macro-region: Goiânia (GO), Petrolina (PE), Rio Branco (AC), Rio de Janeiro (RJ), and Joinville (SC).

This study takes into account narrative and semi-structured interview techniques with health managers and professionals, respectively, directly involved in PNAISH's implementation. The narrative is understood as a way in which experience is represented and retold, and the events are presented in a consistent and meaningful order, enabling the narrator to realize a connection among present, past or future[18]. The narrative production technique was based on Jovchelovitch and Bauer[19]. Based on these authors, to begin the reports, the following initial topic was suggested:

We would like to rescue the history of PNAISH´s first implementation activities in your county. Therefore, we ask for your cooperation in telling us in detail how this Policy arrived here, which were the main strategies used in its implementation, and other aspects that you might think it is important to highlight.

Concerning the semi-structured interview - herein understood as a conversation guided by a research script - the following aspects were included: demographic data, career path, professional training focused on men´s health, care demands; PNAISH´s implementation in the city and relationship with the community.

At first, the study estimated one narrative and three interviews per city. However, based on the principles of a qualitative sample[20], it included a larger number of statements to reach enough data. Thus, the study counted on six narratives and 21 semi-structured interviews.

The study considered, in both narratives and interviews, only the information about how the Policy is perceived by health managers and professionals.

This information pulled out from narratives and interviews were used according to the Method of Meaning Interpretation[21]. This method is based on dialectical-hermeneutical principles that seek to interpret the context, the reasons, and the logic of speech, actions and interrelations among groups and institutions. In the analytical-interpretative course of the texts, the following steps were followed: (a) comprehensive reading, aiming to impregnation, to the overall view and the grasp of particularities of the research material, (b) identification and thematic profile that emerge from statements; (c) identification and questioning of ideas explicit and implicit in the statements; (d) search for broader meanings (socio-cultural), underlying the statements of the research subjects; (e) dialogue among ideas addressed, information from other studies about the subject, and the theoretical referential of the study; and (f) elaboration of interpretive synthesis, trying to articulate objective of the study, the theoretical basis adopted, and empirical data.

Characterization of subjects

Concerning the six subjects of the narratives, this study chose not to describe their characteristics, so they could not be identified.

As for the 21 subjects interviewed, the study noted - in socio-demographic terms - that most of them are professionals married and within 40-49 years old (Table 1).

Most of the interviewees had a health related professional background: ten nurses, six doctors, one psychologist, and three social workers (it was not possible to identify the professional background in one of the interviews). Out of the 21 interviewees, 12 had non-degree specialization graduate course and one of these had already concluded a Masters degree, and one is still studying toward a graduate degree. Out the interviewees with specialization, four of them have specialization in Public Health and two in Family Health. Out of the six doctors, five mentioned specialization course, some accumulating more than one expertise area.

Table 1. Sociodemographic characteristics of respondents (N = 21).

Sociodemographic variables	Total
Region/city	
Midwest/Goiânia	3
South/Joinville	6
Northeast/Petrolina	4
North/Rio Branco	4
Southeast/Rio de Janeiro	4
Sex	
Male	10
Female	11
Age (years)	
23-30	3
30 - 39	4
40 - 49	8
50 - 59	3
No data	3
Marital status	
Married	12
Single	4
Divorced	1
Widow	1
No data	3
Religion	
Catholic	5
Christian	4
Spiritist	4
None	3
Bahái'í	1
No data	4

Presentation and discussion of results

PNAISH assigns different meanings to the research subjects. First, it is necessary to note that in many cases, the interviewees have little or are not familiar at all with the Policy. Some subjects discuss on various issues, but they do not mention any aspect or dimension of the Policy. Others explain that they have never read any document on the subject.

Among those who somewhat knew about the policy, they perceived it with some positivity, in general. This does not necessarily null the broad polysemy that crosses the discussion, nor some criticism towards it.

One of the meanings attributed to the Policy is the perception of such as a comprehensive care that guides actions to approach men as a whole, involving primary care. In this conception, the actions would involve other dimensions beyond the medical clinic, to not only focus on diseases, but to move forward in the promotion of health in general. The entirety, one of the principles of the Brazilian Unified Health System (SUS), is based on four cores: ***needs*** (related to extended care to the demands of health care, not limited to disease and without neglecting it), ***purposes*** (concerning the integration among health promotion, disease prevention, disease treatment and recovery/social reintegration); ***articulation*** (related to the adoption of interdisciplinarity, of multiprofessionality, and of intersectoriality in health care), and ***interaction*** (referring to intersubjective interactions among participants of health care)[22]. The meaning here given by PNAISH subjects refers - directly or indirectly - to these cores. Although this meaning can be more expressed in the field of what is ideally conceived than within everyday actions, there is a positive gain from the implementation, which is the identification of the expanded health meaning that the Policy wants to express.

Another recurrent meaning from the statements is what PNAISH perceives as something episodic. Accordingly, several events are mentioned, such as: "Men's Health Day", "Men's Week," "Father's Day", panels with experts, divulgation in the local media, distribution of brochures, among others. These episodic actions are directed to both male population, aiming to encourage men to seek information and health care services, and health professionals aiming to sensitize them to the issue.

Some of these events express the episodic character of something that is not part of a routine

Ciência & Saúde Coletiva, 17(10):2589-2596, 2012

and that was created specifically to implement the Policy. In many cases, the development of such events is not shown. It may have been a starting point for a work process with male segments, or one more in the set of healthcare actions held by the cities. Some professionals consider such events not enough to implement the Policy.

In one of the cities studied, the local administration promoted the Men's Week, which involved a contest among teams. However, the teams were informed about the event only few days in advance, they did not receive any specific training on PNAISH, and they had to develop actions to get prepared for that week, with no central coordination or more resources sent to them to perform the actions. Some teams extended the working hours for a few days, others created small plays in the community, while others applied a poll with men who were nearby the health facility.

It is worth noting that the promotion of some events - such as Men's Week or a large campaign to disclosure the Policy - took place just before field researchers arrived to respective cities.

PNAISH episodic meaning can be perceived as a reflection of common sense about the implementation of policies reduced to events only and not directed to planning and development of processes. In some statements, there is a criticism to this practice. However, it does not mean that the fact of mentioning events is a reductionism. The events mentioned in narratives can serve as milestones necessary to the proper organization and to the reconstitution of plots about what was experienced by the subjects and by the social groups[18,23]. Thus, temporal references can work as landmarks for the production of narratives, or can symbolically work as identitary synthesis of what is conceived concerning the policy.

Another meaning around some statements is of a policy reduced to urological problems, specifically prostate cancer, rather than other problems that affect health and quality of life of men. As observed by a doctor, the Policy does not have an ***Achilles' heel***, but an ***Achilles' prostate***. Some respondents express a critical view about this, noting that such reduction go against of what is recommended by Primary Care - prevention and promotion work and a comprehensive treatment. Others note that attention by the urologist is not feasible in some places once there is a lack of such professional.

The reduction to urological aspects is explained in part, as PNAISH used to associate a lot with specific campaigns produced by the Brazilian Society of Urology before the Policy was launched, and to general activities of this society that turns this medical specialty into the protagonist of actions aimed at solving public health problems related to the male population[24]. Moreover, such centrality is due also because the National Plan for Implementation of the Policy provided such condition in the definition of its initial goals.

This reduction identified by health professionals still can, through a symbolic association, hide other male health problems than those directly related to male genitalia. Problems in the circulatory system, for example, may not be perceived as part of what is defined as male health.

Establishing prostate cancer and erectile dysfunction as the central problems of men´s health does not only shift the focus from other major issues that jeopardize such health, such as violence, but also reduces male sexuality to disease, regardless of health promotion actions. Besides contributing to further medicalization of the male body, especially when it comes to their sexuality, a fact that started in the fight against syphilis, it finds a fertile ground in sexual impotence[24].

In turn, the promotion of health as a fundamental guiding concept of the Family Health Strategy (FHS) can both enable the enhancement of local microcultures and walk towards the autonomy of individuals, or can be employed as a strategy to direct individuals to individually assume the responsibility for their health, it depends on how it is understood and practiced[25].

Thus, Gaudenzi and Ortega [26] state that the incentive of the Ministry of Health to policies based on a broad view of health, which value autonomy and ways of solidary responsibility - such as is the case of Family Health strategy (FHS) - makes possible to create a unmedicalized healthcare, allowing greater expression of small movements in favor of the rescue of autonomy.

It is noteworthy that PNAISH's discursive purposes are aligned with the National Primary Care, intending to build mechanisms to strength and improve primary care, favoring the FHS and the interdisciplinary dialogue with several groups of organized society, intending to promote systemic interventions covering even the social determinants on health and disease, in addition to the adoption of medical biological measures.

The "Achilles' prostate" in the early implementation of PNAISH represents an important challenge to "make see and believe" such construction.

Finally, there is the meaning assigned to Policy as something vague that brings more tasks to healthcare professionals, not realizing how to bring men to the services and how to develop a

different look to men's care. Thus, men's health is always one more activity that the professional assumes in the unit, beyond those which they are already involved. Accordingly, the arrival of a new policy causes concern among professionals as they have to comply with a new task, amid the difficulties of the municipal system that cannot always meet the existing demands. Along with this concern, the statements also reveal some misunderstanding of PNAISH's purposes.

Another possible explanation to the fact that the Policy is vague refers to the fact that its principles do not provide proper support in the formation of some health professionals. Training based solely and exclusively on semiology and semiotechniques that operate in the biomedical optic is not always able to enable professionals to handle with the expanded health, or with gendered beings.

Some meanings attributed to the Policy can be interpreted with some resistance by some professionals. Perhaps they resist facing the larger number of activities before the precariousness of their working conditions. But resistance may be because of de new, of a set of embedded ***habitus***, that leads to thinking, seeing, and acting in different situations[14]. In other words, perhaps the resistance to comprehensive care of men's health can also be explained by the fact that it deals more with disease than with health, considering more the disease rather than the subject of the disease, or to provide care to women and children only. Thus, it would signal the presence of a care model centered on the organic dimension of care, and the existence of a gender stereotypical look that can lead to the (re) production of inequalities between men and women in health care.

Other meanings can also be interpreted from the logic of reflective thinking, which is able to mobilize a set of theoretical and methodological knowledge from the field of dispositions to articulate knowledge and willingness to understand[27]. Thus, some professionals – even if it is an ideal plan – are seeking alternatives for dealing with health considering gender issues, in which the subjects of health and disease are perceived according to feminine and masculine particularities.

PNAISH places men as the central category of actions. This category, in turn, evokes, as demonstrated above, a set of meanings that refers to previous experiences, but also to belongings of different social fields, particularly to different positions in the healthcare and political area[11,14]. Thus, according to some interviewees, the Policy favors some specialties that traditionally holds the power/doing[28-30] on men's care, such as urology, or even constitutes in ***something episodic***, as the burden falls on those who are in an underprivileged position (health professionals) and the rewards are enjoyed by the group placed in a superior position in politics (politicians and administrators). To others interviewed, the men category is just one of the elements that compose the ***comprehensive care*** and therefore should already be under the jurisdiction and included in the planned activities for primary health care. That is, it is a category equal to others, such as children, women, and elderly. Thus, the meanings attributed to the Policy must be understood in the professional and political context which respective social subjects fall in.

Closing remarks

The data analyzed indicate the multiplicity of meanings that a public policy acquires when considering the different levels and social players involved in the implementation and enforcement of this policy. These are meanings that will guide the practices and actions developed, the reason why its understanding is a key element in monitoring and evaluation the policy.

The attribution of meaning, analyzed in this paper, may signal the professional's engagement with the Policy. PNAISH can be perceived as episodic, eventual, also having a temporary and casual involvement of the professional; it may be something that concerns him or her little, being relegated to other specialties; or may be viewed as unnecessary as it would already be included in the principles and guidelines of primary health care; or understood as one more demand difficult to perform as it finds barriers in the same impediments of other health policies, which also originates from the inseparability among care and management practices to ensure the integrality of actions.

These different contexts should be considered in the implementation of the Policy, striving for the effectively and continuously engagement of the different professionals. This requires that such professionals recognize men's health in their daily practices, perceiving themselves included and involved in the Policy's guidelines. This involves, among other things, the redefinition of ***habitus*** to promote a comprehensive men's health care in a relational perspective of gender.

Collaborations

R Gomes, AF Leal, D Knauth e GS Nogueira da Silva participated in the research, analysis and final writing of the manuscript

Acknowledgements

The authors thank the Technical Area of Men's Health, the Ministry of Health, especially its director, Eduardo Chakora, for invaluable contributions, without which this research would not have been possible.

References

1. Berger PL, Luckmann T. ***Modernidade, pluralismo e crise de sentido: a orientação do homem moderno***. Petrópolis: Vozes; 2004.
2. Berger PL, Luckmann T. ***A construção social da realidade: tratado de sociologia do conhecimento***. Petrópolis, RJ: Vozes; 2001.
3. Fernandes FMB, Ribeiro JM, Moreira MR. Reflexões sobre avaliação de políticas de saúde no Brasil. ***Cad. Saude Publica*** 2011; 27(9):1667-1677.
4. Guizardi FL, Cavalcanti FOL. Por um mundo democrático produzido democraticamente (ou: o desafio da produção do comum): contribuições a partir da experiência do Sistema Único Brasileiro. ***Revista Lugar Comum*** 2009; 27:103-123.
5. Jullien F. ***Tratado da eficácia***. São Paulo: Editora 34; 1998.
6. Singer M, Castro A. Anthropology and Health Policy: A Critical Perspective. In: Castro A, Singer M, editors. ***Unhealthy Health Policy***: A Critical Anthropological Examination. Walnut Creek: AltaMira Press; 2004. p. xi-xx.
7. Manderson L, Whiteford LM. Introduction: Health, Globalization, and the Fallacy of the Level Playing Field. In: Whiteford LM, Manderson L, editors. ***Global Health Policy, Local Realities***: The Fallacy of the Level Playing Field. Boulder: Lynne Rienner; 2000. p. 1-19.
8. Fassin D. Social Illegitimacy as a Foundation of Health Inequality: How the Political Treatment of Immigrants Illuminates a French Paradox. In: Castro A, Singer M, editors. ***Unhealthy Health Policy***: A Critical Anthropological Examination. Walnut Creek: AltaMira Press; 2004. p. 203-214.
9. Pfeiffer J. International NGOs in the Mozambique Health Sector: The "Velvet Glove" of Privatization. In: Castro A, Singer M, editors. ***Unhealthy Health Policy***: A Critical Anthropological Examination. Walnut Creek: AltaMira Press; 2004. p. 43-62.
10. Lenoir R. Transformations du familialisme et reconversions morales. ***Actes de la recherche en sciences sociales*** 1985; 59:3-47.
11. Lenoir R. L'Etat et la construction de la famille. ***Actes de la recherche en sciences sociales*** 1992; 91:20-37.
12. Brasil. Ministério Da Saúde (MS). Secretaria De Atenção À Saúde. Departamento De Ações Programáticas Estratégicas. ***Política Nacional de Atenção Integral à Saúde do Homem***: Princípios e Diretrizes. Documento apresentado à Comissão Intergestores Tripartite (CIT) com as contribuições do Grupo de Trabalho de Atenção à Saúde. Brasília: MS; 2009.
13. Bourdieu P. ***O Poder Simbólico***. Rio de Janeiro: Editora Bertrand Russel; 1998.
14. Bourdieu P. ***Esboço de uma teoria da prática***. Oiras: Celta Editora; 2002.
15. Gomes R, Leal AF, Lima AMP, Knauth D, Moura ECD, Nogueira da Silva GS, Couto MT, Urdaneta M, Figueiredo WDS. ***Avaliação das ações iniciais da implantação da política nacional de atenção integral à saúde do homem - Relatório Final***. Rio de Janeiro: IFF; 2012.

16. Denzin NK. ***The Research Act***: A Theoretical Introduction to Sociological Methods. Chicago: Aldine Publishing Company; 1973.
17. Minayo MCS, Assis SG, Souza ER, editores. ***Avaliação por Triangulação de Métodos***: abordagem de programas sociais. Rio de Janeiro: Fiocruz; 2005.
18. Gomes R, Mendonça EA. A representação e a experiência da doença: princípios para a pesquisa qualitativa em saúde. In: Minayo MCS, Deslandes SF, editores. ***Caminhos do Pensamento***: epistemologia e método. Rio de Janeiro: Fiocruz; 2002.
19. Jovchelovitch S, Bauer MW. Entrevista narrativa. In: Bauer MW, Gaskell G, editores. ***Pesquisa qualitativa com texto, imagem e som***: um manual prático. Petrópolis: Editora Vozes; 2002. p. 90-113.
20. Minayo MCS. ***O desafio do conhecimento***: pesquisa qualitativa em saúde**.** 8ª Edição. São Paulo: Hucitec; 2004.
21. Gomes R, Souza ER, Minayo MCS, Malaquias JV, Silva CFR. Organização, processamento, análise e interpretação de dados: o desafio da triangulação. In: Minayo MCS, Assis SG, Souza ER, editores. ***Avaliação por Triangulação de Métodos***: abordagem de programas sociais. Rio de Janeiro: Fiocruz; 2005. p. 185-221.
22. Ayres JRCM. Organização das ações de atenção à saúde: modelos e práticas. ***Saúde e Sociedade*** 2009; 18(Supl. 2):11-23.
23. Good BJ. ***Medicine, Rationality and Experience***: An Anthropological Perspective. Cambridge: Cambridge University Press; 1994.
24. Carrara S, Russo JA, Faro L. A política de atenção à saúde do homem no Brasil: os paradoxos da medicalização do corpo masculino. ***Physis*** 2009; 19(3): 659-678.
25. Castiel LD. Promoção de saúde e a sensibilidade epistemológica da categoria 'comunidade'. ***Rev Saude Publica*** 2004; 38(5):615-622.
26. Gaudenzi P, Ortega F. O estatuto da medicalização e as interpretações de Ivan Illich e Michel Foucault como ferramentas conceituais para o estudo da desmedicalização. ***Interface Comum Saúde Educ*** 2012; 16(40):21-34.
27. Bourdieu P. ***A dominação masculina***. Rio de Janeiro: Bertrand Brasil; 1999.
28. Foucault M. ***História da Sexualidade, Volume 1: A Vontade de Saber***. 13ª Edição. Rio de Janeiro: GRAAL Editora; 1999.
29. Foucault M. ***Nascimento Da Biopolitica***. São Paulo: Martins Fontes; 2008.
30. Foucault M. ***O Nascimento da Clínica***. 5ª edição. Rio de Janeiro: Forense Universitária; 1998.

Artigo apresentado em 10/06/2012
Versão final apresentada em 28/06/2012