

Men's health and masculinities in the Brazilian Comprehensive Healthcare Policy for Men: a bibliographical review¹

Saúde do homem e masculinidades na Política Nacional de Atenção Integral à Saúde do Homem: uma revisão bibliográfica

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Resumo

Este artigo, orientado pela teoria do gênero sobre masculinidades, revisa os textos que trataram do tema nos periódicos de Saúde Coletiva/Saúde Pública no período de 2005-2011. Os eixos temáticos encontrados coincidem com as prioridades conferidas pela Política Nacional de Atenção Integral à Saúde do Homem, criada pelo Ministério da Saúde em 2008. São eles: o acesso dos homens aos serviços de saúde, sexualidade, saúde reprodutiva, violência e os principais agravos à saúde masculina, contextualizados à luz dos determinantes sociais da saúde. Tais determinantes se baseiam em um tipo de masculinidade tradicional concebida como hegemônica, que apesar de comprometer a saúde masculina, não é o tipo único de masculinidade existente na sociedade. As diferentes masculinidades encontram-se imbricadas no processo saúde/doença vivido pelos homens. Elas devem ser consideradas na busca da adesão dos homens aos serviços de saúde.

Palavras-chave: Políticas Públicas de Saúde; Saúde do Homem; Gênero e Saúde.

Abstract

This article, based on gender theory, reviews the literature about masculinities in collective and public health journals for the period 2005-2011. The principal themes found coincide with the priorities established by the Brazilian National Comprehensive Healthcare Policy for Men: men's access to health services, sexuality, reproductive health, violence and the main challenges to men's health. These themes are based on a traditional type of hegemonic masculinity, which not only compromises men's health, but is not the only type of masculinity that exists in society. These different masculinities are involved in the process of disease and health, and are important in promoting men's involvement with health services.

Keywords: Public Health Policy; Men's Health; Gender and Health.

Introduction

In August 2008, as the Brazilian National Health System (SUS) marked its twentieth anniversary, the principles and directives of the National Comprehensive Healthcare Policy for Men (PNAISH) (Brasil, 2008) were created through the Ministry of Health's Secretariat of Health.

The result of mobilization by various collective entities (sectors of organized civil society, scientific societies, academic researchers, and international agencies that foster research), the document indicates men's health problems as real challenges to public health.

One of the principles highlighted is the need to change men's perceptions about caring for their own health and the health of their family members. Specifically, the objective of the policy is to organize, implant, qualify and humanize, throughout Brazil, comprehensive health care for men within the principles which regulate SUS.

The objective of the general plan is to improve men's health, and in doing so contribute to reducing the indices of male morbidity and mortality, which are considered to be high in relation to women. It also aims to facilitate this population's access to comprehensive primary health care services, which makes the policy more broadly cover men's health.

With regards to men's health concerns, the document cites the literature on men and health to describe their greater vulnerability to illnesses, especially chronic diseases. Men seek health services less than women do (Schraiber et al., 2010; Toneli et al., 2010; Pinheiro and Couto, 2008; Nascimento and Gomes, 2008; Gomes et al., 2007), and when they do, they enter the system with medium and high complexity complaints. In practice, this means that they are in an aggravated state of illness, many times in a state which is beyond cure, as in the case of prostate cancer, at greater cost to the health system.

PNAISH recognizes the social determinants of men's vulnerability to diseases, highlighting that men's non-participation in health services reveals gender stereotypes based on cultural characteristics that regulate a certain type of masculinity in the hegemony, obeying a symbolic order in which disease expresses the body's fragility and, by extension, the patient's fragility.

The objective of this project is, therefore, to analyze men's health and masculinities in PNAISH through the lens of the reflections that these issues have received in recent years in the public health literature.

The theoretical anchor is based on gender studies, which should be understood as a relational category; in other words, it relates to the sociopolitical relationships between men and women, but also between men and between women and their gender pairs, which means to say that gender underlies all social relations, being the first step towards making sense of such relationships as those of power and domination. This is one of Scott's (1990) definitions emphasizing gender as one of the three fundamental pillars which structure the subject's identity, followed by class and race, and to which can be added generation, sexual orientation, and religion.

This definition is marked by the plasticity conferred to the gender category, ceding space to the forms of masculinity and their connections with health and disease, as well as analysis of the conceptions of masculinity contained in the formulation of this specific policy aimed at men and in the literature in the field of public health.

Methodology

To find the texts about men's health and masculinities, we used the Virtual Health Library (Biblioteca Virtual em Saúde, BVS) from Latin-American and Caribbean Literature in Health Sciences (Literatura Latino-Americana e do Caribe em Ciências da Saúde, LILACS), a database which brings together periodicals featuring scientific works specific to the region, especially those referring to public health. It was accessed in March of 2011.

Using the descriptors *men's health* and *masculinities*, we found a total of 27 articles in periodicals specifically directed at public and collective health in the Scielo-Brasil electronic library, also indexed in the BVS.

With relation to the distribution of articles

in scientific journals about public and collective health, the concentration of works produced in Rio de Janeiro and São Paulo stood out, accounting for 75% and 25%, respectively².

The project covered the period from 2005 to March 2011, since a previous study by Gomes and Nascimento (2006) mapped and analyzed domestic scientific production in the area of public health specific to men's health and masculinities for the period 1998-2004 on the following topics: masculine sexuality, masculinity and reproduction, and masculinity and power.

The texts were read and classified, keeping in mind the central ideas they contained, and were later separated by topic. The themes found coincided with the priorities established by the National Comprehensive Healthcare Policy for Men. They are: men's access to health services, sexuality, reproductive health, violence, and the main threats to men's health, seen in the context of the social determinants of health, which are based on a type of traditional masculinity considered hegemonic, which not only compromises men's health, but is also not the only type of masculinity which exists in society.

Refining the concept: understanding masculinities

The topic of masculinities has existed for at least two decades in the social and human sciences. As a result, variations in the concept over this period can be seen which deserve exploration in order to be refined and better understood.

Reference to Connell has become obligatory on discussing this topic, as her theoretic incursions into the analysis of masculinities have been pioneering. Along general lines, Connell defines masculinity as at the same time both a position in gender relations, as well as the practices by which men and women commit to this position, and the effects of these practices on bodily experience, on personality, and on the culture (Connell, 1997).

² Recently, an increase in literature on this topic has been seen with the publishing of more research, in particular regarding the establishment of PNAISH. Referring to production from Sao Paulo, the magazines *Saúde e Sociedade* and *Interface: Comunicação, Saúde, Educação* stand out for their publishing of studies directly related to men's health and masculinities.

The concept of *hegemonic masculinity* is attributed to Connell. Starting from the Gramscian conception of hegemony, it indicates some defining characteristics: a) it was based on the relational configuration of gender practices which are socially accepted, establishing and assuring polarized positions of the dominators and the dominated, exemplarily shown in the subordination between the sexes; b) it does not refer to powerful individuals, but to a type of masculinity taken as an example; c) it has an ideological aspect, in the Marxist sense of the term, since it naturalizes the differences between the sexes, in this way glossing over the socio-cultural construction of gender hierarchies; d) it expresses a position which is always in dispute, and is not a fixed model (Gomes, 2008).

Taking a socialist perspective, Connell postulates that masculine domination responds to a historic and cultural construction of masculinities which should in turn be transformed. To do this, it is relevant to contextualize and contest it in the various social and symbolic spaces in which it appears, not only in social production and reproduction, but also in the sphere of consumption, institutions, in the places of social, workplace, and military struggle (Connell, 1995).

Starting from a constructionist and historic view of masculinities, such as Connell, but including more of the pro-feminist male perspective, Kimmel (1997) underlines the importance of taking into account space and historic time in studying masculinities, as these have distinct meanings from one society to another, as well as being different in the same society over time.

For Kimmel, the gender identities that hegemonic masculinity dictates are composed of the antagonism between masculine and feminine, in the tensions between the pairs of opposing concepts which demarcate the frontiers between genders. In the case of men, this lies in the negation of any feminine characteristics which can be attributed to them. A true man must be aggressive, competent, strong, rational, have unlimited sexuality, as opposed to tenderness, fragility, affectivity, to the contained sexuality of women, revealing in this way the homophobic nature of his gender.

Because they are not fixed, masculinities require

men to continually remake themselves in relation to their peers, and to be legitimized by them. These cultural meanings present hegemonic masculinity as damaging not only for women, when aggression overflows into inter-gender violence, but also for the men themselves, when such paradigms deauthorize the expression of feelings such as love, gentleness, pain, fidelity, etc. (Kimmel, 1997).

Welzer-Lang (2004) emphasizes that in this homophobic model of masculinity, masculine superiority over women is essentialized in the culture; in other words, the hierarchies of gender and power are socially conceived as inscribed in the biological order of bodies in which the masculine takes precedence, resulting in the public sphere as the normal andro-heterocentric policy, delineating the “normal man”, the “real man”, who is a candidate to be a “great man”. In this process, as not all men have the same share of power, the “little men” subordinate to the “more powerful” silence the asymmetrical double standard of inter- and intra-gender relations in a tacit and strategic pact which eclipses the suborning positions of the dominant masculine hierarchy.

It is opportune to remember Almeida (1996), who stresses the typological character of hegemonic masculinity in the molds of the ideal Weberian type; in other words, it is an ideal cultural model, a caricature which informs practices and exercises control of power not only between men and women, but also between men themselves. It is an impossible task, hence the exemplary character. Based on the masculine/feminine dichotomy, it ends up revealing not only the discourse of asymmetries between the genders, but also the internal disparities which make up masculinity itself, such as for example heterosexuality/homosexuality, and hierarchies which range from “more” to “less” masculine, qualified as subordinate variants of the hegemonic model.

Despite a certain consensus that there seems to be a historic and cultural character in the category of gender (Nascimento, 2005), when speaking of masculinities and femininities this accord does not seem to be so evident.

In this sense, Faur (2004), among the various lines of theory which deal with the concept of masculinities, cites the spiritualist or mytho-poetical

perspective, which is represented in South America by Kreimer (1994).

Based on a neo-Jungian reading of some men's life experiences, expressed in regular meetings of men, this author advocates the need for changes in the archetypes of masculinity. The idea is that the feminist movement exposed the emotional and physical wounds resulting from patriarchic masculinity; men are just as much victims of this masculinity as women are. The relationships of masculine domination of women tend to reproduce through an unconscious matrix that establishes the characteristics of what it is to be a man, in this way the men see the need to be providers, aggressive, competitive, etc as natural.

Along general lines, this perspective essentializes masculinities and femininities, placing the differences in an irreducible and hard-to-access psyche. The culture is reified in the masculine unconscious and the social contents of power which cover gender relationships, of domination and subordination reduced to the cognitive aspects or a supposedly vast masculine psychic nature.

We cite Kimmel's observation which illustrates the suggestive way in which gender, class and ethnicity are subsumed in the relationships of power and domination:

Two women conversed: one was Black, the other white. The first asked the other: what do you see in the morning when you look in the mirror? The white-skinned woman answered: I see a woman; the other woman responded: this is the problem, when I look in the mirror I see a Black woman. For you race is invisible, because that's how privilege works (Faur, 2004, p. 26).

Men's health and masculinities

Although PNAISH is aimed at all men, the document states that the main focus is adult men between ages 20 and 59, which corresponds to 41.3% of the economically active masculine population of the country (Brasil, 2008).

This methodological definition is strategic, as stated previously, because not only does it refer to a group which is preponderantly responsible for productive social strength, but also because this

group plays a significant socio-political and cultural role in the society.

Children, women, and older people access health services more often; the idea is to sensitize this other segment of the population, the men, which has a higher rate of non-utilization of services.

Looking at the collective health/public health literature, it was confirmed that men's access to, or better yet, difficulty in accessing health services is a relevant concern (Schraiber et al., 2010; Couto et al., 2010; Toneli et al., 2010; Pinheiro and Couto, 2008; Nascimento and Gomes, 2008; Gomes et al., 2007; Paschoalick et al., 2006; Araújo and Leitão, 2005), and this is one of PNAISH's main objectives.

Schraiber et al. (2010) stress that Atenção Primária a Saúde (Primary Care: APS) - the main access point to health services - is markedly aimed at women's health problems, as prevention and health care are socially characterized as essentially female tasks. This same logic structures the services, actions and statements between health professionals and users, reproducing traditional gender relationships.

Such relationships, as observed by Figueiredo (2005), Gomes et al. (2007) and by Nascimento and Gomes (2008), lie in social representations which see men as having fewer health needs than women do, which are perfectly expressed in the figure of the providing head of household, who is dedicated to work and rarely gets sick, which could lead this person to neglect their health.

In this way, characteristics of a traditional masculinity are reiterated, based on the idea of a nature which provides unwavering physical strength to men, making them naturally predisposed to work in general and to certain work activities, in particular those which demand greater physical strength (Machin et al., 2009).

As demonstrated by Gomes et al. (2007), when asked to elaborate on the motives which keep them away from health services, besides the fact that care is represented as a feminine social practice *par excellence*, various men stressed that the main motives were the problem of missing work during the hours when appointments are commonly scheduled, and lack of specific health clinics which specifically treat men's health problems.

Seeking to understand what is called the “invisibility” of men in day-to-day operations in the APS from a gender perspective, Couto et al. (2010) discuss the mechanisms at work in health which promote inequalities of access. Here it is important to stress that, despite the fact that changes have been seen in communications sent to the population from the Ministry of Health, which include references to gender, generation, and race/ethnicity in the distributed materials, these are not yet perceived in the daily work of health teams. Accordingly, the greatest presence in the APS is women and children, a population which has historically been served by maternal-infant health programs, and older people (Figueiredo, 2005).

The “genderization” of healthcare spaces, which facilitates inequality of access and the “invisibility” of masculine health needs and demands, and above all not forgetting that these pass through the filter of the men themselves, who are exposed to the social stereotypes of gender, to a type of masculinity which represents them as less prone to health problems, and in this way contributing to the characterization of the APS as feminized spaces (Couto et al., 2010).

As suggested by the work of Paschoalick et al. (2006) and Pinheiro and Couto (2008), for the current scenario to change, policies which point to health policies and actions by health professionals should be focused on in order to increase comprehensive care for masculine health, with the presence and effective participation of men in the services, which means reviewing manners and postures of care and service which are still based on a stereotyped masculinity. The idea of awakening men’s consciousness of their specific health needs goes hand in hand with structuring services that meet their demands and overcoming gender stereotypes in various segments of society.

Knauth and Machado (2005) call attention to the relevant fact that before excluding the masculine universe from “care” it is necessary to consider the forms of representation, including its meaning for men, which probably varies between the different segments of society. In this sense, Toneli et al. (2010) suggested, based on empirical information collected from masculine segments of urban society, that care for health and the body mean, respectively, physical

exercise and seeking medical care in extreme situations, while Nascimento (2011), investigating the social representations of health and disease, and the health practices among one hundred men living in cities in the area surrounding Belo Horizonte, indicated that the concern with health that 52% of them reported meant practice of physical exercise and care with their diets.

The theme of masculine sexuality appears significantly in collective and public health production about gender, men’s health, and masculinities (Canesqui, 2010). Among the various periods of masculine sexual life, sexual initiation can be described as a moment of bodily and social learning (Leal and Knauth, 2006) in which the man relates to himself, with his body, but also with the bodies of others who surround him, in particular, to women.

This describes a symbolic moment, when the social values attributed to masculinity are reiterated or transgressed through lived experience. As stressed by Leal and Knauth (2006), masculine sexual initiation is an event marked by social constructions of sexuality, according to which: 1) what is considered to be sexual varies from one culture to another, so the values attributed to encounters between the sexes by societies also are different; 2) sexual behaviors are standardized by societies and human cultures, although their acquisition occurs individually, in a continuous process of acculturation which extends through the entire life of the subjects; 3) individuals’ adaptation to the sexual behaviors sculpted by societies and cultures is not done in a linear and irreversible way in time, as there are spaces for human creativity.

Because it is a period in which health habits related to the exercise of sexuality are acquired and/or transformed, some studies have concentrated on the phase of masculine sexual initiation, with the objective of questioning and indicating educational practices which are capable of promoting and increasing consciousness about health in young men.

In this sense, the study by Rebello and Gomes (2009) of young university students in Rio de Janeiro revealed that sexual initiation, according to statements by the subjects of the study, is anchored in an established socio-cultural model of what it is to be a man, obeying the norms of heterosexual conduct,

and in which penetration is the principal practice attributed to the masculine sex act.

Therefore, sexual initiation is established as a moment in which young men are socially pressured by their peers to prove that they are really “men”; this occurs at younger and younger ages, which leads to carelessness with regards to safe sex, and threats to health caused by sexual transmitted diseases (STDs) and AIDS. However, as the authors observe, other meanings were attributed by various subjects to the beginning of sexual experience, such as the marking of a life stage, the awakening of desire for the opposite sex, in other words, feelings which relativize the values attributed to a hegemonic masculinity and which express masculine sensitivity. Fears, anxieties, and insecurities make up this period of young men’s lives, and should be heard in order to effectively promote health education for this generational group.

Observations from a study by Nascimento and Gomes (2009) move in the same direction; young low-income adolescents from Rio de Janeiro exhibited a mixture of values connected to permission and prohibition of subjects related to sexuality in general and sexual initiation in particular. The young men saw masturbation as a privileged space of masculine sexual initiation, and as something complicated, enjoyable, affectionate, and common moment of learning. The authors concluded that new forms of welcoming and listening need to be developed in health services to meet the sexual requirements of these young men, seeing that in general they do not publically express their apprehensions with relation to sex, with such topics restricted to private forums.

Other surveys (Cunha et al., 2012) indicate important changes in the public and private spheres attributed to gender since the 1970s, currently establishing new constructions of identity which value autonomy and equality in affective relationships, in social construction of the masculine and the feminine, in ideas, as well as in the dialog about sexuality. Nevertheless, these changes do not yet seem to be assimilated by health services, due to the strictly biological manner in which they treat sexuality and reproduction. This is such that Ribeiro (2009), through qualitative analysis with health pro-

fessionals, directors and managers in a city in São Paulo, showed sparse initiatives in differentiation between men and women in counseling about sexuality and human reproduction, and recommended, to this end, the creation and amplification of these spaces in health services.

When looking at sexuality in adult age groups, the studies are sparse. Concepts such as erectile dysfunction, andropause (more recently called Androgen Deficiency of the Aging Male), and male hormone replacement are more common in the media and the public spaces and policy spaces dedicated to masculine health.

We should stress, like Aquino (2005), that such discussions involve multiple interests, among them most prominently those of the pharmaceutical industry which, at its cutting edge, invests in the production of new drugs based on predictions of future markets and the creation of lucrative products.

The Viagra phenomenon arose at the end of the 1990s and is recognizably the start of the process of medicalizing masculine sexuality in middle age (Brigeiro and Maksud, 2009; Aquino, 2005) which increases and accelerates in space and in time.

According to Giami (2007), Viagra was lauded by the scientific community as a new revolution in sex research, keeping in mind the possibility of prolonging masculine sexual activity with advancing age. In these terms, masculine sexuality is centrally located in the penis, and maintenance of a penile erection is the sexual fulcrum of male sexual function; in other words, it is conceived as a strictly organic activity.

Symbolically, the erection appears as a sign of desirable masculinity, of a stereotyped masculine sexuality, which is ostentatious, rejecting any malfunctions, because this indicates personal and social failure.

The bodily standard prized by society, in other words, the young, strong, muscular individual, always sexually ready and available, a real “super man”, appears as the bodily ideal to be pursued in the social arena. Paradoxically, the number of young men who use oral vasodilator drugs (Cialis, Viagra, Levitra) to obtain super-human sexual performance has been seen, as well as anabolic steroid use to acquire a body which is more and more unattainable, placing lives and health at risk.

This is a bodily standard which operates violently (Goldenberg, 2005), sculpted by the contemporary moral of “good shape”, requiring the individual, regardless of age, to control physical appearance while at the same time inciting the maximization of hedonistic experiences.

With relation to youth vulnerability to STDs and AIDS, PNAISH specifies that along with the development of measures which inform youth of their vulnerability to these diseases, large-scale access to contraceptive methods should be guaranteed, as the incidence of both STDs/AIDS and unplanned pregnancy have significantly increased in this age group. From a perspective which seeks to improve the view of masculinities, such policies weave together recommendations, remembering men’s rights to participate in reproductive planning and fatherhood, not only legal obligations. Men, even young men, have the right to participate in the entire process of female gestation, and are also responsible for contraceptive practices, although these obligations are commonly left to women.

As shown in a study by Barbosa and Giffin (2007), negotiation about whether or not to use male condoms, especially in the younger segments of the suburban lower income class, is anchored in traditional gender relationships based on the asymmetry of power which submits women to masculine will. Although it may be consensual among youth that the responsibility for preventing STDs/AIDS belongs to both parties, in practice this does not occur, and remains the responsibility of women, as they themselves admit. The exclusively feminine attributes of self-care, including prevention and bodily care, as shown in a recent study by Cunha et al. (2012), continue to be very much present.

Specifically referring to AIDS, stigmatization stands out, as it is still socially represented as “the disease of others”: homosexuals, prostitutes, drug addicts, those seen by society as “sexually deviant” (Rebello et al., 2011). This is despite the fact that the epidemiological profile of how the disease spreads has changed in recent decades, coming to affect heterosexual men and women of all social classes, in particular the marginalized and vulnerable populations (Stephan et al., 2010).

Such stigmatization brings implications to the

health services, since, as shown by a survey by Garrido et al. (2007) of 17 seropositive working-class men in the city of São Paulo, it ends up limiting health care: by discrimination in the work environment when the condition becomes evident, and accentuated by repeated absences to receive institutionalized health care; by humiliation suffered, which causes workers to quit or even be fired. The psychosocial effects of stigma were stressed in other social relations these workers had, which removed them from social interaction due to fear of rejection, causing depression and psychological problems. In this case, working reaffirms masculine autonomy in the world, and is a principal factor in reconstructing identity, social position and health maintenance.

Demarcating styles of masculinities which depart from the traditional standard, a study by Sutter and Bucher-Maluschke (2008) identified fathers who cared for their children in southern Brazil; these were between age 21 and 34, middle-class, married, with children between eighteen months and 8 years of age. Based on their analysis, the authors concluded that these fathers experience fatherhood with special emotional intensity, demonstrating a disposition contrary to the masculine stereotype that assumes self-control of emotions and negation of care. Studies such as these allow the demonstration of social constructions of masculinities different from the hegemony, delineating their intrapersonal character (subjectivations of self-identity) and interpersonal character (social representations of masculinities).

The fragilities of the “strong sex”, or what men suffer from

PNAISH offers a diagnostic of masculine health, indicating epidemiological data based on rates of morbidity and mortality, and reconciling them with the social determinants of diseases which affect men most.

The data from the masculine health/sickness process are structured based on the following main pillars: violence and tendency to expose oneself to risk, both reflected directly in the rates of morbidity and mortality.

With relation to mortality rates, regardless of cause, a common fact in health studies is obvious: more men die than women. The epidemiological coefficients reveal that masculine mortality is 50% greater than feminine mortality, assuming its highest rate for the 20-39 age group, at a ratio of three masculine deaths for each feminine death. (Laurenti et al., 2005).

As for causes, PNAISH indicates the external causes such as the most common ones. Under this category are traffic accidents, self-inflicted injuries, assaults and homicides, which in 2005 accounted for the majority of male deaths, in other words, 78%.

Analyzing information about the external causes of deaths of men and women in the period 1991-2000, Gomes (2008) showed that male deaths were, in that period, five times greater than those of females. This rate increased when the data were stratified by age group, reaching its peak for the male age group 20-24: 10.1.

Like the author does in that study, it is important to stress that cars and guns are signs of masculine power in western culture. A car does not only represent the social status of its driver, but also autonomy, and the freedom to come and go. In the same way, weapons potentialize the power of submission of the other to personal interests, and by extension, the power of life and death over others. Autonomy, liberty, submission are informed by the stereotype of an ostentatious masculinity (Kimmel, 1997), which nonetheless covers over the risks of its realization in the presumption of a life without limits.

Here, values related to hegemonic masculinity are reiterated, in which strength and power appear as “natural” masculine attributes, and in their expression, for the latter, are achieved by violent acts, mainly between the age groups of younger men (Nascimento et al., 2009).

From an intergender comparative perspective, it is relevant to present the data provided by a study by Batista (2005), which indicate the disparity in mortality rates from external causes between white and Black men in the state of São Paulo. According to the results, Black men die twice as often as white men do from these causes, reaching the greatest occurrence in the age group 20-24, three times more, respectively. As Batista states:

“[...]there is greater mortality for Black men due to aggression with firearms, traumatic aggression and aggression with unidentified objects, perhaps justified by lack of options, of leisure, by having the bar as a space for socialization, guns as a diversion, and ‘nothing to lose’ in life” (2005, p. 77).

Also traumatic is to note that under the category “man”, a concept which is generally used unambiguously, expressing a relationship of supposedly egalitarian domination, distinct masculinities are hidden which do not share the same power. To the contrary of what is supposed to be a man, Black, and young in certain social spaces comes to be a risk factor for death.

The results of this study are significant in the way that they contribute to deconstructing a monolithic vision of power based on the domination of the “strong sex”, besides supplying elements to analyze the masculinities intersected by gender, social class, ethnicity, and generation, relating them to each other. Also significant is the confirmation of social inequalities configured by the relations of power, which are oriented by the subjects’ same structuring pillars that enable the understanding of the living conditions of Black families, which in large part are marked by need: a need for housing, for instruction, for employment and income, and which are overwhelmingly headed by women (Batista, 2005).

Focusing on intergender violence, we cite the study by Alves and Diniz (2005), which through statements from lower income class men in Salvador, Bahia who were married for at least two years, identified traditional representations of masculinity. Among the motives presented by the interviewees for the occurrence of violence against their partners is women’s failure to conform to the role socially attributed to the feminine, revealing the asymmetric relationship established in conjugal relationships, in which the man as the provider is meant to take up the role of domination, and the women the role of subordination.

The intersection of men as subjects in studies on violence, based on references to gender and masculinities, has contributed to the critique of the hegemonic model of masculinity, emphasizing that, for this form of violence to be socially eradicated, it is necessary to bring awareness to men in

particular and society in general (Lima et al., 2008). These authors point to the lack of studies on the topic, suggesting the integration of men in actions aimed at combating violence against women, since interventions and studies about violence against women predominate, with a strong presence held by feminist interests and research centers related to investigations on the female gender in the area of social and human sciences.

Referring to the increase in morbidity rates, PNAISH prevents an evaluative portrait obtained by a historical study of hospitalizations for the period 2000-2007.

Tumors and external causes were those which had the largest impact on masculine morbidity; the 100% increase in the number of cases of neoplasia was noteworthy. Most common were tumors in the digestive tract, respiratory and urinary systems, although when looking at the incidence for the period studied, the incidence of hospitalizations for prostate cancer overtook the other types (a variation of 195.3%) with a 502% variation of costs to the system.

The costs borne by the health system to treat prostate cancer place the preventative exam more as a posture to reduce costs: early detection is the only way to prevent the disease, consequently avoiding its deadliness (Gomes et al., 2008a).

The preventative examination consists of collecting blood samples to measure the prostatic specific antigen (PSA) as well as a digital rectal exam. The Brazilian Society of Urology recommends that men above 50 years old be examined annually, and those with a family history of the disease begin exams at age 40.

Studying men in the city of Rio de Janeiro between 40 and 64 years of age, divided into three groups uniting men from lower and middle classes with varied levels of formal education (semi-alphabetized to post-graduate degrees), Gomes et al. (2008b) sought to learn what the digital rectal examination means to this population, keeping in mind the social representations of fatality associated with cancer.

Interpreting the data they collected based on the gender perspective which covers the concept of masculinities, the authors found: in the less-educated group of the target population, almost in its entirety, the men had not done the test; among the men with

higher education, approximately 63% had already done it. Despite this difference, the authors did not attribute the fact solely to the difference in the degree of education in the interviewees. They took into account the issue of access to services, which was significantly lower for those who did not get the test.

Another point which was found was that the digital rectal exam, regardless of the degree of education of the interviewee, was generally referred to as *touch in a forbidden region*.

In this sense, the authors evoked the construction of the masculine body as opposed to the feminine, as, on the one hand, the front view of men's and women's bodies differentiates them according to their sexual anatomy; on the other hand, the rear view makes them equal.

This overlaps the social representation of virility as a synonym for sexual activity in opposition to the always-passive feminine. Therefore, the digital rectal exam inverts this position, even though it is justified by a greater motive, in this case, the prevention of an incurable disease, which brought various of the more-educated interviewees to refer to the exam as embarrassing. In conclusion, the authors state that, more than the fact that it is physically uncomfortable for the men, the digital rectal exam represents "a blemish on their masculinities".

As for morbidities with external causes, PNAISH informs that the data are still precarious, although it is known that they accounted for 80% of hospitalizations. Due to their degree of magnitude, traffic accidents and violence were stressed, which bring, as stated previously, physical, psychological and social suffering to both those who suffer it as well as their families, and economically impact the health system through hospital expenses, including hospitalization and stays in intensive care units.

By way of conclusion: sizing up the "stature of men"

The National Comprehensive Men's Healthcare Policy (PNAISH) already is a landmark in the discussion of masculine health, as well as the programmatic activities established to promote men's entrance into health services and their priorities in the health-sickness-care process.

In this sense, studies about health and masculinities can support deeper discussions of the barriers to this entrance, which do not simply reside in the structure of the health system to meet the demands of men's health, as these are made up of a web of values and socio-cultural practices, secularly woven, at the same time structuring and structured in men's relationships with their bodies, with their health, and with those which whom they have relationships.

It is necessary to keep a critical eye on PNAISH (Carrara et al., 2009), which is still in the implementation phase, on the one hand creating conditions so that the most interested parties, the men, can be heard, because other interests can overshadow the general enunciated objectives, interests which do not always share the same ideals.

On the other hand, as Hearn (2010) warns, public policy aimed at men and based on gender's critical view of masculinities should take into account the power relationships present in social interactions; that is, those generators of suffering and affliction that are experienced differently by the subjects and which pervade the various social arenas. To see men as victims is not consistent with such a perspective, since it results in a return to the concept of a "universal masculine" abstracted from the relationships of power and domination existent in the socialization of the sexes.

In this way, a contribution that studies about health and masculinities undoubtedly make to the discussion of masculine health is the non-reification of the concept of man, as under this rubric distinct masculinities with different demands for health can be found.

Such studies, therefore, play the fundamental role of making this universal and genderless man who is evoked in social representations as the dominator and unwavering, into a flesh-and-bone individual who gets sick and dies, who belongs to a certain social class, has a color, is part of a generation, is sexually oriented and does not naturally and equally have power in society, as is invariably considered.

Therefore, research about health and masculinities, by approaching this incarnate man in his concrete vicissitudes, sheds light on him, offering a vision not of "great" or "small" men, but of men who are closer to their actual size.

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