BRIEFING ON MEN'S HEALTH FOR WHO GENDER, EQUITY AND HUMAN RIGHTS UNIT

Global Action on Men's Health
February 2016

INTRODUCTION

Global Action on Men's Health (GAMH) is aware that the Gender, Equity and Human Rights Unit at WHO is the process of developing an integrated framework of gender, human rights, equity and social determinants. GAMH also understands that men's issues will be addressed in the framework; we view this is a very significant and much-needed development.

GAMH has prepared this briefing to inform the Unit of its views on how men's health issues could be addressed within the new framework and would welcome the opportunity to discuss these in greater detail during the development of the framework and/or following its completion.

About GAMH

GAMH is a collaboration of a growing number of organisations with an interest in men's health. GAMH's mission is to create a world where all men and boys have the opportunity to achieve the best possible health and wellbeing wherever they live and whatever their backgrounds.

GAMH wants to see:

- Global health organisations and national governments address the health and wellbeing needs of men and boys in all relevant policies
- Men and boys encouraged and supported to take better care of their own health as well as the health of their partners and children
- Health practitioners take greater account of the specific needs of men and boys in service delivery, health promotion and clinical practice
- Other agencies and organisations, such as schools and workplaces, helped to be more aware of their significant impact on the health of men and boys
- Sustained multi-disciplinary research into the health of men and boys
- An approach to health that fully recognises the needs of both sexes in policy, practice and funding and which promotes greater gender equality.

More information about GAMH can be found at www.gamh.org.

THE PROBLEMS WITH MEN'S HEALTH

The evidence of men's unnecessarily poor health is very clear. Data from WHO, the Institute for Health Metrics and Evaluation and elsewhere indicates that men's health outcomes are deeply problematic:[1]

- Globally, male life expectancy, at 68 years, lags five years behind female life expectancy. There is not a single country in which male life expectancy exceeds female. Overall, the gap between the sexes has actually widened since 1970 and will widen further by 2030 – by then, male life expectancy is expected to be seven years shorter than female life expectancy.

- Men have a >40% probability of dying between the ages of 50 and 74 while women have probability of <30%.

- In all age groups except 80 and older, mortality has decreased more for women than men between 1990 and 2013. Men aged 30-39 and over 80 showed some of the smallest declines in mortality and the gender gap in death rates for adults between the ages of 20 and 44 is widening with men doing worst.

- The gap in global healthy life expectancy widened in the two decades after 1990 and, by 2010, was 58 years for men and 62 years for men.

- The global suicide rate in men is almost twice that in women; the European region has the biggest male:female ratio (4.0).[2]

- Males have a higher incidence rate in 32 of 35 cancer sites.[3] In over 80% of countries, the age-standardised death rate for cardiovascular disease is higher for men.

- Out of 67 risk factors and risk factor clusters identified in the Global Burden of Disease (GBD) 2010 study, 60 were responsible for more male than female deaths, and the top 10 risk factors were all more common in men.

- In 2010, three times as many men as women died as a result of tobacco use. 3.14 million men died because of alcohol use compared to 1.72 million women. And almost one million more men than women died from dietary risk factors, such as low fruit and vegetable intake and eating too much processed meat.

- Almost 90% of deaths attributable to occupational risk factors in 2010 were male. The two biggest occupational risks were injuries and exposure to particulate matter, gases, and fumes.

- About 1.25 million people die each year as a result of road traffic accidents and some three-quarters (73%) are men.

There are some broad explanations for men's poorer health outcomes at the global level. Men are far more likely than women to be at risk from an unhealthy lifestyle (including smoking and hazardous levels of alcohol consumption), to be exposed to occupational physical and chemical hazards, and to use health services ineffectively, particularly primary care and screening. Men are particularly reluctant to seek help for mental health problems, whether from family, friends or health professionals.

It seems clear that, across the world, men's perception of the 'male role' inhibits important aspects of self-care and appropriate help-seeking. Currently, 25% of all Russian men die before the age of 55 years, compared with only 7% of UK men. The difference is due mostly to alcohol and cigarettes. Research suggests that, for many working-class Russian men, the heavy consumption of strong spirits is linked to male status and a perceived 'ideal of the real working man.'[4]

Several studies in sub-Saharan Africa have suggested that notions of masculinity not only increase the risk of acquiring HIV but also inhibit men from getting tested for HIV, accepting their HIV positive status, taking instructions from nurses, and engaging in health-enabling behaviours including using hospital services appropriately.[5] Disproportionately fewer men than women access antiretroviral therapy (ART) across Africa, men start ART later in the disease course than women, and they are more likely than women to interrupt treatment and to be lost to follow-up.[6]

Health policies and services have not systematically sought to engage men. This is true at the local, national and global levels. An analysis by the Men's Health Forum (MHF) of 147 local strategic health needs assessments (JSNAs) in England in 2014 found that only 18% adequately recorded information by gender and were thus aware of specific health issues for males and females.[7] The Men's Health Caucus of the American Public Health Association (the largest public health organisation in the world) has noted that, in the USA, there has been 'no centralized national effort to coordinate the fragmented men's health awareness, prevention, and research efforts on the regional, state, and local level.'[8] Both MHF and the Caucus believe that national men's health policies would help to tackle this deficit.

A study of the policies and programmes of 11 major global health institutions, including WHO, found that a focus on the 'prevention of and care for the health needs of men [is] noticeably absent.'[9] A recent Lancet editorial, commenting on global initiatives on adolescent health, observed that 'the emphasis is on adolescent girls … boys are an important, and neglected, part of the equation.'[10]

THE CONSEQUENCES OF POOR MEN'S HEALTH

There are several significant consequences of poor men's health:

- Too many men lead lives that are too short, painful and unfulfilled. Given that the highest attainable standard of health is a fundamental right of every human being, men's unnecessary suffering must be seen as unethical.

- Women can be adversely affected. This is most obvious in the area of sexual health but women are also impacted by the economic impact of losing a breadwinner, having to assume caring responsibilities (which can in turn cause loss of income and restrict educational and employment opportunities), and male violence linked to alcohol misuse. Moreover, women have to face the emotional distress of losing a partner, father, son or brother prematurely.

- Premature male morbidity and mortality has an economic cost. This has been estimated at some GB £335 billion annually in the United States[11] while the economic burden associated with smoking, excess weight, alcohol and physical inactivity in Canadian men has been estimated at about GB £18 billion a year.[12]

- Men's health problems have a drag effect on population health, affecting the speed at which improvements leading to better health for all can be implemented and achieved.

THE CASE FOR ACTION

The case for action to improve men's health is slowly but steadily becoming more widely accepted. Three national governments – Australia, Brazil and Ireland – have implemented national men's health policies since 2008. Although their impact and effectiveness has

varied, they do demonstrate a significant level of commitment by the governments concerned and men's health advocates believe that such policies have a potentially important role to play in other countries.[13]

Although the UK, Canada and Denmark do not have national policies, their governments have for several years provided significant funding for men's health projects. The Canadian Provincial Government of British Columbia has provided several grants including one for CAN $5m over five years. The Men's Health Forum in England and Wales has, since 2009, been one of a small number of NGOs to have been designated Strategic Partners of the Department of Health. In the USA, in January 2016, the White House, in partnership with the Department of Health and Human Services, Men's Health Network and Disruptive Women in Healthcare, hosted a men's health symposium with speeches from Cabinet Secretary Broderick Johnson and Surgeon General Dr Vivek Murthy. Concern about the health of men is also reflected in the establishment of the UK All Party Parliamentary Group on Men's Health in 2001 and of the bi-partisan Congressional Men's Health Caucus in the USA in 2007.

Professor Sir Michael Marmot looked at gender in his report on Europe for WHO and argued that national governments should develop strategies that 'respond to the different ways health and prevention, and treatment services are experienced by men and women ... and ensure that policies and interventions are responsive to gender'. [14] In a more recent report on health inequalities in the UK specifically, Marmot highlighted the fact that deprivation has a bigger negative impact on men's health outcomes than women's, and called for a greater policy focus on men's health to help tackle this.[15]

The head of the WHO's Gender, Equity and Human Rights Unit has suggested that gender, including men, should be taken into account in the implementation of the UN's recently agreed 17 Sustainable Development Goals (SDGs).[16] Indeed, it is difficult to see how the SDG health targets on reducing premature mortality from non-communicable diseases, preventing and treating substance abuse, and tackling road traffic accidents can be achieved without action that takes account of gender differences and men specifically.

The need to address men's issues was also made very clearly at a global high-level meeting on men, adolescent boys and AIDS co-convened in December 2015 by UNAIDS, Sonke Gender Justice and the International Planned Parenthood Federation.[17] The meeting reflected the growing awareness of the need for a global shift in the discussion on HIV and gender so that it becomes more inclusive of men and encourages their greater positive engagement in all aspects of the AIDS response in order to improve their outcomes and to reduce vulnerability among women.

As well as a growing understanding that men need to be included in public health policy and practice, there is now a good evidence base that shows that 'gender sensitive' health interventions aimed at men can improve outcomes. Sport has been shown to be an effective medium for engaging men in lifestyle improvement programmes[18] and research suggests that many prefer men-only weight management interventions.[19] A study of the core elements that make for successful work with boys and men around mental health promotion, early intervention and stigma reduction found that the settings within which interventions take place need to be 'male friendly' and culturally sensitive to the specific requirements of different groups of men and boys.[20] Interventions aimed at men to increase the uptake of chlamydia screening and to tackle other sexually transmitted infections, improve early diagnosis for testicular cancer and to change attitudes to dangerous driving have also proved effective.

FUTURE APPROACHES TO MEN'S HEALTH

GAMH recommends that in developing its approach to gender and men, the Gender, Equity and Human Rights Unit takes account of the following 12 key points:

1. Action on men's health, and on women's health, should take place within a gender mainstreaming framework that properly addresses the health of both sexes in the context of promoting gender equity. Ireland's Health Service Executive has published a national gender mainstreaming framework that provides a good model.[21]

2. An intersectional approach to men's health is necessary to take account of ethnicity, age, socio-economic status, sexual identity, etc. as well as gender. This will help to identify those men in the greatest need of support.

3. Action should not be focused exclusively on men in the most deprived groups. Because there is a clear social gradient in men's health outcomes, action is needed at all levels to reduce the gradient with the ultimate aim of achieving health equity.

4. Interventions should be based on a range of different approaches, both 'gender sensitive' and 'gender transformative', so long as they are supported by a good evidence base. Health interventions aimed at men should not set out with the specific aim of 'changing masculinity'; however, of course, in some areas (e.g. sexual and reproductive health) challenging male gender norms and attitudes to women may be necessary to the success of an intervention; in other areas, it might be an unintended outcome. Some ostensibly 'gender-neutral' actions – e.g. alcohol and tobacco controls, road traffic safety measures and occupational health and safety regulations – can also have a disproportionately beneficial impact on men.

5. Work to improve men's health must not impact adversely on women's health interventions, e.g. by diverting attention or resources. It must also not have the effect of positioning men as 'victims' in way that inhibits their accountability for unacceptable behaviours, including gender-based violence.

6. Work with men must take account of issues that not only affect women directly (e.g. sexual health and violence) but also are primarily relevant to men (e.g. tackling obesity, cancer prevention and early diagnosis, alcohol misuse, suicide). The focus of work with men need not be exclusively on issues where they 'do worse' than women; men with some conditions where they are less affected (e.g. body image disorders, osteoporosis, post-natal depression, breast cancer) have been overlooked but are nevertheless of importance to men and their health.

7. The primary focus for national and global policy approaches to men should public health and the social determinants of health. Although improvements in clinical treatments for men are still needed (e.g. in the area of prostate disease), the medical domain is relatively well-developed. The priority for action is improving prevention through a wide range of interventions (social, economic, educational, occupational and health) and enabling earlier diagnosis through better use of health services.

8. A 'whole systems' approach is needed to tackle men's health with action by governments, health services, employers, trade unions, NGOs and community organisations, the media, and others. Improving boys' educational achievement is of particular importance.

9. Stereotyping men must be avoided. It is not the case, for example, that all men avoid seeking help for all health problems, that all men are unwilling or unable to talk about their feelings or that all men take risks with their health (by smoking, drinking too much alcohol or driving dangerously).

10. Masculinity (or masculinities) should not be pathologised. There is certainly evidence that men whose attitudes are most positively associated with male role norms are more likely to exhibit negative health behaviours but there are also many male role norms which can be socially desirable and health-enhancing, e.g. courage, wanting to provide for one's family, being goal-focussed, valuing physical strength and fitness, humour in the face of adversity. It is important that action to improve men's health seeks to build on their strengths.

11. Men's health is still a relatively little-understood and under-recognised field with currently only a weak foothold in public health policy and practice. Its importance and relevance therefore should be highlighted by WHO and other relevant organisations rather than simply appearing on a long list of issues to be addressed. Furthermore, because men's health is now a specialist area of professional activity, recommendations for action on men's health must be supported by a range of accessible information and training materials backed by research and evidence of good practice. Policymakers and practitioners cannot be left to assume that men's health interventions can be developed and delivered without adequate support.

12. Further (non-medical) research into men's health is needed to support this emerging field of activity. Two important areas for future research are, first, evaluating men's health interventions in order to identify what works (and does not work) with different groups of men and, secondly, understanding better how men use health services, especially primary care and how services can be made more accessible to men.

IMMEDIATE NEXT STEPS FOR WHO

GAMH suggests that the Gender, Equity and Human Rights Unit:

1. Convenes a symposium on gender and health to discuss the forthcoming framework and plans for its implementation. Such meeting should include representatives from a range of organisations with expertise in men's health.

2. Provides information about men's health and a resource guide on the WHO website.

3. Works with GAMH and others to ensure that men's health is optimally integrated into its work on gender.

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www.gamh.org

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