



GLOBAL ACTION ON
MEN'S HEALTH

ABSENT-MINDED

The Treatment of Men in Global Mental Health Policy

Natalie H Leon and Christopher J Colvin



A report from Global Action on Men's Health

GLOBAL ACTION ON MEN'S HEALTH

Global Action on Men's Health (GAMH) was established in 2013, launched during International Men's Health Week in June 2014 and registered as a UK-based charity in May 2019. GAMH brings together organisations and others with an interest in men's health in a new global advocacy network.

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. Far too many men and boys suffer from health and wellbeing problems that can be prevented. Globally, male life expectancy at birth is just 71 years but poor male health is not sufficiently recognised or effectively tackled by global health organisations or most national governments..

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.

GAMH uniquely represents a wide range of organisations and individuals with experience of policy development, advocacy, research and service delivery. GAMH's focus is primarily on public health and the social determinants of health, it is concerned about a broad and cross-cutting range of men's health issues and has a strengths-based view of men and boys.

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ABBREVIATIONS

ADHD	Attention-deficit hyperactivity disorder
DALYs	Disability adjusted life-years lost
GAMH	Global Action for Men’s Health
LMIC	Low and middle-income country
NCDs	Non-communicable diseases
NGO	Non-governmental organisation
PPND	Paternal Perinatal Depression
SDG	Sustainable Development Goals
WHO	World Health Organization
YLDs	Years of healthy life lost due to disability
YLLs	Years of healthy life lost due to premature mortality



“Men are largely absent from the mental health policy produced by many of the leading organisations in global health.”

Foreword

Men’s mental health problems are clear. Globally, the rate of suicide in men is more than twice as high as in women. Men consume nearly four times more pure alcohol per capita than women. Many men attach stigma to mental health issues and do not seek help and instead self-medicate with addictive substances and behaviours such as gambling. Men may also ‘externalise’ their distress through behaviour that is anti-social, aggressive or violent. Yet common mental health problems such as depression and anxiety often remain under-diagnosed and under-treated in men.

Many men who end up in prison have severe mental health problems that are made worse by their experience of incarceration. Black men in many white majority countries face a double barrier – race and gender – when in need of mental health care and are less likely to seek help because they find a system ill-equipped to assist them when they do.

Despite all these problems and more, this report finds that men are largely absent from the mental health policy produced by many of the leading organisations in global health. While policies may refer in passing to some of the issues concerning men, this rarely leads to any analysis of the policy changes required to make a difference to men’s outcomes.

Fortunately, there are now signs of change, including increasing public and professional discussion of men’s mental health. The need to tackle male suicide is more widely recognised and at least one country, Denmark, has taken steps to support men with perinatal depression. The COVID-19 pandemic led to greater use of online mental health support services by men showing the potential for the future development of this approach. The adoption of overarching men’s health policies by some countries at national or state levels could also accelerate action on mental health.

Global Action on Men’s Health will take advantage of these new opportunities and use the evidence in this report to advocate for men to be taken more fully into account in future mental health policy. We need to see male-targeted initiatives on prevention, early diagnosis, treatment and care by the key international organisations engaged in programme, practice, and policy development.

We are very grateful to Natalie Leon and Chris Colvin, both GAMH members, for all their work on this important report. Their painstaking analysis of a wide range of reports and documents has provided the robust research needed to help us make the case for a new and more inclusive approach to mental health policy.

Peter Baker, Director, Global Action on Men’s Health



Executive Summary

In the past, gender-specific surveillance of the health problems of males has not been prioritised, inequities in men's health have mostly been overlooked by global, regional and national health organisations, and gender equity strategies in health, where they exist, have been equated with addressing women's health. A gender equity focus is now beginning to be extended to men's health to reduce the disproportionate impact on men of a range of health issues identified in Sustainable Development Goal 3, including, among others, higher morbidity, and premature mortality from non-communicable diseases (NCDs).

NCDs, including mental health disorders, are responsible for the highest burden of disease globally, with mental, neurological and substance use disorders together accounting for 10% of the global burden of disease and 25% of years lived with disability in 2019. While women have higher rates of diagnosed depression and attempt suicide more often than men, men die from suicide at substantially higher rates than women, in some geographical settings, up to four times the death rate of women. Men also have substantially higher rates of substance abuse than women, as well as higher rates of interpersonal violence. Boys and adolescent males are particularly vulnerable, with higher rates of conduct disorder compared to girls, and with mental health and social impairments that track into adulthood.

Specific policy initiatives in mental health are needed to get a better understanding of gendered disease patterns for men and to identify evidence-informed strategies to address male health needs. Achieving this will require sustained and effective advocacy for considering the mental health of men in policy. As part of the effort to support and promote this policy advocacy, this report surveys global mental health policy documents from a wide range of global health actors and examines the ways in which men are currently addressed in these documents, if at all.

Half of the policy-relevant reports provided some form of sex-disaggregated data on mental health, but for the most part, these were cursory references that were limited in scope, and depth. Detailed reference to gender-differentiated patterns in mental health burden and care were less common. While there were gaps across reports in reporting on sex-disaggregated data, there was widespread acknowledgement of the value of sex-disaggregated data, and commitments to strengthening the capacity of country monitoring and surveillance systems to produce disaggregated data on a range of social determinants.

In most reports, gender was acknowledged as a determinant alongside other socio-demographic determinants of mental health, but with no gender analysis to explain mental health risks and vulnerabilities of boys and men. Gender disparity was discussed in relation to the disproportionately negative effects of gender on the mental health of women. cursory references were made to the mental health needs of men in these reports. Men were usually mentioned in comparative

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sex-disaggregated data alongside mention of women, and sometimes, when commenting on data that show higher prevalence among males, especially suicide, substance abuse and conduct disorder. Indirect reference to men was found in reference to mental health of people in prison and in the military, settings where men are overrepresented. While some reports called for a human rights approach to gender and other disparities in mental health, there were no explicit recommendations for gender-responsive strategies that address the mental health of boys and men.

This review reflects on the lost opportunities for addressing mental health of men and women equitably in these policy reports. It discusses how global policy reports can increase their focus on gender inequities in mental health, starting with more comprehensive and balanced reporting on gender disparities that address both genders equitably, and making gender-informed recommendations to address the gender-differentiated mental health needs of both women and men.

The review concludes with an analysis of the windows of opportunity for recognising the mental health needs of men in global policy. Advocates should focus on expanding knowledge of the problem and possible solutions, leveraging the growing number of international and national organisations interested in men's health to develop integrated and holistic policy strategies, and build long-term coalitions and networks with individuals and institutions on issues related to men and mental health, including leveraging parallel policy initiatives on women's health and on health promotion more broadly.



Background

There is increasing global, regional and national recognition of the inequitable gender-related health gaps in men's burden of most communicable and non-communicable diseases, men's limited access to and utilization of health care, and men's increased morbidity and mortality compared with women.^{1,2,3,4,5,6} Globally, there is a significant difference in life expectancy between men and women, with men dying on average 5 years earlier than women, and with higher disability adjusted life-years lost (DALYs), DALYs being a combination measure of morbidity and premature mortality.⁶ Despite much variation across WHO regions in the male-to-female mortality rate, in 40 out of the 48 WHO region and age group combinations, excess mortality rates among the males were higher than those of the females.⁶ The differences in health and mortality between men and women are complex and depend on the social, behavioral, and epidemiological context.⁷

In the past, inequities on men's health have mostly been overlooked by global, regional and national health organisations, gender-specific surveillance of men's health has not been prioritised, and gender strategies in health, where they exist, have been equated with addressing women's health.^{4,5,8,9,10} Addressing gender inequities related to health and health care for women has rightfully been a priority for decades, supported by international gender equity targets, like the Sustainable Development Goals (SDGs). And, in part due to this policy prioritisation, progress has been made in tackling the many forms of health inequities that women around the world face, including gender-based violence, sexual and reproductive health, mental health challenges and non-communicable diseases like cancer and heart disease, among others. Women's health remains an unfinished project, however, and requires continued – and greater – attention.

This gender-equity focus is now being extended to men in an effort to reduce the disproportionate impact on men of health issues identified in SDG3, including, among many others, premature mortality from non-communicable diseases (NCDs), substance abuse and road traffic accidents.¹¹ There has been an increase in international recognition of men's health needs and new opportunities for policy development have emerged, partly because of a better understanding of the role of gender in health. Emerging evidence of the burden of disease on men's health and its costs, especially during the Covid-19 pandemic, have contributed to this increased awareness of male health.²

There are now multiple academic centres, international NGOs and advocacy groups bringing greater focus to men's health. Several countries have even developed national policies that focus on improving male health, notably Australia, Brazil, Iran, Ireland, and more recently, Mongolia, the Philippines, South Africa, and Malaysia.⁹ WHO's European Region has also published a men's health strategy covering its 53 Member States.⁹ These male health-focused policies are a major step forward, and this momentum should be extended to key areas where men face a

specific inequitable burden of disease, such as suicide in the context of poor mental health.

Global, regional and national level consideration of men's needs, experiences and preferences regarding mental health promotion, treatment and care can have important impacts in terms of prioritizing focus, actions, and resources. Specific policy initiatives in mental health are needed to get a better understanding of the gendered disease patterns for men and to identify evidence-informed strategies to address male health needs. But achieving this will require sustained and effective advocacy for policy attention to the issue of men and mental health. As part of the effort to support and promote this policy advocacy, this report surveys global mental health policy documents from a wide range of global health actors and examines the ways in which men are currently addressed in these documents, if at all. This in-depth look at the ways in which men's needs, experiences and preferences are considered in these documents points to gaps in the global policy context but also to opportunities for the development of policy initiatives which will improve men's outcomes. The report concludes with reflections on the kinds of strategies that policy advocates might pursue in increasing attention to and engagement around the issue of men and mental health..

“Globally, an estimated 462 million men live with a mental health disorder.”

Unmet need among men for prevention, treatment and care

NCDs, including mental health disorders are responsible for the highest burden of disease globally.⁶ Global estimates in 2023, across all ages, indicate that mental, neurological and substance use disorders together accounted for 10% of the global burden of disease (DALYs) and 25% of years lived with disability in 2019.⁶ Men have a higher probability of premature mortality from NCDs than women (measured as years of healthy life lost to premature mortality, or YLLs).^{6,12} Most of the disease burden from mental disorders come from morbidity rather than mortality, stemming from reduced quality of life due to living with disability (measured as years of healthy life lost to disability, or YLDs).¹² Since 2000, depression and anxiety have been among the leading causes of morbidity, with global estimates that depressive disorders alone were the second leading cause of global morbidity (after back and neck pain), accounting for 5.6% of all morbidity.¹²

Recent global estimates indicate a slightly higher prevalence rate of mental health disorders among women (13.5%) than men (12.5%).¹³ Mental health disorders covers a wide range of illnesses, however, and within this broad category, there are important further variations by gender. Women, for example, suffer from diagnosed depressive and anxiety disorders at a rate 50% - 65% higher than for men, while men suffer from substance abuse, interpersonal violence, conduct disorder, autism and attention deficit hyperactivity disorders (ADHD) at significantly higher rates than women.^{5,12,13} Globally, an estimated 462 million men live with a mental health disorder.¹³ Men are more at risk for the top health risk factors, especially for alcohol and tobacco consumption, with alcohol use being

“Young people face distinct mental health challenges, with mental health conditions (depression, anxiety, and conduct disorders) being among the leading causes of illness and disability among adolescents, globally.”

the leading risk factor for people in the 25-49 year age group.¹⁴ Globally, in 2019, men consumed nearly four times more pure alcohol per capita than women did, and tobacco use prevalence was higher among men than among women.⁶ Suicide is another area in which men’s risk significantly outweighs women’s in most settings. Globally, women are more likely to attempt suicide than men, yet twice as many men die by suicide than women.¹⁵ According to the WHO’s 2019 global report on suicide, male risk for mortality from suicide can be more than four times the risk in females, depending on the geographical setting, with higher male to female suicide mortality ratios found in high-income countries.^{12, 15, 16}

One area where male depression may be underrecognized is paternal depression, though in the last decade there has been increasing research on depression among male partners of women who are pregnant or have recently given birth. Paternal Perinatal Depression (PPND) is considered a specific condition that affects many fathers between pregnancy and the first year after childbirth. PPND rates are estimated to be about half that of maternal post-partum depression rates, at 8-10%, with the highest rates 3 to 6 months into the postpartum period.^{17, 18} The emotional states of mothers and fathers influence each other, with maternal and paternal depression rates showing a significant correlation, and PPND is associated with adverse mental and social impairments in children and adolescents.¹⁷ PPND rates may be an underestimate due to male underreporting and masking of symptoms through other forms of behavioural disturbance such as disengagement, substance abuse or anger and aggression.¹⁸

Young people face distinct mental health challenges, with mental health conditions (depression, anxiety, and conduct disorders) being among the leading causes of illness and disability among adolescents, globally.^{6, 19, 20} Risk of suicide is again a good example of some key demographic and geographical variations. Rates of suicide have been declining globally over the last 30 years, with the exception of the Americas, where it has markedly increased.¹⁶ Despite the decreases in most parts of the world, however, suicide remains the 4th leading cause of death globally for young men, after road traffic accidents, interpersonal violence and TB.¹⁶ Although more than half of suicides (58%) occur below the age of 50 years, suicide rates continue to increase in older adults, with greater increases among men.^{12, 15} For instance, the rates for people aged over 70 are more than twice that of the working population (12).¹²

There are also important regional variations in these data, with most suicides (75%) occurring in low and middle-income countries (LMICs), with higher rates among young adults compared to high income countries.¹⁵ The African region, for example, has a rate of suicide almost twice that of the Eastern Mediterranean region. Men who are part of gender and sexual minority communities are in turn at significantly higher risk of suicide and related mental health conditions than other men.²¹

Childhood behavioural disorders are another example of gender variation with disproportionate effects for male youth. Childhood behavioural disorders were among the top five causes of morbidity for adolescents of all genders in 2019, but with disproportionately higher rates for young males age 10-14 years.¹⁹ Globally men are also twice as likely to

die from injury, with a disproportionate effect amongst young males. For instance, men and boys accounted for 80%, 75% and 69% of deaths due to homicide, road traffic injuries and suicide respectively in 2019.⁶ Interpersonal violence is a particular risk, with homicide representing the second leading cause of death among boys and young men aged 15–29 years.⁶ One of the concerns associated with higher adolescent male mental health burden is that mental health conditions in adolescent males are known to track into mental health rates in adulthood.¹⁹

Poor mental health outcomes are also closely related to (as both drivers of and consequences of) numerous other risk factors for poor health that men and boys suffer from disproportionately. For example, while overall diagnosed depression rates among men are lower than in women, mental distress among men may be more indirectly expressed through external behavioural disturbance, such as through alcohol and drug misuse, through anger and aggression towards self and others, and general risk taking (associated with road traffic accidents and injuries).^{10, 14, 22} Indirect symptoms of distress among males, together with men's reduced health seeking behaviour, may result in under-diagnosis of mental health conditions such as depression among men.^{10, 22, 23}

There is a substantial gap between people needing care for mental conditions and those with access to care. For example, only 29% of people with psychosis and only one third of people with depression receive formal mental health care.⁶ Treatment coverage for effective substance use disorders is low, with less than 1 in 5 people receiving treatment, and less than 1 in 10 in LMICs.⁶ The gap in access to care may affect men more as underutilization of primary health services by men has been identified as a problem globally, including for high priority infectious disease like HIV and TB, and noncommunicable disease, and for mental health.^{10, 24, 25} Men are less likely to engage with health services and to access preventive services than women and are more likely to drop out of care.²⁵ While most research has focused on how harmful gender norms related to masculinity influenced healthcare seeking behaviour among men, little is known about how gender norms may be embedded and perpetuated within health care institutions to limit access for males.^{10, 24}

These overall global, regional and national level estimates of gendered mental health burdens hide important variations within and between different geographic contexts, class positions, racial and ethnic identities and other intersecting social determinants.^{12, 26} Patterns of variation in mental health burden—between various sub-groups of men and women, and among men themselves—are in turn the result of a complex mix of factors. These include underlying biological mechanisms, patterned differences in exposure to risk factors, inequalities in access to prevention, treatment and care, and varying distributions of competing risks among different groups and contexts. A recent review of adolescent and young adult male mental health identified a series of critical gendered determinants of men's mental health outcomes, including: high rates of health service disengagement, low rates of mental health literacy, gendered stigma, cultural expectations and masculinity, distinctive gendered differences in mental health diagnosis, and low levels of service acceptability among many men.⁵

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An important limitation in our understanding of these complex dynamics of gender and mental health is the fact that many of the existing studies come from high-income country settings, embed heteronormative framings of sex and gender in their datasets, and/or skew towards more privileged populations with better access to health care.²⁷ Further research into the underlying patterns, and mechanisms of the mental health needs of men is needed. Whatever the weaknesses in our data, however, the research is consistent in pointing to significant levels of unmet need for men when it comes to mental health prevention, treatment and care.



Methods

Objectives and overall methodological approach

The objectives of this report are to:

- Assess the ways in which men are currently considered in global and regional mental health-related policy, and,
- Develop recommendations for policy advocacy strategies that global, regional, national, and local advocates might use to promote better inclusion of men's needs in mental health-related policy.

The methodological approach drew on rapid review methods to identify, map and synthesise relevant information. This approach involved developing a protocol and a stepwise process of searching and screening records for relevance, reviewing eligible full-text records and extracting data relevant to the questions of interest, and then synthesising the data. Rapid review techniques balance the need for timely results with a commitment to maintaining the robustness, meaningfulness, transparency, and trustworthiness of the findings.²⁸

Data sources for describing the burden of disease and identifying evidence-based strategies and policy development strategies included academic literature and technical reports from governments and NGOs. Data sources for the policy review objective were policy-relevant documents from global and regional organizations, including formal policies, guideline documents, strategic plans and resolutions, progress reports, best practice documents and clinical guidelines.

Searching

We identified and categorised the relevant organisations working in the field of mental health policy and searched their websites for policy-related documentation. Policy can mean many different things, so we looked for a variety of sources including policy documents and resolutions, policy and clinical guidelines, strategic plans, progress reports, and best practice recommendations. The focus was on global and regional level policy organisations, both government and non-governmental agencies, as well as on key policy making stakeholders in mental health and related health, research, and advocacy agencies. These included international health agencies such as the World Health Organisation (WHO), and other regional health agencies such as the European Union. The mental health-related health care agencies included those with a focus on depression, suicide, and risk factors such as alcohol abuse.

An iterative search process was used to identify further sources of information, starting with organizations listed in the protocol and

identifying more organizations by following leads we found in the reports, as well as doing open searches. Suggestions were also gathered from the GAMH executive.

Selection of records for inclusion

A list of relevant organisations was developed by searching for global and regional organisations that focus on mental health and/or mental health-related (eg. chronic disease, substance abuse) organisations. Further reports were identified by following up on references mentioned on the identified websites and reports. The websites of key organisations were searched for policy relevant documentation—i.e., documents indicating organisational vision, strategies and action plans in relation to mental health. These included policy and guideline documents, documents on recommendations and best practices, codes of conduct, standard operating procedures (SOPs), memorandum of agreements, resolutions and declarations, all of which were then assessed for relevance. We excluded the following kinds of documents: national level policy documents, academic papers, except if it related to a Lancet Commission (as the latter is aimed at supporting global policy development), and multi-media data sources that were not presented as a policy-relevant reports (such as multi-media webpages, blogs, webinars, or conference presentations).

The review identified around 70 potentially relevant documents and, from these, a sample of 25 was selected for analysis. As this was a rapid review using mixed methods, sampling was required to ensure a manageable number of reports for analysis, while ensuring the sample was a fair representation of the underlying set of reports. The criteria for the purposive sampling was determined by the research question and aimed to provide variation and representativity of relevant areas in terms of the scope of the topic (general and specific mental health disorders, including substance abuse), and types of organizations that contribute to the policy landscape (multi-national agencies, non-governmental organizations, advocacy and funding organizations) and, where feasible, regional geographic representation. The most up-to-date documents were prioritised.

The final set of sampled reports included global, regional health agencies with multinational and transnational health reach (eg. WHO) and its regional affiliates, global and regional mental health association and NGOs (eg. World Federation for Mental Health – WFMH), global and regional mental health advocacy networks (eg. International Association for Suicide Prevention – IASP) and APEC Digital Hub for Mental Health, and international research funding agencies (eg. the National Institute of Mental Health – NIMH).

Data extraction and synthesis

A set of data extraction domains was developed, based initially on the questions of interest stated in the protocol, and then adapted based on the emerging data from the reports. If and how men were considered in the policy documents was the key issue of interest. Where there was little direct information on mental health needs of men in these documents, different sources that could provide an indirect measurement of whether sex and/or gender were considered in these reports were sought. Another indirect measure was reports that included target groups that may be predominantly male, such as people in prison and/or associated with the criminal justice system, people in the military and veterans. This review also looked at policy on risk factors where males are at high risk, such as substance abuse.

A set of terms to search for relevant information was developed for the following areas: the presence of sex-disaggregated data, reference to gender determinants and gender equality/equity, the context of reference to men and women, reference to subgroups of the population where men may be more predominant in numbers, interventions focussing on men or women, and more. As part of the data extraction, a quick overview of the purpose and scope of the report was completed. The set of search terms was then used via the Find function in the PDF formats of the papers to identify the relevant areas of the report for review. A Word document was created to extract data on whether key terms appeared in the document, how many times, and information that related to any of the key measures of interest was extracted and pasted.

To map and synthesise the information, an Excel spreadsheet was created to map the key measures, from general to specific. These measures were then combined into categories that synthesised the information for the report.



How men and gender are considered in global and regional mental health policy

Overview of included policy documents

Most documents (19 out of 25) focused on global level policy and guidance, authored by international, multi-lateral organizations. The bulk of these were from the WHO (13 out of 19 global-level reports). Two of the WHO reports were surveillance reports that mapped mental health resources and services (globally and for the Eastern Mediterranean region) with updated data on a range of areas (eg. mental health policies, legislation, financing, human resources, information systems, and the availability and utilization of mental health services). These two Mental Health Atlas reports^{26,29} were included as they represent a major data resource that can inform mental health policy. Other global reports were from NGOs with a focus on mental health, including the World Federation for Mental Health (WFMH)¹⁵ and the International Association for Suicide Prevention (IASP).³⁰

While most global-level reports focused on general mental health policy, this review included reports on high-burden conditions such as depression and anxiety²² and suicide. One of these suicide-related reports was a WHO report,³¹ one was from the WFMH¹⁵ and the third was from the IASP³⁰. One global report on reducing harmful use of alcohol was included as substance use disorders are considered part of mental health conditions, and these disorders are often more prevalent among men. A report addressing non-communicable diseases (NCDs) in prison, including mental health, was included as men make up most of the imprisoned population.³² A global report on perinatal depression was included to examine how the issue of male perinatal depression is addressed since this is an emerging mental health concern for men.³³ The review included six regional-level reports on mental health policies, two from Europe,^{32,34} and one each from the African region,³⁵ the Eastern Mediterranean region,²⁹ the Asia Pacific region,³⁶ and the Pan American region.³⁷ Two Lancet Commission reports were included, including one on depression²² and another on global mental health and sustainable development since these reports aim to synthesize evidence to inform global policy.¹³ Table 1 provides a full listing of the mental health-related policy documents sampled and where they contributed information to key areas of interest in this report.

The sections below describe the extent to which gender and men's health are reflected in these policy-related documents. The findings are presented in three sections, starting with (a) general reference to

Table 1. Global and regional mental health-related policy relevant documents selected for analysis

			Sex dis- aggre- gated data	Gender dispari- ties	Women & mental health	Men & mental health	Male pre-dom- inant groups	Gender analysis re: men
General mental health policy – International and multinational organizations								
1	WHO	WHO 2022. World mental health report: transforming mental health for all	X	X	X		X	
2	WHO	WHO 2021. Comprehensive mental health action plan 2023–2030		X	X		X	
3	WHO	WHO 2022. WHO guidelines on mental health at work		X	X			
4	WHO	WHO 2021. Guidance on community mental health services: promoting person-centred and rights-based approaches		X	X			
5	WHO	WHO 2023. Mental health, human rights and legislation: guidance and practice		X	X		X	
6	WHO	WHO 2019. The WHO Special Initiative for Mental Health (2019-2023): Universal Health Coverage for Mental Health		X	X			
7	WHO	WHO 2021. World Mental Health Atlas 2020	X	X	X	X	X	
8	WHO	WHO 2023. Global Accelerated Action for the Health of Adolescents (AA-HA!): guidance to support country implementation 2020	X	X	X	X	X	X
9	WHO	WHO 2022. Guidelines on mental health promotive and preventive interventions for adolescents: helping adolescents thrive	X	X	X	X	X	X
10	WHO & UNICEF	WHO & UNICEF 2022. Global Case for Support - UNICEF and WHO joint programme on mental health and psychosocial well-being and development of children and adolescents	X	X	X	X	X	X

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			Sex dis- aggre- gated data	Gender dispari- ties	Women & mental health	Men & mental health	Male pre-dom- inant groups	Gender analysis re: men
General mental health policy – International and multinational organizations (cont.)								
11	WHO	UN 2020 May. Policy Brief: COVID-19 and the Need for Action on Mental Health			X	X		
Suicide: mental health policy – International and multinational organizations								
12	WHO	WHO 2021. Live life: an implementation guide for suicide prevention in countries.		X	X	X	X	
13	WFMH	World Federation for Mental Health (WFMH) 2019. Mental Health promotion and suicide prevention	X	X	X	X	X	
14	IASP	International Association for Suicide Prevention (IASP) 2019. The 5 Year Strategy 2019 – 2023						
Other mental health-related policy – International and multinational organizations								
15	UN WHA	UN World Assembly (WHA) 2020 June. Promotion and protection of all human rights, civil, political, economic, social, and cultural rights, including the right to development		X	X		X	
16	WHO	WHO 2021 (October). Global alcohol action plan 2022-2030 to strengthen implementation of the Global Strategy to Reduce the Harmful Use of Alcohol	X	X	X	X		
Regional mental health-related policy								
17	EU	EU Commission 2017. Joint action on mental health and well-being. Mental Health in All Policies. Situation analysis and recommendations for action	X	X	X	X	X	X
18	WHO Euro	WHO European region 2022. Addressing the noncommunicable disease (NCD) burden in prisons in the WHO European Region	X	X	X	X	X	

Table 1. Global and regional mental health-related policy relevant documents selected for analysis

			Sex dis- aggre- gated data	Gender dispari- ties	Women & mental health	Men & mental health	Male pre-dom- inant groups	Gender analysis re: men
Regional mental health-related policy (cont.)								
19	WHO PAHO	WHO 2023. WHO Pan American Health Organisation (PAHO) Policy for Improving Mental Health		X	X		X	
20	CDC Africa & AU	Africa CDC and African Union (AU) 2022. Noncommunicable Diseases, injuries prevention and control and mental health promotion strategy (2022-26).	X				X	
21	WHO EMRO	WHO EMRO 2022. Mental health atlas 2020: review of the Eastern Mediterranean Region(22)	X	X	X	X	X	
22	Asia Pacific Economic Region (APEC)	APEC Digital Hub for Mental Health 2019. A New Horizon for Occupational Health. APEC White Paper on Workplace Mental Health and Safety		X	X	X		
Other								
23	Lancet Commis- sion	Herrman 2022. Time for united action on depression: a Lancet–World Psychiatric Association Commission	X	X	X	X		
24	Lancet Commis- sion	Patel 2018. The Lancet Commission on global mental health and sustainable development		X	X	X	X	
25	WHO	WHO 2022. Guide for integration of perinatal mental health in maternal and child health services			X	X		

gender differentiated burden of disease, as reflected in provision of sex-disaggregated data to b) recognition of the role of gender in mental health more generally, and finally, (c) the extent to which reports engaged more directly with men’s mental health needs. In this report we use the term ‘sex’ when referring to sex-disaggregated data, and the term ‘gender’ when referring to broader social categories (though sex and gender is sometimes used interchangeably in the policy reports).

A: Engaging with gender through provision of sex-disaggregated data

A quick way to examine if and how men have been considered in policymaking is to see whether policy documents provide sex-disaggregated data, and the scope of this data. Sex-disaggregated data give a breakdown by sex of a range of different disease prevalence and outcome measures. Sex-disaggregated data is a crucial first step in understanding and addressing gender disparities that may exist in mental health risk and prevention, service access, and treatment outcomes. When sex-disaggregated data is presented alongside data that is disaggregated by other social determinants such as age, ethnicity, minority, and disability status, it can provide further information for a detailed analysis of underlying disparities in mental health promotion, disease prevention and care. (For ease of reading, sections of quotes pertaining to the topic of interest are highlighted in **bold**).

“Sex-disaggregated data is a crucial first step in understanding and addressing gender disparities that may exist in mental health risk and prevention, service access, and treatment outcomes.”

Provision of sex-disaggregated data

About half of the reports (12 out of 25) provided some form of sex-disaggregated data.^{12, 15, 19, 20, 22, 26, 29, 32-35, 38} For the most part, these were cursory descriptions, with limited quantity, scope and depth of data. Five reports produced more detailed sex-disaggregated data.^{12, 15, 26, 29, 32} This involved providing data for a larger number of mental health conditions, and/or using visual representations of data (tables, figures) or more detailed narrative summaries. In the rest of the reports, sex-disaggregated data was limited to only a couple of narrative descriptions of gendered distribution of disease or risk factors.

In three reports, the two WHO Atlas surveillance reports^{26, 29} and the WHO Mental health for all report,¹² visual representations were accompanied by narrative summaries that described gender-differentiated outcomes. To illustrate, an example from the WHO Mental health for all report is shown below, where a table details the prevalence of mental disorders across age and sex for 2019 (see Box 1 for an extract of Table 3.1).¹²

In addition to the table shown below, the report also provided a narrative summary. For example, with reference to depression, it was noted that depression and anxiety were more common among women than men, while substance abuse was more common among men.

Depressive and anxiety disorders are about 50% more common among women than men throughout the life-course, while **men are more likely to have a substance use disorder**.¹² (pg. 43)

And further, with respect to gender differences in older adults:

Around 13% of adults aged 70 years and over lived with a mental disorder in 2019, mainly depressive and anxiety disorders. **Sex differences in rates of mental disorders increase in this age category as 14.2% of women and 11.7% of men aged over 70 years are estimated to have a mental disorder**.¹²(pg. 44)

More detailed sex-disaggregated data is also provided in a recent (2023) WHO report on Global Accelerated Action for the Health of Adolescents

Box 1. Prevalence of mental disorders across age and sex (2019)

	ALL AGES (millions)	ALL AGES (%)			AGE (%)								AGED 20+ YEARS (%)		
		ALL	♂	♀	<5	5-9	10-14	15-19	20-24	25-49	50-69	70+	ALL AGES	♂	♀
Mental disorders	970	13	12.5	13.5	3.0	7.6	13.5	14.7	14.1	14.9	14.7	13.1	14.6	13.4	15.7
Schizophrenia	24	0.3	0.3	0.3				0.1	0.3	0.5	0.5	0.2	0.5	0.5	0.4
Depressive disorders	280	3.8	3.0	4.5		0.1	1.1	2.8	4.0	4.8	5.8	5.4	5.0	4.0	6.0
Bipolar disorder	40	0.5	0.5	0.6			0.2	0.6	0.7	0.7	0.7	0.5	0.7	0.7	0.7
Anxiety disorders	301	4.0	3.0	5.0	0.1	1.5	3.6	4.6	4.7	4.9	4.8	4.4	4.8	3.6	5.9
Eating disorders	14	0.2	0.1	0.2			0.1	0.3	0.4	0.3			0.2	0.2	0.3
Autism spectrum disorders	28	0.4	0.6	0.2	0.5	0.5	0.5	0.4	0.4	0.4	0.3	0.3	0.3	0.5	0.2
Attention Deficit / hyper-activity disorder	85	1.1	1.7	0.6	0.2	2.4	3.1	2.4	1.7	0.9	0.3		0.7	0.4	1.1
Conduct disorder	40	0.5	0.7	0.4		1.1	3.6	2.1							
Developmental disorders (idiopathic)	108	1.5	1.5	1.4	2.2	2.3	2.2	2.0	1.8	1.3	0.7	0.4	1.1	1.1	1.1
Other mental disorders	117	1.6	1.9	1.3			0.1	0.4	1.0	2.2	2.6	2.7	2.2	2.7	1.8

Source: WHO, 2022 World mental health for all - table 3.1

(AA-HA!). The report highlighted the effects of gender and age across many of the health conditions covered. For instance, the gendered trend in mortality from suicide for girls is outlined.

Self-harm is prevalent across all countries and contexts, and is a major cause of death among young people. During adolescence, it occurs mainly among older adolescents, and was the fourth leading cause of death in the 15-19 years age group, and the **third leading cause of death for older adolescent girls in 2019**.¹⁹(pg. 62)

The WHO 2022 European region NCD in prisons report³² provided several examples of sex-disaggregated data with respect to the prison populations in Europe. The main comparisons were with the burden of disease for non-prison populations, for the same gender group. For instance, the report noted that gendered suicide patterns found in the community are also reflected in prison populations, but at higher rates compared to non-prison populations.

...suicide accounts for 50% of all prison deaths (66). **Suicide rates have also been shown to vary markedly according to sex**, similar to the pattern observed in the outside community but with a considerably

Box 2a. Age-standardised suicide rate per 100,000 population (2019)

	MALE	FEMALE	BOTH SEXES
Global	12.6	5.4	9.0
WHO Region			
AFR	18.0	5.2	11.2
AMR	14.2	4.1	9.0
EMR	9.1	3.5	6.4
EUR	17.1	4.3	10.5
SEAR	12.3	8.1	10.2
WPR	9.6	4.8	7.2
World Bank income group			
LOW	15.2	5.3	9.9
LOW-MIDDLE	13.1	7.1	10.1
UPPER-MIDDLE	10.7	4.1	7.3
HIGH	16.5	5.4	10.9

Source: WHO, Global Health Estimates, 2000-2019 - table 4.2.2

higher imbalance. **Suicide was reported to be three times higher in males living in prisons and nine times higher in females living in prisons, when compared to the general population³²(pg. 17)**

The two WHO Atlas surveillance reports that mapped mental services globally and in the EMRO region, stood out for the detailed amount and scope of sex-disaggregated data they provided compared to other reports. Both the WHO World mental health atlas 2020, a global report,²⁶ and the Eastern Mediterranean region (EMRO) mental health atlas²⁹ provided extensive sex- (and age) disaggregated data on burden of disease and service utilization among a broader range of mental health

Box 2b. Total inpatient care admissions* (N=91)

	NUMBER OF COUNTRIES	FEMALE (%)	MALE (%)
Global	91	42%	58%
WHO Region			
AFR	15	39%	61%
AMR	21	39%	61%
EMR	13	32%	68%
EUR	23	45%	55%
SEAR	5	35%	65%
WPR	14	43%	57%
World Bank income group			
LOW	8	44%	59%
LOW-MIDDLE	21	36%	62%
UPPER-MIDDLE	30	42%	58%
HIGH	32	44%	56%

* Mental hospital, psychiatric unit, community residential facility
Source: WHO, Global Health Estimates, 2000-2019 - table 4.2.2

system support services (governance, financial, human resources and information systems). To illustrate, two examples of the many tables of data from the WHO World mental health atlas are shown in Boxes 2a and 2b.

In the WHO global atlas report, Table 4.2.2 reported on in-patient care admissions (mental hospital, psychiatric unit, community residential facility), disaggregated by sex, for WHO regions and World Bank income groups.²⁶ Tables were accompanied by narrative summaries that pointed to gender, age and geographic distributions. For Table 4.2.2, the gender-differentiated distribution was noted, including that there was a higher proportion of inpatient care access for males.

The number of countries reporting the availability of sex disaggregated data on mental health inpatient care was lower (Table 4.2.2). When the data on total inpatient care admissions were disaggregated by sex, they showed a higher proportion of males (58%) versus females (42%) globally, as well as across all WHO regions and different income groups.²⁶(pg.87)

Similarly, for Table 5.2.1, and throughout the report, the narrative summaries accompanied the tables and figures of data and described the gender distribution where relevant. For instance, for Table 5.2.1, the report highlighted that there was a higher burden of suicide mortality for males compared to females.

As shown in Table 5.2.1, the global age-standardized suicide rate in 2019 was estimated at 9.0 deaths per 100 000 population; this represents a 10% reduction in the rate of suicide since the 2013 baseline of 10.0 per 100 000 population. **Rates continue to be higher among males than females, at 12.6 and 5.4 per 100 000 respectively in 2019.** While the majority of deaths by suicide occurred in low- and middle-income countries (77%), where most of the world's population live.²⁶(pg.102).

A similar level of detail for sex-disaggregated data was also provided in the regional WHO EMRO World Atlas. See Box 3 for an extract of Table 5.1 – “Suicide rates per 100,000 population in 2013 and 2019 in the Eastern Mediterranean Region, by country group and by gender”.²⁹

In other reports the reference to sex-disaggregated data was scant. For instance, the WHO Global alcohol action plan report³³ made only three references to sex-disaggregated data in a lengthy report. One reference was to alcohol-related mortality rates for women and men.

In 2016, an estimated 2.3 million deaths and 106.5 million DALYs among men globally were attributable to alcohol consumption. For women, the figures were 0.7 million and 26.1 million, respectively.³³(pg.5)

Similarly, in the EU 2017 report on Mental health in all policies,³⁴ two references were made to sex-disaggregated data, one highlighting that men made up 80% of suicides in Europe and the second noting that women were estimated to become the majority (two-thirds) of the projected increase in depression in the European region.³⁴

In summary, as shown above, the presence of sex-disaggregated data

Box 3. Suicide rates per 100,000 population, Eastern Mediterranean Region

REGION/ COUNTRY GROUP	2013	2019	% REDUCTION IN RATE
All			
Eastern Mediterranean	5.70	4.76	16%
Group 1	5.60	4.95	12%
Group 2	3.77	3.41	10%
Group 3	8.55	8.41	2%
Female			
Eastern Mediterranean	2.95	2.40	19%
Group 1	2.13	1.80	15%
Group 2	2.33	2.27	3%
Group 3	5.68	5.47	4%
Male			
Eastern Mediterranean	6.88	6.34	8%
Group 1	6.91	6.36	8%
Group 2	5.24	4.65	11%
Group 3	11.83	11.75	1%

Source: WHO EMRO Mental Health Atlas 2020 - table 5.1

can assist in identifying broader gendered patterns of mental health conditions and service access, but there are gaps in reporting. While nearly half of the reports provided some form of sex-disaggregated data on mental health, for the most part, these were cursory references that were limited in quantity, scope and depth. Detailed reference to gender-differentiated patterns in mental health burden and care were less common.

Calls for more sex-disaggregated data

Over half of the reports (13) acknowledged the importance of sex-disaggregated data and called for more sex-disaggregated data in reporting and monitoring.^{12, 13, 19, 20, 26, 29, 31, 33, 37, 38, 39, 40, 41} For instance, all three reports on adolescent health and well-being noted that the lack of sex-disaggregated data limited their ability to do a gender sub-analysis of disparities in mental health.^{19, 20, 38} The WHO-UNICEF report on psychosocial well-being and mental health of children and adolescents²⁰ described this lack and how it limits knowledge about gaps and disparities.

Comprehensive, age- and sex-disaggregated data on child and adolescent mental health, psychosocial well-being and development, and the mental health and well-being of caregivers are sorely lacking, limiting what we know about exposure to risk factors, prevalence of mental health conditions, and access to available prevention and care services.²⁰(pg. 9)

A recent (2023) WHO report on adolescent health noted that adolescent health-related indicators draw on nationally representative household surveys like the DHS and MICS, but that the latter did not include adolescent boys and young men.¹⁹ The WHO World mental health atlas report indicated that, globally, some 30% of countries were not able to provide sex-disaggregated data in response to the WHO survey, and that capacity decreased with lower country income-level.²⁹

The capacity of information systems to disaggregate data by age and sex declined consistently across income groups, with 54% of low-income countries disaggregating data by age and fewer than 50% of countries in this group disaggregating data by sex (Figure 1.7 and Table 1.2).²⁶(pg. 20)

The reports called for sex-disaggregated data alongside data on other social determinants (like age) to allow for the design of inclusive approaches to address inequities. For example, in the WHO-UNICEF children and adolescent report,²⁰ the need for sufficiently disaggregated data was one of the key recommendations made. Also highlighted was the need to strengthen country health information systems to strengthen surveillance. Planning, programme development and monitoring systems for health need disaggregated data that allow for disaggregation on multiple social determinants, including gender, age, disability, sexual orientation, ethnicity and other social, economic and environmental determinants of health.^{12, 19, 20, 29, 37} This focus was made explicit in a WHO-Pan-American (PAHO) regional report on strengthening mental health. Strengthening data systems was one of the five strategic actions in the report, namely, “Strategic Line of Action 5: Strengthening data, evidence, and research”.³⁷ This strategy aim was:

To guide policies to reduce mental health disparities and promote equity, the data should be disaggregated by gender, sex, age, education, income/economic status and related measure (eg. housing status, food security), race or ethnic group, national origin, geographic location, disability status, sexual orientation, and other social, economic and environmental determinants of health, where possible.³⁷ (pg. 18)

To summarise, while there were gaps across reports in reporting on sex-disaggregated data, there was widespread acknowledgement of the value of disaggregated data, and there are global and regional commitments to strengthen country monitoring and surveillance systems to produce data that is disaggregated by sex and by other socio-demographic determinants.

B: Awareness of the role of gender in mental health

To examine whether reports engaged with gender beyond merely presenting sex-disaggregated data, this review looked at whether and how the concepts of gender, gender disparity and gender equity were used in these reports. Questions included: To what extent did the reports identify gender as a social determinant, and in what way was gender-responsiveness in policy and practice addressed?

Gender as a social determinant of mental health

Most reports (21 out of 25) referred to gender in some way. In four reports, reference to gender, gender disparities, and other social determinants of illness were absent.^{30, 35, 42, 43} The most common reference to gender was naming sex or gender as a determinant of mental health problems, alongside other socio-demographic variables such as age, ethnicity, socio-economic status, minority status and more. Gender (alongside other social determinants) was sometimes also named as influencing the experience of and access to mental health care. For instance, in a recent (2023) WHO report on mental health and human rights, sex/gender was noted as a factor that influences mental health experience and access to quality care.

“The WHO World mental health atlas report indicated that, globally, some 30% of countries were not able to provide sex-disaggregated data.”

A wide range of factors influence a person’s mental health as well as their access to quality care and support; these include the person’s age, sex, sexual orientation, sex characteristics, gender identity or expression, disability, caste, racial, indigenous or ethnic origin, socioeconomic status, migration or refugee status, and other markers of identity.¹⁹(pg.31)

Gender is regarded as both a risk factor and a protective social factor that can influence mental health, as noted in the WHO Mental health for all report.

And prevailing beliefs, norms and values – **especially in relation to gender,** race and sexuality – can also be hugely influential.¹² (pg.22)

Reports made recommendations that advocated for a human-rights based approach to promote equitable access to health care.^{12, 19, 23, 39, 44} In the WHO World Mental health for all report, this human rights approach is outlined as one of four functions of the health sector:

The health sector can provide a range of **equitable and rights-based services, irrespective of age, gender,** socioeconomic status, race,

ethnicity, disability or sexual orientation.¹²(pg. 18)

Similarly, the WHO Comprehensive mental health action plan stated the importance of gender-related considerations for equitable access to universal health coverage.

Regardless of age, sex, socioeconomic status, race, ethnicity or sexual orientation, and following the principle of equity, persons with mental disorders should be able to access, without the risk of impoverishing themselves, essential health and social services that enable them to achieve recovery and the highest attainable standard of health.³⁹ (pg. 5)

Gender inequality and mental health

The area with the most attention paid to gender in these reports was the influence of women's gender inequality on women's health. In these contexts, gender inequality referred to the unequal and reduced power of women in relation to men and was associated with stigma, prejudice, social exclusion, and economic exclusion. Gender inequality was described as a structural risk factor alongside other social determinants such as social and economic inequalities that undermine women's mental health.^{12, 34, 40} The WHO PAHO policy for improving mental health noted that poor mental health can be both a cause and a consequence of gender inequality, a sentiment that was acknowledged across most reports.

Poor mental health is both a cause and a consequence of poverty, compromised education, gender inequality, ill health, and other global challenges.³⁷(pg. 6)

The WHO/UNICEF report on mental health of children and adolescents noted that gender inequality and resultant gender norms result in stressful life events that disproportionately affect agency and choice among girls, such as child marriage and early and unintended childbearing, and are likely drivers of depression and anxiety in adolescent girls.²⁰ The reports noted the negative effects of gender inequalities for girls and added that boys may also be negatively affected by putting them at higher risk for self-harm and a range of behavioural disorders.

Gender inequalities shape all aspects of children's mental health and well-being, and it is important to note both gendered determinants and gendered outcomes. **Girls are more likely to experience violence, lower education, poverty, and psychological distress and as a result face a higher likelihood of internalizing conditions such as depression and anxiety. Mental health conditions in male adolescents put them at high risk of suicide, conduct disorder, alcohol and substance use, and interpersonal violence.**²⁰(pg. 27)

Of interest is that, as reflected in this quote above, the WHO-UNICEF report was the only one where the potential risk to mental health of boys was mentioned in the context of gender-inequality. Such references to the effect of gender on men's health was rare.

Gender-sensitive approaches to mental health

Reports referred to the need for 'gender responsive' approaches to address mental health, and used terms like 'gender-equal', 'gender-inclusive' and 'gender-sensitive'. In most cases, the term gender-responsiveness seem to refer mainly to the need to address the disproportionate effects of gender inequality on the mental health of women. For instance, reports noted the need to pay special attention to addressing pregnancy-related mental health and to discriminatory practices such as gender-based violence, restrictive sexual reproductive health practices and child marriage. A report from the UN World Health Assembly on the promotion of human rights called for a rights-based approach to health, including the need for gender-sensitive interventions to address the vulnerabilities facing women and girls.⁴⁴

Recognizing that women and girls with mental health conditions or psychosocial disabilities at all ages, in particular those using mental health services, face an increased vulnerability to violence, abuse, discrimination and negative stereotyping, and underscoring the need to take all appropriate measures to ensure access to mental health and community services that are gender-sensitive...⁴⁴(pg. 3)

A gender equal and inclusive approach was described as a core principle of the Joint programme of the WHO-UNICEF report on child and adolescent health. The report advocated for considering the role of gender in all policies and programmes, also called 'gender mainstreaming'.

Planning, implementation, and evaluation will be child- and family-centred, gender equal and inclusive, and will prioritize human rights-based, equity-focused,...²⁰(pg. 16)

The WHO report on human rights in mental health pointed to the need for legislation to promote gender-responsive health services. This would require health providers to be informed of how gender norms shape people's life experience and mental distress.

Gender differences can impact the experience of mental health conditions and care in mental health services. **Legislation can help to promote gender-responsive services by requiring that people working in mental health care are informed of issues such as how gender and sexuality norms and stereotypes shape life experiences** (eg. violence and abuse); day-to-day social, cultural, and family realities; expressions and experiences of mental distress; and care and support requirements and responses.²³(pg. 103)

Gender-responsiveness received detailed attention in the recent (2023) WHO report on adolescent health. The report offered a set of questions for a gender analysis of adolescent health programming and outlined a scale for gender-responsiveness to guide the development of programmes. The continuum of the scale included approaches that were gender-unequal, to gender-blind, to gender-sensitive and gender-responsive, with the latter including gender-specific and gender transformative approaches.²³ An extract from the gender responsive scale is shown in Box 4 below.

The same WHO adolescent report also emphasised the need for gender

mainstreaming of health programmes, which they defined as: “a process of assessing the gender implications for both adolescent boys and girls of any planned action, including legislation, policies and programmes in all areas and at all levels.”¹⁹(pg.163). The report encouraged health programming to be gender-transformative as far as possible.

Without gender mainstreaming, programmes risk being gender unequal or gender-blind. **Adolescent health and well-being programmes and interventions should, at a minimum, be gender-specific and, ideally and when possible, gender-transformative.**¹⁹ (pg.163).

Nevertheless, while this report emphasized a call for gender-responsive programming, no specific male gender responsive recommendations were made to address mental health needs of boys and male adolescents.

In sum, most reports referred to the importance of gender, alongside other social determinants of mental health burden of disease, with a focus on how gender inequality has a disproportionately negative effect on the mental health of women. The reports advocated for gender-responsiveness in mental health care, using a human rights approach that addresses gender-differential needs and promotes equitable access to health care, but did not make gender-responsive recommendations to address mental health needs of men.

Box 4. Gender responsiveness scale, WHO 2023 report on adolescent health¹⁹

Gender-specific

Deliberately targets a specific group of girls or boys for a specific purpose; does not challenge gender roles or norms

Example:

- organising an information campaign to prevent injuries from burns with messages addressing the different causes of burns in boys and girls. It addresses girls in households and boys in sports clubs.

Gender-transformative

Addresses the causes of gender inequality; transforms harmful gender roles, norms and relations, promotes gender equality

Example:

- community programme supporting families to value girls' education
- cash-plus transfer programmes that directly address social norms; this includes norms in relation to domestic and care work within the household and access to income-generation opportunities
- encouraging boys to question established stereotypes of masculinity
- enable adolescent girls to participate equally in programme design and implementation

C: Engagement with men's mental health

As shown earlier, the presence or absence of sex-disaggregated data, and general awareness of the role of gender in mental health, were ways to examine engagement with gender and mental health. Recognizing gender disparities and inequities for both genders would be important to understand and address inequities in mental health better and this review therefore examined the extent to which reports showed an explicit awareness of men's mental health needs.

All reports, except two^{30, 35} made mention of gender and mental health conditions in some basic way (eg. sex-disaggregated data, gender as a determinant). Twenty-three (out of 25) reports referred to gender-differentiated effects with respect to the mental health needs of women mostly, as detailed earlier. Gender-differentiated effects on mental health needs of men were also reported on, but much less so. In 15 out of 25 reports, there was some mention of men or boys, or a reference to the mental health of men, but for the most part these were cursory references, that were limited in quantity, scope and depth.^{13, 15, 19, 20, 22, 26, 29, 31-34, 36, 38, 42, 43} For instance, the most common references to men and mental health described the gender distribution of mental disorders between the two sexes, through the provision of sex-disaggregated data. A second area was when higher prevalence rates for men were mentioned, in certain commonly known conditions, such as in suicide, alcohol use disorders, and conduct disorder, and for less common conditions (eg. in digital disorders, like 'gaming disorder', which refers to negative impacts of excessive use of the internet including gaming and other digital technologies). Finally, some reports described the mental health needs of subgroups where males are overrepresented, such as in the criminal justice system (prison) and the military. Examples are detailed below of the different ways that male mental health was reflected in reports, together with discussion of the extent that male gender-responsive interventions were addressed.

Men and depression

For the most part, information on men was limited to a few references to the gender distribution of depression. Males were also mentioned in reference to how gender may influence depression symptoms differently for males,²² and in how such symptoms may be under-recognised by health providers.²³

With respect to gender distribution, the Lancet Commission report on the prevalence of depression based on a 2019 Global Burden of Disease study noted rates of depression for women were almost twice as high as for men and differed across regions.

The estimated point prevalence among both women and men was highest in North America (4.4% for women and 2.5% for men) and lowest in the Western Pacific (2.3% for women and 1.3% for men); it was intermediate in other world regions both for women (2.8–3.6%) and men (1.9–2.0%),²²(pg. 12)

It further noted that depression rates for men also differed across regions, with the highest prevalence being in Africa.

Among men, estimated prevalence [of depression] was highest in Africa (4.8%), lowest in the Western Pacific (2.8%), and intermediate in other regions (3.5–3.8%).²²(pg. 12)

The report noted that the reasons for these regional differences are unknown and may be due to real geographically distributed risk factors but could also be due to methodological limitations of survey tools.

Depressive symptoms in men might present differently, that is, in a more “externalizing spectrum” compared to women, involving more behavioural disturbances.

However, in a subpopulation (more frequently in men), depression might instead be part of an externalising spectrum, also including anger attacks, aggression, substance abuse, and risk-taking behaviour.²²(pg. 19)

Gender stereotyping may also result in different treatment responses for men and women. For instance, the WHO 2023 Human rights report noted that gender-stereotyping by health providers may result in higher prescription of psychotropics for women and under recognition of mental distress of men.

Gender-related stereotypes may influence the diagnosis of mental health conditions and lead to higher prescription rates of psychotropic drugs for women.⁴⁵ **Conversely, gender stereotyping in men can lead to the invisibility of mental distress.**^{45,23}(pg. 20)

Men and suicide

While more women attempt suicide than men globally, the higher prevalence of fatal suicide among men was noted in several reports.^{12, 15, 26, 29} For instance, in the WHO World mental health for all report, gender-differentiated suicide rates and higher mortality rates among men was described.

Suicide rates also vary between males and females. Globally, women are more likely to attempt suicide than men. And yet twice as many men die by suicide than women do. In high-income countries the male-to-female ratio for death by suicide is even higher, at three men to every woman.¹²(pg. 47).

The regional WHO EMRO Mental health atlas report pointed to a decline in suicide rates in the region, between 2013 and 2019, but with a slower decline among men (8%) compared to a 19% decline for women.²⁹

Although most suicides suicide attempts occur in women globally, the female to male mortality ratio indicates a disproportionate effect on men. The phenomenon of more common non-fatal suicides among females and the use of more violent methods resulting in higher mortality for men, has been termed the ‘gender paradox’ in suicide.¹⁵

There are many regional differences, with most suicides occurring in LMICs, but with the comparative rates of mortality for men in HICs being

twice as high as in LMICs:

Some 75% of all cases of suicide globally occur in low- and middle-income countries. **In high-income countries, three times as many men die by suicide than women, but in low- and middle-income countries the male-to-female ratio is much lower at 1.5 men to each woman.**¹⁵(pg. 35).

“The phenomenon of more common non-fatal suicides among females and the use of more violent methods resulting in higher mortality for men, has been termed the ‘gender paradox’ in suicide.”

The World Federation for Mental Health (WFMH) report on suicide prevention provided data on suicide that was disaggregated not only for gender, but also for age and country income level (15). This report stood out for the level of detail it provided with reference to men and suicide, compared to the other reports reviewed. It also appeared to be fairly even-handed in reporting gendered patterns for both genders. (15). The data showed how gender intersected with other social determinants such as socio-economic status in relation to suicide, as detailed in Box 5 below. For example, the age and gender profile differs across countries, with young adults and women attempting suicide more in LMICs, compared to higher suicide rates among older men in LMICs. There appears to be a continued increase in suicide rates among older adults, especially among men.¹⁵

The WFMH report went further to provide detail on gender-differentiated effects on men. For example, it was noted that some psychosocial and situational risks, such as the loss or absence of an intimate partner appeared to increase vulnerability to suicide for elderly men. Other psychosocial stressors, like impending legal action, recent imprisonment or upcoming release from custody, and substance abuse were also mentioned as risk factors.¹⁵ As detailed in Box 5, men are also more involved in perpetrating “murder suicides”, often in situations where they were involved in talking care of an ill or disabled spouse. Finally, the report noted that men were less likely to communicate their suicidal thoughts before attempting suicide, compared to women and younger people.¹⁵

INTERVENTIONS

The WMHF report also referred to potentially effective intervention strategies in the military that have relevance for men. There are indications that post-discharge follow-up care in military psychiatric hospital settings in the US were successful at suicide prevention (15). Other interventions have been suggested that may pertain to males. For example, the WHO Live life report on suicide prevention referred to the need to build capacity for early identification for suicide prevention, noting that programmes should carefully consider who to capacitate and which client groups to prioritize (eg. bartenders and hairdressers serving male clients).³¹

Box 5. Summary of information on men and suicide in the WFMH report

- The gendered distribution of suicide shows the proportion of violent deaths it makes up for both men and women:

Globally, suicide deaths account for 50% of all violent deaths (i.e., from interpersonal violence, armed conflict and suicide) in men, and 71% of such deaths in women (WHO, 2014).¹⁵ (pg. 35).
- Most cases of suicide (75% of suicides) occurs in LMICs.
- In LMICs there are higher suicide rates for young adults and women compared to higher suicide rates for middle aged men in HICs.
- The male suicide mortality rate is higher than for females with differences between country income levels. The female-to-male ratio suicide fatality rate in high income countries is a ratio of 1:3, as compared to LMICs where the ratio is 1:5.
- Suicide rates continue to increase in older adults with a greater increase among men.
- Psychosocial factors influence suicide vulnerability, including loss or absence of an intimate partner for men, especially for elderly men (80+ years old):

Men, particularly when single, widowed or divorced, are often reported to be at increased risk of suicide.¹⁵ (pg. 14)
- Older adults are disproportionately affected by “domestic murder-suicide”, with most of the perpetrators being men against their female spouse:

The vast majority of cases of murder-suicide are committed by men against a female spouse with a firearm. As many as 40% of the actors were involved in providing assistance to a spouse with a long-term illness or with a disability.¹⁵ (pg. 15)
- Men and older adults are less likely to communicate about their suicide than women and younger people:

As a matter of fact, communication of suicidal thoughts tends to be less common among men and older adults who die by suicide than it is among women and younger people who do it.¹⁵ (pg. 15)

Men and behavioural disorders

Men were also named directly when describing more common behavioural mental health conditions that affected boys more heavily, such as conduct disorder and attention deficit disorder. Included in this category is interpersonal violence. For instance, in Table 3.1 in the WHO Mental health for all report (shown in Box 1 earlier), the data indicated large sex-differences for conduct disorder and attention-deficit hyperactivity disorder (ADHD) that disproportionately affected males (12).

The WHO-UNICEF report on children and adolescents also commented on the higher burden on boys of behavioural disorders such as conduct disorder and ADHD.

Globally, girls are more likely than boys to suffer from emotional disorders, such as anxiety and depression, **whereas boys suffer more from behavioural disorders, such as attention-deficit hyperactivity disorder (ADHD) and conduct disorder.**²⁰(pg. 6)

In the recent (2023) WHO report on adolescent health, conduct disorder rates among adolescents were highlighted as being among the top five sources of morbidity, but with a particularly high burden for younger male adolescents. These account for the leading cause of years of healthy life lost due to disability (or YLDs) for younger adolescents with “one YLD representing the equivalent of one full year of healthy life lost due to disability or ill-health.”¹⁹(pg. 57).

Childhood behavioural disorders were in the top five causes of adolescent morbidity in all modified WHO regions in 2019, regardless of sex or age group. **The burden of these disorders is particularly high among 10- to 14-year-old males, for whom they were the leading cause of YLDs in 2019.**¹⁹(pg. 63)

The same WHO 2023 report on adolescent health also noted that interpersonal violence was among the leading causes of mortality for adolescents and young people globally. Interpersonal violence referred to “intentional use of physical force or power by one person against another, with a high likelihood of causing injury, death, psychological harm, mal-development or deprivation.”¹⁹(pg. 57). It includes all types of physical and/or emotional ill-treatment, sexual abuse, neglect, negligence and commercial or other exploitation, fighting and bullying, gang-related violence, threats with weapons and homicide. The report did not specify the burden of interpersonal violence for men compared to women.

Interpersonal violence is among the leading causes of death in adolescents and young people globally. Its prominence varies substantially by region, accounting for 40% of reported deaths in the **Americas LMICs (up to 66 deaths per 100 000 among older adolescent boys)** and 28% in African LMICs.¹⁹(pg.57)

The WHO-UNICEF report on children and adolescents also referred to the increased vulnerability of male adolescents to conduct and other behavioural disorders, including risk for interpersonal violence.

Mental health conditions in male adolescents put them at high risk of suicide, conduct disorder, alcohol and substance use, and interpersonal violence.²⁰(pg. 27)

Sexual abuse in children and youth is noted as a risk factor for later mental distress for both genders. The WHO 2023 adolescent health report noted that one in every five women and one in every thirteen men were affected by sexual abuse.¹⁹ Of interest is that this is the only report where male youth were included as potential victims of sexual abuse.

It was highlighted that mental health conditions in older adolescents, such as conduct disorder and substance abuse, track into adulthood

for men.¹⁹ This was mentioned as an added imperative to address these conditions in childhood. One example is where adolescent behavioural conditions track into adulthood through increased risk of involvement in the criminal justice system.^{15, 19, 26, 31, 34, 38, 44} For instance, the WHO 2022 report on mental health of promotion of adolescent mental health referred to a range of social and health impairments associated with these behavioural disorders and the persistence of these childhood impairments into adulthood, including a link between childhood conduct disorder and later delinquent and criminal activities.³⁸

Externalizing behaviours can cause significant issues in school, peer, and family functioning. They can persist into adulthood, increasing the risk of substance use. Evidence shows that conduct problems in adolescence cause social and health impairments, resulting in poor educational, occupational, health and other negative outcomes in adulthood. **Moreover, conduct disorder is strongly linked to delinquency and criminal activity.**³⁸(pg. 26/28)

The disproportionate effects on males were not always explicitly stated when reports referred to childhood behavioural disorders and impairment into adulthood. However, this may be implied, given that some reports acknowledged the higher burden of behavioural disorders among boys and adolescent males, and given that males are overrepresented in the criminal justice system.

Increased use of digital technology may also be associated with mental health and social impairments among adolescents, though the evidence is inconclusive.¹⁹ A new mental health ICD category, called digital gaming disorder, was reported to be more common among men.

It [gaming disorder] is more common among men than women and it can result in marked distress and significant impairment in personal, family, social, educational or occupational functioning.¹²(pg. 124)

INTERVENTIONS

A few reports made recommendations for how to address behavioural disorders, but none mentioned male-specific interventions. In the WHO report on promotion adolescent mental health, evidence was sought for interventions that prevent conduct disorder as one of six key questions on promoting child and adolescent mental health.³⁸ For instance, the report prioritised the need to find solutions for conduct disorder and made this a focus area for recommendations, asking the question: "Should psychosocial interventions be considered for adolescents with disruptive/oppositional behaviours in order to prevent conduct disorders, self-harm and/or other risky behaviours?"³⁸ One report referred to the risk to mental health of issues in relation to involvement with the criminal justice system, including recent imprisonment, and recent release from prison,¹⁵ while another called for public policies that promote non-violence.⁴⁴

Men and alcohol

The majority of reports (17 out of 25) discussed the issue of substance use disorder as a common mental health condition with some drawing attention to higher prevalence among males,^{12, 13, 15, 19, 20, 26, 31-42} The WHO Global alcohol action plan reported figures on alcohol use disorder as high as 84% for men, compared to 16% for women.³³ Alcohol-related mortality figures and disability-adjusted life years of three to five times higher rates for men were also reported.³³ In the WHO 2023 adolescent health report, alcohol use among youth was noted as a concern, with males being at higher risk for heavy episodic drinking:

Worldwide, more than one quarter of all people ages 15–19 years were estimated to be current drinkers in 2016, amounting to 155 million adolescents. **In 2016 the prevalence of heavy episodic drinking among all adolescents ages 15–19 years**^{31, 45} was 13.6%, which represents 45.7% of heavy episodic drinkers among those adolescents drinking any alcohol, **with males most at risk.**¹⁹(pg. 63)

“The WHO Global alcohol action plan reported figures on alcohol use disorder as high as 84% for men, compared to 16% for women.”

While several reports highlighted the need for interventions to prevent substance abuse, there were no male-specific recommendations made in any of the reports. Some indirect references were made. For example, the WHO Live life suicide prevention report referred to the WHO’s Gap programme (delivered in Turkey, Brazil, Iran and elsewhere) that aims to integrate mental health services and suicide prevention into substance abuse services by training primary care workers.³¹ The report also referred to strengthening alcohol control policies in Russia, a move that was linked to the reduction in deaths related to alcohol, especially for males.³¹

Men and paternal perinatal depression

Maternal perinatal depression, which is the development of adverse mental health changes during pregnancy and after childbirth, affects the wellbeing of the mother but can also affect the wellbeing of the baby. As mentioned earlier, men also experience mental health changes during the pregnancy of their partner and after the birth, but less is known about this condition.

WHO recently (in 2022), developed a guide to integrate perinatal mental health services for women in maternal and child health services.⁴³ The report made a couple of references to partners of mothers, which could be taken to imply predominantly male partners. One instance is the recommendation that partners, and family should be included in psychoeducation about perinatal depression, including information on how to support women during the perinatal period. There was also recognition of mental health risk for partners. Three points of relevance to males were made: one is the acknowledgement that partners are also at risk for poor mental health, the second is that positive mental health of the partner can be protective for the woman, and the third is the recommendation for an ‘inclusive approach’ to the mental health of the whole family. As described below, this could include mental health screening, treatment and support services for partners and families.

Partners and other close family members involved in care-giving are also at risk of anxiety and depression in the perinatal period.

Positive mental health among partners and other caregivers can protect against the development of PMH conditions and negative effects on children.³² Preventing and treating mental health conditions may benefit the whole family. Most MCH services focus on the health of women and infants. **Often, partners and other caregivers feel that they have no right to support. It is important that services take an inclusive approach to the mental health of the whole family**, when possible, and design PMH services for all caregivers, which may include screening, treatment and referral to support groups.⁴³(pg. 15)

Mental health in male subgroups

Several (16 out of 25) made indirect reference to mental health needs in areas where men could be considered the predominant group. This included references to the criminal justice system, prison populations and people in the military. While these groups are not synonymous to men, men are usually in the majority, and it is helpful to recognise that men may have unique needs in these settings.

Several reports (14 out of 25) referred to mental health in prisons and the criminal justice system.^{12, 15, 19, 20, 26, 29, 31, 32, 34, 35, 37-39, 44} For example, the EU report on Mental health in all policies included a sub-section on mental health in criminal justice and prison systems that referred to the link between conduct disorder in childhood and later criminal activity.³⁴ Protection of human rights of people with mental health conditions, including those involved with the criminal justice system, is a key focus in the WHO 2023 report on human rights legislation for mental health, including legislation to ensure equal treatment under the law, and to avoid discriminatory practices.²³ The WHO World mental health plan also referenced the need to address the mental health needs of people in the criminal justice system, both in prison and in the community. It described the multi-layered risk of human rights violations for people with mental illness when they are tried for a crime:

People who were tried for a crime and found not guilty because they have a mental health condition often suffer human rights violations. In some jurisdictions, these people are kept in prisons without adequate care and support, while in others they may be transferred to a forensic psychiatric hospital (or section) where they are often treated like prisoners, with severely restricted freedoms.¹² (pg. 241)

The WHO European prison report provided the most detailed focus on mental health of people in prison, noting that men make up over 90% of the prison population in Europe.³² This report compared the burden of disease between prison and non-prison populations, with a particular focus on prioritizing the mental health needs of imprisoned women. It noted that there was an increased burden of NCDs among prison populations compared to non-prison populations, including for mental health. The gendered distribution of rates of attempted suicide and suicide mortality in prison reflected that found in the outside community in Europe, but with a higher burden for those in prison.

As a result of all these issues, suicide accounts for 50% of all prison deaths. Suicide rates have also been shown to vary markedly according to sex, similar to the pattern observed in the outside community but with a considerably higher imbalance. **Suicide was reported to be three times higher in males living in prisons and nine times higher in females living in prisons, when compared to the general population.**³²(pg. 17)

In this report, there is more engagement on the mental health needs of female prisoners compared to that of males, as females are considered a minority, “special population” in need of care.³² Most of the interventions in this report are therefore focussed on addressing imprisoned women’s mental health needs.

INTERVENTIONS

These subgroups also featured in report recommendations. One report noted the importance of integrating mental health issues in other relevant sectors, including with the criminal justice system.²⁶ Others highlighted the need for judicial system staff (prison officers, judges) to have capacity-building skills for early identification and intervention with high-risk subgroups,³¹ and called for public policies that promote non-violence.⁴⁴ The Lancet Commission on global mental health and sustainable development report pointed to evidence of the effectiveness of increased funding for child and youth mental health care services, noting it can positively affect future unemployment, and reduce use of welfare benefits and contact with criminal justice. It pointed to examples in HICs of effective psychosocial interventions for conduct disorder.¹³

Reports also made indirect reference to men by pointing to mental health risks associated with military combat and for military veterans^{12, 15, 31} and child soldiers.²⁰ The WHO suicide prevention report noted that the (US) President’s Roadmap to Empower Veterans and End a National Tragedy of Suicide (PREVENTS) established a three-year action plan to address suicide among veterans in the USA.³¹ The WFMH report on suicide prevention noted positive effects of a post-discharge psychiatric care intervention to prevent suicide in the military.¹⁵

With respect to other mental health stressors that may have different effects on males and females, one report made mention of gender-differentiated workplace stressors on mental health.³⁶ The APEC report on Asia Pacific mental health in the workplace described how (female) gender inequality, together with other social dynamics, like hierarchy and seniority may be influencing how women and men are treated at work. For example, women reported more emotional abuse and being discredited as professionals compared to men, while men reported experiencing more abusive working conditions compared to women. Reports on bullying incidents also differed by gender. For instance, women in management positions reported more bullying than men, and men in non-managerial positions reported more bullying than women.³⁶ The APEC report provided a relatively balanced account of burden of the mental health stressors for both females and males.

To summarize, while there are some explicit references to the mental health needs of men in these reports, most of these references were limited in quantity, scope, and depth. Men were usually mentioned in comparative sex-disaggregated data alongside mention of women, and when discussing conditions more prevalent among males. Where there was sometimes a description of increased burden of mental health problems among men (especially suicide, substance abuse and conduct disorder), none of these reports made explicit reference to these as sources of gender disparity that warranted particular attention. There were no examples of reports providing a gender analysis that aimed to explain mental health risks and vulnerabilities, and how gender-responsive approaches may benefit mental health promotion and care among men. There was a lack of recommendations for explicit gender-responsive recommendations to address the mental health of men.

Nevertheless, gender-neutral recommendations to address priority mental health conditions, such as suicide, alcohol abuse and behavioural disorders, may benefit males given the higher burden of these conditions among males. Indirect reference to male health needs was also found in references to the mental health needs of sub-groups where males are overrepresented, such in prison populations and in the military.

Closing Reflections on the Consideration of Men in Global Mental Health Policy

Need for high-level policy reports to include consideration of equity, including gender equity

Several reports indicated that they are guided by human rights, gender equality and equity principles and declarations. Although reports made general references to the need to address inequities associated with gender and other social determinants of mental health, none of the reports made this their focus. It could be argued that for high-level global and regional policy reports, there is not the opportunity to address details of gender and other disparities in mental health. This raises the question of what level of commitment to addressing inequity in mental health should be reflected in these high-level policy reports.

A second issue is whether in addition to these policy reports, there should be high-level reports dedicated to examining and addressing inequities more specifically, including on gender inequity and its intersection with other social determinants.

Need for a comprehensive and balanced approach to reporting on gender differences

Although none of the reports made it their focus to address gender (and other) inequities, several reports nevertheless referred to the effects of gender inequality on women's mental health. Reports highlighted the disproportionate burden on women's mental health that was associated

with gender inequality and gender discrimination and stressed the importance of addressing these effects.

Several reports linked the framing of mental health priorities to the priorities in the Sustainable Development Goals (SDGs) and this included addressing gender inequality (SDG 5). In some of these reports, the attention paid to the effects of gender inequality on women's health appears to be linked with their alignment to the SDG goals.

The imperative to address the disproportionate effects of gender inequality on women's mental health is clear. Focussing only on addressing effects of gender inequality of women, however, has consistently ignored other gendered patterns of inequity in mental health, including for men. There is a need to identify and address male health needs, especially where those are clearly disproportionate (such as for suicide, substance abuse and conduct disorder). One way to address the needs of both genders equitably is to identify gender inequities consistently for both genders and to make gender-informed recommendations to address all identified inequities. Two reports, one on suicide prevention¹⁵ and one on mental health in the workplace³⁶ set a good example for how paying equal attention to gendered patterns across both genders can, in effect, provide useful information on men's health patterns and needs, alongside that for women.

Missed opportunities for gender-informed interventions for men and mental health

Several reports provided sex-disaggregated data, and some provided reflection on gendered patterns of mental health needs and service utilization. However, none of the reports used an equity perspective to address mental health inequities for both genders. Addressing inequities in women's mental health that were driven by underlying patterns of gender inequality was the main way that reports engaged with the role of gender differences in these reports. As mentioned above, more comprehensive, and balanced approaches to analysing and addressing gender differences may allow for more opportunities to address men's inequities directly.

Nevertheless, several reports provided information on men's mental health needs by including subgroups that are male dominant, such as people in prison, the military and in the criminal justice system, as well as those with substance abuse and conduct disorder. Discussion of mental health among these male dominant sub-groups provides a good opportunity for engaging with men's mental health needs. It was also an opportunity for addressing inequities in men's mental health through gender-informed, male-specific interventions. Nevertheless, none of the reports in this review engaged directly with the issue of male health inequity and there was little reference to gender-informed interventions that could be recommended for men. These represent lost opportunities to address gender and other mental health inequities. Future updates of these reports may want to consider how to engage with the mental health needs in ways that allow for gender-informed solutions for both genders.



Policy Advocacy for men and mental health

Given the relative lack of substantive attention to questions of men, gender and mental health in these global policy documents, it is critical to think more deeply about where the windows of opportunity might be for increasing the recognition of men's mental health needs in global policy and how best to take advantage of those windows of opportunity.

An earlier report from GAMH on men and global cancer policy used a simple but useful framework with which to think about the challenges and opportunities of policy advocacy—Kingdon's 'three streams' model of policy windows of opportunity and agenda setting.⁴⁶ This model is equally relevant for the question of men and global mental health policy. This approach begins with an analysis of the 'problem stream', the 'policy stream' and the 'politics stream' related to a policy issue. The Problem stream is the current understanding among stakeholders of the nature, scale and impacts of the problem at hand. The Policy stream is comprised of the policy solutions—real or potential—that are on the table for debate and decision-making by those stakeholders. And the Politics stream is the set of external events, institutions and conditions in the political environment that can either close down or open up opportunity for policy change.

Kingdon's model argues that when all three streams intersect at the same time, an alignment that can be carefully facilitated by 'policy entrepreneurs', then policy issues can move 'up the agenda' and policy change is more likely. Below are reflections and recommendations about policy advocacy strategies for moving men and mental health up the global policy agenda, organised by these three streams.

The Problem Stream

Developing the problem stream requires both the production of new knowledge about a problem as well as the translation of new and existing knowledge about the problem in all of the spaces with policy actors might be. For men and mental health, strengthening the problem stream will require policy advocates to:

- **1** Build a robust, nuanced and diverse research evidence base about the problem: Mental health is an extremely broad category, and its determinants and outcomes are equally complex. In a number of mental health domains – such as in suicide mortality, substance abuse, conduct disorder and interpersonal violence – the overall burden of mental health disorders falls disproportionately on men. Across the spectrum of mental health challenges, though, there are critical variations among sub-groups of men, across different settings, and for different disorders. Recognizing men in all their diversity means building an evidence base that speaks to the widely varying

needs and experiences of different men. Researchers should also ensure they are not missing important and transferable lessons from research outside their area of expertise. This applies both within mental health (for example, where researchers on substance abuse and depression, for example, might be working in professional silos) but also beyond mental health. Many of the critical gender-influenced risk factors for mental health, for example, are also risk factors for other communicable and non-communicable diseases.

The significant literature on men, HIV and sexual and reproductive health, and the growing literatures on men and diabetes and men and cancer could offer valuable insights for those building research and policy on men and mental health. More interdisciplinary research is needed in research programmes on culture, men and gender, including on promising intervention strategies that have shown success in specific contexts and communities, including online initiatives¹⁰. Other research gaps are mental health of adolescent boys and young men, including research that is aimed at redefining and reshaping the socialization of boys and young men towards promoting their better mental health and those of others around them⁵, and mental health needs of marginalised and minority men, such as refugee and migrant, indigenous, sexual and ethnic minority men¹⁰.

- **2** Work to make this evidence base accessible: Some of the research on men's health that has had the most policy impact has been research that is both rigorous and respected scientifically and disseminated in ways that reach audiences beyond the typical journal article. Sarah Hawkes' work on men and tobacco and alcohol use is a good example of this, as is Shawn Malone's work with Population Services International (PSI) on the needs and experiences of men living with HIV. This may also involve increased discussion about the subject, through for example on social media to increase awareness of the problem. Evidence only becomes impactful as part of the problem stream if it is packaged and delivered strategically.
- **3** Leverage interest in existing areas of concern: It is often useful to build deeper knowledge around a health problem and/or population by beginning with an aspect of that problem and/or population that is currently on the policy agenda. For example, it may be strategic to leverage the by-now steady and significant presence of NCDs on the global health agenda as well as the rapidly growing recognition at global, regional and national levels of the problem of suicide as a way of building broader interest in and concern around men and mental health more generally. Similarly, the current attention to COVID-19's impact on the mental health of young people is an opportunity for exploring highlighting the distinctive ways in which young men and young women experience these mental health challenges, and the distinctive gender-informed ways in which these problems might be addressed.

The Policy Stream

Developing the policy stream requires, ideally, both the development and evaluation of new strategies for addressing the problem through policy (whether this is high-level guidance and statement of principles, or on-the-ground health interventions). But even hypothetical or untested solutions can be brought to the table if they are intuitive, resonate with indirect parallels in other contexts, do not have obvious harms, and/or have the support of key stakeholders. For men and mental health, strengthening the policy stream will require policy advocates to:

- **4** Build a robust, nuanced and diverse evidence base on promising interventions: As with research about the problem, research on policy solutions to address the problem needs to be rigorous and should take into account the tremendous diversity of men's experiences and the contexts in which they live. At the same time, feasible policy solutions are ones that are transferable to similar settings, and 'scalable' within local and national contexts. Developing an evidence base that prioritizes neither one-size-fits-all approaches nor overly customised and locally specific approaches requires a nuanced and theoretically informed methodology. Research on solutions should also actively learn from the experience in other disease domains (such as the relatively large literature on interventions around men and SRH). Advocates and researchers should also build on intervention research that is nominally gender neutral (such as a lot of work in prisons), to both borrow useful lessons for their own work as well as offer researchers in this area insights on designing and evaluating more gender-informed approaches.
- **5** Consolidate and build from emerging best practices for men and mental health: Despite the relative absence of men in global mental health policy, there are a number of important places in research and policy where these issues have been addressed thoughtfully and in some detail. The WHO's recent guide on improving perinatal mental health services⁴³ is a good example of a step towards more meaningful integration of men in mental health policy—both for the ways men 'as partners' can affect the mental health of women in the perinatal period as well as for the ways men's own mental health needs unfold during this time. The recent Policy Statement from the American Academy of Pediatrics similarly broadens the conversation around perinatal mental health to include substantive recognition of men's mental health needs.⁴⁷ The Australian Charter for Men's Mental Health provides another useful source of best practice for supporting men that are general and generalizable enough to be translated to other policy contexts. None of these policies provide a comprehensive, globally applicable or fully evidence-informed set of strategies, but they are an important place to start. Building on and consolidating early gains in a policy area is a critical way to save time and resources and build cross-project learning.
- **6** Leverage the growing number of national and global men's health policies and advocates to develop integrated and holistic strategies: The growing number of countries developing

national men's health policies represent a critical opportunity to coordinate with men's health advocates in other sectors, not only to share resources, ideas and momentum, but also to work together to develop more complex, more holistic and better integrated interventions for men's health more generally, that will have benefits for men's mental health outcomes in particular. Where there are multiple smaller interest groups each pitching for national men's health policy responses specific to their own population group or disease domain, a great deal of energy and synergy will be drained from the process. As argued above, most of the risk factors for mental health and many of the ways in which policy might intervene to better support men's mental health are not specific to mental health. Developing solutions alongside advocates for other health problems is crucial for a feasible and effective gendered approach.

The Politics Stream

Developing the politics stream is the most difficult since it involves events, institutions and conditions that are outside of the immediate purview of those working in their own specific policy problem area. However, there is still plenty of value in paying attention to the broader political environment and making strategic use of both predicted and unpredicted situations. For men and mental health, strengthening the politics stream will require policy advocates to:

- **7** Leverage parallel policy development for women, or for men and other health issues: The announcement of new policy initiatives and priorities in adjacent domains can be an important opportunity to advocates for men and mental health. The above-mentioned WHO guide on perinatal mental health has, understandably, a strong focus on women, but its inclusion of men's mental health is meaningful as it integrates men both 'as partners' of women and men as persons in their own right, who have independent perinatal mental health needs and challenges. The increasing recognition of domestic and sexual violence could, similarly, prompt further reflection on the ways men's mental health challenges serve as both a driver of much of this violence, as well as a critical point of intervention to address it. In both cases, advocates for women's health and advocates for men's health should be aligning their efforts much more closely.
- **8** Build long-term coalitions and networks with individuals and institutions working on issues indirectly related to men and/or mental health: Making an effective and sufficiently rapid response to changes in the broader political environment requires much more than ad hoc efforts to link across sectors, campaigns and interest groups when an opportunity arises. Policy entrepreneurs who can take advantage of unexpected developments in the broader environment root their success in long-term coalition building that is in turn rooted in a shared understanding of mutual interests and lessons that can be shared across domains.

Finally, a WHO 2020 review reported on how sociocultural constructions of masculinities relate to men's mental health seeking in the WHO European region and made practical policy considerations that support and expand on those suggested in this report.¹⁰

Organizations for advocacy

Based on reports identified and reviewed here, the WHO and its regional offices, together with partner organisations (such as UNICEF), are key organisations to engage with to advocate for increased focus on the gender disparities, and more specifically, to advocate for gendered approaches that address male equity in mental health. Other organizations of interest include the World Federation for Mental Health and the International Association for Suicide Prevention.

Policy recommendations for addressing how sociocultural constructions of masculinities relate to men's mental health seeking¹⁰

The WHO 2020 report suggested the following policy considerations:

- promote collaboration and partnerships between the health sector and community organizations working with diverse groups of men across projects (eg. cultivating responsible and involved fatherhood, violence prevention, addressing substance abuse), including engaging schools, parent and community stakeholders,
- educate health- and social-care professionals about how gender influences how men present with mental health problems (and the need for gender-responsive approaches to treatment).
- develop male-friendly initiatives tailored to the values, customs and priorities of those groups of men most in need,
- promote strengths-based approaches to men's mental health that build on positive aspects of traditional masculinity and normalize mental health issues,
- engage with health-focused multi-media programmes to promote men's awareness and engagement with peer and expert support platforms (including online platforms with relevant information and resources).

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